Case Based Learning Exercise in Psychiatry

Contents

A note for the users

General

The book is intended to help the students and clinicians in psychiatry to deal with the commonly prevalent disorders in their everyday practice.

Wide range case scenarios with diverse problems reflect mostly diagnosis, differential diagnosis, comorbidity and co-occurrence, assessment including risk assessment, psychopathology, investigations, psychometrics, etiological formulation, drug treatment, management of side effect of medications, managing treatment refractory cases, non-drug measures including various from of psychotherapy, counselling and common social therapy and prognosis.

Case wise answers are given with the aim of facilitating learning. Most of the answers are divided into three parts: given information, extracted information and the assigned task. One should not necessarily follow this protocol best understanding of the problems and its solution. However, to reach the assigned task, one should start from the sociodemographic information of the patient in a structured way. The 'given information' section will help the reader to organize the information as per standard history protocol. The extraction of information is vital as it helps to narrow down the possibilities and gives a clearer look into the cases.

Please note that, based on given and extracted information both ICD and DSM diagnosis is possible. For that both ICD and DSM diagnosis are given (ICD first than DSM) when asked for specific diagnosis in the questions (where the name of assigned diagnosis is same in both classifications, the one diagnosis has been given). It is the user's choice to select either one. The diagnosis based on two classifications are conventionally well acceptable. Then they should organize the answer accordingly. Furthermore, neither the diagnosis nor the management provided here are not the end at all. It is the reader's freedom to make the answers based on his/her expertise. Here, that must be evidence based.

Specific

<u>For Students</u>

This book helps in performing good clinical work in outpatients, inpatients, emergency, and follow-up, presenting cases to consultants, grand round, workshops and other forums and facilities acquiring hands on skills. However, constant simulation with the real cases is necessarily strengthened by problem-based learning.

In the assessment of post-graduate psychiatry programs (FCPS Psychiatry, MD psychiatry, and MD Child Psychiatry), CBLE directly covers nearly half of the written examination in the form of scenario-based questions, covers other half (SAQ, IOE and related) and indirectly in all components of clinical examinations. Two sections of the book have been done to make it align with program contents of both General Psychiatry, and Child and Adolescent Psychiatry and to facilitate sequential learning and easy-look reading. Students of General Psychiatry will find the suitable case scenario in the Child and Adolescent Psychiatry section for their child and adolescent part of the program. Similarly, students of Child Adolescent psychiatry will see their required learning contents in the General Psychiatry section.

Reading carefully and imagining the case scenario for a brief time at the starting point to visualize the problem situation is very useful to proceed for this learning exercise. It helps in generating thought and organizing the task. That makes the task easier.

The answer format is possibly best for learning skills of the problem solving both individual reading and discussion in-group for all students of different postgraduate psychiatric courses and for similar courses in other disciplines.

For answering the case-based scenario question in written examination in postgraduate psychiatric courses, the same answer format in this book can be used in traditional long questions.

Students should think about the types and contents of the scenario-based questions and allocated marks. Where the questions are short, specific, objective and structured with two or more stems with low marks (as in the residency programs), the answer format and contents given in this book requires modifications accordingly.

Most vital component is extraction that comes from logical deduction and inference can be drawn from it. Therefore, for need based answering, we strongly advise to shift the extraction under assigned task as appropriate or to provide direct answers by breaking the extractions' part by part as required for the answer. In any way, vague, illogical, and unnecessary (for example, writing the components of a history taking proforma/patient's record sheet) answer is unexpected and will not carry any marks.

In a few case scenarios, the provided answers are long, particularly where clear understanding is required or difficult to find answers in books or journals in a collective form, but the problems bear high value in the cultural context of Bangladesh. In such cases, answers need to be summarized for creating short versions of answers.

The learning from this book can easily be transferred to all forms of clinical examinations (short case and long case, OSPE/SCA, SBA) and in oral examination. Students should develop the tricks of transferring knowledge and needs more and more practice.

Unanswered case scenarios are provided for stimulating self and group learning that certainly help in understanding abilities and test the power of assimilating knowledge and skills and directive of areas of further learning.

There is a strong need of comparing similar or nearly similar cases and managing such cases during day-to-day clinical works with the case scenarios provided in this book that certainly will facilitate learning.

<u>For Clinicians</u>

This book is useful for quick reference during clinical work and facilitates evidence based and value-based practice.

The answers are based on the local contact considering feasibility, practicability and applicability that will be helpful or for selecting the right treatment options. However, considering the individual variation of the cases with the same diagnosis, personalization of treatment plan is the rule rather than exception.

In fact, rare treatment options are required for a small number of cases. Therefore, it is always better to select the tested options prioritized in this book.

Acquiring updated information is the part of continuous learning for better understanding of the cases in clinical practice and for more alternatives of the intervention. This book hopefully will help in this learning and stimulate the particular areas of further search.

For Teachers

The given case scenarios and answer framework will help in conducting case-based learning exercise teaching sessions. It is tested as highly effective and useful for the students and can serve as a model for such teaching. However, it should be clear that designing one's own session is totally under the jurisdiction of a teacher considering the teacher's own style of teaching, and students' needs, experience, and their current learning status.

This book will help in setting questions with all components like case scenarios, question components, weighted mark allocation and answer hints. It would be better to select real cases for such purposes and certainly, this book will help in such selection because such components in this book are prepared from the real cases.

Hopefully, this book will help in examining the written scripts in terms of right judgement by setting quality assessment.

Happy reading.

Abbreviations

ABC	antecedent behavior and consequences
ACEi	angiotensin-converting enzyme inhibitor
ACEs	adverse childhood experiences
ADLP	active daily living program
ADS	Alzheimer's Disease Scale
A/E	adverse effects
AED	antiepileptic drug
APD	antipsychotic drug
ARF	acute renal failure
ARCD	age related cognitive decline
ASD	autism spectrum disorder
BAC	blood alcohol concentration
BDI	Beck Depression Inventory
BDZ	Benzodiazepine
BPRS	Brief Psychiatric Rating Scale
CAD	coronary artery disease
CAMH	child and adolescent mental health
CAMHS	child and adolescent mental health services
CAT	computerized axial tomography
CBC	complete blood count
CBT	cognitive behavior therapy
CBZ	carbamazepine
CD	conduct disorder
CKD	chronic kidney disease
CPK	creatinine phosphokinase
CrCl	creatinine clearance
CRF	chronic renal failure
CRP	C-reactive protein
C/S	caesarean section
CSF	cerebrospinal fluid
CT	computed tomography
CVD	cerebrovascular disease
CXR	chest x-ray
DAWBA	Development And Wellbeing Assessment
DBD	disruptive behaviour disorder
D/D	differential diagnoses
DBD	disruptive behaviour disorder
DBT	dialectic behavior therapy
DLB	dementia with Lewy bodies
DM	diabetes mellitus
DSM	*Diagnostic and Statistical Manual of Mental Disorders*
DSS-A	Dhaka stress scale-adult
DSS-Ad	Dhaka stress scale-adolescent
EBM	evidence based medicine
ECG	electrocardiogram
EE	expressed emotions

EMDR	eye movement desensitization and reprocessing
EPSE	extrapyramidal symptoms
EEG	electroencephalogram
ERP	exposure and response prevention
ESR	erythrocyte sedimentation rate
FAB	functional analysis of behavior
FEP	first episode psychosis
FGA	first-generation antipsychotic
FTD	fronto temporal dementia
GAD	generalized anxiety disorder
GCS	Glasgow comma scale
GDD	global developmental delay
GDS	geriatric depression scale
GMC	general medical condition
GP	general practitioner
GTCS	generalized tonic clonic seizure
HADS	Hospital Anxiety and Depression Scale
0oHAM-A	Hamilton Anxiety Rating Scale
HAM-D	Hamilton Depression Rating Scale
HFA	hysteric conversion reaction
HCR	high functioning autism
HTN	Hypertension
H/O	history of
IAD	illness anxiety disorder
ICSOL	intracranial space occupying lesion
ICU	intensive care unit
ID	intellectual disability
i.e.	that is
IQ	intelligence quotient
LFA	low functioning autism
LFT	liver function test
MADD	mixed anxiety and depressive disorder
MADRS	Montgomery-Asberg Depression Rating Scale
MDD	major depressive disorder
MDT	multidisciplinary team
MI	myocardial infarction
MMPI	Minnesota Multiphasic Personality Inventory
MMSE	Mini Mental State Examination
MoCA	Montreal Cognitive Assessment
MSSI	Modified Scale for Suicidal Intent
MRI	magnetic resonance imaging
M/S/E	mental state examination
NAD	no abnormality detected
NASA	nor adrenergic and specific serotonergic antidepressant
NCD	neurocognitive disorder
NMS	neuroleptic malignant syndrome
NOFTT	non-organic failure to thrive
NREM	nor rapid eye movement
NTK	nice to know
NVD	normal vaginal delivery

OCD	obsessive compulsive disorder
ODD	oppositional defiant disorder
OPD	outpatient department
OSAH	obstructive sleep apnea hypopnea
OTC	over the counter
PET	positron emission tomography
PD	personality disorder
PMR	progressive muscular relaxation
prn	pro re nata (as required)
PSSS	psychological short stature syndrome
PTSD	post-traumatic stress disorder
RBS	random blood sugar
REM	rapid eye movement
RFT	renal function test
RTA	road traffic accident
SDQ	Strengths and Difficulties Questionnaire
SES	socio economic status
SIADH	syndrome of inappropriate antidiuretic hormone secretion
SGA	second generation antipsychotic
SLD	specific learning disorder
SNRI	serotonin and norepinephrine reuptake inhibitors
SOL	space occupying lesion
S/S	sign symptom
SST	social skills training
SSRI	selective serotonin reuptake inhibitor
SUD	substance use disorder
TCA	tricyclic antidepressant
TBI	traumatic brain injury
TFT	thyroid function test
TLC	total leucocyte count
TLE	temporal lobe epilepsy
TPHA	treponema pallidum hemagglutination assay
TSH	thyroid stimulating hormone
USFDA	United States Food and Drug Administration
VDRL	Venereal Disease Research Laboratory
WAIS	Wechsler Adult Intelligence Scale
WISC	Wechsler Intelligence Scale for Children
WHO-DAS	WHO Disability Assessment Schedule
Y-BOCS	Yale-Brown Obsessive-Compulsive Scale

Part 1: General Psychiatry

Chapter 1: General Adult Psychiatry

1. A 22-year-old student was referred to psychiatry OPD by a university medical officer. He appears to be perplexed, frightened, self-talking and expresses persecutory beliefs. He has no previous psychiatric history.
   a) Write down the differential diagnosis providing logical deduction from the given information.
   b) Prepare a list of laboratory investigations that you would consider in the first step.

Given information

Demography and referral
Age- 22 years
Sex- Male
Occupation- Student
Referred from- GP
Referred to- Psychiatry OPD

Chief complaints
Fearfulness, perplexed, suspicious and self-talking

M/S/E findings
Appearance: perplexed
Thought: persecutory belief likely delusion

Extracted information

Persecutions, perplexity, and fearfulness indicate that this young man has both delusion and evidence of hallucination expressed through self-talking that are the hallmark of psychosis. As there is no prior history of psychiatric disorder, it is clearly suggestive of first episode psychosis.

Most common causes of psychosis at this age are psychotic disorder, commonly schizophrenia and spectrum disorders. Here, duration of illness is essential for the diagnosis as for schizophrenia at least 6 months, for schizophreniform at least more than 1 month and for brief psychotic disorder at least 1 day are required.

Substance withdrawal or intoxication is common at this age. Here, history of substance dependence along with either sign symptoms of withdrawal/intoxication, laboratory findings and temporal relationship with psychotic features are necessary. Here, in this case with age and occupation, possible drug of abuse could be alcohol, opioid, cannabis, amphetamine and hallucinogens.

This case may be of delusional disorder. However, indirect evidence of hallucinations and patterned presentations of psychosis and this age is less likely.

This could be the effect of other medications that cause psychosis like steroids or general medical conditions, including TBI or as presentation of confusional state that requires evidence from history, physical examination supported by laboratory investigations. Though there is no such specific information, exclusion of organic cause is essential.

Stressors particularly recent onset, severe, one or multiple can cause psychosis, particularly brief psychotic disorder or hysteria either conversion or dissociation, can present with psychotic symptoms. However, these features are usually transient, inconsistent, sideline features and explainable with other features of hysteria and cultural context. Similarly, transient psychotic-like features may present in acute stress disorder or PTSD in response to extraordinary stressors. Here, there is no evidence of such features in the given information. However, for other psychosis stressors can act as precipitating factors. Thorough exploration of stressor(s) is required.

Assigned task

a) Differential diagnosis

From the above extraction, from the given information most possible differential diagnosis are

1) Schizophrenia or other primary psychotic disorder/Schizophrenia Spectrum Disorder
2) Substance withdrawal or intoxication
3) Psychotic disorder due to TBI or other General Medical Condition

b) First line Investigations

The aim of first line investigation to confirm the diagnosis and immediate management. With this view, the first line investigations are:

- Routine: CBC with ESR, CXR, Urine R/E for baseline information
- Dope test: Urine for cannabinoids, opioids, amphetamines-for exclusion of substance misuse
- Imaging of brain- CT/MRI to exclude possible organic cause and any correlates of schizophrenia

[NTK: Common causes of perplexity- extreme anxiety, PTSD, acute onset psychosis]

2. A 25-year-old male patient with refractory schizophrenia is under clozapine 400 mg/day in bid dose for 4 weeks with good response though the derogatory and distressful voices still present. Due to his associated obsessional doubt, fluoxetine 40mg/day is given. After developing a sudden seizure attack, he has been prescribed sodium valproate 600 mg /day. Now the patient comes with a further seizure attack.
   a) Prepare a checklist for the assessment of this case.
   b) Outline treatment plan.

Given information

Demography and referral
Age-25 years
Sex- Male
Referred to-Psychiatric facilities
Reason for attendance- Seizure episode

Chief complaints

- Seizure attack 2 times following multiple psychotropic medication
- Hearing voices as part of the symptoms of schizophrenia

- Obsessional doubt

History of present illness
Schizophrenia, refractory under clozapine therapy (400 mg/day)
Good treatment response but derogatory auditory hallucination present
Comorbid OCD present for which getting fluoxetine (40 mg/day)

Medical history
Seizure most likely due to the effect of current medication. Valproate (600 mg/day) is prescribed for seizure but further attack occurred.

Extracted information

The man is a case of treatment refractory schizophrenia. Active derogatory hallucinatory voice is present that makes the patient distressful though other symptoms are remitted as evident by the word 'response.' This condition is not sufficient to say the condition as partial remission or clozapine resistant schizophrenia as the clozapine therapy goes 4 weeks.

Further increment of clozapine at the highest therapeutic dose is difficult because of seizure attack that is likely a side effect of clozapine. At the same time there could be a possibility of rapid increment that may cause seizure.

Situation is clumsier due to comorbid OCD and its treatment with fluoxetine. The fluoxetine also decreases seizure threshold and seizure attack possibly due side effects of both the drugs.

Despite giving valproate 600 mg/day the seizure is uncontrolled that is further indicative lowering of seizure threshold.

Assigned task

a) Checklist for the assessment
   - Details of two seizure episodes- Onset, types, duration, fall, injury from the reliable informant, and video telemetry (if any) checking, EEG report with special emphasis on time relation with medication.
   - Evaluating the present status of types, severity, extent and patients' reaction to symptoms of schizophrenia.
   - Evaluating dose increment schedule- Rapid increment can cause the precipitation of seizure.
   - Comparing the present status of symptoms with the symptom status prior to clozapine therapy.
   - Evaluating the overall OCD condition and its details of drug treatment with fluoxetine particularly, duration of treatment and response.
   - History of OCD or any other psychiatric disorder including treatment and outcome.
   - History of epilepsy (if any) either primary or due to side effects of psychotropic medication.
   - Patient's and caregiver's perception and expectation about the disorder, management and treatment outcome.
   - Risk assessment as there are still derogatory voices which increases risk of harm to self and others.
   - Psychometric tool: BPRS (Validated in Bangla).
   - Investigation:
     1st line- Routine investigation: CBC, LFT, S. Creatinine, EEG
     2nd line- CT scan or MRI for any secondary cause of seizure.

b) Outline treatment plan

- Explanation and advice and support to the patients and caregivers about the overall situation and further intervention.
- Increasing the dose of valproate at optimum level.
- If uncontrolled, omission of fluoxetine and applying non drug measures like ERP/CBT for OCD.
- If uncontrolled, reduction of clozapine and then increasing more slower than before with careful observation and video monitoring.
- Cognitive remediation therapy for residual schizophrenia symptoms.
- If the condition is clozapine refractory schizophrenia- applying a feasible protocol.

[NTK
A diagnosis (or diagnoses) is necessary but not enough for making a treatment plan. Inclusion of axial and circumstantial issues along with the diagnosis only can make an effective treatment plan. One or more comorbidity is also common in clinical practice, particularly personality disorder. Careful clinical assessment is necessary to avoid under or overinclusion. Furthermore, general guidelines or protocol for treatment is necessarily important but not applicable to all patients with the same disorder(s). It is the question of treatment of the particular case and treatment plan must be adopted for him/her for effective outcome that is well acquainted as personalization of the treatment. All these are integral parts of evidence based and value based practice.]

3. A 35-year-old male comes with marked distress. He is upset, as he believes that his wife is not sexually faithful for 2 years of his married life.
   a) How will you assess the case to reach a diagnosis?
   b) What treatment will you adopt for this patient at this point?

Given information

Demography and referral
Age- 35 years
Sex- Male
Marital status- Married
Duration of marriage- 2 years

Chief complaints
- Conviction that his wife is sexually unfaithful
- Upsets related to the conviction

M/S/E findings
Appearance- marked distressful

Extracted information

Belief of the wife's sexual unfaithfulness is either delusional or factual. Here the term "belief" goes more in favor of delusion, more specifically delusion of jealousy. As the patient is brought to the doctor, it can be said that the "belief" is not factual and not shared by his family members.

The content of the delusional (or factual) belief is stressful and the patient exhibits the appropriate emotional response to the belief. There is a possibility of having depressive features as the consequence of his belief.

This type of belief may be found as symptoms of schizophrenia and other related disorders, the effect of drug misuse (mostly with alcohol, cocaine, cannabis), personality disorder-paranoid or schizoid.

Assigned task

a) Assessment to reach the diagnosis

History
Family H/O psychiatric illness (schizophrenia, delusional disorder)
Premorbid personality (schizotypal, paranoid)
Personal history as substance abuse
H/O past psychiatric illness

M/S/E findings
Appearance & behavior
Thought: Whether it is in idea or delusion
Perception: associated hallucination
Mood: depressed/euthymic

Physical exam:
If H/O substance abuse: related change may occur
Tachycardia/bradycardia
Mydriasis/eye change
Conjunctival congestion in cannabis

Investigations
Specific investigation:
Urinalysis for dope test
Blood alcohol concentration

b) Treatment plan

- Treatment should be based on diagnosis.
- Schizophrenia spectrum disorder, atypical antipsychotic (e.g. risperidone or olanzapine) starting at minimum effective dose and increasing the dose according to response followed by psychosocial management.
- If substance related disorder, the target of intervention is achieving sobriety.
- If personality disorder, crisis intervention followed by psychotherapy.

[**NTK: General assessment format of a case with psychiatric disorder**
Onset-acute, gradual
Features: Pattern, frequency, persistency, dominancy, extend, and severity of symptoms
Course: Persistent, episodic, waxing and waning
Efforts taken: by self, family, physicians including treatment and outcome
Impact: Distress, level of functioning in main domains of daily life- personal, familial, occupational, recreational and burden to family/caregivers
Cause: Predisposing, precipitating, precipitating
Risk and resilience factors

Premorbid personality
Risk: predictable risk of self and others
Strengths: abilities and skills useable in treatment
General examination for general health status
Systemic examination: for co-occurring illness and secondary cause
Mental state examination: for the findings related to features and possible comorbidity
Perception of patient and caregivers about the problem and expectation form the physician
Relevant laboratory investigations- immediate and later-to confirm the diagnosis and to make treatment plan
Relevant psychological testing-to assess, severity, problem area and treatment outcome.]

4. A 40-year-old man is getting clozapine for his psychosis. He is smoker, obese and has significant amotivation. Suddenly he developed chest pain, respiratory distress, fever, and hypotension.
   a) Mention the areas of assessment keeping in mind the differential diagnosis for these newly developed problems.
   b) List the laboratory investigations you need to do for confirming your diagnosis.

Given information

Demography and referral
Age-40 years
Sex- Male

Chief complaints
- Chest pain
- Respiratory distress
- Fever
- Hypotension
- Amotivation and negative symptoms

Present psychiatric diagnosis
Psychosis

Treatment history
Under clozapine therapy

Extracted information

From the given information, it is apparent that the patient is a case of schizophrenia and most likely refractory schizophrenia as he is getting clozapine. Clozapine has rare but life threatening cardiovascular adverse effects. The chief complaints of the patient are highly suggestive of clozapine induced cardiovascular side effects. The differentials are-
- Clozapine induced myocarditis
- Clozapine induced cardiomyopathy
- Clozapine induced pulmonary embolism
- Comorbid cardiovascular disorder (e.g. acute MI)

Assigned task

a) Areas of assessment

Risk factors
- Age, obesity, smoking
- Family and personal H/O CVD, HTN, dyslipidemia, DM
- Life style: sedentary or not
- Dose, duration, abrupt increase of clozapine

Physical exam
- General exam- pulse, BP, temperature, respiratory rate
- Features of heart failure- Edema, cough, shortness of breath

b) Lab investigations

- CBC with ESR- Neutrophilic leukocytosis on myocarditis
- ECG- related ischemic changes may be found
- CXR- enlarged heart shadow in cardiomyopathy
- Echocardiography- to see the functional status of the heart
- Troponin-I- inflammatory marker for acute cardiac events
- CRP- general marker of inflammation
- Lipid profile- to see comorbid dyslipidemia

5. A 30-year-old depressed patient has failed to respond to therapeutic doses of sertraline, mirtazapine and venlafaxine. For his worsening of mood, low food intake and the emergence of psychotic features, he has been admitted in the inpatient psychiatry unit.
Answer the following with evidence-based deduction of the given information.
a) List the information you need to gather at this point.
b) Make a list of first line investigations as part of your management plan.
c) What management plan do you need to adopt for this patient?

Given information

Demography and referral
Age-30 years
Sex- Male
Admitted to inpatient psychiatry unit

Chief complaints
- Depressed mood worsening gradually
- Low food intake
- Emergence of psychotic features

Psychiatric Diagnosis
Depressive Disorder

Treatment received
Full therapeutic dose of sertraline, venlafaxine, mirtazapine

Treatment outcome

Poor response, core features of depression present with increased worsening features for which he is hospitalized.

Extracted information

The middle-aged man in this scenario is a diagnosed case of major depressive disorder. The disorder is severe and persistent because he did not respond to therapeutic dosage of three different groups of antipsychotic drugs.

Treatment with SSRI (sertraline), NASA (mirtazapine) & SNRI (venlafaxine) is very much indicative that this case is treatment refractory.

At this state with presence of psychotic features are usually mood congruent delusions (guilt, persecutory, loss, nihilistic) and hallucinations (auditory second person, derogatory content, and command).

Presence of mood incongruent psychotic features are not unlikely though less frequent in depression. Furthermore, at this age, primary psychotic disorder may develop that needs exclusion.

Depressive stupor may present which is evident from food refusal and hospitalization. Stupor is a cardinal feature of catatonia. Therefore, causes of stupor and catatonia-both organic and nonorganic need exploration.

In this state of food refusal and persistent severe depression, detrimental effects over general health is likely. Further, depression due to any general medical condition may present. For that, detailed medical assessment is necessary.

Assigned task

a)Information need to be gathered/List of information

- Reviewing the diagnosis of depression (core features, biological features & peripheral features); any manic episode.
- Evaluation of psychotic features (delusions, 2nd/3rd person auditory hallucinations), specification of diagnosis (severe with mood congruent/incongruent psychotic feature).
- Full treatment history and outcome.
- Any enduring stressor/new stressor.
- Co morbid substance misuse (cannabis, hallucinogen).
- Co morbid medical conditions (DM, hypothyroidism).
- Compliance to the drugs (full/partial).
- Family H/O psychiatric disorder-particularly depression, suicide and self-harm.
- Risk assessment- suicidal thought and behavior, past self-harm and other predictors of suicide.
- Strengths of the patient & family support which can be used in treatment.
- Thorough general and systemic examination for general health status and signs of any physical disorder, particularly related to the organic causes of stupor.
- Mental state examination in detail- particularly in the areas of catatonic features, mood and affect, pessimistic thoughts and suicidality, delusions, hallucinations and cognitive status.

b)First line investigation

Purpose of the first line investigation is to confirm the diagnosis, patient general status for making an immediate treatment plan. These are:

For general health status
Routine: CBC, Urine R/E, and CXR

For checking the effect of low food intake
- RBS
- ECG
- Serum electrolyte
- Liver function test

For exclusion of common organic causes
- Toxicology screening
- Thyroid function test

c)Management plan:

General management
Ensuring nutrition, hydration & hygiene.

Specific management
Here, protocol of treatment refractory depression will be applied as feasible and practicable. The options are as follows:

i. Increasing the dose of antidepressant if tolerance permits according to standard treatment protocol
ii. Combining antidepressants
iii. Tricyclic antidepressant
iv. Addition of atypical antipsychotic
v. Electroconvulsive therapy
vi. Addition of Lithium
vii. Addition of Thyroxine

6. A 25-year-old male developed an acute episode of schizophrenia 5 years back. His symptoms were remitted significantly after one year of treatment with olanzapine. Subsequently he becomes aloof, lack of drive, odd and inappropriate social behavior and affective bluntness. He spends most of the time at home and does almost nothing.
a) What treatment options will you consider for this case?
b) What information will you provide to the caregivers?

Given information

Demography and referral
Age- 25 years
Sex- Male

Chief complaints:
- Aloof
- Lack of drive
- Odd and inappropriate social behavior }developed after one year of treatment with olanzapine

- Affective bluntness
- Severe functional impairment

Diagnosis
Schizophrenia

Duration
5 years

Drug treatment
Olanzapine, symptoms responded after one year of treatment

Extracted information

Presenting features of this man with early adulthood is clearly indicative of negative symptoms.

Careful evaluation is necessary to confirm whether these are primary or secondary negative symptoms as both could be possible in schizophrenia.

Particularly the presence of affective flattening, alogia (lack of speech, lack of content of speech), anhedonia, and avolition are indicative of having primary negative symptoms with this case.

Despite having olanzapine, the patient has entered into residual phase of schizophrenia because of odd and inappropriate social behavior which indicates attenuated positive symptom along with negative symptoms i.e. residual schizophrenia with predominant negative symptom.

This residual state with mixed symptoms at this age certainly indicates a worse outcome.

Assigned task

a) Treatment options will be considered for this case
- If possible, switching to drug with less chance of metabolic syndrome and at the same time preventing recurrence. Amisulpiride has some proven efficacy over negative symptoms.
- Active daily life programming.
- Psychosocial therapy- rehabilitation of schizophrenia; Behavior therapy; token economy.
- Home based rehabilitation- as we have no formal rehabilitation center, family will help as a unit to psychosocial treatment.
- Precaution against high expressed emotion.
- Graded activity with increased responsibilities and diversity.
- Priority based service.

b)Information need to provide to the caregivers
- Explaining the usual phases of schizophrenia in contrast with the patient's exhibited phase-active and residual phase which is commonly expected.
- Informing the different courses of schizophrenia and the course that he has—acute episode with partial remission. Mentioning the common course is episodic with interepisodic residual features and this patient has such predictable course
- Informing the gross outcome of this disorder that only 20% appears to be a favorable outcome. At the same time, informing that outcome may not be adequately predictable and there is huge individual variation.
- Explaining the role of medication overactive phase and residual phase symptoms with special emphasis on the nonpharmacologic measures for negative symptoms. Informing the noncompliance and its possible worsening situation, particularly relapsing to the active phase.

- Informing the good and bad prognostic factors of this disorder, particularly early onset and presence of negative symptoms.
- Mentioning the recognized psychosocial measures to minimize the negative symptoms
- Mentioning the role of family, particularly giving daily living support in such condition of the patients along with informing adverse effect of understimulating or overstimulating initiatives
- Informing them of further treatment measures for their patient.

[NTK:
Phases of Schizophrenia:

1) Prodromal phase- 10% (OCD, anxiety, minor psychiatric symptom);
2) Acute phase- 90%
3) Residual phase- attenuated positive symptoms/ negative symptoms; Krapelin's simple Schizophrenia; very small minority starts with residual phase

Types of negative symptoms:

1) Primary negative symptom, which is an enduring part of Schizophrenia.
2) Pseudo negative symptom/secondary negative symptom due to depression, effect of medication, institutionalization or may be a response to positive symptoms.]

7. A 52-year-old woman lost her husband, who died suddenly of a stroke 3 years ago. They had been staying alone for almost a decade with infrequent visits from her son & daughter who live abroad. About a week after death, she heard his voice clearly talking to her as he would in a routine manner in the next room. She went back & checked but saw nothing. Subsequently, she often heard his voice conversing with her & she would discuss her daily matters with him. This however provokes anxiety, sadness and gradually she was preoccupied with his thoughts.
a) Mention your possible diagnoses through logical deduction of given information.
b) What are the areas needed to explore to reach a diagnosis?
c) How will you manage the case at this stage?

Given information

Demography and referral
Age- 52 years
Sex- Female
Marital status- Widow

Chief complaints:

- Hearing deceased husband's voice
- Anxious, depressed
- Preoccupied with the thoughts of the husband

Life events
Death of husband 3 years back, living alone, children apart

Extracted information

Features suggestive of abnormal grief reactions that become more complex and blended with anxiety, depression and hearing voices in the form of conversation with her deceased husband.

This voice could be a part of grief reaction (hallucination/pseudohallucination) predisposed with significantly long isolated living of the couples. However, the pattern of onset (after a week) and her initial reaction of following instruction, surprise, indicates acute onset of psychosis.

Anxiety and depression mainly come from the reaction of voice and isolated single life with an under level of family support.

Full-fledged syndromal depression with severe nature is the strong possibility of converting progression of psychopathology from grief to psychotic depression.

Suicidal risk is severe enough in this old age with isolated living, lack of family and possibly social support, husband's death, grief reaction, psychotic features. anxiety and depression.

Thorough medical assessment is necessary for possible general medical conditions at this age and reviewing of existing physical disorders (if any).

Assigned task

a) Differential diagnosis

From the logical deduction of given and extracted information, the differential diagnosis are,

i. Psychosis: Schizophrenia-Late onset /Delusional disorder/Unspecified psychosis
ii. MDD with psychotic feature
iii. Abnormal bereavement (persistent complex bereavement disorder; not adjustment disorder because duration is long)

b) Areas need to be explored

- Assessment of features of abnormal/complex bereavement with evaluating initial progression of stages of bereavement and any fixation with particular stages.
- Thorough evaluation of voice whether it is part of abnormal grief or hallucination.
- Other psychotic features- Delusion, disorganized speech and behavior.
- Features of depression- low mood, lack of interest, lack of energy, reduced sleep and appetite, psychomotor retardation, feeling of inappropriate guilt, poor concentration and death wishes.
- Risk assessment- suicidality, including assessing all suicidal risk factors. assessment of physical risk likely at this age with lonely living
- Any previous episode or history of past psychiatric illness.
- Family history of mental illness.
- Drug or substance abuse history.
- Medical history-existing medical condition and treatment.
- Premorbid personality.
- Present living condition- level of family and social support.
- Strength of the patient (e.g. good physical health).

c) Management

i. General management
   - Explanation, advice and support.
   - Hospitalization- as chance of having suicidal risk as well as lack of feasibility in home treatment.
   - Measures to prevent possible suicidal risk.

- Maintenance of nutrition.
- Treatment for any physical illness.

ii. Specific management: According to diagnosis.

MDD with psychotic features:
Applying management protocol of major depression. SSRI (sertraline or fluoxetine) with atypical antipsychotic (olanzapine) is preferable in the first step (TCA not preferred, as age is 52).

Psychotic disorder:
More specifically protocol for particular disorders.
Atypical antipsychotic (Olanzapine or Aripiprazole).

Complex bereavement
Counselling-for acceptance, working through the stages of grief, adjustment to life without the deceased.
Medication-SSRI, sedative-hypnotics-usually short acting BDZ (lorazepam, alprazolam), low dose antipsychotics (SGA) as per requirement.
Support groups- for old bereaved people.

8. A 28-year-old housewife presents with an attempt of self-injurious behavior to her right lower limb for one month. She repeatedly says to arrange to cut her leg and that will be good for her. On asking why she wants to do that, she says that this question is unnecessary and she cannot tell it. She is distressful, restless, and disheveled. Answer the following with evidence-based deduction from the scenario.
a) What is the differential diagnosis?
b) How will you proceed to reach the diagnosis?

Given information

Demography and referral
Age- 28 years
Sex- Female
Occupation- Housewife

Chief complaints
- Repeated attempt to self-injurious behavior- 1 month
- Repeated request to arrange limb cutting- same duration

M/S/E findings
Appearance and behavior- Distressful, restless and disheveled

Extracted information

The housewife attempts self-injurious behavior which is recent. Self-injurious behavior commonly found in personality disorder (PD) especially borderline personality disorder, depressive disorder, psychotic disorder and substance related disorders. PD can be excluded given the recent onset of the behavior.

Action could be a part of depressive disorder as the housewife appears distressful. As she refuses to disclose the reason of her request, there might be some severely stressful event behind this. Whatever the reason, the intensity can be said to be severe.

The housewife might be deluded or hallucinated and requesting limb cutting as per delusional belief or hallucinatory voice. To establish psychotic disorder delusion and/or hallucination along with other psychotic features must be present.

Thus, the request for limb cutting may be a part of delusion or hallucination or merely an expression of severe depression associated with inappropriate guilt.

Assigned task

a) Differential diagnosis

From the given information and its extraction, the possible differentials are,

- Single episode/ recurrent depressive disorder, severe
- Single episode/recurrent depressive disorder, current episode severe, with psychotic features/ Major depressive disorder with mood congruent psychotic feature
- Schizophrenia and other primary psychotic disorders/ Schizophrenia spectrum and other psychotic disorders

b) How to proceed

- Eliciting the reason behind the act (guilt feeling/why right leg).
- Explanation of cutting (guilt/derogatory voice).
- Predominant mood (depressed/ apathetic).
- Exploring psychotic features (delusion, hallucination, disorganized speech, disorganized behavior and negative symptoms).
- Personal or family history of psychiatric illness.
- Premorbid personality.
- Predisposing, precipitating or perpetuating factors.
- Psychometric tools
  BDI if features suggest depressive disorder (validated in Bangla BDI is available)
  Validated BPRS- if features suggest psychotic disorder

[NTK
In clinical psychiatric practice, psychometric tools or rating scales are mainly used for strengthening clinical judgement. It helps in qualifying and quantifying the problems, specifying problem areas, selecting treatment options and assessing the effectiveness of intervention. Therefore, such a tool needs to be used for what it is made and certainly be used by the person for whom it is made. Only culturally adopted or validated tool should be used]

9. A 40-year-old female has been suffering from schizophrenia for the last 12 years. She has been treated with a series of antipsychotics and finally responded with clozapine, 550 mg in a divided dose. Her only persisting symptom is infrequent hearing of a mostly unclear voice though she is not reacting as before.

a) What could be a further treatment plan?
b) How will you counsel the patient and her caregivers?

Given information

Demography and referral
Age- 40 years
Sex- Female

Chief complaints
Hearing voices which is unclear, infrequent and patient does not reacting to it- duration not mentioned, seems a long

Present psychiatric disorder
Known case of Schizophrenia

Duration
12 years

Treatment history
- Treated with series of antipsychotic drug
- Responded with clozapine 550 mg

Extracted information

The middle-aged female is diagnosed with schizophrenia for 12 years and has been treated with several APD. It can be assumed that the dose and duration are adequate but as no response are observed, she has been switched to clozapine. So, she is a case of treatment for refractory schizophrenia.

Course of her illness is continuous for a long duration.

She has been responded with 550 mg of clozapine. However, her response is partial as she still hears unclear voices but this time she is not reacting as before.

The symptoms that cause functional impairment are the target of treatment. In this case, the active phase symptoms are present but in less severe form. The dose of clozapine to achieve this response is high considering the gender of the case. Dosage over 550 mg is usually associated with seizure. So, the dose of the drug should not be increased for the symptoms which is not distressing and most likely not amenable to treatment.

Assigned task

a) Further treatment plan

Biological therapy
Clozapine monitoring and maintenance of similar dose because the patient is responding to the dose and further dose increase will lead to increased adverse effect burden.

Psychosocial therapy

Feasible treatment options are
- CBT
- Cognitive remediation
- Social skills training
- Family education
- Illness management skills

b) Counselling of patient and caregiver

- Meet up the caregiver's expectation
- Reducing expressed emotions
- Benefits of psychotherapy
- Explaining further treatment plan
- Emphasis on adherence
- Natural course of illness
- Prognosis and prediction
- Follow up schedule
- Maintaining daily routine

10. A 30-year-old man survived after jumping from the rooftop. He got admitted in the Orthopedic department of your hospital due to multiple fractures and other complaints. After his stability, he has been asked why he did such an act. He replied that he had no way other than such an act as he was commanded to do so. The symptom has been present for over 6 months. He is anxious, sad and occasionally perplexed. You are requested to see this patient.
a) Write your first diagnostic impression with reasons.
b) What will be your treatment plan?

Given information

Demography and referral
Age- 30 years
Sex- Male
Source of referral- Orthopedics department
Reason for referral- Psychiatric assessment

Chief complaints
- Suicidal attempt- recent
- Hearing commanding voice- more than 6 months

M/S/E findings-
Appearance: Sad, perplexed
Mood: Anxious

Present physical illness
Multiple fracture; treatment received

Extracted information

The young adult male has jumped from the rooftop following a hallucinatory command. The command may be imperative as he says he has no other way than doing it. Severe imperative hallucination found in Schizophrenia, MDD with psychotic features and alcoholic hallucinosis.

Here the auditory hallucination has been present for a significant period which rules out alcoholic hallucinosis.

Sadness is a core feature of depression. However, psychotic features in depression are usually mood congruent and not associated with anxiety or perplexity. Rather, anxiety and perplexity are the prominent features of the acute phase of psychosis (perplexity present in delusion of persecution, other hallucination, delusion of control etc.). So, diagnosis of MDD with psychotic features can also be ruled out giving the most weight to the diagnosis of schizophrenia.

Assigned task

a) First diagnostic impression with reasons

Based on the given information and its extraction, the first diagnostic impression is Schizophrenia because of

- Command hallucination
- Anxiety and perplexity are active phase symptoms

b) Treatment plan

General management

- Maintenance of hydration, nutrition and personal hygiene.
- Assessing the further suicide risk and taking precaution for prevention.
- Orthopedic rehabilitation.
- Periodical monitoring for symptomatology assessment.
- Discussion and communication with the referring doctor that the patient should not be discharged rather referred to psychiatry before discharge planning.
- Assessment of co-occurring medical illness.

Specific management

Atypical antipsychotic drug preferably olanzapine/risperidone along with ongoing orthopedic treatment.

11. A 26-years-old male has been suffering from schizophrenia for the last 6 years. He has been treated with a series of antipsychotics with poor outcome and finally significantly responded with clozapine. Though most of the symptoms disappeared and decreased in intensity and frequency, still he has hearing of voices with derogatory comments that makes him resentful, fearful and occasionally excited. The drug has been increased up to 600 mg/day with divided dose but no further improvement is observed.
    a) What could be a further treatment plan for this patient?
    b) What are the points you have to communicate to the patient and his caregivers about further treatment and its outcome.

Given information

Demography and referral

Age- 26 years
Sex- Male

Chief complaints
- Hearing voices with derogatory content
- Reaction to the voices is resentful and fearful

Present psychiatric diagnosis
Schizophrenia for 6 years

Treatment received
Clozapine 600 mg

Treatment outcome
Most sign symptoms either disappeared or reduced in intensity or frequency.

Extracted information

The scenario in the given information suggests that this is a case of treatment-refractory schizophrenia (did not respond to a series of antipsychotic drugs).

Significant response to clozapine has been observed. But not all symptoms are responded fully to the usual dosage of clozapine. The persisting symptoms of hearing derogatory voices makes the person resentful and fearful.

Persisting symptoms and the contents are very much indicative of a classical pattern of hallucination of schizophrenia which needs further intervention.

Assigned task

a) Further treatment plan

First option
Increase dose of clozapine up to maximum dose if tolerance permits with clozapine monitoring.

Second option
If the patient does not respond to the maximum dose of clozapine or adverse effect develops, augmentation with haloperidol/aripiprazole/amisulpride or lamotrigine/valproate or ECT.

Third option
i. Psychosocial intervention
ii. Further psychoeducation about further treatment and outcome
    - CBT
    - Cognitive remediation
    - Insight oriented therapy
    - Revision of active daily life programming (ADLP)

b) Points to communicate to the patient and his caregivers about further treatment and its outcome

- The most common course of schizophrenia is multiple episodes with inter episodic residual features.

- After adequate treatment one third of patients may not respond to interventions and another one third respond partially.
- Emphasis on psychological and social management should be given.
- Lowering expressed emotions.
- Reducing hours of daily contact with relatives with high expressed emotions.
- Adjusting expectations of the caregivers.
- Improving communication.
- Emphasis on active daily life programming.
- Ensuring adequate sleep and nutrition.
- Abstinence from illicit drugs and alcohol.

12. A 20-year-old female referred by a neurologist to you appears with sudden loss of memory, frequent fall, excited with irrelevant talks. On asking about her problems, the symptoms immediately exaggerate. The girl looks cheerful, talks lulling and one time she falls on the ground and shows peculiar gait during efforts for standing.

a) Mention the underlying psychopathology in explaining these symptoms

b) List the cardinal information for the assessment of this case.

Given information

Demography and referral

Age- 20 years

Sex- Female

Referred to- Psychiatric facility

Referred by- A neurologist

Reason for referral- Assessment and management

Chief complaints

- Sudden loss of memory- recent duration
- Frequent fall, excitement- subsequent duration
- Irrelevant talks- subsequent duration

M/S/E findings

Appearance and behavior- Cheerful, lulling speech, suggestible, odd gait

Extracted information

Such clusters of sensory and motor symptoms are inconsistent with any neurological or general medical condition and further strengthened by psychiatry referral by a neurologist.

There is clear existence of attention seeking behavior evident with the exaggeration of symptoms when she asked, la belle indifference (cheerful appearance ignoring the impairment) and the peculiar gait (indicative of astasia abasia).

Onset of symptoms is sudden and is very much indicative of presence of stressor (s) or conflict that she fails to cope with.

Referral from a neurologist also indicates that the features are not caused by any neurological disease and likely there were no abnormal findings in investigations. The demographic profile also reinforces the non-organic nature of the symptoms.

All the features clearly indicate that this young woman is a case of Dissociative neurological symptom disorder/ Conversion Disorder.

Assigned Task

a) Psychopathology to explain the symptoms

Considering the diagnosis from the extraction of the given information, the explainable psychopathology could be as follows:

Core psychopathology

- Primary gain - resolution of her stressor or conflict that she failed to cope with happened through abnormal ways that expressed through her presenting symptoms without awareness. Initially it always happens in unawareness.

- Secondary gain- The patient is likely receiving additional reinforcement in the form of extra care, receiving unnecessary interventions and investigation, nurturance, demand or need fulfilment mostly present in awareness.

Other psychopathology

- Conversion- The patient's psychological distress converted to presenting somatic symptoms through an intrapsychic process.

- Dissociation- Her amnesia develops by splitting the memory of distressful events and related memory from the res part of the memory with the aim of resolving psychological distress.

- Repression-*La belle indifference* of the patient has developed through a process of displacing distressful experience, or events from conscious to unconscious areas of mind that gives relief to the distress that she is unable to cope. This happens primarily in unawareness and not intentional.

- Regression or infantilization- Her lulling speech at this age is a childish behavior which is clearly age inappropriate due to regression of individual mental age to lower level of his chronological age.

- Attention seeking- exaggeration of her problems during interview indicates her abnormal illness behavior as well as help seeking behavior may be blended with her personality traits like dependent nature, needing help for problem resolution.

b) List of cardinal information for the assessment of this case

- Details of the symptoms including types, frequency, persistency, onset and duration.
- Treatment received up to this point including any maltreatment.
- Identifying cardinal stress and conflict as triggering symptoms.
- Presence of other stressors and its relation with illness.
- Any vulnerability in the patients' personality traits.
- Parental attitude and behavior.
- Impact of the disorder on the patients and family including fate of the proposed marriage.

- Strengths of the patient and level of family support.
- Patient and her parents' understanding about illness and their expectations.

13. A 25-year-old male student was referred to psychiatry OPD by a GP who suddenly started shaking of the whole body followed by fits for a variable period, mute, and sleep disturbances. Anxious parents informed that he has relational turmoil for this he was worried. The man looks normal, tries to respond verbally with lip movement but the voice is not audible. He agreed to give answers by writing and when he started writing, he became fit and tended to fall.

a) What is the single most likely diagnosis based on logical interpretation of the provided information?
b) What treatment will you offer for this case?

Given information

Demography and referral

Age- 25 years
Sex- Male
Occupation- Student
Referred by- GP
Referred to- Psychiatry OPD

Chief complaints

- Sudden onset of fit and fall in several times for variable period- recent event
- Mute- subsequent event
- Sleep disturbances- subsequent event

M/S/E findings

Appearance – Normal, rapport built, attention seeking
Speech- Tries to respond verbally with lip movement, voice not audible

Extracted information

Frequent fit and fall with variable period of time, pattern of mutism, tendency to communicate clearly inconsistent with any general medical condition and cannot be explained and seems to be psychogenic.

There is a clear existence of suggestibility, and sudden fit can be explained as attention seeking behavior.

Onset of symptoms is sudden and related with relational turmoil. This is very much indicative of the presence of stressor or conflict, which could be distressful at this age.

Though age and gender are not a common combination for conversion disorder, the symptom profile is clearly indicative of conversion disorder.

Assigned Task

a) Diagnosis

From extraction of information, the best possible diagnosis is Dissociative neurological symptom disorder/ Conversion disorder-mixed type.

b) Treatment will be offered for this case

General

- Explanation, support and advice to the patient and caregivers
- Hospitalization- if the patient warrants crisis intervention, and needs further assessment.
- Reducing reinforcement
- Managing over concerns and worries of the parents
- Maintenance of adequate food, nutrition and vitals.
- ADLP initially minimum with gradual increment towards normal level.
- Symptomatic

Suggestion- starting initially with simple suggestions for minimizing symptoms. Encouraging the patient if she does the task. Suitable relaxation technique can be added for better results

If insomnia – adopting sleep hygiene and sedative-hypnotics if required
If anxiety and distress - relaxation and anxiolytics

Specific

- Resolution of stress or conflict by adopting a suitable option either removal, or modification, or acceptance.

Preventive

- Individual psychotherapy- with the combination of supportive psychotherapy, stress coping, assertion training, social skill training, CBT can be used. The focus will be minimizing vulnerable components of a patient's personality like anxiety prone mood, poor stress coping ability, dependent, avoidant, uncontrolled emotion, and misperception of social cues, tendency to see and deal with the environment only through their own perspectives.

- Remedial learning and other measures of rehabilitation with the aim of regaining premorbid functional status.

- Establishing or rebuilding if necessary, a patient's social network.

- Family counselling- to support family, practicing desired parental behavior, practicing sharing and communication.

- Family therapy- if dysfunctional family, family conflicts including marital discords by positive parenting, family therapy and couple therapy where appropriate.

[NTK
The term “hysteria” is traditionally related with psychiatry since its evolution. The term is popular and valid to date in clinical practice, usually in the form of HCR (hysteric conversion reaction). In current classification systems of mental health disorder (both ICD and DSM), there is no existence of hysteria as it has been split into dissociative, conversion disorder and variants. The possession state in terms of “Jinn possession” is one of such a variant named as possession trance disorder.

Patients with hysteria frequently attend psychiatric facilities and are one of the common reasons for hospitalization. Transient psychotic presentation of hysteria is also not. It is said that hysteria is prevalent more in nonwestern societies and commonly found among children and the female population. Evidence

suggests that it is more or less prevalent in all corners of the globe in all age and either sex. As this disorder has to be encountered in the cultural context of Bangladesh and as no well-organized information on the psychopathology and treatment available in conventional textbook, organized psychopathology and standard treatment protocol of hysteria are provided here.

Psychopathology of hysteria

Psychopathology of hysteria still is not clear at all, despite huge research efforts. Historically, psychopathological explanation of this disorder is based on psychodynamic theory of unconsciousness. Though this explanation is interesting and popular, it has no such evidence based findings in favor. On the other hand, as neurological manifestations of hysteria are most common, researchers put efforts to find a neurobiological explanation of this disorder. Findings like, the areas of the brain that are responsible for communication with other body parts have reduced blood flow, this may cause neurological symptoms associated with conversion disorder. It is possible that these changes in blood flow may be caused by the brain receiving information about physical or emotional stressors. This and other findings like abnormal firing in the synapse are not persistently consistent and therefore no conclusion can be made. However, it is assumed that overall, the psychopathology of this disorder could be very complex and we have to wait for the facts and findings.

Regardless of the cause of the disorder, it is important to remember that the symptoms are very real; affected individuals are not faking symptoms of the disorder. Therefore, current practice is using the words 'awareness' and 'unawareness' instead of the psychodynamic terms 'consciousness' and 'unconsciousness'. As the psychiatrists have to know the evolution of psychiatry as a discipline, the conventional psychopathological elements are summarized below that are interactive and diverse in nature.

Core psychopathology
Gain:
Primary gain- resolution of conflict, stress or adversity in pathological ways expressed through symptoms not in awareness. Initially it always happens in unawareness.

Secondary gain- additional reinforcement in the form of extra care, receiving unnecessary interventions and investigation, nurturance, demand or need fulfilment mostly presents in awareness. This gain can be explained by the behavioral principle of operant conditioning.

Deviant illness behavior as part of abnormal sick role that comes from social learning. Attention seeking usually starts as part of abnormal illness behavior later increased by reinforcement and may persist after remission if not properly handled. This is also a sign of unresolved psychological factors.

Other psychopathology
Repression-The process of displacing distressful experience, stress or conflicts from conscious to unconscious areas of mind that gives relief to the distress that a person cannot cope with. This happens primarily in unawareness and not intentional. That is the reason for la belle indifference. However, through the course of time, or due to intervention that comes to awareness that may cause recurrence of distress either transient or in enduring form.

Regression or infantilization- behaving childish behavior, which is clearly age inappropriate due to regression of individual mental age to lower level of his chronological age.

Suggestibility- modification of symptoms, cognition and behavior through suggestions. It is basically an expression of personality traits like dependent nature, needing help for problem resolution. This is used to confirm the nonorganic nature of symptoms and as initial treatment options.

Psychopathology of Conversion and dissociation
Conversion- intrapsychic process of converting psychological distress to somatic symptoms expressed through the apparently unexplained medical symptoms either motor, sensory, autonomic or mixed.
In addition, all of the general psychopathology of hysteria as mentioned above.

Dissociation- intrapsychic process of splitting one or more part of the mental process or covert behaviour from the rest with the aim of resolving psychological distress. The common expression of dissociation is amnesia, or amnesia and self-agnosia usually associated with fugue state. Other uncommon expressions are dual or multiple personality, trans state and possession state. Jinn's possession in our culture is another example where dissociation blended with shred belief that comes from social learning.

Psychopathology Possession State (Jinn Possession)
Core psychopathology is related to shared belief. For example, belief in the existence of Jinn and its possession clearly exists in our culture and is shared by the patient and caregivers and achieved through the process of social learning. Therefore, odd and inappropriate behavior in Jinn possession is just an expression of the belief-behavior relationship of the society. Observational learning usually reinforces this. However, other forms of psychopathologies as stated earlier play critical roles in precipitation and perpetuation of this state.

Overall, manifestations of hysteria can simply be explained as cry for help. All these psychopathological phenomena can explain the symptoms of hysteria, give indication of the problem areas, help in understanding personality traits, making treatment and prevention plans.

Standard treatment protocol of hysteria

General
Explanation, support and advice to the patient and caregivers
Explain the nature of disease, cause, psychopathology, treatment and outcome in their understandable way. Do not oversimplify, like nothing needs to be worried or nothing is wrong with the patient, because that may create neglect of the patient or caregivers might believe that patient is feigning and can be expressed by humiliating the patient. Alternatively, do not be overly concerned that it can increase reinforcement and attention seeking of both patient and caregivers.

Hospitalization
If patient warrants crisis intervention, has stupors, needs further steps for exclusion or evaluation of organic etiology, marked behavioral problems including excitement, when stressor or conflict is unexplored in routine procedures, for minimizing overprotection and secondary gain, and when the family are not in a position to receive treatment in OPD basis. However, keep in mind hospitalization for long duration can slow remission and exerts abnormal illness behavior and chances of relapse immediately after discharge.

Symptomatic treatment
Maintenance of adequate food, nutrition and vitals.
If insomnia – give sleep hygiene and hypnotics for short duration if necessary.
If anxiety and distress - relaxation and anxiolytics.
If hyperventilation-relaxation, breathing in a polythene bag.
Maintenance of an active daily living program.
Initially minimum with gradual increase of activities. Set it with discussing patients on “as much as you can” basis.

Reducing secondary gain or reinforcement
Show empathy with firmness. Manage over concerns and worries of caregivers and their overprotective behavior if any; do not use unnecessary interventions or placebos. Avoid unnecessary investigations. If necessary, explain it. For example, “I’m giving some routine examination just to check your general health

status as we give routinely" or I'm giving this investigation due to your physical health matters, not related to your present problems. Be careful from any neglectful act that cannot be equated with the means of reducing gain.

Specific

Minimizing symptoms

Suggestion- This component of treatment should start initially and can be tested by the patient's level of suggestibility earlier during clinical examination. Provide simple suggestions for minimizing symptoms and encourage them to do so in front of you. Encourage the patient if he/she does the task. It may be a relaxation, graded task towards normality as deemed fit. If necessary, give hypnotic suggestions. Give practicing tasks and ask them to show you later. Engage nurses or co-workers to monitor the task and support patients. It is expected that the patient will engage in the task. You just need to keep his/her motivation for gradually increasing the task towards normality.

Resolution of stressor or conflict

It is the core of the whole treatment. Ensure that you have identified the stressors or conflict correctly. If you are unsure, do exploratory psychotherapy, and if necessary, do aided psychotherapy like an amobarbital interview or abreaction. Remember that a patient might have one or more stressors or conflicts or psychosocial distress. In that case, usually one plays as primary and others are antecedents or consequences. If you are sure, discuss freely the matter with the patient, and with caregivers to select one of the following options:

a. Removal- removing the cause that creates stress or conflict. This is ideal but most of the cases are not possible or feasible.

b. Modification- modifying the cause of stressor or conflict at an acceptable level.

c. Acceptance- accepting the cause of stressor or conflict without any change that is either removal or modification is not possible or plausible in any ways.

If necessary, apply problem solving strategies, counselling, supportive psychotherapy, cognitive therapy, and insight-oriented psychotherapy, family counselling to make them clear about the pros and cons of all the options so that patients can adopt any of the above options. Always keep in mind that you should act as facilitator not a decision maker though you need to show your concern and active role as a physician.

After selecting an option, work for the strategy and actions that require immediately and afterwards. Define the role of everyone for achieving sustainable outcomes. Carefully observe the patient's thoughts and behavior that can go either to relaxation or further distress. If it proves a wrong decision of selecting options, work on it again with enthusiasm.

Preventive Measures

This will be aimed from initiation of treatment and should be the focus during follow-up.

Working with patient

Individual Psychotherapy- Any vulnerable component of a patient's personality traits like anxiety prone mood, poor stress coping ability, dependent, avoidant, uncontrolled emotion, misperception of social cues, tendency to see and deal with the environment only through their own perspectives. For this stress coping, assertion training, social skill training, CBT can be used.

Remedial education and other measures of rehabilitation with the aim of regaining premorbid functional status.

Establishing or rebuilding a patient's social network.

Working with the family

Family Counseling-Managing dysfunctional family, unhealthy parental behavior, family conflicts including marital discords by positive parenting,

Family therapy and couple therapy where appropriate.

Developing supporting measures in the family partly sharing and communication.

14. A 24-year-old woman presents with amnesia, impulsive-aggressive, self-injurious behavior, food refusal and recent overdosing. She has a repeated history of self-harm, impulsivity and unstable relationships. She looks sad and irritable.
    a) Mention the most possible dual diagnosis giving evidence form the information and extraction from the above scenario.
    b) Give an outline of the assessment plan.

Given information

Demography and referral
Age- 24 years
Sex- Female

Chief complaints:
- Amnesia- duration not mentioned
- Impulsivity- same duration
- Aggressiveness
- Self-injurious
- Food refusal
- Overdosing- most recent event

History of present illness
H/O repeated self-harm, unstable relationship and impulsivity

M/S/E findings
Appearance- Irritable, sad

Extracted information

The type of amnesia is non-organic because of the patient's younger age, sudden onset & fluctuating course. The causes of non-organic amnesia are conversion disorder, PTSD and borderline PD.

As there is no history of extraordinary stressor so PTSD can be ruled out. Conversion disorder and borderline PD remains the best possible diagnosis. However, the longitudinal history reveals personality disorder, most likely to be borderline. BPD patients usually present with conversion, depression, anxiety, exaggeration of personality problems and somatization.

The young aged female appears irritable and sad. This is a reflection of her present mood. Maybe it is dysphoria due to the current stressor, maybe it is due to an incomplete mechanism of dissociation or maybe it is isolated depressive disorder.

Assigned task

a) The most possible dual diagnosis

From the given information and the extraction, the most possible diagnosis is Dissociative neurological symptom disorder/ Conversion Disorder & Borderline PD (BPD).

b) Assessment plan

- Exclusion of core features of depression & PTSD.
- Onset of the symptoms (Adolescence or early adulthood indicates PD).
- Course and order of appearance.
- Symptom pattern, extent & severity.
- Other features of BPD (Affective instability, fear of abandonment, unstable and intense interpersonal relationship, identity disturbance, chronic feeling of emptiness, difficulty controlling anger and transient stress related paranoid ideation).
- Impact on family, sociocultural and academic life.
- Assessment of risk to self & others (Reason and intent behind the current overdosing, plan of further attempt etc.).
- Strength & weaknesses- strengths are important because treatment should build on favorable features as well as attempting to modify the unfavorable ones.
- Perceptions and expectations of the girl and her family.
- Application of psychometric tool
  Validated MMPI to assess her personality traits

15. A 23-year-old university student has been arrested from the prime minister's official gate by police and is brought to you for assessment. It is alleged that he was shouting," I want to meet the prime minister and put some proposal for the development of the country". He also mentioned that a conspiracy was going on against the prime minister. On physical examination, his blood pressure was 165/100 mm Hg.
Answer the following through systematic and logical approach.
a) What are the areas you need to explore in his present history?
b) What additional information would be useful?
c) What is your differential diagnosis?

Given information

Demography and referral
Age- 23 years
Sex- Male
Occupation- University student
Referred by- Police
Reason for referral- Psychiatric assessment

Chief complaints
- Shouting in provocation
- Conviction of conspiracy against prime minister
- Self-important idea

Physical examination
BP- 160/100 mmHg

Extracted information

Inflated self-esteem is present as the university student shows unusual familiarity with the prime minister and is arrested from the prime minister's official gate.

Possible grandiosity is present in the form of ability (he has some proposal for development of the country), nearly delusional level. It indicates mood congruent psychotic features.

Possibly irritable mood as the man was shouting continuously.

Such a type of mood feature and thought process are hallmarks of bipolar disorder. Schizophrenia spectrum disorder is another possibility. Considering the age of the young man, substance related disorder should also be kept in mind.

Psychotic disorder in GMC sometimes shows similar symptoms. But here, no other feature of general medical disorder has been mentioned. However, this differential should be kept in mind while taking history in detail.

Assigned task

a) Areas need to be explored

History of present illness
Onset- Suddenly or gradually (after any stressor or general medical condition).
Duration- this episode and previous episode, if any.
Course- Persistent or episodic.
Impact: Distress, level of functioning in main domains of daily life- personal, familial, occupational, recreational and burden to family/caregivers.
Efforts taken: by self, family, physicians including treatment and outcome.
Cause: Predisposing, precipitating, precipitating.

Family history
Family history of psychiatric illness especially mood and psychotic disorder.

Personal history
Substance use history- current and past.
Forensic history.

Co-occurring medical illness
With special emphasis on thyroid dysfunction and hypertension status.

Past psychiatric history
Past manic or depressive episodes whether present or not.

Risk and resilience factors
Risk: predictable risk of self and others.
Strengths: abilities and skills usable in treatment.

b) Additional information

- General examination for general health status assessment.
- Systemic examination: for co-occurring medical illness and secondary cause.
- Mental state examination: for the findings related to features and possible psychiatric comorbidity.
- Perception of patient and caregivers about the problem and expectation from the physician.
- Relevant laboratory investigations- immediate and later-to confirm the diagnosis and to make a treatment plan.

- Relevant psychological testing-Young Mania Rating Scale/ BPRS.

c) Differential diagnosis

From the logical extraction from given information, following differentials are obtained.
- Bipolar type I disorder/ Bipolar I Disorder
- Schizophrenia and other primary psychotic disorder/ Schizophrenia Spectrum and Other Psychotic Disorder
- Disorders due to substance use or addictive behaviors/ Substance-Related and Addictive Disorder

16. A 32-year-old housewife presents with intrusive thoughts of contamination and severe washing rituals. She has been diagnosed as OCD and subsequently treated with fluvoxamine followed by clomipramine with adequate dose and duration. She has also received exposure with response prevention appropriately. Initially, there is a significant response but after three months, her condition relapses. She does compulsive behavior aggressively and says that it is rational.
a) What will be the further treatment plan?
b) What information do you need to give to the patient and family members at this point?

Given information

Demography and referral
Age- 32 years
Sex- Female
Occupation- Housewife

Chief complaints
- Intrusive thoughts of contamination
- Severe washing rituals
- Thinks it as rational

Present psychiatric diagnosis
Obsessive-Compulsive Disorder

Treatment history-
- Fluvoxamine, Clomipramine (adequate dose and duration)
- Exposure and response prevention (ERP)

Extracted information

The middle-aged housewife is a diagnosed case of OCD on the basis of her intrusive thoughts of contamination and severe washing rituals. The obsessive thought and compulsive ritual most likely impaired her familial, social and other important areas of functioning for which she seeks treatment.

She received two groups of anti-obsessive drugs (SSRI and TCA) and psychological treatment (ERP). Though there is significant response initially, after three months relapse occurs. It indicates the waxing and waning course of OCD and this is most likely to be a case of refractory OCD.

The lady aggressively performs compulsive rituals after relapse. This time she also feels that her thoughts and acts are rational. This clearly reflects her development of poor insight.

Before treatment planning, reassessment is needed especially other features of OCD, drug compliance, comorbid psychiatric illness, events precipitating the disorder and role of family in maintaining the illness (family accommodation).

Assigned task

a) Treatment plan

Biological

i. Augmentation with another SSRI is the first choice.
ii. Addition of anti-psychotic (Risperidone or aripiprazole) with SSRI combination.
iii. ElectroConvulsive Therapy if above procedures fail. Alternatively, Deep Brain Stimulation (if available)

Psychosocial

i. Psychoeducation to the housewife and her family
ii. Relaxation exercise- breathing and progressive muscular relaxation
iii. ERP (reinitiated)
iv. CBT (ERP can be incorporated in CBT as behavioral part)

b) Information to the patient and the family members

- Nature and course of the disorder (mostly waxing and waning).
- Importance of adherence to treatment.
- Importance of psychological treatment.
- Identifying the triggering factors.
- Improving stress coping ability of the person.
- Addressing the problems of family accommodation.
- Prognostic factors.
- Importance of carrying on the active daily life schedules.
- Empathetic attitude of family members.
- Addressing problems of comorbid psychiatric illness especially depression and anxiety.

[NTK
Main indication of psychosurgery is the OCD, if it is refractory to all form of treatment and intractable to the patient]

17. A 35-year-old patient with schizophrenia is under clozapine and responded well. Recently, he developed a repetitive thought of something worse will happen, as mother will die if he does not touch specific things. To prevent this thought, he does some bizarre motor movement that is somewhat stereotypic in nature.
    a) What are the areas you need to assess?
    b) How will you manage this case?

Given information

Demography and referral

Age- 35 years
Sex- Male

Chief complaints

- Repetitive thoughts of something worse will happen- recent onset
- Compel to touch to minimize thought
- Bizarre motor movement- subsequent development to prevent the thought

Present psychiatric diagnosis
Schizophrenia, maintained on Clozapine

Extracted information

The middle-aged man is possibly a case of refractory schizophrenia because he is under clozapine. It can be said that he is now in partial remission as no active phase symptoms are currently present.

Obsessive-compulsive symptoms in schizophrenia has three possibilities- it may come as a part of schizophrenia, as an adverse effect of antipsychotic medication especially clozapine and as a co morbid obsessive-compulsive disorder.

OCD features can be part of the prodromal stage of schizophrenia and only considerable as part of schizophrenia when the active phase develops.

At this stage, presenting complaints are less likely to be considered as new features of schizophrenia. Rather it is very much indicative of Obsessive-Compulsive Disorder. Here, obsession is an intrusive thought of possible harm and compulsions are touching and doing bizarre and stereotyped motor movement. Therefore, the existence of OCD can be considered as a comorbidity.

Though uncommon, sometimes OCD-like features can be developed due to Clozapine that needs thorough evaluation.

The aim of assessment and management is to differentiate between obsessive-compulsive symptoms and schizophrenia.

Assigned task

a) Areas need to be assessed

History

- Other features of OCD (whether it is the patient's own thought, distress related with the thought, resistance).
- Temporal relation between Clozapine and OCD symptoms.
- Whether the symptoms are part of Schizophrenia.
- Risk factors of OCD- family history, past history, any OCD spectrum disorder, OCD traits,
- Distress of the patients for the symptoms
- Impact on a patient's daily life.
- Other drug history including substance history.

Psychometric assessment

- YBOCS for OCD (validated Bangla version is available)
- Validated BPRS for psychosis

Physical examination

General examination- Body weight, BMI, Pulse, BP.

Lab investigation
Baseline investigations for assessing general health status- CBC, ECG, RBS, SGPT, S. creatinine.

b) Management

- Standard treatment protocol for OCD should be given. Non-sedative SSRI should be preferred (e.g. Fluoxetine) as Clozapine has significant sedative properties.
- Psychological management: Psychoeducation, relaxation therapy, ERP , CBT (if ERP does not work and person have cognitive ability to take CBT)
- ADLP

[NTK: Nearly 20-30% Schizophrenia cases have comorbid OCD]

18. A 36-year-old woman comes to you for follow-up who is under disodium valproate and valproic acid for her manic episode that is partially remitted. You come to know that she is 4 months pregnant.
a) List the information you need to be gathered.
b) List the steps of further management.

Given information

Demography and referral
Age- 36 years
Sex- Female
Referred to- Psychiatry OPD
Reason for referral- Follow up

Present psychiatric diagnosis
Manic episode

Treatment receiving
Valproate

Response to drug
Partially remitted

Personal history
4 months pregnancy

Extracted information

The middle-aged lady is a diagnosed case of bipolar I disorder because there is a single manic episode. Only one manic episode is sufficient to diagnose bipolar I disorder. As she is 36 years old, it is very much unlikely to be her first episode.

The lady is a valproate responder. She has been partially remitted that indicates the core features are not present currently and/or 2 months have not elapsed since she responded.

Teratogenicity risk is high with valproate. So, atypical antipsychotic and other mood stabilizers remain the first choice for this age-sex group. As in this case valproate is used, most likely it is not her first episode and she did not respond to other drugs.

Assigned task

a) Information need to be gathered

Status of the disorder
- Number and frequency of total episodes (both manic and depressive)
- Age of onset
- Severity of episodes
- Need for hospitalization
- Presence of psychotic feature
- Any peripartum episode

Treatment history
- Drugs prescribed to the patient previously
- Name, dosage and response to each drug
- How long been the patient using valproate
- Estimated time and dose needed for valproate to respond

Co-occurring medical illness
With special emphasis on thyroid disorder, SLE and DM.

Co morbid substance use
Amphetamine, cannabis, alcohol or BDZ history if relevant.

Precipitating factor for the most recent episode
It will help to take precautionary measures for preventing further episodes.

Current social circumstances
Family support of the woman, relationship with husband are important for treatment planning.

b) Further management

- Abrupt discontinuation of valproate may lead to rapid relapse. So, the aim should be tapering off the drug when full remission is achieved.
- If there is risk of relapse, an atypical antipsychotic drug can be used instead (Haloperidol/Olanzapine).
- If there is no option left except valproate, then the patient and the caregivers should be informed about the teratogenic effect of valproate and the risk benefit ratio of continuing and discontinuing drug.
- Avoidance of stress and regular sleep is an important non-pharmacological method to avoid relapse.
- Supplementation of multivitamin (as pregnancy enters into the second trimester, there is no role of folic acid alone).

19. A 30-year-old man attends in follow-up who is diagnosed as depressive disorder and getting sertraline 50 mg/day since last two weeks. He says that he has a lack of sexual desire as well as dysfunction.

a) Mention the areas you need to evaluate further.
b) What measures do you need to take?

Given information

Demography and referral
Age- 30 years
Sex- Male
Referred to- Psychiatry OPD
Reason for referral- Follow up

Chief complaints
- Lack of sexual desire
- Sexual dysfunction

Present psychiatric diagnosis- Depressive disorder

Treatment receiving- Sertraline 50 mg/day for two weeks

Extracted information

Sertraline is an antidepressant from the SSRI group. Antidepressant dose of sertraline starts from 50 mg/day and ranges up to 200 mg/day. One of the troublesome adverse effects of SSRI is sexual dysfunction. It can occur after a few days up to a year after starting SSRI.

Sexual dysfunction is one of the important biological features of depression. Low sexual drive and sexual dysfunctions may result from anhedonia or it may be an isolated biological feature.

In the above-mentioned scenario, the young man is a diagnosed case of depression. Sertraline has only been started two weeks back in a minimum effective dose (50 mg/day). It is very much unlikely that sertraline in this dose for such a short duration can exert the effect on sexual function.

Considering the facts, the problem is most likely due to depression (biological feature).

Assigned task

a) Areas need to be evaluated

Sexual dysfunction

Onset of problem (new onset or persist from beginning)
Problem areas- desire, arousal, orgasm or resolution
Relationship with partner
Sociocultural belief about sex

Depressive features
Presenting features of depression
Improvement following initiation of drug
Level of functioning
Previous episode and sexual problem in the episode if any

Cooccurring psychiatric illness and history of substance abuse

Anxiety disorder and OCD should be ruled out. Amphetamine, cannabis, opioid, alcohol history is also important.

Co morbid medical illness and drug history (e.g. Beta-blocker)
With special emphasis on thyroid disorder, neurological disorder and rheumatological disorder.

Risk assessment
Especially for suicide and self-harm

Physical examination
General examination- Nutrition and hydration status, evidence of substance abuse.

Mental state examination
Mood- severity of depression; thought- Obsessive thoughts or anxious preoccupations.

Psychometrics
BDI for depression (validated Bangla version is available)
ASEX for sexual dysfunction (validated Bangla version is available)

b) Measure to be taken

Counselling that the problem is a biological feature of depression and will go away as depression disappears.

20. A 28-year-old woman is a diagnosed case of bipolar disorder, recent episode manic who attends in psychiatry OPD as part of periodic follow-up. She is getting disodium valproate & valproic acid along with quetiapine. Her symptoms have significantly remitted since the last five months. She has had three mood episodes in the last three years and the average duration of each episode is about 7 months. Now, she wants to conceive a child.
    a) What information is necessary to address her desire?
    b) How will you counsel this patient?

Given information

Demography and referral
Age- 28 years
Sex- Female
Referred to- Psychiatry OPD
Reason for referral- Periodic follow up

Present psychiatric diagnosis
Bipolar I disorder, currently in partial remission (for 5 months)

Course and episodes
3 episodes in last 3 years (each 7 months)

Treatment history
Disodium valproate, quetiapine

Recent concerns
Wants to conceive

Extracted information

This is the 4th mood episode in the last 3 years. The young lady is currently in partial remission with some symptoms remaining. Overall, she is in stable condition and comes for routine follow up.

All the previous episodes remitted by 7 months and the current episode also responded well with medication by 5 months of onset. Considering the past history, this episode is likely to be remitted fully within 2 months.

Though there is no history of rapid cycling, prophylaxis might have been planned as she has been experiencing episodes in each year.

The recent concern of the lady is to conceive a child. Addressing the issue needs thorough evaluation of her obstetric and psychiatric history.

Assigned task

a) Information needs to be addressed

Obstetric history
Number and gender of children of the patient
Contraceptive history (can be withdrawn after 2 months)
Any history of peripartum mood episode

Psychiatric history
Details of past episodes
Family history of psychiatric illness
Stressor/ precipitating factor for each episode
Drug history- prophylaxis/adverse effect
Compliance status

Co-occurring physical illness
Thyroid dysfunction, DM, rheumatological disorder.

Perception and expectation of the family members about the patient's desire and current condition
Their expectation from the treatment and outcome in terms of the patient's wish.

Assessing patient's knowledge about the disorder
Nature and course of the disorder, importance of adherence to treatment, impact of childbirth on her mental health should be addressed.

Risk assessment
Risk assessment for the woman and for other family members.

b) Counselling

- Explaining the patient about the course and prognosis of the disorder.
- Explaining the benefit and risk of conceiving.
- The patient can conceive, but has risk of further episodes during pregnancy.

- If no issue/related stressor, can conceive now.
- Folic acid supplementation if the patient is determined to take a child.
- Continuing prophylaxis (options are-Olanzapine, Trifluoperazine, Chlorpromazine, Paliperidone).

21. A 30-year-old male has been under treatment for his schizophrenia for the last one and half years. He is on olanzapine 20mg/day. Now he wants to marry and asks whether it could help in his treatment.
a) List necessary information that is required to counsel this patient.
b) Mention the issues you need to communicate during counselling this patient.

Given information

Demography and referral
Age- 30 years
Sex- Male

Present psychiatric diagnosis
Schizophrenia

Treatment receiving
Olanzapine 20 mg/day; duration of treatment is 1½ years

Recent concern
Wants to marry and thinks that marriage will help in his treatment

Extracted information

The young male is a diagnosed case of schizophrenia. Duration of his illness is more than one and a half years. He is taking a typical antipsychotic drug (olanzapine) and responded to 20 mg/day. He is most likely to be in partial remission because the most common course of schizophrenia is multiple episodes with inter-episodic residual features.

It is a widely held misconception that mental disorders, especially psychotic disorders improve with marriage. In this scenario the person also holds the belief. His concerns should be addressed with facts.

Assigned task

a) Information required for counselling

- Duration and course of illness
- Treatment history
- Compliance of the patient
- Family support
- Personal history including history of substance use
- Co-occurring medical illness
- Premorbid personality
- Patient and family's perception about the disorder, treatment outcome and prognosis
- Possible impact analysis

- Employment status of patient

b)Issues to be communicated

- Natural course and prognosis of Schizophrenia
- Patient's good and bad prognostic factors
- Importance of continuing medication
- Avoidance of stressor
- Abstinence from illicit drugs
- Importance of maintaining a daily routine including adequate sleep
- Recognition of early signs of relapse
- Advice to share the patient's condition with the to-be-bride and her significant others. Otherwise, if things are hidden it may hamper regular intake of drugs and make the disorder worse when flashed.
- Risk of genetic transmission of Schizophrenia
- Regular follow up

22. A 26-year-old woman who is a diagnosed case of borderline personality disorder admitted in the psychiatry department after serious overdosing.

a) List the measures you will take immediately for preventing further self-harm.
b) What information will you gather to assess suicidal risk?

Given information

Demography and referral
Age-26 years
Sex- Female
Admitted in department of Psychiatry
Reason for admission- serious overdosing

Present psychiatric diagnosis
Borderline personality disorder

Extracted information

This woman is a diagnosed case of borderline personality disorder. Persons with borderline personality disorder have instability of interpersonal relationship, self- image and affects and marked impulsivity. Recurrent suicidal behavior is one of the diagnostic criteria of BPD and may occur as a result of affective disturbance or impulsivity. In this scenario the young lady attempted suicide by serious overdosing. It is clearly indicative of strong suicidal intent rather than impulsivity.

Recent life crises may lead to the event of overdosing. Another possibility is comorbid depression which is commonly found in BPD. Substance use disorder and bipolar disorder are also found. So, thorough history is needed for identifying the reason behind the attempt.

As the patient is referred to the psychiatry department, initial emergency management might be given in an emergency setting before referral.

Assigned task

a) Measures to be taken immediately

- Sedating the patient after a short assessment.
- Attendance of the patient should be made aware about further attempts.
- Close monitoring by the attendant and hospital staff must be ensured.
- All staff should be informed and proper handover during shift change should be made.
- Labelling the patient's file about the risk of further attempt.
- Keeping away sharp weapons and other risky materials from the patient's reach.

b) Assessing suicidal risk

Current attempt

- Patients intent (dying/getting relief/threatening someone).
- Planned/ impulsive?
- How found/ any precaution against discovery?
- Suicide note written or not?
- Anyone close informed or not?
- Patient's idea about overdosing (which drug/lethality of the drug/ patient's knowledge about the drug).

Feeling of the patient when she was discovered

- Feeling relieved or not?

Risk of further attempt

- Any plan for further attempt?
- Current social circumstances.

Resilience factor

Factors that will prevent her from further attempts. (e.g. religious belief, small kids).

Co morbid psychiatric illness

Special emphasis on mood disorder and substance abuse.

Co-occurring medical illness

Any chronic illness presents or not?

Stress coping pattern of the patient

Adaptive/maladaptive, Problem focused/emotion focused?

Previous attempts (if any)

- How many times
- What method used
- Planned/Impulsive

[NTK:
American Association of Suicidology creates an acronym for assessing warning signs of suicide.
IS PATH WARM: Ideation, Substance use, Purposelessness, Anxiety, Trapped, Hopelessness, Withdrawal, Anger, Recklessness, Mood swing]

23. A 22-year-old woman attends in psychiatry OPD who says that she has been watched whenever she stays in and uses the toilet. She is upset and irritable.
a) List the related information necessary to find out the reasons for her problem.
b) What are your differential diagnoses?

Given information

Demography and referral
Age- 22 years
Sex- Female
Referred to- Psychiatry OPD

Chief complaints
Concerns about being watched in toilet

M/S/E findings
Appearance- upset
Mood and affect - irritable

Extracted information

The young aged female has either conviction or doubt that she is being watched in the toilet. If it comes as a conviction the likely diagnosis is Schizophrenia or other primary psychotic disorders/ Schizophrenia Spectrum Disorders.

If the idea comes as an intrusive thought, it is likely to be obsessional and the diagnosis is Obsessive-compulsive disorder.

Possibility of being factual can be ruled out as the patient is referred to Psychiatry OPD.

Assigned task

a) Information needed to reach a diagnosis

- Whether the young woman thinks or believes about the watching, or she hears or sees.
- If it comes as a thought, is it intrusive and irrational?
- Does she do anything to neutralize the thought?
- If the feeling comes as a perception (hears or sees), what is the quality of the perception (real or fantasy)?
- Is the perception controlled by will?
- If the thought is a belief, what is the explanation behind this?
- Any proof for or against the belief?
- Any other abnormal mental phenomena present or not?
- Any possibility for the event of being factual?

b) Differential diagnosis

From the given information and logical deduction of the information, the most possible differentials are,

1) Schizophrenia or other primary psychotic disorder/ Schizophrenia Spectrum Disorder.
2) Obsessive-compulsive disorder/ Obsessive-Compulsive Disorder.

24. A 32-year-old petty officer brought by his parents who starts saying that he is the son of the president of the USA and the owner of Microsoft. He hears and does daily tasks from Dhaka through a special device that is superior to the internet. His parents say that he shouts and becomes violent without apparent reason; not going to his office and now takes very little care of himself. He has a long history of cannabis intake.
    a) What else is required to reach a diagnosis?
    b) What investigations do you need to do at this point?

Given information

Demography and referral
Age- 32 years
Sex- Male
Occupation- Petty officer
Accompanied by- Parents

Chief complaints
- Says he is the son of US president and owner of Microsoft
- Hears and does daily tasks through device superior to internet
- Shouts and becomes violent without apparent reason
- Not going to office
- Poor self-care

Personal history
Cannabis intake for long

Extracted information

The middle-aged petty officer has a delusion of grandiosity in the form of identity as he claims himself as son of the US president and owner of Microsoft. Delusion of control is present because the officer believes his tasks are controlled by devices superior to the internet.

Extracampine hallucination is present as he hears voices from Dhaka.

Unprovoked violence is a part of disorganized behavior.

Poor self-care is a negative symptom.

Functional impairment present as he is not going to office and not taking personal care.

The middle-aged man has a long history of cannabis intake. If it is cannabis induced psychosis, it should have manifested earlier. So, it is more likely to be schizophrenia spectrum disorder and cannabis may predispose the patient to schizophrenia or may precipitate the episode or perpetuate the course.

Considering the demographic profile and symptom pattern, the most probable diagnosis is Schizophrenia spectrum disorder.

Assigned task

a) Information needed to reach the diagnosis

- Onset- sudden/insidious
- Duration (Schizophreniform disorder or schizophrenia)
- Personal and family history of psychotic disorder
- Treatment history (drug used, times taken to respond, adverse effect profile, adherence to the drugs)
- Detailed history of cannabis use
- Temporal relationship between cannabis and the episode (presence of symptoms beyond 1 month of abstinence from drug indicates that the episode is not a drug induced one)
- History of any other substance use
- Risk assessment for self and others

b) Investigations:

Specific investigation to rule out substance induced disorder
Urine for dope test

General investigations for routine health check up
CBC, RBS, ECG, SGPT, TFT, Serum creatinine, Fasting lipid profile

[NTK:
Odd behavior is all that goes against expected behavior including disorganized behavior.
Disorganized behavior is apparently unexplainable by context of time or by other causes.]

25. A 41-year-old male works as a banker. In late 20's he was diagnosed with schizophrenia. Because of his unremitting auditory hallucinations, eventually prescribed clozapine and that responds well. Five-year letter, obsessive thoughts and compulsive urges to make anti religious and sexual comments. He is worried that he would act, and scared of leaving home. He becomes increasingly withdrawn and isolated. More recently, compulsive checking of doors and taps are developed. No paranoia, apathy, blunting of affect and poverty of thought observed. The declines in social and occupational functioning are developed.
a) How will you explain the patient's present situation?
b) Outline the possible further management plan.

Given information

Demography and referral
Age- 41 years
Sex- Male
Occupation- Banker

Chief complaints

- Diagnosed case of Schizophrenia for 20 years
- Obsessive symptoms (religious, sexual) and compulsive features (anti religious and sexual comments) for 15 years
- Fear of acting on the compulsions
- Compulsive checking of doors and taps developed recently
- Marked functional impairment- recent

Treatment History

Refractory schizophrenia and responded with Clozapine since 21 years of age.

M/S/E findings

Affect- No apathy or blunting present
Thought- Normal, no poverty of thought or paranoia was observed
Perception- No hallucination

Extracted information

The middle-aged banker has been suffering from schizophrenia for 21 years. He has been on clozapine for almost the same duration. With drugs, he has been living a functional life. However, after 5 years of diagnosis of schizophrenia, he develops OCD (religious and sexual obsessions). For the last 15 years, he has been living with schizophrenia and OCD.

The most common course of schizophrenia is multiple episodes with inter episodic residual features and for OCD most common is waxing and waning courses. Though the religious and sexual obsessions present from the very beginning, the compulsive door and tap checking is a recent addition. For this new feature, the banker develops severe functional impairment though he managed to lead at least functional life earlier.

Obsessive compulsive symptoms in schizophrenia has three possibilities- it may come as a part of schizophrenia, as an adverse effect of antipsychotic medication especially clozapine and as a co morbid obsessive-compulsive disorder. Here, schizophrenia and OCD present as comorbid conditions because OCD symptoms develop 5 years later and present in absence of active phase symptoms.

Though psychotic symptoms have responded to clozapine and currently no active phase symptoms are present, clozapine clearly has no effect on minimizing OCD symptoms. Rather, currently OCD features are increasing and overall impact is assumed to be severe.

[NTK:

- OCD comorbid with schizophrenia in roughly 20 % cases
- Obsessive-compulsive symptoms in 20-30%
- OCD in schizophrenia patient is long standing and persisting, less responding to conventional treatment
- Functional impairment is severe
- Increased risk of suicide
- Long stay in hospital
- Poor treatment outcome]

Assigned task

a) Explaining patient's situation
(Write from extracted information)

b) Further management plan

- Comprehensive treatment in bio-psycho-social model
- *Biological*
  SSRI (Fluoxetine)/ TCA (Clomipramine)
  Continuation of Clozapine
- *Psychological*
  ERP/CBT/Distraction/thought stopping and satiation
- *Social*
  Family support, occupational support, switching the job.
- Prevention of suicide risk.

[NTK: Clozapine, Risperidone, Aripiprazole and Trifluoperazine has anti OCD property]

26. A 32-year-old woman presented in psychiatry OPD who leaves from her house in Dhaka 7 days back in the morning without informing family members and is found in Cumilla at night after extensive search. She cannot recall the events during that period. Similar episode happened two years back.
    a) What are the areas you need to assess?
    b) What investigations do you need to do considering differential diagnoses?

Given information

Demography and referral
Age- 32 years
Sex- Female
Referred to- Psychiatry OPD

Chief complaints
- Left house 7 days back without informing family members
- Found out after extensive search
- Cannot recall the events during episode

Past psychiatric history
Similar episode 2 years back

Extracted information

The lady in the scenario left the house without informing family members. As the family members found her after extensive search and concerned about her disappearance, so the event might not be a result of family feud or other personal issues. Rather, it is most likely due to a neuropsychiatric problem. Amnesia of the event reinforces the claim.

Amnesia is the core feature of amnestic disorders. This can be resulted from organic or functional disorders. Among the organic causes, head injury or effect of substance can be ruled out as there is no history of such.

Similar episode occurred two years back. So, it can be assumed that the lady is relatively well in between. Among the functional disorders, schizophrenia, bipolar disorder can be ruled out considering the episodic nature and absence of mood and thought features. Aggressive outburst of personality disorder might be a possibility but the duration of such amnesia is very short.

Considering the overall scenario, the most likely organic differential is complex partial seizure and non-organic differential is dissociative amnesia with dissociative fugue.

Assigned task

a) Areas need to be assessed

Thorough history of the event
- Immediate precipitating factor of the event
- History of seizure
- Whereabouts during the event
- How found
- Damage caused by the disappearance
- Detailed history about the past episode

Thorough assessment of amnesia
- Amnesia- localized (only the event period), selective (specific aspect of the event) or generalized (identity and life history)
- Degree of severity of amnesia by giving clue of the period (amnesia of the amnesia)
- Memory of important autobiographical information
- Sense of identity

Other features
- General physical and mental health status in between the episodes
- Other perceptual abnormality (depersonalization, derealization, hallucination or illusion)
- Family history of psychiatric disorder
- Co morbid depression, anxiety or substance abuse
- Pre-morbid personality and preferred stress coping method
- Predisposing factor (e.g. history of childhood abuse), precipitating and perpetuating factors
- Risk assessment
- Efforts taken by self and the family about the problem
- Perception of the lady and her family about the problems and expectation from treatment

General physical examination
To assess general health status and any co-occurring physical illness

Mental state examination
To assess findings related to amnestic disorders and other co morbid psychiatric illness

b) Investigations

Laboratory investigations

i. General (For assessing general health status)
CBC, RBS, SGPT, S. creatinine, Fasting lipid profile, TFT, ECG, CXR

ii. Specific (To rule out neuropsychiatric disorder)

EEG
Brain imaging (CT scan or MRI)

Psychometric tool
MMSE (validated Bangla version is available)

27. A 24-year-old man attends Psychiatry OPD due to severe discomfort, feelings of senselessness and anxiety who thinks that his cheeks gradually compress inward that worries him but others cannot find such deformity. Repeated consultations do not reveal any organic etiology. He starts not shaving his beard to cover it up. The boy says that he feels uncomfortable in social situations due to his possible ugly appearance and gradually becomes infrequent in college attendance. On questioning, he says that his age could be more than said because of his thick pattern of hairs of his beard. He is a good student and performs his study at home.
a) What could be the most likely diagnosis based on given and logical extraction from the scenario?
b) Make an assessment plan to reach a diagnosis and make a comprehensive treatment plan.

Given information

Demography and referral
Age- 24 years
Sex- Male
Occupation-Student
Referred to-Psychiatry OPD

Chief complaints
- Conviction and worries of gradual compression of cheek despite of no such evidence of deformity
- Severe discomfort, feelings of senselessness and anxiety for this thought
- Frequent medical consultation for this despite reported no organic etiology
- Starts not shaving of his beard to cover it up so that nobody can see
- Avoiding school and social situation due to fear of being criticized for her imagined ugly appearance
- Assuming that his age more than the record due his thick beard hair

Extracted information

The young man's belief of cheek compression and ugly face is not real, rather his distorted thought seems to be persistent as evident with so many events.

He is preoccupied about the deformity that is evident from his behavior of not shaving beard to hide this imagined deformity, doubt of his chronological age and discomfort in social situations and infrequent college attendance.

Anxiety is clearly fixed with deformity and feeling of senselessness is the heightened form of this anxiety rather than panic or other anxiety.

The pattern of repetitive thought and doubt is not indicative of its delusional nature.

Confined at home and distress indicate increased severity of problems and disruption of daily life.

Assigned task

a) Diagnosis

From the information in the case scenario and its extraction, the most likely diagnosis is Body dysmorphic disorder/ Body Dysmorphic Disorder (BDD).

b) Assessment plan

Assessment of physical flaws
- Determine physical flaws slight or absent.
- Preoccupied with one or more non-existent or slight defects in their physical appearance.

Identification of the thought/dysfunctional belief
- Level of insight about the imagined deformity
- Impact of globalization and mass media regarding beauty
    - Cultural, social and historical figures influences
    - Presence of body image and body image dissatisfaction
- Psychological-Childhood adversity

Behavior related to the thought
- BDD related repetitive behaviors as well as BDD related ideas and delusion of reference.
- Engaged in one or more repetitive behaviors- Onset, duration and types of persistency.
  Mirror checking
  Skin picking
  Seeking reassurance

Impact assessment
Distress and impairment due to preoccupation.

Comorbid psychiatric illness
- H/O Eating Disorder.
- Muscle dysmorphia.
- Checking for any other symptoms of psychosis, depression, social anxiety, OCD and related disorders for exclusion or comorbidity.

Risk assessment
- Suicidal risk assessment- rate of suicide is high in BDD.

Assessment of temperamental traits

Psychometric tools
Validated Body Dysmorphic Disorder Questionnaire (BDDQ).
Alternatively, validated Body Image Disturbance Questionnaire (BIDQ) or BDD-YBOCS can be Used.

28. A 30-years-old housewife is assigned the diagnosis of Major Depressive Disorder during her first visit in psychiatry OPD. Subsequent assessment reveals that she has obsessive thoughts of contamination and compulsive cleaning since the last 10 years that run in a waxing and waning course. Since last one year, the obsessive-compulsive symptoms have turned severe in nature. Furthermore, blasphemous obsession and compulsive begging of pardon appear. More recently, she mutters

frequently and becomes confined herself in the house. Significant decline of personal, familial and social functioning observed.

a) Make an effective treatment plan for this woman.

b) Outline the prognosis of this case.

Given information

Demography and referral

Age- 30 years

Sex- Female

Occupation- Housewife

Referred to- Psychiatry OPD

Chief complaints

- Obsession- dirt and contamination, blasphemous- increased in last one year
- Compulsion- cleaning, begging pardon- increased in last one year
- Self-muttering- recent onset
- Significant impairment of personal, familial and social functioning- recent onset
- The patient confines herself at home- recent onset

Present psychiatric disorder

MDD- recently diagnosed

OCD- 10 years

Extracted information

The housewife in the scenario has been suffering from OCD for 10 years with waxing and waning courses. So, the onset is in her twenties and it increases the risk of poorer prognosis. Recently her symptoms have become more complex with new symptoms.

Her long-standing obsessions are dirt and contamination and blasphemous thoughts are of recent onset. Cleaning is a compulsive behavior in response to thoughts related to dirt and contamination and begging pardon is in response to blasphemous thoughts. Avoidance is also a compulsive feature.

Self-muttering is usually a hallucinatory behavior occurring in response to hearing unseen voices. However, in this case self-muttering is most likely to be an expression of pardon seeking. The obsessive blasphemous thoughts are very much distressing to the patient and lead her to do such compulsive behavior.

Major depressive disorder has been present as a comorbid psychiatric illness. MDD is frequently comorbid with OCD. Comorbidity may cause less improvement of both the disorder, increased risk of suicide, less effect of drug and any other treatment and negative impact on the patient and related persons.

Symptoms can be reduced with proper treatment but there are possibilities of recurrence as the course is waxing and waning.

Assigned task

a) Effective treatment plan

Drug treatment
SSRI (Fluoxetine/Sertraline/Fluvoxamine)
[NTK: Fluvoxamine is the FDA approved drug for OCD]
Augmentation with Lithium
Augmentation with atypical antipsychotic (Risperidone/Aripiprazole)
ECT

Psychological treatment
Psychoeducation with special emphasis on the nature and course of the disorder
Behavior therapy (Relaxation therapy, ERP)
CBT
Long term treatment plan, follow up and proper rehabilitation to prevent relapse and further deterioration

Other options
Deep brain stimulation (if available)
Other neurostimulation procedures

b) Outline of the Prognosis

There is a chance of partial remission if she follows the treatment protocol and is adherent to it. However, there is further chance of relapse as the onset is earlier, course is prolonged and there is significant functional impairment. Moreover, the natural course of OCD is waxing and waning.

There is five-fold increased risk of suicide in patients with MDD and OCD.

29. A 25-year-old man who has been diagnosed as schizophrenia and is on haloperidol 20 mg/day. After 2 weeks, he has complained of restlessness, inability to sit at one place and fidgetiness.
    a) What are the treatment options for this case?
    b) Make a list of information you will provide to the patient and caregivers.

Given information

Demography and referral
Age- 25 years
Sex- Male

Chief complaints
- Restlessness
- Inability to sit at one place
- Fidgetiness

Duration- 2 weeks

Present psychiatric diagnosis
Schizophrenia

Treatment history
Haloperidol 20 mg/day

Extracted information

Neuroleptic induced akathisia is the most probable diagnosis as the symptoms developed after 2 weeks of starting haloperidol. Haloperidol is a first-generation antipsychotic which has a high propensity to cause EPSE.

Akathisia (leg feeling) should be differentiated from agitation (anxious feeling in head) as both the symptoms present with similar complaints.

Other differentials may be

- Increased presenting symptoms of schizophrenia which can be excluded by order of appearance of symptoms and searching the reason behind restlessness.
- Agitation of Depression can be excluded by absence of a core feature of depression that is low mood and lack of interest.

Assigned task

a) Treatment options

As the most probable diagnosis is haloperidol induced akathisia, the likely feasible treatment options are as follows:

- Reducing the dose of haloperidol, if possible.
- Switching to second generation antipsychotics, preferably to Quetiapine or Olanzapine.
- Adding beta-blockers like Propranolol 30-80 mg/day.
- Low dose of (15mg) Mirtazapine can be considered.
- If no response or inadequate response, other options are:
  Antimuscarinic drug (e.g. tetrabenazine 6 mg/day)
  Benzodiazepine (e.g. Diazepam up to 15 mg/day or Lorazepam 0.5-3 mg/day) (It should be avoided in contraindications like asthma, bradycardia).
- If all the options are appearing to be ineffective, clonidine 0.2-0.8 mg/day can be considered.

b) The necessary list of information for the patient and the caregiver are

- Reassuring about the new symptoms.
- Explaining the rate of occurrence, course, treatment and outcome of Akathisia.
- Selecting treatment option akathisia and informing your steps of actions in an understandable way.
- Explaining in brief about the sign symptoms, etiology, treatment options and prognosis of Schizophrenia.
- Available biological treatments including 1st and 2nd generation antipsychotic drugs (APD), their mode of action, time needed for response, common, less common and rare adverse effects, strategies to manage adverse effects, chances of withdrawal phenomena.
- If the patient responds to Haloperidol, it is better to continue the drug with the lowest possible dose.
- If the patient did not respond or if the patient or his caregiver choose, alternate drugs can be prescribed which have the least chance of developing movement disorder.

30. A 25-year-old male patient with refractory schizophrenia is under clozapine 400 mg/day in bid dose for 4 weeks with good response though the derogatory and distressful voices still present. Due to his associated obsessional doubt, fluoxetine 40mg/day is given. After developing a sudden seizure attack, he has been prescribed sodium valproate 600 mg /day. Now the patient comes with a further seizure attack.
    a) Prepare a checklist for the assessment of this case.
    b) Outline the treatment plan.

Given information

Demography and referral
Age-25 years
Sex- Male
Referred to-Psychiatric facilities
Reason for attendance- Seizure episode

Chief complaints
- Seizure attack 2 times following multiple psychotropic medication
- Hearing voices as part of the symptoms of schizophrenia
- Obsessional doubt

History of present illness
Schizophrenia, refractory under clozapine therapy (400 mg/day)
Good treatment response but derogatory auditory hallucination present
Comorbid OCD present for which getting fluoxetine (40 mg/day)

Medical history
Seizure most likely due to the effect of current medication. Valproate (600 mg/day) is prescribed for seizure but further attack occurred.

Extracted information

The man is a case of treatment refractory schizophrenia. Active derogatory hallucinatory voice is present that makes the patient distressful though other symptoms are remitted as evident by the word 'response.' This condition is not sufficient to say the condition as partial remission or clozapine resistant schizophrenia as the clozapine therapy goes 4 weeks.

Further increment of clozapine at the highest therapeutic dose is difficult because of seizure attack that is likely a side effect of clozapine. At the same time there could be a possibility of rapid increment that may cause seizure.

Situation is clumsier due to comorbid OCD and its treatment with fluoxetine. The fluoxetine also decreases seizure threshold and seizure attack possibly due side effects of both the drugs.

Despite giving valproate 600 mg/day the seizure is uncontrolled that is further indicative lowering of seizure threshold.

Assigned task

a) Checklist for the assessment

- Details of two seizure episodes- Onset, types, duration, fall, injury from the reliable informant, and video telemetry (if any) checking, EEG report with special emphasis on time relation with medication.
- Evaluating the present status of types, severity, extent and the patients' reaction to symptoms of schizophrenia.
- Evaluating dose increment schedule- Rapid increment can cause the precipitation of seizure.
- Comparing the present status of symptoms with the symptom status prior to clozapine therapy.
- Evaluating the overall OCD condition and its details of drug treatment with fluoxetine particularly, duration of treatment and response.
- History of OCD or any other psychiatric disorder including treatment and outcome.
- History of epilepsy (if any) either primary or due to side effects of psychotropic medication.
- Patient's and caregiver's perception and expectation about the disorder, management and treatment outcome.
- Risk assessment as there are still derogatory voices which increases risk of harm to self and others.
- Psychometric tool: BPRS (Validated in Bangla).
- Investigation:
  1st line- Routine investigation: CBC, LFT, S. Creatinine, EEG
  2nd line- CT scan or MRI for any secondary cause of seizure.

b) Outline treatment plan

- Explanation and advice and support to the patients and caregivers about the overall situation and further intervention.
- Increasing the dose of valproate at optimum level.
- If uncontrolled, omission of fluoxetine and applying non drug measures like ERP/CBT for OCD.
- If uncontrolled, reduction of clozapine and then increasing more slower than before with careful observation and video monitoring.
- Cognitive remediation therapy for residual schizophrenia symptoms.
- If the condition is clozapine refractory schizophrenia- applying a feasible protocol.

31. A 20-year-old married girl admitted in the neurosurgery department who becomes unconscious and has a small intracranial hemorrhage in the right frontal region after falling from a rickshaw. After conservative treatment, she becomes stable. However, suddenly she developed difficulty in speech, frequent fit, weakness of limbs, tempered behavior, sleep disturbances, and for that referred to psychiatry. The girl did excellent in her HSC exam and is currently preparing for university admission test. She is six-week pregnant. Her family members are markedly worried about her situation.
    a) What is the best possible diagnosis?
    b) Outline the management plan.

Given information

Demography and referral
Age- 20 years
Sex- Female
Occupation- Student
Marital status- Married
Referred from neurosurgery department

Chief complaints
- Difficulty in speech
- Frequent fit
- Weakness of limbs
- Tempered behavior
- Sleep disturbances

Onset- sudden

Personal history
Six-week pregnancy
Preparing for University admission test

Medical history
Small intracranial hemorrhage due to fall currently stable with conservative treatment.

Extracted information

Traumatic brain injury (TBI) status
Development of symptoms after fall indicates it is a case of TBI. But it was not severe enough and recovery was complete with conservative management. So, it can be concluded that presenting symptoms are not due to neurological abnormality.

Stressors/precipitating factor
Early marriage
Pregnancy
Highly intelligent and excellent result in HSC
Upcoming admission exam

Perpetuating factors
She may perceive possible academic failure
Pregnancy
Reinforcement from family members.

Assigned task

a) Best possible diagnosis

From the given information and its extraction, the best possible diagnosis is Dissociative neurological symptom disorder/ Conversion Disorder with mixed symptoms because
- The problems have onset following TBI but the severity and extent of symptoms do not match the pathology.
- Symptoms persist though TBI has been managed.
- Patient has multiple stressors.
- Persistent reinforcement helps to maintain the symptoms.

b) Management

Referral note should include:
- The diagnosis
- Management outline with proper explanation
- Follow up plan

- Preventive strategy

32. A 28-year-old woman presents in psychiatry OPD who suddenly starts hitting her newborn baby 7 days after child's birth. This repetitively happens and threatens the baby's life. The woman looks very indifferent.
    a) Prepare a checklist of assessment mentioning the areas and reasons.
    b) What could be possible diagnoses?
    c) Outline the management plan for this case.

Given information

Demography and referral
Age- 28 years
Sex- Female
Referred to- Psychiatry OPD

Chief complaints
- Hitting her newborn baby after 7 days of birth
- Hits in a manner that is threatening to baby's life

M/S/E finding:
Affect- Indifferent

Extracted information

The woman has developed the problems after 7 days of her childbirth. So, the duration is more than 7 days.

Among the postpartum psychiatric disorders, most common is depression. However, this is not postpartum depression because the onset is not insidious rather sudden and mood is incongruent as her affect was indifferent. Core features and other features of depression are also not mentioned.

Most likely it is due to psychotic features as the onset is sudden the patient hits the child brutally and appears indifferent.

[NTK:
Common postpartum psychiatric disorders are as follows:
MDD
Bipolar disorder
Delirium
Schizophrenia spectrum disorders
Other psychiatric disorders (e.g. Anxiety disorder, OCD)]

Assigned task

a) History checklist

- Risk assessment for the baby (for making a decision whether the child can stay with the mother and can be breast-fed).
- Risk assessment for the mother (any commanding voice, chance of suicide).

- Other psychotic features (delusion, hallucination, disorganized speech and negative symptoms) and mood of the patient.
- Past psychiatric illness.
- Any previous post-partum episode.
- Family history of mental illness.
- Drug and treatment history.
- Family support of the patient and other resilient factors.

b) Best possible diagnosis

Based on the extraction of given information, the best possible diagnosis is Schizophrenia spectrum disorder/Brief psychotic disorder with postpartum onset. Traditionally it has been termed as postpartum psychosis.

c) Management plan

- Hospitalization.
- Child should be separated from the mother and breastfeeding should be supervised.
- Drug management
  If the patient has had a similar episode before and responded to a specific drug, that drug should be reinstituted. Otherwise,
  -Tablet haloperidol or olanzapine for psychotic features.
  -Tablet clonazepam for immediate tranquilization of the patient and ensuring sleep for the first few days.

33. A 27-year-old male presents at the gastroenterology ward with the complaints of severe abdominal pain and hematemesis. He reports tenderness during palpation and distress. Subsequent investigations revealed no abnormality. Review of the medical record shows that this is the third time in the past year that the patient has appeared for medical attention. On each previous occasion, no identifiable medical problem could be uncovered. Despite his hematemesis in the ward as he said, neither he is able to show nor is observed. He has been referred for psychiatric evaluation. When he is confronted with the history, the patient confesses that he manufactures his symptoms before coming to the hospital. He says that he knows this is wrong, but he cannot stop himself from doing this.

a) What is the most likely diagnosis for this case on the basis of logical deduction of given information?
b) Mention your assessment and treatment plan.

Given information

Demography and referral

Age- 27 years
Sex- Male
Referred from- Gastroenterology department
Referred to- Psychiatry department

Chief complaints:

- Severe abdominal pain- duration not mentioned
- Hematemesis, neither showed by patient nor could be observed

Past medical history

Sought medical help twice in the past year but no abnormality was found.

Physical examination
Tenderness during palpitation and distress.

Investigations
NAD

On confrontation by psychiatrist- patient confesses that he manufactures the symptoms and despite knowing its wrong, he cannot stop himself from doing this.

Extracted information

This is the third time the young man seeks medical attention for his gastrointestinal problem. In each episode, no objective evidence has been found despite thorough physical examination and investigations. This clearly indicates deliberate production of physical symptoms.

The young man used to hide his deception associated with symptom production. However, when confronted by a psychiatrist, he admits that he manufactures the symptoms. Despite knowing it is wrong, he could not stop himself from doing this. His only motivation behind this is presenting himself as physically ill.

No obvious secondary gain or external rewards associated with the falsification of symptoms.

Deliberate production of physical symptoms is found in factitious disorder and malingering. It is the motive which differentiates these two. A malingerer produces symptoms to gain materialistic, achievable benefit or reward. On the other hand, a person suffering from factitious disorder deliberately produces symptoms only in order to obtain a sick role.

Assigned task

a) Diagnosis

From the logical deduction of given information, the most likely diagnosis is Factitious disorder imposed on self/ Factitious Disorder Imposed on self, Recurrent episodes.

b) Assessment and treatment plan

Assessment
- Whether the man has any external benefit from this falsification of symptoms.
- What do his family members or significant others think about his illness?
- Predisposing, precipitating and perpetuating factors.
- Comorbid psychiatric illness.
- Resilient factors.

Management
- Minimizing mortality and morbidity.
- Minimizing harm.
- Steering the person toward treatment in an empathetic, non-confrontational and face-saving manner.
- Treating underlying psychiatric disturbances.

- Appointing a guardian for medical and psychiatric decisions.

34. A 32-year-old woman appears in psychiatry OPD with incoherent talks, excessive religiosity, marked lack of concentration, agitation, excessive talkativeness and marked distress for 3 days. She has relocated to a new house 2 months back and cannot adapt herself with the new situation. Further, she watches a video that contains horrific afterlife fiction.
    a) What information do you need to gather to reach a diagnosis?
    b) What could be your treatment plan?

Given information

Demography and referral
Age- 32 years
Sex- Female
Referred to- Psychiatry OPD

Chief complaints
- Incoherent talks
- Excessive religiosity
- Marked lack of concentration
- Agitation
- Excessive talkativeness
- Marked distress

Duration of illness- 3 days

Stressors
Relocation & failed to adapt
Watches horrific video

Extracted information

The middle-aged woman has been relocated to a new house 2 months back and since then she cannot cope up with the new situation. Moreover, she watches a video showing horrific afterlife action which made her more distressed. She cannot cope with the first stress and later on the 2nd event takes place. Therefore, defense mechanisms for both the events are playing a role in psychopathology.

Stress is related to almost all psychiatric disorders. However, it is directly related to depressive disorders, conversion disorder and trauma and stressor related disorders.

In this case, the features of distress, agitation and lack of concentration have been present for 3 days. Core features of depressed mood and lack of interest need to be evaluated. If it can be established, the provisional diagnosis of depressive disorder can be made. Conventionally it can also be termed as transient depressive symptoms.

Conversion disorder is another possibility. Psychotic presentation of conversion disorder is often found in South Asia due to the impact of culture on symptom presentation. In conversion, usually a person is indifferent about his/her apparently severe disability. Here, distress is present which may be a defense mechanism as a result of partial conversion.

Relocation is a kind of ordinary stress. The emotional and behavioral symptoms presented by the woman within 3 months of exposure to the stress raises the possibility of adjustment disorder. However, watching horrific videos may be a kind of extraordinary stress if the person perceives it as such. Considering these factors trauma and stressor related disorder remains an important differential.

Assigned task

a) Information needed for diagnosis

- How the relocation affects the woman, whether she perceives it as a stress or not.
- Mood (predominance, persistency and pervasiveness).
- Presence of any psychotic-like feature.
- Features of depression.
- Any gain associated with the symptom production.
- Past medical or psychiatric illness.
- Personal and family history.
- Premorbid personality of the woman.

b) Treatment plan

- According to diagnosis.
- Adjustment disorder
    - Resolving stressful problems and aiding to the natural process of adjustment
    - Encouraging problem solving coping responses
    - Anxiolytic may be needed for short term

35. A 21-year-old female appears with fear of increasing weight despite having significantly low body weight. She takes a low quantity of food, does vigorous exercise, and long cycling with the aim of burning calories. She repeatedly confronts her parents about their concerns of her low body weight. Occasionally, she takes an excessive amount of food and vomits thereafter.
    a) What is the most likely diagnosis?
    b) Outline the assessment plan.

Given information

Demography and referral
Age-21 years
Sex-Female

Chief complaints
- Fear of increasing body weight despite of significantly low body weight
- Thought related compensatory behavior like decreased food intake & increase calorie burning
- Confronts parents
- Parents concerned about low body weight

Extracted information

The weight loss is pathognomic because the girl has significantly low body weight though she takes compensatory measures to reduce weight further. The pattern is very much suggestive of eating disorders considering the age and gender.

Despite having significantly low body weight, she has compensatory behavior to burn calories & she repeatedly confronts her parents about their concerns of her low body weight. That means she has a distorted perception of body weight. Restriction of energy intake leading to significantly low body weight along with distorted cognition about body weight and shape is the core diagnostic feature of anorexia nervosa.

Excessive intake followed by vomiting is usually found in bulimia nervosa & binge eating disorder, but bulimic & binge eaters usually have normal or increased body weight & their main complaint is impulsive intake of food not fear of increasing weight.

In normal excessive eating a person has control over eating. However, in binge eating there is excessive and impulsive intake and the person does not have control over eating.

Assigned task

a) Diagnosis

From the logical deduction of given information, the best possible diagnosis is Anorexia Nervosa with significantly low body weight, binge-purge pattern/ Anorexia Nervosa Binge-eating/purging type.

b) Assessment plan

Assessment of eating

- How low is the body weight?
- Need for hospitalization?
- What is a typical day's eating? What are the mealtime arrangements at home and at school/ work?
- To what degree is she attempting restraint?
- Is there a pattern? Does it vary? Is eating ritualized?
- Does she avoid particular foods? If so, why?
- Does she restrict fluids?
- What is her experience of hunger or of any urge to eat?
- Does she feel out of control?
- How do binges begin? How do they end? How often do they occur?
- How does she make herself vomit?
- Does she take laxatives, diuretics, emetics, or appetite suppressants? If so, with what effects?
- Does she fast for a day or longer?
- Can she eat in front of others?
- Does she exercise? Is this to 'burn off calories'?

Assessment of psychological issues

- What does she feel about her body and her weight?
- If she is restraining her eating, what is her motivation?
- Does she feel fat? Does she dislike her body? If so, in what way?
- Does she have a distorted body image? If so, in what way?

- What does she feel would happen if she did not control her weight or her eating?
- Does she fear loss of control? Is she able to say what she means by this?
- Does she feel guilt or self- disgust? If so, what leads her to feel this?
- Does anything about her disorder lead her to feel good?
- What are her feelings before, during, and after binges?
- What has she told others about her eating disorder— if anything?
- What does she think about her disorder? What does she make of it?

Assessment of impacts
Health impact and impacts on personal and social life.

Risk assessment
Risk of suicide and other self-harm behavior.

Strength assessment
The strength of the girl which can be used for management of eating disorders.
Parents perception and expectation
What is their idea about such a type of behavior? What do they already know? What do they expect from psychiatric management?

Assessment of comorbid psychiatric illness
Depression, obsessive compulsive and related disorder (esp., skin picking, hoarding disorder) and impulse control disorder (commonly present).

General and systemic examination
Body weight & BMI, pulse & BP, temperature. System specific examination for assessing impact of low food intake.

M/S/E
Depressive symptoms; characteristic psychopathology of anorexia nervosa.

Investigation
CBC with ESR with PBF, blood urea & serum electrolyte, blood glucose, LFT, TFT & ECG.

36. A 27-year-old woman with a third trimester pregnancy comes with self-muttering, aggressiveness and suicidal attempts. She believes that her family members will kill her baby.
    a) How will you assess this case keeping in mind the diagnosis?
    b) Outline the management plan.
    c) What information do you need to provide the caregivers based on your prediction?

Given information

Demography and referral
Age- 27 years
Sex- Female

Chief complaints:
- Suicidal attempt
- Self-muttering
- Aggressiveness
- Belief that family members will kill her baby
  Duration not mentioned, seemingly recent

Obstetric history
3rd trimester pregnancy

Extracted information

The pregnant woman presents with a suicidal attempt in her third trimester. Most common psychiatric disorders related to suicidal attempts are depressive disorder and psychotic disorder. In this scenario, suicidal attempts may be due to derogatory/commanding hallucination or may be due to severe depression.

The woman has self-muttering behavior which is most likely to be in response to a hallucinatory voice. Aggressiveness may also be due to delusion or hallucination. The woman also believes that her family members will kill her baby. This belief can be explained by persecutory delusion.

Considering the scenario, the most possible diagnosis is schizophrenia spectrum disorder. Another differential to be considered is MDD with mood congruent psychotic features.

[NTK:
About 95% peripartum cases can be diagnosed as a separate disorder
Most common psychiatric diagnoses in peripartum period are
1) MDD
2) Bipolar disorder
3) Schizophrenia
4) Delirium
5) Anxiety (mostly in 1st trimester)

Completed suicide
15-20% due to MDD
5-10% case due to psychosis
5% due to Substance related disorder
10% due to other causes (e.g. PD)]

Assigned task

a) Assessment

Symptoms
Extent, severity and other associated features
Schizophrenia- incoherence, other delusions, hallucinations
MDD-mood, onset, other features of depression

Past H/O psychiatric illness
Psychosis/depression [60% MDD & 30% psychosis relapse during pregnancy]
Previous peripartum episode

Impact
Impact on personal and familial life (e.g. Poor nutrition and hygiene, impact of suspicion toward others).

Treatment history

Pattern of help seeking behavior? History of taking management from traditional healers? History of taking drugs? Treatment history in previous episodes, if any.

Risk assessment
For the mother & the baby.

Strength & support of the family
Emotional, Physical or economic strength.

Current obstetric status and co occurring other physical illness
General health status of the mother and fetus in utero/presence of any physical disorder like DM, HTN, Thyroid dysfunction/ drug history.

General and systemic examination
General examination of appearance, body weight, nutritional status, anemia, edema and other relevant examinations. System specific examination especially the obstetric status.

M/S/E
Appearance- general and facial appearance, gesture, posture, rapport, odd social and odd motor behavior.
Mood- Depressed, anxious or apathetic?
Speech and thought- Negative automatic thoughts, suicidal thoughts and delusions.
Perception- all modalities of hallucinations.
Insight- present or absent.

Investigation
General health status- CBC, Blood grouping & Rh typing, RBS, SGPT, S. creatinine, Urine R/E, TFT, USG of pregnancy profile.

b) <u>Management plan</u>

i. Hospitalization
If risk is severe; if liaison between psychiatric & obstetric care needed; general physical condition not good enough; chances of non-compliance; lack of social support.

ii. Biological management
After evaluation of drug history,

For psychosis
FGA preferably haloperidol/trifluoperazine/chlorpromazine.
SGA olanzapine/clozapine/ lurasidone.

For depression
Amitriptyline/imipramine/nortriptyline/sertraline/fluoxetine.

For sleep
Amitriptyline, antihistamine- promethazine.

c) <u>Information</u>

Prediction of what the disease could be & prediction of risk & explanation to the family members.

36. A 32-year-old man appears in psychiatry OPD with a family member who suddenly becomes suspicious, hears threatening voices of aliens, controlling the experience of preventing him from doing his desired act for 2 weeks. He had a manic episode one year back that responded well in treatment. He looks fearful, agitated and excited.

a) What is the best possible diagnosis?

b) Outline the management plan.

Given information

Demography and referral
Age- 32 year
Sex-Male
Referred from- Psychiatry OPD

Chief complaints

- Sudden onset suspiciousness-2 weeks
- Hearing voices- same duration
- Controlling experiences, which prevent him to do his desired act- same duration

M/S/E finding
Appearance-fearful, agitated, excited

Past psychiatric history
Manic episode 1 year back, treated and remitted

Extracted information

Considering the scenario, best possible differentials are,

- Brief psychotic disorder (if this episode is found to be a separate one)
- Schizophrenia (if the manic episode is actually a part of psychosis and in between the episode the man shows residual features)
- Schizoaffective disorder (if the past manic episode was mixed with schizophrenia like features and current features is without effective features)
- Substance or medication induced psychotic feature either in intoxication and withdrawal state (psychotic feature usually non-bizarre type)

Sudden onset of unexplained suspiciousness indicates psychopathology of psychosis. It may be a response to the delusion of persecution or reference. Hallucinatory voices may also raise suspiciousness.

Hearing the voice of aliens and controlling experiences (passivity phenomena) is a hallmark of schizophrenia. Though the duration is of 2 weeks the pattern of symptoms are very much predictive of schizophrenia.

As the onset is sudden, the person becomes fearful of the experiences. Unprovoked agitation and excitement cannot be explained by any other psychopathology except disorganized behavior of psychosis.

Considering all it can be said that this person has psychotic disorder with prediction of the course towards schizophrenia. Detailed assessment and closed follow-up is essential for this case.

Assigned task

a) Best possible diagnosis

From the given information and the logical deduction, the best possible diagnosis is Acute and transient psychotic disorder/ Brief Psychotic Disorder with prior H/O manic episodes.

b) Management plan

General management
Explanation and reassurance to the caregiver.
Ensuring hydration, nutrition and personal hygiene.

Specific management
- Biological management- atypical antipsychotic drug (e.g. Risperidone/Olanzapine) with anticholinergic if needed.
- Sedative drug in low dose to control agitation in the first few days.
- Follow up after one week.

[NTK-previous manic episode may be prodrome of schizophrenia or may be a clear manic episode. 10% schizophrenia patient start with bipolar]

37. A 25-year-old woman has rushed to the emergency department asking for help. She describes recurrent episodes of fearfulness, palpitation, faintness, hyperventilation, dryness of the mouth with perioral paresthesia and carpopedal spasm. Her symptoms last 10-15 minutes and have increased since their onset 3 months ago. She is worried she may be having a heart attack. An ECG shows sinus tachycardia.
a) What is the single most likely diagnosis?
b) What is the immediate and ultimate intervention?

Given information

Demography and referral
Age- 25 years
Sex- Female
Referred to- Emergency department

Chief complaints
- Episodes of fearfulness
- Palpitation, faintness, hyperventilation, dryness of mouth
- Perioral paresthesia and carpopedal spasm
- Worry about heart attack
  Duration- 3 months, recurrent episodes, each episode- 10-15 minutes

Investigation
ECG- sinus tachycardia

Extracted information

The young woman rushed to the emergency as she felt she needed immediate help. Her symptoms appear suddenly and reach a peak soon. Such a pattern suggests the possibility of cardiac events. It is likely that this young woman is extremely fearful of a heart attack.

The signs and symptoms are episodic, multiple, increasing number of episodes with decrease in inter episode period. As it is episodic, cardiac or other organic illness must have been excluded earlier. In such cases, symptoms are highly suggestive of somatic anxiety.

The episodic pattern of symptoms most likely suggestive of panic disorder. Here persistent fear of attack provokes further anxiety either as panic symptoms or as anxiety symptoms in between attack or both.

It may be due to other psychiatric disorders where the core component is somatic anxiety. These are:

Somatic symptom/somatic anxiety due to GMC/psychiatric condition/comorbid GMC & psychiatric condition.

Somatic symptom disorder with unexplained somatic symptom; not due to other psychiatric disorders (e.g. Depressive disorder, IAD).

Example: Headache may be due to

Somatic anxiety (GMC/psychiatric disorder)
Somatic Symptom Disorder
Other psychiatric disorder (depression, IAD)

However, any other features of such disorders are not mentioned and not indicative.

Assigned task

a) <u>Most likely diagnosis</u>

Core feature of the patient is somatic anxiety leading to hyperventilation. Hyperventilation syndrome is associated with high levels of anxiety i.e. fixed anxiety. Here the most possible diagnosis is panic disorder because the anxiety is fixed to the somatic symptoms raising the fear of death.

b) <u>Management plan:</u>

General management
Empathy, support, reassurance, paper bag ventilation/BDZ (Alprazolam, but NICE does not recommend)

Specific management
Biological management- SSRI (fluoxetine/sertraline)
Psychological management- Immediate- Relaxation exercise
Subsequent- CBT (thought challenge by explaining the somatic symptoms of anxiety, no findings of heart attacks on ECG)

[NTK:
Symptoms of anxiety

Somatic and autonomic
Palpitations
Difficulty in breathing
Dry mouth
Nausea
Frequency of micturition
Dizziness
Muscular tension
Sweating
Abdominal churning
Tremor
Cold skin

Psychic (psychological)
Feelings of dread and threat
Irritability
Panic
Anxious anticipation
Inner (psychic) terror
Worrying over trivia
Difficulty in concentrating
Initial insomnia
Inability to relax]

38. A 45-year-old woman has been brought to the psychiatry department by her sister who is sad and fatigued. She is eating more and has sleep disturbance and hears the voice of her husband who died 2 years ago.
Based on your logical deduction of the given information─
a) What is the most appropriate diagnosis?
b) Make the assessment plan for subsequent treatment plans.

Given information

Demography and referral
Age- 45 years
Sex-Female
Referred by- Family member
Referred to- Psychiatry OPD

Chief complaints
- Sad, fatigue- duration not mentioned, likely long
- Eating more- subsequent development
- Sleep disturbance- same duration
- Hearing voices of the deceased husband- same duration

Associated life event- Death of husband 2 years back

Extracted information

The middle-aged widow has been presented with sadness and fatigability which are important clinical findings of depressive disorders. Overeating and sleep disturbance are also found in depression.

Hearing the voice of the deceased husband is a psychotic feature. Third person auditory hallucination is usually found in schizophrenia spectrum disorder but also can be present in mood disorder with psychotic features and in abnormal grief reaction. However, in the schizophrenia spectrum, other psychotic features are also present along with hallucinations.

Abnormal or complex bereavement also presents with sadness, fatigability and transient psychotic features, but the duration is more than 6 months. Here, the duration is very much prolonged. Therefore, an abnormal grief reaction is unlikely.

Depressive features frequently found in grief reactions. Whether depression presents as a symptom or a separate disorder needs careful assessment. To be recorded as depressive disorder, global loss of self-esteem, retardation, guilt and suicidality have to be present none of which is stated in the scenario.

Assigned task

a) Diagnosis

From the logical deduction of given information, the most appropriate diagnosis is Major Depressive Disorder, severe with mood congruent psychotic feature

b) Assessment for treatment plan

Symptom assessment
Frequency, persistency and extent of mood symptoms
Psychotic symptoms
Comorbid psychiatric symptoms

Impact
Impairment in social, occupational and other areas of functioning

Etiological factor
Predisposing (e.g.- biological- mother depressed/co-morbid medical illness, psychological- early sexual abuse, social- socially isolated)
Precipitating factor
Perpetuating factor

Assessment of co-occurring medical illness

Risk assessment
Physical danger to self and others; suicidality; command hallucination.

Strength assessment
Financial capital, social capital, special ability.

Psychometric tool
BDI (Validated in Bangla)/ HAM-D for depression.

Past psychiatric history and drug history
Any previous mood episodes? Medication history?

Caregiver's perception and expectation
About her illness. Expected outcome from treatment.

39. A 20-year-old man appears in psychiatry OPD who has palpitation, dyspnea, chest compression, sweating and sleep disturbance. He trembles during his class presentations, worries to keep and make friends and finds it hard to be easy in social situations. For one year, he repetitively thinks about his past acts and upsets to find his possible faults. He worries about future events, cannot concentrate on his work and performs badly during exams.
Based on your logical deduction and interpretation of the given information in the scenario─
    a) What is the best possible diagnosis?
    b) Make a treatment plan for this case.

Given information

Demography and referral
Age- 20 years
Sex- Male
Referred to- Psychiatry OPD
Referred by- Self

Chief complaints
- Palpitations, dyspnea, chest compression, sweating
- Sleep disturbance
- Worries to keep and make friends; apprehension; social anxiety; poor concentration
- Repetitively thinks about past; upset with possible faults
- Performs badly during exam

Extracted information

Chief complaints of the young man can be deconstructed into somatic symptoms (palpitations, dyspnea, chest compression, sweating) and psychic symptoms (worries to keep and make friends; apprehension; social anxiety; poor concentration; repetitively thinks about past; upset with possible faults).

Considering the symptom pattern, most likely differentials are, generalized anxiety disorder, social anxiety disorder, panic disorder and mixed anxiety and depressive disorder.

Apprehensive thoughts about real life concerns and worry about past and future are core features of generalized anxiety disorder. The physical symptoms are somatic presentations of anxiety. Sleep disturbance and poor concentration are also diagnostic features of GAD. Upsetting with possible faults usually found in depression but here no other core feature of depression is present.

The student trembles during class presentations, cannot make and keep friends and finds it difficult to be easy in social situations. Together these features indicate anxiety in social situations where his activities might be monitored. But, worrying about real life issues and worrying about the past and future are against social anxiety disorder.

Very high level of anxiety may present with panic symptoms but here abrupt surge of intense fear is absent which is the core feature of panic disorder. So, panic disorder can be excluded.
Mixed depressive and anxiety disorder is unlikely because, core features of depression are low mood, lack of interest and negative cognition about self, world and future.

Bad performance during exams is evidence of functional impairment.

[NTK:
To diagnose a psychiatric disorder
- Presence of positive criteria i.e. core features & associated features
- Absence of negative criteria
- Persistency & predominance
- Impact criteria i.e. features causing serious impairment in 5 domains (personal, family, social, occupational & recreative) are needed]

Assigned task

a) Best possible diagnosis

According to given information and its logical deduction, the best possible diagnosis is Generalized anxiety disorder.

b) Treatment plan

General management
- Appropriate support, reassurance, empathy.
- Psychoeducation about the nature and course of the disorder.
- Discussing with the patient about treatment options.

Specific management
- Psychological management: Relaxation (exercise/meditation) initially followed by CBT.
- Biological management:
  Drugs can only be prescribed when the patient is highly upset and cannot concentrate on psychotherapy or when 1st line psychological management is not responding enough.
  - For short term- anxiolytics (centrally acting BDZ/peripherally acting propranolol).
  - When long term medication needed- Antidepressant in low dose/antipsychotic in low doses (e.g. sertraline 25 mg 1 tablet at morning after meal).
- Social management- Social skills training.

[NTK:
General consensus is that all anxiety disorder's management is mainly non-pharmacological.]

40. A 34-year-old man presents with low mood, low food intake and most of the time lies in bed in the last 2 months. he says that his abdominal structures are rotten as he is already dead and is surprised that no one is burying him.
    Doing logical extraction of the given information answers the following.
    a) What is the most likely diagnosis?
    b) Outline the management plan.

Given information

Demography and referral
Age- 34 years
Sex- Male

Chief complaints
- Low mood
- Low food intake
- Lying in bed
- Belief that his abdominal structures are rotten and he is already died

  Duration- 2 months

Extracted information

The middle-aged man has been referred for psychiatric assessment and management. He has a low mood which is the defining criteria of major depressive disorder.

Low food intake is possibly due to reduced appetite or food refusal.

Lying in bed due to psychomotor retardation (psychomotor retardation ranges from monotonous voice, slow pacing, increasing pause to lying in bed and ultimately stupor) possibly going to stuporous condition.

Belief that his abdominal structures are rotten and he is already dead is definitively suggestive of nihilistic delusion.

Assigned task

a) Most likely diagnosis

From the logical deduction of given information, the most likely diagnosis is Depressive disorder, severe, with psychotic symptoms/ Major Depressive Disorder with mood congruent psychotic feature.

b) Management

Thorough assessment especially treatment history, whether it is refractory depression or not and risk assessment for suicide and self-harm is essential prior to starting treatment.

Immediate management
Hospitalization (if patient denies than compulsory admission according to Mental Health Act, 2018)
Explanation and reassurance to the caregivers
Ensuring hydration and nutrition; care of bowel and bladder

Ultimate management
Biological management options depending on the patient's drug history

i. SSRI or SNRI (venlafaxine)
ii. TCA

iii. Combination of SSRI with antipsychotic drug
iv. ECT

41. A 62-year-old man presents with a low mood, does not find worth in living and lacks self-care. His son says that he frequently converses with his deceased wife who died 6 months back.
    a) What is the best possible diagnosis to explain his condition?
    b) Make a checklist of the information for the treatment plan.

Given information

Demography and referral
Age-62 years
Sex-Male
Accompanied by- Son

Chief complaints
- Low mood- duration not mentioned, likely long
- Does not find worth in living
- Lack of self-care
- Converses with deceased wife who dies 6 months back

Extracted information

The old widower presents with a low mood which is suggestive of depressive disorder. At this stage of life depression is often related to bereavement. Death of the man's wife 6 months back is definitely a stressor for him. The resulting symptoms could be a normal extension of bereavement or could be depressive disorder. However, if the duration was <6 months the diagnosis could be MDD or complex bereavement; as the duration is > 6 month so it is MDD.

Lack of self-care indicates anhedonia and impaired functioning.

"Does not find worth living" is a negative cognition & it indicates suicidality.

Psychomotor retardation, decreased self-esteem and suicidality are three important features which is present in MDD but rarely present in bereavement.

Conversation with his deceased wife suggests either he has been living with dead wife in an imaginary world and withdraws himself from the environment or strong possibility of having hallucination.

As the old man is accompanied by his son, it can be assumed that his son is concerned about his health.

Assigned task

a) Best possible diagnosis

   From the logical deduction of the given information, the best possible diagnosis is Depressive disorder with psychotic symptoms/ Major Depressive Disorder with mood congruent psychotic feature

b) Checklist of information

Features of bereavement
Longing for the deceased wife, preoccupation with the circumstances of the wife's death, thoughts of joining her along with emotional and somatic features.

Features of depression
Feeling of inappropriate guilt, low self-esteem and suicidal thoughts along with other depressive features.

Features of psychosis
Thorough evaluation of hallucination; presence of delusion (of persecution, guilt, nihilism and others).

Treatment history
Any management in last 6 months, if yes then what was the outcome.

Co-occurring physical illness
DM, HTN, Thyroid dysfunction or others.

Co morbid psychiatric illness or substance abuse
Anxiety, depression, dementia, alcohol or substance use history should be evaluated.

Risk assessment
Risk assessment for suicide and self-harm.

Strength assessment
What are the strengths of the person (e.g.- family support) that can be used for management purposes?

Impact assessment
Level of impairment of the old man's social, occupational and other important areas of functioning.

42. A 31-year-old woman presents with two weeks following childbirth who loses feeling for the child, loses appetite, sleep disturbances & intrusive thoughts of harming the baby.
    a) What is your diagnosis that explains best of her condition?
    b) What treatment plan do you want to adopt for this case?

Given information

Demography and referral
Age- 31 years
Sex- Female

Chief complaints
- Losses feeling for the child
- Loses appetite
- Sleep disturbance

Duration- Starts 2 weeks following childbirth.

M/S/E finding
Thought- intrusive thought about harming the baby

Extracted information

The middle-aged woman comes two weeks following childbirth which is a high time for postpartum psychiatric disorders. Considering the given scenario, the possible differential diagnosis are,

i. Postpartum depression because she lacks interest in taking care of the baby, loses appetite, has sleep disturbance and intrusive thoughts of harming the baby following childbirth.

ii. Exacerbation of preexisting depressive disorder, if history of any previous episode.

iii. Obsessive- compulsive disorder because of intrusive thoughts of harming the baby. However, in absence of other features of obsession, the intrusive thoughts can be better explained by depression.

Assigned task

a) Best possible diagnosis

The logical deduction of given information suggests the best possible diagnosis is Mental or behavioral disorder associated with pregnancy, childbirth or the puerperium, without psychotic symptoms/Major Depressive Disorder with peripartum onset.

b) Treatment plan

General management
Explanation and reassurance, ensuring hydration and nutrition and hospitalization if risk of harming self or the baby and lack of support.

Specific management

i. Biological treatment
SSRI preferably Sertraline starting in low dose and gradual increment of dose according to response.
Low dose BDZ for short duration prn.

ii. Psychological treatment
CBT when acute symptoms resolve and the mother is capable of taking the therapy.

iii. Social management
Encouraging the mother to maintain daily life as far as she can.
The breastfeeding should be continued keeping in mind the peak plasma concentration of the drug. Another family member should be involved in caregiving of the newborn.

43. A 36-year-old female attends in psychiatry OPD who attempts suicide 10 times. There is no history of psychiatric problems and neurological examinations are normal.
a) Mention the areas of your assessment plan.

b) Outline the best possible management plan for her.

Given information

Demography and referral
Age- 36 years
Sex-Female
Referred to- Psychiatry OPD

Chief complaint
Suicidal attempt 10 times

Past psychiatric history
No psychiatric problems

Neurological examination
Reveals no abnormality

Extracted information

This middle-aged woman had a history of 10 suicidal attempts. However, she has no psychiatric problems. In the absence of psychiatric disorder, the most possible cause of repetitive suicidal attempt is socio-environmental factors like family conflict and adversity or repeated exposure to unbearable stressors.

The reason for repetitive suicidal attempts, risk factors of subsequent suicidal attempts and predictors of developing psychiatric disorder warrant evaluation.

Factors in her personality traits including stress coping abilities are also necessary to evaluate.

Even in absence of any psychiatric disorder or problem, reputed self-harm behavior itself is such a condition that needs clinical attention.

Assigned task

a) Areas of assessment

- Stress assessment especially relational stress and general ways of stress coping.
- Assessment of depression.
- Professional and financial areas- whether any problems regarding those areas.
- Problems unrelated to stress, rather problems with her problem solving.
- Personality assessment- Predominant affect, cognition, interpersonal relationship and impulsivity with special emphasis on features of borderline personality disorder.
- Predictors of suicide- Current and past H/O suicidal attempts, methods used, intent; personal H/O MDD; personal or family H/O depression.
- Current social circumstances of the woman.
- H/O drug or substance abuse.
- Personal and family history of psychiatric disorder.
- Resilient factor which can be used for management purposes (e.g. family bonding, religious values, professional efficiency).
- M/S/E
- Psychometric assessment

Modified scale for suicidal intent (MSSI) for assessing suicidality (validated Bangla version is available).
Validated MMPI for personality assessment.

b) Management plan

General management
Hospitalization if current suicidal intent is present.

Core management
Improving stress coping ability and problem solving.

Other management options
Explanation, Reassurance to the caregiver.
Psychological management- DBT for suicidality and BPD; CBT if associated cognitive distortion.
Biological treatment if needed (Lithium/Clozapine/SSRI are anti suicidal drug).
Social management- Social skills training.

[NTK: Disorders related to suicide psychopathology

1) MDD
Negative automatic thoughts, psychotic features with derogatory content, cognitive features blended with psychotic features.
Predictors of suicide in depression- marked retardation and persistent negative cognition; repetitive psychotic features like delusion (nihilism, others), hallucination (derogatory); Psychosocial adversity; Past history and pattern of self-harm.

2) Bipolar disorder
Depression (suicide 15-20%)
Mania (suicide 5-8%)

3) Schizophrenia and delusional disorder
Command hallucination/ imperative hallucination.
Persecutory delusion (2 forms: External- shows aggression and Internal- searching for persecutor, fearful, anxious).
Purely due to passivity (made thought, act, impulse, affect and emotion).
Reaction to delusional belief; could be bizarre/non- bizarre.

4) Substance use disorder
Alcohol/ others

5) Personality disorder
Borderline- impulsivity, fear of abandonment (attempts more common than completed suicide), attention seeking, depression.
Histrionic and antisocial- depression, impact of the disorder.
All PD- persistent failure to cope with stress.

Prevalence of suicide is 7.8%
Attempted suicide- 20-40% cases have psychiatric disorder; 60% cases have not.

Causes of suicide-
- Psychiatric disorder

- Chronic long-term debilitating condition
- Stress (relational, financial etc.)
- Social causes such as poverty, war, brainwash etc.]

Things to be remembered during assessment of the middle-aged woman are,

- Whether intent of suicide was present or not? Whether attempts were impulsive?
- The woman is under stress and failed to resolve. The suicidal attempts are cry for help.
- Impaired problem-solving ability.
- Possibly intent is low because 10 times attempt. However, the expression of committing suicide is a way of help seeking.]

44. A 71-year-old man has been admitted in internal medicine who presents with fever for 3 days and confusion. There is no significant past medical history. He has got a psychiatric referral.

a) What is the best possible diagnosis?
b) List the information you need for managing the case.
c) How will you manage the case?

Given information

Demography and referral
Age- 71 years
Sex- Male
Referred from- Internal medicine
Referred to- Psychiatry

Chief complaints

- Fever for 3 days
- Confusion

Past history
No past medical history

Extracted information

The old man has got a referral from internal medicine and he has no prior medical history. It can be assumed that he does not have a psychiatric history as well.

The man has had a fever for 3 days. Most likely it is due to infection as no prior medical history is present. Confusion develops as a consequence of fever.

The old male has been referred from internal medicine to the psychiatry department. The most likely reason behind this is development of behavioral disturbances following fever and confusion. Confusion and behavioral disturbance develop after fever is most likely due to delirium.

Assigned task

a) Best possible diagnosis
From the given information and its extraction, the best possible diagnosis is Delirium.

b) Information needed

History

- Baseline cognitive function and recent changes in mental status.
- Recent changes in disorder, new diagnoses, complete review of systems.
- Drug history including OTC drug and herbal preparation; drug interactions.
- Any H/O alcohol or sedative drug.
- Any pain or discomfort (e.g.- Urinary retention, constipation, thirst).

General examination

Temperature, oxygen saturation, RBS, pulse, BP.

Physical and neurological exam

Occult infection, dehydration, acute abdominal pain, DVT, other acute illness; sensory impairments, focal neurological signs, meningeal signs.

Investigations

Routine: CBC, urine R/E, RFT, LFT, serum calcium, RBS, arterial blood gas, serum electrolytes, blood culture, syphilis serology.

Contextual- Urinalysis, CXR, drug screen, cardiac enzymes, MRI/CT scan of brain, EEG, lumbar puncture.

c) Management

General measures

- Relieve distress, control agitation and prevention of exhaustion.
- Reduction or omission of psychoactive drugs (e.g.- anticholinergic, sedative or opioids); lower dosages; avoidance of prn dosing; non-drug approach for sleep and anxiety.
- Management of medical issues (infections, metabolic disorders); hydration and nutrition; managing hypoxia.
- Reorientation strategies- Encouraging family involvement; avoidance of unnecessary staff change; addressing sensory impairment.
- Maintaining safe mobility.
- Normalizing sleep-wake cycle- Discouraging napping and encouraging exposure to bright light at daytime; non-pharmacological sleep protocol and quiet room at night with low level lighting.

Specific management

- Pharmacological management if there is severe agitation or severe psychotic symptoms.
- Antipsychotic medications are 1st line. Haloperidol 1-5 mg/day, at every 6 hours, 1st dose can be given IM.
- Contraindications of APD: co existing dementia especially Lewy body dementia; alcohol withdrawal and epilepsy (risk of seizures). In these cases, Lorazepam can be used.

[NTK
Core feature of delirium
Confusion

Other features
Onset- Rapid onset

Fluctuation over 24- hour period
Course- Temporal course
Appearance and behavior- Agitation
Perplexity
Behavioral and other symptoms
Mood- Irritability
Affect- Labile affect
Speech- Word finding difficulty
Thought- Thought disorder
Delusions
Perceptions- Perceptual disturbances
Cognition- Impaired attention
Disorientation about time and place
Impaired memory
Reversal of sleep-wake cycle]

45. A 36-year-old man with a history of schizophrenia is brought to the emergency department by his friends due to drowsiness. On examination, he is generally rigid.
Doing logical deduction and interpretation of the given information─
a) What is the single most likely possible diagnosis?
b) Outline the assessment and management plan?

Given information

Demography and referral
Age- 36 years
Sex- Male
Referred to- Emergency department

Chief complaints
- Drowsiness
- Generalized rigidity

Present psychiatric diagnosis
Schizophrenia

Extracted information

The middle-aged man is a diagnosed case of schizophrenia. Most likely he is under neuroleptic medication. He has been present with drowsiness and generalized rigidity. Considering the scenario, The best possible differential diagnosis are,
- Neuroleptic malignant syndrome
- Catatonia
- Meningoencephalitis

Assigned task

a) The best possible diagnosis

The best possible diagnosis is neuroleptic induced NMS because the patient is a diagnosed case of schizophrenia so he must be on antipsychotic. Other drug induced EPSE does not cause generalized rigidity. In catatonia, the patient may be rigid but no drowsiness present. Meningoencephalitis is associated with fever and presence of other objective evidence and investigation reports.

b) Assessment and management

Symptoms of NMS

- Motor and behavioral symptoms- generalized rigidity, agitation, restlessness.
- Autonomic symptoms- hyperthermia, hypo/hyperthermia, tachycardia/bradycardia, tachypnoea.
- CNS/ mental/cognitive symptoms- confusion and other behavioral symptoms, visual hallucination, illusion.
- Complication- ARF, thromboembolism, cardiovascular collapse.

Information need to be gathered

- Drug history- name, dose, duration of the psychotropic and h/o anticholinergic drug.
- Other relevant medical history.
- Comorbid substance use.
- Physical exam- pulse, BP, temp., hydration status, catatonia
- Investigation
  CBC with ESR
  SGPT, CPK
  Renal function test, liver function test
  ECG

Management

- Stop the offending drug
- Oxygen inhalation
- Rehydration
- Alkaline diuresis (NaHCO3)
- Hemodialysis if needed
- D2 agonist- dantrolene, amantadine or bromocriptine
- Benzodiazepine

Prevention

Rational prescribing: starting low, going slow and precautionary follow up.
Early diagnosis of symptoms (Not to get confused with worsening of psychosis).
Managing physical illness properly.
After recovery, reassessing and reintroducing drugs of low potency.

46. A 30-year-old woman in tears describing constant irritability with her 2 small children and inability to relax. She describes herself as easily startled with poor sleep and disturbed nightmares following a house fire a year ago, while the family slept.

a) What is the most likely diagnosis?
b) What treatment will you offer this woman?

Given information

Demography and referral
Age- 30 years
Sex- Female

Chief complaints
- Irritability
- Inability to relax
- Startled with poor sleep
- Disturbing nightmare

Predisposing factor
House fire a year ago.

M/S/E findings
Appearance- tearful.

Extracted information

Tearful appearance and constant irritability are features of emotional disturbance, mainly depression. Startled responses are evidence of hyperarousal and nightmare re-experiencing. These two features are not characteristic of depressive disorder.

All the features start after an incident of house fire which is most likely to be perceived by the patient as extraordinary stress. Emotional and behavioral features after stressful events that can be better explained by stress indicates trauma and stressor related disorders. Considering the extraordinary nature of the stressful event, the differentials may be acute stress disorder or post-traumatic stress disorder. However, the duration is about a year thus the diagnosis of acute stress disorder can be ruled out.

PTSD remains the best possible diagnosis as the following features start after an extraordinary stressful event.
- Hyperarousal- Startled response
- Reexperiencing- Nightmare
- Negative alteration of mood- depression, irritability, tearful, tense

Assigned task

a) Most likely diagnosis

From the extraction of given information, the most likely diagnosis is Post traumatic stress disorder/ Posttraumatic Stress Disorder.

b) Treatment

Biological
SSRI preferably tablet fluoxetine/sertraline/paroxetine up to maximum licensed dose for depressive features.

Psychological
Psychotherapy
Individual psychotherapy- after getting workable recovery
Prolonged exposure therapy
Trauma- focused CBT can be considered
EMDR

47. A 25-year-old woman has schizophrenia and responded well with risperidone 8 mg/day. Subsequently she developed hyperprolactinemia and switched to aripiprazole. Her hyperprolactinemia is managed well but symptoms recur.
a) What is the checklist of information you need to gather as part of your assessment?
b) How will you manage the case?

Given information

Demography and referral
Age- 25 years
Sex- Female
Reason for referral
- Assessment and management
- Periodic follow up

Chief complaints
- Relapsing of Schizophrenia symptoms
- Replacement of medication to aripiprazole
- H/O neuroleptic induced hyperprolactinemia

Present psychiatric diagnosis
Schizophrenia

Treatment history
Risperidone 8 mg/d and developed hyperprolactinemia, so switched to aripiprazole.

Extracted information

Hyperprolactinemia produces bothering symptoms especially in this age and sex group of patients.

There might be possibilities of other adverse effects (e.g. hypersomnia, weight gain) because only hyperprolactinemia can be managed by other ways like reduction of the offending drug/ stoppage/switching/adding/ dopamine agonist.

As there are relapsing symptoms of schizophrenia so aripiprazole might not be working.

Probably the young woman has developed insomnia (due to schizophrenia or due to switching to aripiprazole) which is one of the troublesome symptoms.

[NTK: discontinuation symptoms more common with FGA, TCA and sedative-hypnotics]

Other causes of hyperprolactinemia may be excluded by the physician who switched to aripiprazole.

Assigned task

a) Checklist of information
- Relationship between dose of risperidone and appearance of A/E (whether patient can be switched to risperidone.
- Patient's socio-demography especially marital issues/child issues/study which is directly affected by hyperprolactinemia.
- What symptoms are produced due to hyperprolactinemia and how the patient is bothered?
- Other A/E, both desired (sleep) and undesired (weight gain)
- Current psychotic features that reappear after starting aripiprazole.
- Any withdrawal or discontinuation symptoms?
- Thorough drug history, before and after risperidone.
- Patient's current social circumstances, level of functioning.
- Thorough H/O schizophrenia including onset, course, predominant features and impact.
- Family history of psychiatric illness and treatment.
- Risk and strength assessment.

b) Management

The aim of management is to treat the relapsing symptoms and at the same time addressing the troublesome adverse effects. Therefore, the options are as follows.

i. If the patient never takes amisulpride/quetiapine, these drugs can be prescribed.
ii. Initiation of clozapine if appropriate.
iii. If possible, going back to risperidone and addition of aripiprazole/dopamine agonist.

Other non-drug measures for managing hyperprolactinemia related adverse effects should be promoted (e.g. physical exercise, weight reduction, and healthy diet plan).

[NTK:

Drugs causing hyperprolactinemia
Haloperidol, Chlorpromazine (FGA); Risperidone, Olanzapine (SGA)

No effect on prolactin
Quetiapine, Amisulpride, Clozapine

S/S of Hyperprolactinemia
Male: Gynecomastia, Galactorrhea, reduced libido
Female: Galactorrhea, Amenorrhea, reduced libido, development of ovarian tumor, Infertility.]

48. A 32-year-old man presented with mutism. Three weeks back he was markedly agitated. During the interview, he showed marked negativism.
Outline the steps of assessment.

Given information

Demography and referral
Age- 32 years
Sex- Male
Referred to- Psychiatry OPD

Chief complaints
- Mutism- for 3 weeks
- Agitation- same duration

M/S/E finding
Appearance and behavior- Negativism

Extracted information

The middle-aged man has mutism, agitation and negativism. These three are among other features of catatonia. Thus, it can be said the man has catatonia.

Catatonia is a psychomotor disorder characterized by-
i. Motoric immobility may be severe (stupor) or moderate (catalepsy and waxy flexibility).
ii. Decreased engagement may be severe (mutism) or moderate (negativism).
iii. Excessive and peculiar motor behaviors can be complex (stereotypy) or simple (agitation).

In extreme cases, the same individual may wax and wane between decreased and excessive motoric activity. In this case, the total duration of symptoms is three weeks and within this period the person shows agitation followed by mutism and negativism.

Catatonia usually occurs in the context of mood disorder, psychotic disorder and conversion disorder. Conversion disorder is unlikely in such a sociodemographic profile. Possibility of the psychotic disorder is less because the history is very short and no prior psychiatric history is mentioned. Considering the duration and symptom pattern, the catatonia is most likely due to depressive disorder.

Assigned task

Steps of assessment
- Pattern and extent of the catatonic features; presence of other catatonic features.
- Course of the catatonic features because catatonia has waxing and waning courses. Here, the patient was agitated 3 weeks ago. Now the patient is mute so other features might be present in these 3 weeks. Catatonic features are relatively unstable.
- Risk assessment- risk for self and others.
- Features present before 3 weeks-
    - Psychiatric disorder (Bipolar/MDD/Schizophrenia spectrum/ NDD esp. ASD/Conversion disorder).
    - Medical disorder (Neurological: Neoplasm, head trauma, CVD, encephalitis; Metabolic: hypercalcemia, hepatic encephalopathy, homocystinuria, DKA).
    - Medication or substance induced catatonia especially neuroleptic induced.
    - Isolated catatonia.
- General health condition
- Here, catatonia may be due to MDD because symptoms are of recent onset, starting with mutism and now presented with negativism. Agitation in between might also be a feature of depression and irritability.

- History of MDD that is whether there is retardation before agitation.
- Exclusion of Schizophrenia spectrum disorder or Bipolar disorder.
- Exclusion of medical causes, medication or substance.
- Baseline investigation.
- Lorazepam challenge test-
    - 1-2 mg Lorazepam IV; after 5 minutes the patient is reexamined. If no change, a 2nd dose is given and the patient is reassessed.
    - Positive response- marked reduction (at least 60%) of catatonic sign symptoms.
    - If IM or oral dose, interval of 2nd dose should be 15 to 30 minutes respectively.

49. A 30-year-old male brought to a psychiatric emergency who is severely excited, abusive and shouted continuously.
    a) Outline your assessment and management plan in the first step.
    b) What steps will you take to tranquilize this patient?

Given information

Demography and referral
Age- 30 years
Sex- Male
Referred to- Psychiatric emergency

Chief complaints
- Excited
- Abusive
- Shouting

Extracted information

Excitement, abusive behavior and continuous shouting in a middle-aged male person may occur in a severe stressful situation. However, the referral to psychiatric emergency indicates underlying psychiatric disorder. Most likely differentials could be schizophrenia spectrum disorder, acute mania substance related disorder and personality disorder.

Assessment should be based on longitudinal history and precipitating factors. In the schizophrenia spectrum, such type of behavior may occur in response to delusional beliefs of being persecuted or distressing hallucinatory voices. It may also happen as a part of disorganized behavior. Triggering factors lead to acute exacerbation of mania and the acutely disturbed violent behavior may result. Intoxicated person may display such behavior after recent ingestion of drugs or alcohol. Personality disorders, especially cluster B often show violent, disturbed behavior when they perceive threat or danger.

Assigned task

a) Assessment and management plan

History
Onset and the circumstances of the current episode.
Past psychiatric illness.

Co morbid medical illness.
Personal history including substance and forensic history.
Premorbid personality, especially cluster B PD symptomatology.
Risk assessment for suicide, self-harm and harm to others.
Strength assessment

Investigations
Dope test
Baseline investigations (CBC, SGPT, S. creatinine, RBS, Lipid profile, ECG).

Management
Rapid tranquilization protocol followed by general management of hydration, nutrition and personal hygiene and disorder specific management.

b) Steps for rapid tranquilization (Step 2 to Step 4 are stated based on locally available drugs)

Step 1
De-escalation, time out, placement as appropriate.

Step 2
Oral treatment:
If the patient is on regular antipsychotic, Lorazepam 1-2 mg/Promethazine 25- 50 mg can be added.

If the patient is not on APD, Olanzapine 10 mg/ Risperidone 1-2 mg/Quetiapine 50-100 mg/ Haloperidol 5 mg can be given.

Repeating after 45-60 minute if insufficient effect, considering combination of sedative and APD.
Switching to step 3 if 2 doses fail or the patient poses a significant risk.

Step 3
IM treatment:

Lorazepam 2 mg/ Promethazine 50 mg/ Haloperidol 5 mg.

Repeating after 30-60 minutes if insufficient effect, considering combining Haloperidol and Lorazepam/Promethazine.

Step 4
IV treatment:

Diazepam 10 mg over at least 2 minutes.

Repeating after 5-10 minutes if insufficient effect (up to 3 times).

Flumazenil should be kept at hand.

Step 5
Seeking expert advice for transferring into a medical unit for administration of IM ketamine (if available).

50. A 33-year-old man referred by an internist presents himself bearing huge medical documents. He says that he is sufficiently convinced that he has some sort of illness that causes multiple physical symptoms mainly palpitation, difficulty breathing and feeling of fainting but doctors could not find any disease. Now he avoids moving alone due to his extreme fear of death that caused serious disruption of his regular life. He expresses disappointment with his treatment and plans to go abroad for better management.
a)What is your diagnosis by doing logical extraction of given information?
b)Make an assessment plan for the case.

Given information

Demography and referral
Age-33 years
Sex- Male
Referred from- Internal medicine

Chief complaints
- Palpitation
- Breathing difficulty
- Feeling of fainting
- Extreme fear of death leading to avoidance of moving alone
  Duration- not mentioned, seemingly long

Past medical history
Brings a huge medical document.

M/S/E finding
Mood- Disappointment with medical treatment

Extracted information

The middle-aged man has been convinced that he has some sort of physical illness. However, the symptoms he experiences are not specific. For such symptoms he underwent a series of consultations and lots of investigations though nothing reveals any abnormality. Therefore, he is preoccupied with the illness related thoughts and planning to go abroad for better management.

Anxiety symptom is a core feature of any anxiety disorder and somatic anxiety is the commonest cause of looking for consultation. Somatic anxiety presents in somatic symptom disorder, illness anxiety disorder, anxiety disorders and depressive disorders.

Illness anxiety disorder (IAD) is of two types: primary and secondary (depression, OCPD, delusion of illness, schizophrenia, anxiety disorders ranging from panic to GAD).

In primary IAD, patients will either say the name of the disease or say the disease could not be identified. It is usually associated with depression. Sometimes it may present in obsessive form. However, in the scenario the man has palpitation and difficulty breathing which may lead to his suspicion of having some cardiac or respiratory disease. The extreme fear of death leading to disruption of life is the consequences of his increasingly heightened anxiety and related thought of possible illness.

Though it resembles a panic disorder, his heightened anxiety is not sudden and episodic like a panic attack. His fear of going out of home is related to fear of death due to illness not like agoraphobia

where thoughts and concerns are related to difficulty escaping in the worst situation. As panic disorder frequently coexists with IAD thorough assessment is necessary for comorbidity and possibility of future development.

Assigned task

a) The diagnosis

From the logical deduction of given information, the best possible diagnosis is Hypochondriasis /Illness Anxiety Disorder

b) Assessment plan

Details of the presenting symptoms
- Onset, duration, pattern and course of the symptoms.
- Whether the symptoms are the same or changing over time.
- Pattern of help seeking throughout the course of perceived illness.

Comorbid psychiatric illness
- With special emphasis on depression, OCD, GAD and delusional disorder (hypochondriacal)

Co-occurring physical illness
- Whether any medical disorder or derangement in investigation has been found during the medical assessment and whether it has any impact on the person.

Etiological formulation
- Predisposing factors- premorbid personality, childhood experiences about illness.
- Precipitating stress or conflicts.
- Perpetuating factors like any kind of incentive gains and benefits from sick roles.

Impact assessment
- Level of impairment in social, occupational, familial and other important areas of functioning.

Perception and expectation
- Knowledge and perception about the illness and expectation from the treatment of the man and his significant others.

Risk assessment
- Risk for self and others because chances of physical and financial exploitation.

Strength assessment
- Support system of the man that can be used for management of IAD.

Physical examination
- Careful evaluation of systemic examination as the patients are often dismissed as chronic complainers.

51. A 25-year-old woman has an intrusive thought that God is her husband. That causes her severe distress and she frequently begs pardon to God. Subsequently she started irresistible hair pulling that caused her relieved tension.
    a) Prepare a checklist of the assessment areas.
    b) Outline the management plan.

Given information

Demography and referral
Age- 25 years
Sex- Female

Chief complaints
- Intrusive thoughts that God is her husband
- Severe distress
- Begging pardon to God
- Irresistible hair pulling

Extracted information

Intrusive thoughts are presenting features of anxiety disorders, depressive disorders and obsessive compulsive and related disorders. The content and nature of the thought are important differentiating features. If the content is bizarre and distressing and patient beliefs that it is her own thought, then OCD is the final diagnosis. The obsessive thought is associated with compulsive behavior or avoidance of triggers.

In anxiety disorder the intrusive thoughts are related to real life stresses. In depression, the core feature is depressed mood and the intrusive thoughts are negative automatic thoughts.

Hair pulling is a diagnostic feature of trichotillomania. However, in this case trichotillomania can be ruled out because the hair pulling is a compulsion related to relieving tension of OCD.

Bizarre thought is one of the important features of schizophrenia but here the thought is intrusive in nature and ego dystonic type. Moreover, in schizophrenia intrusive thoughts are believed to be implanted rather than the patient's own thoughts. Thus, psychotic disorders can be ruled out.

Assigned task

a) Checklist for assessment

- Onset- insidious/sudden after any incident.
- Course and duration?
- Any previous episodes?
- Whether the thought is her own thought or it is an inserted one?
- Reactions to the thought.
- Associated compulsive behaviors?
- Other obsessive thoughts?
- Level of impairment in personal, academic, familial and other important areas of life.
- Family history of psychiatric illness especially OCD.
- Treatment history including drug history, non-drug measures (e.g. ERP, CBT) and compliance to the treatment.

- Comorbid psychiatric illness with special emphasis on depression.
- Co-occurring physical illness (e.g. thyroid dysfunction).
- Premorbid personality assessment.
- Risk assessment- risk of suicide and self-harm must be assessed as depression is frequently co morbid.
- Strength assessment for the resilient factors that can be used for management purposes.
- Psychometric tool
  Validated Y-BOCS symptom checklist
  Y- BOCS severity scale (Validated Bangla version is available)
  BDI (For comorbid depression)

b) Management

Biological management
Cap. Fluoxetine 20mg at morning with gradual increasing the dose over 2-3 weeks depending on improvement (Maximum 80 mg/day).
Addition of atypical APD (Aripiprazole/Risperidone) can be done if response to SSRI is poor.

Psychological management
Exposure and response prevention (Flooding or graded exposure).
CBT if associated cognitive distortions present.

52. A 25-year-old woman was brought to the emergency by her boyfriend. She has many superficial lacerations on her forearm. She is so distressed and constantly says her boyfriend is going to end the relationship. On questioning, she denies trying to end her life.
a) Based on your evidence-based deduction, mention the most likely diagnosis.
b) What relevant information you need to gather for making a treatment plan?

Given information

Demography and referral
Age- 25 years
Sex- Female
Referred to- Emergency department

Chief complaints
Very much distressed in the fear of ending of love relationship

On examination
Superficial laceration on forearm

M/S/E finding
Appearance- Distressed
Thought- No suicidal thoughts

Extracted information

The young-aged female has been brought to psychiatric emergency due to an acute relationship crisis. She is in fear of abandonment by her boyfriend and has an intense interpersonal relationship.

Moreover, she shows self-harm behavior when she is in crisis. The pattern is very much suggestive of borderline personality disorder.

Recurrent suicidal behavior, gesture, threats and self-mutilating behavior is one of the diagnostic criteria of BPD. However, in this case no suicidal thoughts, ideas or plans are present.

Though the young woman is 25 years old, it is very much likely that the personality pattern has been manifested from adolescence or early adulthood, the period of onset of personality disorders.

Assigned task

a) <u>The most likely diagnosis</u>

From the evidence-based deduction of the given information, the most likely diagnosis is Borderline Personality Disorder.

b) <u>Relevant information for making treatment plan</u>
- Age of onset
- Pervasiveness of symptoms
- Other features of Borderline PD
  Predominant mood and history of affective instability
  Impulsivity
  Identity crisis
  Chronic feeling of emptiness
  Difficulty controlling anger
  Transient stress related paranoid ideation or dissociative symptoms
- Comorbid psychiatric illness especially depression
- History of substance abuse
- Strength and support
- Risk assessment for further self-harm event and suicidal ideation
- Psychometric tool
  MMPI (Not validated in Bangla)
  Self-harm Inventory (Validated in Bangla)

[NTK: Mnemonic for remembering criteria of BPD is 3 A, 3I, EPS
Affective instability, fear of **A**bandonment, difficulty controlling **A**nger, **I**dentity crisis, unstable **I**nterpersonal relationship, **I**mpulsivity, chronic feeling of **E**mptiness, stress related **P**aranoid ideation, **S**uicidal behavior.]

53. A 30-year-old man appears in psychiatry OPD with an anxious distressed condition. He says that he has intrusive thoughts about diabetes after curiously assessing his blood sugar level at home which was 3.8 mg/dL. Subsequently, he has consulted a number of physicians with repeated relevant investigations despite clear exclusion of diabetes. He agrees with the physician's opinions. However, repeated thoughts of past “3.8 mg/dL " findings upset him that caused disruption of his daily activities.
    a) What are the possible diagnoses?
    b) How will you manage the case?

Given information

Demography and referral
Age- 30 years
Sex- Male
Referred from- Psychiatry OPD

Chief complaints
- Intrusive thoughts about diabetes
- Repeated consultation with physicians even after clear exclusion of diabetes
- Disruption of daily activities due to the thoughts

M/S/E finding
Appearance- Anxious distressed

Extracted information

Disorders which present with intrusive thoughts of illness are OCD, Other anxiety disorder, illness anxiety disorder, depressive disorders and hypochondriacal delusion.

Obsessive thoughts of OCD are intrusive, irrational, distressing and perceived as a person's own thoughts. Moreover, covert or overt compulsion may present. Here, this early middle-aged man has persistent thoughts of a fixed blood glucose level that he cannot exclude from her mind though he is concerned about its irrationality. His repetitive consultation and likely measuring blood glues level could be his compulsion as his help seeking behavior goes beyond the point of rationality.

The core feature of anxiety disorder is worrying thoughts that are rational but difficult to control. In GAD, thoughts are regarding day-to-day events and usually associated with somatic symptoms of anxiety. Insight is intact in anxiety disorders. However, the worry is fixed with one thing not pervasive in nature as expected in GAD. Therefore, the person may be a case of Other anxiety disorder.

In illness anxiety disorder, a person is preoccupied with having a serious illness and high level of anxiety present regarding personal health status. Repeated health checking behavior may be present. However, the person is not convinced at all by the negative investigation findings. In this vignette, the man agrees with the physician’s opinion. Thus, IAD is unlikely.

Depressive disorder is another possibility as the person is anxious and distressed. However, absence of other features of depression excludes the possibility.

In hypochondriacal delusion, a person is strongly convinced that he has some serious illness despite evidence to the contrary. Insight is invariably impaired. Here in this case, the person has no such conviction and he accepts the rational explanation of the consulting physiciansTherefore, hypochondriacal delusion can also be excluded.

The man has intact insight and agrees with his physician about not having diabetes. It is his intrusive thoughts that is bothering him which indicates he is able to receive CBT

There is a high possibility of premorbid anxious personality traits. His occupation should be assessed to see whether there is any professional influence (e.g. lab technician, nurse). Areas of impairment also to be assessed.

Assigned task

a) The possible diagnoses

From the logical deduction of given information, the possible diagnoses are
- OCD
- Other anxiety disorder
- Anxious avoidant PD

b) Management

First line of management
Relaxation or Benson's applied relaxation
CBT with the aim of identifying the thoughts and feared outcomes of altered blood sugar levels, associated feelings and altering the related behaviors.
Physical exercise

Second line of management
(If person does not respond or is not willing to take the first line management)
Drug management- low dose SSRI (usually 25-50 mg Sertraline) for 6-9 months.

54. A 20-year-old graduate student, had three short lived episodes of auditory hallucinations. Each episode had occurred when she did study at night to combat his academic load. The voices she had heard were marked auditory hallucinations which lasted only a few minutes but had really frightened her. Before the episodes, she reports feeling fainting for a few minutes and also experiencing the sense of *de javu.*
Based on your logical deduction and interpretation of the given information─
a) What is the most possible diagnosis?
b) Summarize your treatment plan.

Given information

Demography and referral
Age- 20 years
Sex- Female
Occupation- Student

Chief complaints
- Feels faint for few minutes at night in awakening, episodic- duration not mentioned likely recent
- Sensation of *déjà vu* along with- same duration
- Three episodes of hearing voices, short-lived prior fainting experience that frightened her –same duration
- Associate stressor- Academic load

Extracted information

This late adolescent girl is clear and at least three episodes short lived auditory hallucination, followed by experiencing fainting and *deja vu* for a few minutes. Clearly indicates the girl has temporal lobe epilepsy. Persistent anxiety or stress precipitates such epileptic episodes. The girl is stressed with her academic load and tries to cover it up by doing night time study, possibly depriving sleep.

Her frightening experience is due to psychological reaction to unusual events particularly auditory hallucination and likely a normal response.

De javu can be associated with persistent anxiety. Though this girl is anxious about her academic issues, this is state anxiety and other features do not support the anxiety disorder.

This girl could be a case of conversion disorder due to her inability to cope with academic load with the presentation of fit-like features and hearing voices. However, her presentation is not anomalous and inconsistent, clearly clustered and explainable by epileptic type of episode.

That could be due to sleep deprivation or normal experience of excessive load. Here it is clearly episodic typical for TLE and repetitive in nature with 3 or more times that will not happen in normal experience or else.

Assigned task

a) The best possible diagnosis

From the extracted information of the given information in the case scenario, the best possible diagnosis is Temporal Lobe Epilepsy/ Complex partial seizure because,

- Symptoms are short lived, episodic; precipitating aura present and the experience is frightening.
- Not associated features of conversion disorder like attention seeking behavior, la belle indifference is present and the symptoms are not anomalous.
- Good insight present.
- *Déjà vu* related with neurobiological abnormality.

b) Treatment

Explanation, assurance and empathic support to the girl and caregiver.
AED- with inadequate dose and duration following the general principle of prescribing AED.
Monotherapy with carbamazepine or oxcarbamazepine is the first line.
Alternative AEDs for monotherapy- levetiracetam/valproate/topiramate/lamotrigine.
Dose adjustment can be done after follow up of the patient and considering the response and adverse effect profile.

[NTK
Roughly, 60% respond well with AED monotherapy and the rest 40% have drug resistant Epilepsy (DRE). Valproate should be best avoided in girls with childbearing age. Other measures are combined therapy, neurostimulation like vagus nerve stimulation, deep brain stimulation, trans cortical stimulation; also has the option of micro neurosurgical measures including temporal lobectomy for intractable TLE]

55. A 20-year-old girl referred from ophthalmology OPD to psychiatry OPD who saw a terrific RTA in which a young boy died. The night of the event, she could not sleep and the day after she suddenly lost her vision.
Based on your extraction and interpretation of the given information─
a) What is the most likely diagnosis?
b) Outline the treatment plan.

Given information

Demography and referral
Age- 20 years
Sex- Female
Referred from- Ophthalmology OPD
Referred to- Psychiatry OPD

Chief complaints
- Sudden loss of vision
- Sleep disturbance

Precipitating factor
Witnessing a horrific RTA

Extracted information

Though loss of vision is an organic problem, sudden loss of vision after witnessing a horrific RTA suggests psychiatric nature of the disorder.

Loss of vision is a sensory deficit. Altered sensory function after a stressful event is highly suggestive of conversion disorder in which the girl repressed the stressful experience and develops denial as a part of defense mechanism. Defense mechanism helps her to deal with the reality which is ego-threatening.

As the problem arises following an extraordinary stressful event, acute stress disorder is another possibility. However, the altered neurological function can be better explained by conversion disorder.

Assigned task

a) Most likely diagnosis
From the extraction of given information, the most likely diagnosis is Dissociative neurological symptom disorder, with visual disturbance/ Conversion Disorder with sensory loss.

b) Treatment plan

General management
- Explanation and reassurance to the patient and the caregiver about the diagnosis, nature, treatment plan & outcome of the disease.
- Encouraging to maintain daily life as he/she can maintain.
- Expressing empathy.

Specific management
i. Psychological:

Patient focus

- Symptom reduction by suggestion- Encouraging the girl to try to see as better as possible.
- Explorative psychotherapy- Identification of stressor & perceived threat associated with the event. Resolution of stress by removal/modification/acceptance.
- Supportive psychotherapy.

Family focus
- Reduction of reinforcement/abnormal illness behavior/secondary gain.
- Encouraging desired behavior, discouraging undesired behavior.

ii. Biological:
If comorbid depression is present, SSRI (Sertraline/Fluoxetine) can be added. BDZ (Clonazepam) can be given for short duration for immediate relief of anxiety and ensuring sleep.

iii. Social:
Continuation of daily activities as much as she can.

Preventive strategies
- Improving stress coping ability.
- Modifying patient's personality factors (CBT if problems with cognition, SST if poor social skills).
- Modifying environment, caregiving style if overprotective or any other dysfunctional in nature.
- Offering continued help.
- Active daily life programming.

[NTK:

Principles of applying reinforcement

- Selecting motivating reinforcement.
- Must be applied immediately.
- Reward should be specified & verified by mutual agreement.
- Few rules, applied rigidly.]

56. A 24-year-old female who has been diagnosed as a case of conversion disorder having paraplegia since last 10 months. She has been admitted into the psychiatry department 3 times for her problem but never achieved full remission. Now, she presents in psychiatry OPD with added features of mutism and episodic hyperventilation.
    a) How will you assess this case?
    b) Outline the management plan.

Given information

Demography and referral
Age- 24 years
Sex- Female
Referred to- Psychiatry OPD

Chief complaints
- Paraplegia- 10 months
- Mutism- recent development
- Episodic hyperventilation- recent development

Present psychiatric diagnosis
Conversion disorder (10 months)

Past history
3 times hospitalization but never enjoys full remission

Extracted information

The young woman is a diagnosed case of conversion disorder. As she has been admitted in a psychiatric inpatient unit for 3 times in the last 10 months, it can be assumed that neurological differentials have been ruled out. Moreover, recent development of features of mutism and episodic hyperventilation reinforces the diagnosis of conversion disorder.

Dissociation and conversion occur when a threatening event has been repressed subconsciously by a person as a part of defense mechanism. From that perspective, conversion is related to stress. Though the onset of conversion is directly related with stress, the further events might not have that association. Chronicity of conversion may result from a single threatening event.

Persistency of previous symptoms or chronicity of conversion may be due to
- real stress not identified at first
- unresolved stress
- persistent secondary gain (from caregiver or from physicians)
- other maintaining factors (neglect/reinforcement)

There is also the possibility of the stressor being identified and resolved but accompanied with a toxic stress (strong, frequent and/or prolonged adversity).

[NTK: Chronicity not only develops to victims but also to the witnesses of violence]

Development of new symptoms indicate new stressors. The scenario altogether indicates poor stress coping ability of the woman, the area which needs to be addressed properly.

Assigned task

a) Steps of assessment

- Re- evaluating the case and re- evaluating the diagnosis.
- Reassessing the stress/ conflict/trauma and identification of which stressor is causing the symptom.
- Whether the stress is resolved or not.

- Vulnerability factors (especially personality, adverse childhood experiences, comes across a lot of stressor, enduring stressor).
- Associated features of conversion- suggestibility, La belle indifference, attention seeking behavior.
- Maintaining factors- severe functional impairment; persistent secondary gain.
- Physical examination (e.g.- disuse atrophy leads to bed sore; breathlessness leads to respiratory alkalosis).
- Comorbid psychiatric disorder- anxiety and depression (incomplete conversion/ due to psychological reaction to conversion.
- Prognostic factors- persistency of 2 or more comorbidity and the disorder is unidentified, unaddressed and unresolved indicates poor prognosis.

b) Management plan

- Should be personalized.

- Hospitalization for crisis intervention; identification and management of stressor (can be done by free association, Amobarbital interview/abreaction aided intervention, hypnosis, Explorative psychotherapy).

- *General management*

  Explanation and reassurance to the patient and the caregiver.
  Support.
  Ensuring hydration and nutrition.
  Active daily living program.
  Symptom reduction by suggestion and if needed hypnotic suggestion.

- *Specific management*

  i. Psychological management
  Patient focused-
  - Managing the stressor by removal/acceptance/modification.
  - Identification of secondary gain.

  Caregiver focused-
  - Reduction of reinforcement
  - Encouraging desired behavior (encouraging to walk, physiotherapy but not walking aid).
  - Discouraging undesired behavior (e.g. not responding when the patient wants something by gesture, rather encouraging her to talk as much as she can).

  ii. Biological management
  Anxiolytic if needed.

  iii. Social management
  Preventive measure: improving stress coping ability.

57. A 33-year-old male has been admitted for his recurrent manic episode despite continuing treatment. During the phase of increasing good response, he becomes confused and restless for 2 days that are worsening. Urgent investigations revealed Hb-10 gm/dL, ESR- 47 mm in 1st hour, TLC- 4000/Cumm, Na+ 128 mmol/L, Cl- 108 mmol/L and K+ 3.4 mmol/L.
    a) What is the best possible explanation of this condition?
    b) List the steps of your action plan.

Given information

Demography and referral
Age- 33 years
Sex- Male
Referred to- Psychiatric IPD

Chief complaints
- Confusion and restlessness for 2 days which is worsening

Present psychiatric diagnosis
Bipolar I Disorder, multiple episode (currently manic)

Treatment history
Rx response is good

Investigations
Hb-10 gm/dL
ESR-47 mm in 1st hour
TLC- 4000/mm3
S. Electrolyte- Na+ 128mmol/ L, Cl- 108 mmol/L, K+ 3.4 mmol/L

Extracted information

Primary psychiatric diagnosis for the middle-aged man is bipolar I disorder with multiple episodes, currently manic. He is receiving treatment for primary disorder and responding.

As there is history of recurrent manic episodes, so most likely he has been receiving antipsychotic and mood stabilizer. With this treatment, for the last 2 days, he develops confusion and restlessness that is delirium.

The blood picture shows mild anemia, slightly raised ESR and TLC is lower range of normal values. From these values, infection and malignancy can be ruled out and it may be the hematologic A/E of psychotropic drugs. Moreover, the electrolyte level shows hyponatremia and hypokalemia which is a common association of psychotropic induced SIADH.

Therefore, the delirium is caused by use of one or more psychotropic drugs.

[NTK:
- Agranulocytosis is the most common hematologic A/E of neuroleptics. Other less common findings are aplastic anemia, leukopenia and thrombocytopenia.
- Low potency drugs (e.g. Chlorpromazine, Clozapine) cause more A/E than high potency drugs. Clozapine is also responsible for Eosinophilia and Eosinophilic cardiomyopathy.
- Among mood stabilizers, Lithium causes leukocytosis and thrombocytosis, Carbamazepine agranulocytosis and Valproate macrocytic anemia, leucopenia, thrombocytopenia and increased MCH & MCHC.
- Among antidepressants, agranulocytosis occurs with TCA (esp. Imipramine) and Mirtazapine. SSRIs cause bruises and bleeding as it increases CNS serotonin and reduces platelet store of serotonin by preventing reuptake, reducing aggregability and depleting stores.]

Assigned task

a) Possible explanation

From the evidence-based deduction of the history and investigations, the condition is Delirium which is due to psychotropic induced hyponatremia due to SIADH. From the extraction it has been apparent that the patient is a case of bipolar disorder manic phase and responding to treatment. Commonly atypical antipsychotic and mood stabilizers are used for treating bipolar disorder. With increasing dose, the patient developed delirium for which no better explanation is found.

b) Management plan

This is a case of severe hyponatremia. Though the Na+ level is 128 mmol/L, the patient develops delirium with that level. Therefore, it can be said it is a case of severe hyponatremia. The steps should be as follows

- Stopping the offending drug/drugs.
- Urgent referral to specialist.
- Correction of hyponatremia as advised by specialist but avoiding rapid correction (chances of pontine demyelination).
- Re institution of the drugs with slower increase in dosage or replacing drugs with a better alternative, whichever is appropriate.

[NTK:
The primary symptoms of hyponatremia are restlessness, drowsiness, myoclonic jerks, and generalized convulsions followed by confusion, coma and death if not treated properly.

- Atypical APD causes hyponatremia by their serotonin mediated effects on 5HT-2 and 5 HT-1c receptors which leads to release of ADH.
- Typical APD stimulates the thirst center causing polydipsia resulting in hyponatremia.
- Carbamazepine stimulates central ADH release and potentiates effects of ADH.
- Lithium causes paradoxical hyponatremia by developing diabetic insipidus.
- ADD esp. SSRIs and Valproate cause hyponatremia by developing SIADH i.e. inappropriate amount of ADH secretion from hypothalamus.]

58. A 30-year-old male with schizophrenia under 300 mg clozapine/day is admitted in the psychiatry department due to relapse. Gradually, this dose has been increased to 500mg/day. After 10 days of admission, he develops fever, tachycardia, chest pain, and dyspnea. His BP was 90/55 mmHg. Instant ECG shows ST elevation. The patient is mildly diabetic and under medication.
Based on your logical deduction of the given information─
a) What is the best possible diagnosis?
b) What steps will you take at this moment?

Given information

Demography and referral
Age- 30 years
Sex- Male
Referred to- Psychiatric IPD
Reason for referral- Relapse of schizophrenia

Chief complaints

- Fever

- Chest pain
- Dyspnea

Present psychiatric diagnosis
Schizophrenia

Treatment history
Clozapine 300 mg/day which has been increased up to 500 mg/day after admission

On Examination
Pulse- tachycardia
BP- 90/55 mmHg

Investigation
ECG- ST elevation

Extracted information

Most likely diagnosis for this vignette is treatment resistant schizophrenia as the patient comes with relapse even with the dose of 300 mg/day.

It can be anticipated that the dose is not working. Therefore, physicians decided to increase the dose.

Rapid increment of clozapine (200 mg/day over two weeks) gives rise to symptoms of fever, dyspnea and chest pain and examination findings were tachycardia and hypotension. ECG shows ST elevation. These findings are an expression of myocarditis.

The most common cause of myocarditis is viral infection; however, hypersensitivity myocarditis occurs in response to medication. Toxic metabolite of clozapine, increased blood catecholamine by inhibition of norepinephrine transporter and Ig E mediated hypersensitivity reaction causes myocardial damage and release of proinflammatory cytokines and inflammatory infiltrates in the heart. Therefore, the myocarditis is most likely to be clozapine induced.

Possibly no relation of DM with current situation because it is mild and managed with medication.

Assigned task

a) Best possible diagnosis

From the logical extraction of given information, the best possible diagnosis is clozapine induced myocarditis because no evidence of viral or other type of myocarditis and symptoms appear within two weeks of rapid dose increment.

[NTK:
Myocarditis occurs within 4 weeks of clozapine initiation or dose increment whereas cardiomyopathy occurs later (even after 9 months)]

b) Steps to be taken

Further investigation

CBC (to exclude viral illness, pneumonia and sepsis)
CRP
CXR (evidence of heart failure)
CK-MB
Troponin I
Echocardiography

- If the patient has a heart rate (HR) of 120 bpm or greater, CRP 50 to 100 mg/L, or troponin two times upper limit of normal or less, it is recommended that troponin and CRP levels be measured daily until symptoms subside, and clozapine may be continued.
- However, if troponin increases to two or more times the upper limit of normal or CRP exceeds 100 mg/L, clozapine should be stopped and the patient should be referred to a cardiologist for further evaluation.
  ACEi (Captopril, Lisinopril) and Beta blocker (Carvedilol, Metoprolol) should be started as soon as Clozapine induced myocarditis (CIM) is suspected.

59. A 55-year-old man who is a diagnosed case of MDD and under SSRI for 2 years with good response attends psychiatry OPD for review. He describes the last few months of worsening fatigue, daytime sleepiness and generally "not feeling good". He is adherent to medication and denies stressors. He sleeps well but has frequent awakenings with choking sensation and has nocturia. His wife says he snores very loudly and intermittently stops breathing and gasping for air. But he says he snores since childhood and adds "all the men in my family are snorers". He is hypertensive, diabetic and receiving treatment for these. He complains of heartburn and erectile dysfunction and headache. On examination he weighed 89 kg, BP 145/90. He appeared tired but without a depressed mood or cognitive decline.

a) What is the best possible diagnosis for his additional presenting complaints?
b) Make a list of the assessment areas to confirm diagnosis and make a treatment plan.

Given information

Demography and referral
Age- 55 years
Sex- Male
Referred to- Psychiatry OPD
Reason for referral- follow up

Chief complaints

- Worsening fatigue
- Daytime sleepiness
- Not feeling good though denies stressor } last few months
- Interrupted sleep due to choking sensation and nocturia
- Wife complaints snoring and intermittent gasping
- Heartburn
- Erectile dysfunction
- Headache

Present psychiatric diagnosis
MDD

Treatment history
SSRI for 2 years with good response, adherence good

Co-occurring physical illness

DM, HTN (controlled with medication)

General examination:
Body weight- 89 kg
BP- 145/90 mmHg

M/S/E findings
Appearance- tired
Mood- not depressed
Cognition- intact

Extracted information

The middle-aged man is diagnosed with a case of MDD and responds to medication. Revaluation of depression during follow up visits reveals he is stable.

Though this visit is a follow up visit, the man develops new symptoms of fatigue and sleepiness which are more notable than depression.

Loud snoring, episodes of choking sensation and gasping strongly suggestive of OSAH. Repeated arousal from sleep is further evidence of apnea to restore normal breathing. No other features of GMCs for explaining all these symptoms. Other symptoms of heartburn, nocturia, sexual dysfunction, headaches reflect the multisystemic effects of OSAH.

Risk factors like above age 50, obesity, and family H/O of snoring for all men go as further supporting evidence of OSAH.

Assigned task

a) Possible diagnosis

The logical deduction of the given information suggests the best possible diagnosis is Obstructive Sleep Apnea Hypopnea (OSAH)/Obstructive sleep apnea (Pickwickian syndrome).

b) Assessment

- General physical assessment-systemic examinations for any other associated disorder and status of present disorders.
- General assessment of a psychiatric case.
- Sleep history, Sleep diary,3rd party report.
- Assessment of risk factors: BMI and others.
- Video telemetry.
- Polysomnography-to confirm the diagnosis and assess severity.
- AHI (Apnea hypopnea index); 15 &□/hour is diagnostic for OSAH.
- AHI=15 or□ Mild □15-30 Moderate □30 severe.
- Other indexes (Oxygen desaturation index, % Time with O2 saturation <90%, Arousal index, Sleep stage% N1, N2, N3, N4, REM) give clear pictures as supporting evidence and also for indicative for a treatment plan.
- Other relevant lab investigations.
- Relevant information for appropriate referral.

60. A 30-year-old sales executive referred by a urologist to a psychiatrist who has recurrent impaired penile erection during sexual act in a fluctuating course for 1 year of marriage. Despite of his intense desire, he now avoids sex due to repeated failure in several times and fear of failure. His wife says she tried her best from her part but did not experience any complete sexual act that makes her annoyed. The man becomes hopeless as the problems remain, is worried about the possible worse fate of marital life, and cannot concentrate on his day-to-day task. He had premarital sex in one occasion that was a failure and denied any substance abuse.

a) What is the most likely diagnosis?
b) Outline your management plan.

Given information

Demography and referral
Age-30 years
Sex-Male
Occupation-Service
Marital status- Married
Referred by-Urologist
Referred to-Psychiatrist

Chief complaints

- Difficulty in erection during sexual act- 1 year
- Worries and hopelessness about the problems and marital life- subsequent development
- Impairment of functioning-subsequent development

Extracted information

The problem is mainly his erectile problems evident by the person's information as well as wife's statement about non experience of any complete intercourse that starts at the beginning from his marital life.

Urologist's referral for psychiatric consultation indicates the problem has no explainable organic etiology that needs to be confirmed.

Patient might have believed of having any organic etiology that is indicative by his taking consultancy from a urologist and possibility of taking other consultancies within one year of his marital life.

Recent avoidance of sexual act can be better explained by his performance anxiety from repeated failure and fear of further failure certainly not due to lack of sexual desire. The man falls into a vicious cycle of fear and avoidance that is further strengthened by partner's annoyance that replaces her initial cooperation. However, the patient's recent and enduring stressors need to be assessed for better understanding this case and treatment plan.

The problem is not likely due to the effect of any substance that is evident from his statement.

Patient's hopelessness is clearly the consequence of persistency of the problem and worries and lack of concentration in his task due to possible worse effects on marital life rather than primary anxiety, depression or other stressors. However, comorbid anxiety and depression need to be assessed.

Failure of his premarital sex is possibly normal incidence and that may influence his thought about the cause of his problem. Alternatively, it could be indicative of the primary type of the problem. Therefore, the patient's perception about her problem needs to be explored.

Mal-intervention, unnecessary medical investigation and treatment and the person's irrational expectation from treatment and expectation failure may demoralize the patient that could be perpetuating factors.

Overall. All earlier treatment and its outcome need to be assessed for an effective treatment plan.
There is sufficient evidence of patient's distress and functional impairment and possibly in all domains.

Assigned task

a) Diagnosis

From the given information in the case scenario and extracted information, most likely it is a case of Erectile Disorder.

b) Treatment plan

- Explanation, empathy and support with special emphasis on the nature of illness, possible outcome and interventional plan.
- Psychoeducation and sex education with special emphasis on behavioral-sexual skills.
- Lifestyle modification (weight reduction, smoking cessation, physical exercise and balanced diet).
- Active daily living program at optimum level.
- Explaining the role of the partner in the intervention.
- Anxiety reduction through relaxation and systematic desensitization
- Drugs:
  SSRI-low dose for anxiety and adequate for depression.
  PDE5 inhibitors- Sildenafil or Tadalafil along with other nondrug therapy.
- Sex therapy- Focusing on adequate foreplay, sensate focus exercise, demonstrating erection by masturbation (if sleep erection is normal) along with stepwise components as usual.
- Marital therapy (if any interpersonal issue or any other indications).
- CBT- For negative cognition and if depression.

61. A 28-year-old female schoolteacher presents by herself to a psychiatrist who has lack of interest in sexual acts. Usually she tries to avoid the act in any way, but in the face of husband's need, did the act but feels no enjoyment. As she loves her husband, the problems make her distressed. She also has headaches, sleep disturbances and finds little interest in doing work. She also expresses that since her teen life she finds no interest on sex. When asked she does not tell more. Subsequently on separate interview, husband says that since 2 years of marriage he fails to bring her significantly aroused leading to initiate sex less frequently.

a) Extract the logical information for the case scenario to reach the best possible diagnosis.
b) How will you treat this case?

Given information

Demography and referral

Age-28 years
Sex-Female
Occupation-School teacher
Marital status- Married
Referred by-Self
Referred to-Psychiatrist

Chief complaints

- Lack of interest in sexual during sexual act- 2 years
- Headache and sleep disturbances
- Worries about her problems and its effect
- Distressful and Impairment of functioning

Extracted information

The woman has diminished interest in sexual activity, which is indicative of having sexual arousal disorder.

This problem is at a significantly high level experienced from the starting of her marital life that indicates the primary and severe nature as stated by the woman and statement of her husband.

She also does not experience enjoyment of sex that could be part of lack of arousal or lack of orgasm that indicates the possibility of female orgasmic disorder.

Her gradual avoidance of sexual acts clearly can be explained by low arousal but possibility of experiencing pain during sexual activities could be indicative of associated penetration disorder and need to be explored.

Patient's headache, sleep disturbances and diminished interest in work are likely due to her inner anxiety and depression as the consequence of her sexual problem. However, comorbid anxiety and depression need to be assessed.
At the same time sexual problems associated with other nonsexual psychiatric disorders need to be assessed.

She has no interest on sex since adolescence, the cause to be explored as PTSD due to early sexual abuse which is usually related with this type of problem.

At the same time, patient's recent, past and circumstantial adverse childhood experiences and enduring stressors need to be assessed for better understanding of the etiology and treatment plan.

There is no such information of having any general medical condition, substance misuses and drugs that may cause this problem that need assessment, especially hormone levels. However, patterns of referral and given information are supportive of its nonorganic nature.

Main strength is likely their loving relationship and interest of engagement in treatment evident by the woman's statement, her efforts to act despite her unwillingness and husbands to make sexually aroused and active. Husband's recent infrequent effort of sexual act can be explained by his disappointment and understanding wife's unwillingness to act.

There is sufficient evidence of the patient's distress and functional impairment in her conjugal and occupational domains.

Assigned task

a) Diagnosis

From the information given in the case scenario and extracted information, the best possible diagnosis is lack or loss of sexual desire or Female Sexual Interest/ Arousal Disorder.

b) Treatment plan

- Explanation, empathy and support with special emphasis on nature of illness, possible outcome and interventional plan and mentioning their affection-the main strength of the couple.
- Psychoeducation about the nature and progress of the problems.
- Explaining the role of the partner in the intervention.
- Anxiety reduction through simple breath holding technique or progressive muscular relaxation. Other methods of relaxation can be applied if necessary.
- Mindfulness- patient is directed to focus on the sexual act and maintain an awareness of all types of sensation.
- Sexual skill Training with due consideration on behavioral-sexual skill.
- CBT- with special emphasis on cognitive restructuring and communication about the sex.
- Drugs:
  SSRI- effective for arousal and for anxiety and depression.
  Androgen- as an adjunct with the aim of improvement of sex drive.
  Lubricants and moisturizers- if lack of vaginal lubrication is associated with low libido.
  Sex therapy- stepwise application of all components- sex education, prohibition of intercourse at the beginning, sensate focus exercise, gradual reinitiating of normal sexual act.
- Marital therapy – if indicated.
- Treating any comorbid psychiatric disorders if any, especially PTSD in this case.

62. A 26-year-old petty businessperson attends psychiatry OPD who is referred from dermatology OPD with the complaint of white discharge with urine that he believes as “Dhatu" followed by weakness since his adulthood. He thinks that this happens due to any sexual disease and recalls his masturbatory habit as the cause. He consulted widely from traditional healers to non-psychiatric specialists and underwent huge investigations but no disorder was found and the problem remained rather gradually worsening. He also complains of multiple pains and sleep disturbances. He is extremely worried about this and now fears to marry.

a) List the information you require to assess this case.
b) Outline a treatment plan for this young man.

Given information

Demography and referral
Age-26 years
Sex-Male
Occupation-Petty business
Marital status- Unmarried
Referred from- Dermatology OPD

Referred to-Psychiatry OPD

Chief complaints

- Passage of white discharge through urine that he believes as sperm- approximately 8 years
- Worried about the problem-likely same duration
- Weakness, multiple aches and sleep disturbances
- Fear of marriage- recent development

Extracted information

Passage of a whitish discharge with urine that he believes and described as “Dhatu” is synonym of semen in local cultural context. This belief is erroneous and inconsistent with medical conditions and likely is a shared belief and the condition is known as “Dhat” Syndrome. The perceived white discharge is proved as prostatic fluid commonly phosphate mixes with urine.

Further, his conviction of having disease is based on the first erroneous belief and possibly not hypochondriacal or delusional.

Feeling weakness after urine discharge is likely explainable by the shared belief that sperm is the source of body power and loss of it causes depletion of physical and mental energy.

Multiple aches likely due to somatization and could be a physical manifestation of his anxiety associated with sleep disturbances as the manifestation of his increased worriedness.

This anxiety is increased with the possible negative consequences of his persistent anxiety resolve problem expressed through fear of marriage.

Fear of marriage is strongly indicative of the existence of having sexual dysfunction with the patient.

Overall, the symptoms satisfy the diagnosis of other anxiety disorders. It is likely that he has other somatic and psychic anxiety that need exploration for any form of anxiety disorder.
It is very much clear from the pattern of referral, exhaustive consultations along with investigations with no abnormality that the problem is clearly non-organic.

Rather this type of help seeking behavior can make the patient’s belief firmer and more complex and can make the patient demoralized- all these are strong perpetuating factors and make the treatment difficult.

As most of the Dhat syndrome is associated or caused by another psychiatric disorder commonly anxiety, depressive, hypochondriasis/illness anxiety disorder and sexual dysfunction, thorough psychiatric assessment for confirmation of the primary and comorbid diagnosis are required.

He also has erroneous beliefs about masturbation as a cause of his problem. This belief as a cause exists in the local culture along with many other types of false beliefs. Therefore, the patient’s belief and perception about the cause need to be explored.

There is sufficient evidence of the patient's distress and possible functional impairment.

Assigned task

a) Diagnosis

From the given information in the case scenario and extracted information, the best possible is Dhat syndrome/ Other anxiety disorder.

b) Treatment

- Explanation, support and advice to the patient. Empathetic but firm verbal reassurance is the most important means.
- Psychoeducation with special emphasis on explaining the cause and effect of the problem in an understandable way. A simple but lucid sex education followed by scientific explanation is most effective.
- Practical demonstration of removing the turbidity of a phosphate loaded urine by addition of acid is extremely helpful. This procedure can be described and advised to the patient to do it at home.
- Anxiety reduction through simple breath holding followed by progressive muscular relaxation- particularly helpful for his multiple aches.
- Anxiolytics- Mirtazapine is preferable because of his anxiety and sleep disturbances. Alternatively, SSRI preferably sertraline or fluoxetine. Other anxiolytics can be given. However, benzodiazepine should be avoided considering possible dependency.
- Maintaining an active daily living program is necessary.
- Treating any comorbid psychiatric disorder accordingly, if any.

63. A 38-year-old woman has always been extremely neat and conscientious, a good performer in her executive post of a corporate company. She stays long after normal working hours to check on the punctuation and spelling of letters that she prepared during the day. Although her work is impeccable, she has few close relationships with others. Her boss referred her to a psychiatrist for counselling after she repeatedly got into fights with her co-workers. "They just don't take the job seriously,'' she said disapprovingly about them. ''All they seem to want to do is joke around all day.''
a) What is the most likely preliminary diagnosis for this patient?
b) Outline the main areas of assessment to make the treatment plan.

Given information

Demography and referral
Age- 38 years
Sex-Female
Occupation-Service
Referred to- Psychiatrist
Referred by-Office boss
Reason for referral-Psychiatric assessment and treatment

Chief complaints
- Extremely conscientious in her work including minor matters
- Persistent and repetitive physical aggression to co-workers at workplace
- Thinks that her colleagues are not serious in work rather take it as joke

Premorbid personality
Few close relationship, good performer, extremely neat

Extracted information

The middle-aged woman has neat and conscientious traits. There is confirmed evidence of perfectionist traits. She used to focus on details, follow routine and love orderliness and having a sense that there is only one way to do thing-rigid evident in her statement.

Premorbid personality reveals she has few close relationships. Possibly, there is a lack of sense of diversity and humor.
Evidence of impairment of at least 2 personality areas; loss of sense of self derived from work pattern (identity crisis) and rigidity and stubbornness negatively affect interpersonal relationships.

All these features go in favor of OCPD.

Not borderline PD, though repeated fights because it can be explained by her inflexibility, rigidity and orderliness.

Not OCD because of the evidence of traits rather than obsessive thoughts and compulsive acts.

Assigned Task

a) Diagnosis

From the given information and its extraction, the most likely diagnosis is Obsessive-Compulsive Personality Disorder (OCPD).

b) Assessment Plan

Main areas of assessment to make the treatment plan are:

- Desire of seeking treatment or help and its intensity-for engagement task and subsequent long-term non-directive therapy.
- Following the general assessment line.
- Impairment status of functioning areas.
- Listing disgraceful, annoying and stressful objects, activities and situations for behavior therapy, extinction, rewards.
- Aggravating factors-for counselling to avoid, minimize, acceptance.
- Comorbidities or associated features- anxiety and depression for specific Rx.
- Stressors- for stress management therapy and adopting coping strategies.
- Level of preparedness for group therapy.

64. A 40-year-old man attends in psychiatry OPD by himself who is persistently querulous, impulsive and has unstable interpersonal relationships. After completing his masters, he starts doing a job. Up to this point, he does about 23 jobs consequently and most of the time have been fired. He is unemployed now. His first wife left him and has persistent discord with present wife. Throughout the conversation he appears indifferent.
a) What is the most likely diagnosis?
b) Make an assessment plan of cardinal areas for the case.

Given information

Demography and referral

Age- 40 years
Sex- Male
Referred to- Psychiatry OPD
Referred by – Self

Chief complaints
- Persistent discord with present wife
- Recently been fired from job

Personal history
Frequent change of job, most of the times fired
First wife left him

Premorbid personality
Querulous, impulsive
Unstable interpersonal relationship

M/S/E finding
Appearance- Indifferent about the impairments

Extracted information

Persistent querulousness, impulsive behavior and unstable interpersonal relationships are the core features of personality disorder. Here the onset of the problems is indicative of long duration from circumstantial evidence.

This gentleman did almost 23 jobs after completion of his Master's degree. In most of the cases he has been fired. Thus, it can be said the pattern has been developed from his early adulthood which is typical for personality disorder.

In cluster B type of PD, borderline and antisocial types are associated with impulsivity. BPD is associated with impulsivity in a potentially self-damaging manner. In ASPD, impulsivity manifests by failure to plan ahead. In this case, the person has been fired from his job several times which is also evidence of consistent irresponsibility. Moreover, his first wife left him and persistent discord present with second wife. The pattern is very much similar to antisocial personality disorder.

Throughout the conversation the person remained indifferent about his severe impairment of functioning, another diagnostic criterion for antisocial personality disorder.

Assigned task

a) Most likely diagnosis
From the given information and its logical extraction, the most likely diagnosis is Antisocial Personality Disorder (ASPD).

b) Assessment plan

- Other clinical features of ASPD like:
  Failure to conform to social norms; performing acts that are grounds for arrest.
  Deceitfulness.
  Irritability and aggressiveness

Reckless disregard for the safety of self or others.
Lack of remorse.

- Early history of disruptive behavior especially conduct disorder with onset before the age of 15 years.
- Any other psychiatric disorder in childhood
- Associated features- lacks empathy, inflated or arrogant self-appraisal, history of drug abuse, forensic history.
- Adverse childhood experiences like maltreatment, dysfunctional family and related issues
- Through assessment for possible comorbidity, mainly substance misuse or exclusion of other psychiatric disorders like depression.
- Risk assessment.
- Assessment of resources of the patient.
- Strengths of the patient usable in treatment planning

65. A 24-year-old patient attends in psychiatry OPD who has a diagnosis of avoidant personality disorder and is getting psychotherapy. Since the last 3 months, he appears to be marked anxious, keeps himself isolated and talks very little. Subsequently, he did not turn up for his previous two appointments. You have been asked to assess the patient.

a) Gather relevant information related to his recent changes in behavior considering differential diagnoses.
b) What could be the revised management plan for this case?

Given information

Demography and referral
Age- 24 years
Sex- Male
Reason of referral- follow-up and assessment

Chief complaints

- Marked anxiety- 3 months
- Keeps himself isolated- recent development
- Talks very little same duration

Present psychiatric diagnosis
Avoidant Personality Disorder

Treatment history
Getting psychotherapy, missed previous two appointments

Extracted information

The core features of avoidant personality disorder are social inhibition, feeling of inadequacy and hypersensitivity to negative evaluation that are most likely to be present from adolescence or early adulthood of the patient as he already receives the diagnosis.

His recent problems will be either exaggeration of his traits or manifestation of developing other psychiatric disorders.

The first thing that should be assessed is any recent life crisis which led to such exacerbation of his anxiety features.

Major depressive disorder may be a possibility because anxiety and depression are very close to each other. Isolation and decreased speech may be a part of negative thoughts and rumination and lacking interest in the external world.

Another possibility is any form of psychotic disorder. In schizophrenia spectrum disorder, marked anxiety may present due to delusional mood or as a response to the psychotic features. Staying isolated and talking little may also be the part of negative symptoms (social withdrawal and alogia) or response to the positive symptoms (fear of being persecuted, hearing commanding voices etc.).

The person might develop anxiety disorder in which the core feature is excessive anxiety and worry about a number of activities. The severity of the apprehension may lead to staying isolated and talking very little. GAD patients show anxious temperament in their early life. Missing two sessions of psychotherapy may be the expression of the resultant functional impairment. To confirm the diagnosis of GAD, duration must be of 6 months and other features must be present. Any such shortage, other anxiety disorder is the alternative diagnostic provision. However, comorbid diagnosis of anxiety disorder in Avoidant PD must be made with caution.

Assigned task

a) Information need to be gathered

According to the differentials

- Acute exacerbation of personality disorder features- Recent life crisis.
- MDD- Low mood, lacks interest in previously pleasurable activities, decreased sleep and appetite, psychomotor retardation, feeling of inappropriate guilt, lacks enjoyment, forgetfulness and recurrent thoughts of death.
- Schizophreniform disorder- Presence of delusion, hallucination, disorganized speech, grossly disorganized behavior or other negative symptoms.
- Other areas- Personal and family history of mental illness, social circumstances of the patient, drug or substance history, assessment of functioning.
- GAD/Other anxiety disorder-Contents of the worrying thoughts.
    - Somatic symptoms of anxiety.
    - Exclusion of substance use/induced disorder.
    - Exclusion of general medical conditions, especially thyroid dysfunction.
- Risk assessment especially suicidality.

b) Revised treatment plan

General management
Hospitalization for proper assessment.
Ensuring hydration, nutrition and monitoring of vitals.
Crisis intervention with low dose BDZ.

Specific management
Continuation of treatment of anxious PD customizing with present situation.
According to additional diagnosis.

66. A 41-year-old woman brought to psychiatry OPD by her family. The family reports that since the last three years she has had trouble controlling her movements. She has frequent and brisk jerks of the pelvis and limbs as well as grimacing and smirking movements of the face. Recently, she forgets easily and cannot do her usual activities.

a) Mention the most likely diagnosis giving your logical interpretation of the provided information.
b) Outline the required information and investigations.

Given information

Demography and referral
Age- 41 years
Sex- Female
Referred to- Psychiatry OPD
Referred by- Family members

Chief complaints
- Trouble controlling movements- 3 years
- Frequent, brisk jerks of pelvis and limbs- 3 years
- Grimacing and smirking movements of face- 3 years
- Easily forgets- Recent onset
- Cannot do her usual activities- Recent onset

Extracted information

The woman presented here is middle-aged. Onset of motor problems is at least 38 years of age.

At such age, motor abnormalities are unlikely to be functional and most likely to be due to neurological abnormalities. Involuntary jerky movements are termed as chorea and it is one of the presenting features of Huntington's disease, vascular chorea, Sydenham's chorea, Wilson's disease, cerebral palsy, juvenile Huntington's disease and benign hereditary chorea. Except Huntington's disease and vascular chorea, other disorders have onset in childhood. So, in this case, possibilities are Huntington's disease or vascular chorea. However,as there are features of cognitive decline and progression is slow, vascular cause can be ruled out. Moreover, the average age at diagnosis of Huntington's disease is 40 years.

Progressive cognitive impairment is a core feature of Huntington's disease. Early decline of executive functioning (e.g. processing speed, organization and planning) occurs followed by learning and memory impairment. Psychiatric and cognitive abnormalities can predate motor abnormality by at least 15 years. Probably the family did not seek help for executive dysfunction or psychiatric problems (e.g. irritability, anxiety, and depression) that appeared earlier and ignored the motor problems thinking it as functional. Now when the memory starts declining and functional impairment occurs, they ask for consultation.

As functional impairment is present, the disorder can be said to be at an advanced level.

Assigned task

a) Most likely diagnosis

From the given information and its subtraction, the most likely diagnosis is major neurocognitive disorder due to Huntington's disease.

b) Required information and investigations

- *History*
  First noticeable change in behavior (e.g. cognitive decline- executive dysfunction; behavioral- apathy, impulsivity, disinhibition).
  Motor abnormalities (bradykinesia, apraxia, ataxia, dysarthria).
  Associated psychiatric problem (e.g. irritability, depression, anxiety).
  Positive family history of Huntington's disease.
  [NTK: Huntington's disease is one of the very few disorders in psychiatry which is autosomal dominant one having complete penetrance]

- *Physical examination*
  General and neurological examination

- *Investigations*
  Psychological assessment-
  Validated MMSE

  Lab investigation-
  Genetic testing
  MRI of the brain (volume loss in basal ganglia particularly in caudate nucleus and putamen).
  [NTK: A diagnosis of definite Huntington's disease is given in the presence of unequivocal, extrapyramidal motor abnormalities in an individual with either a family history of Huntington's disease or genetic testing showing a CAG trinucleotide repeat expansion in the HTT gene located on chromosome 4.

67. A 28-year-old single, unemployed man presents with low mood, low energy, diminished interest, guilt feelings for 2 months. His father informed that he began to show similar features from early adulthood episodically that happens many times. Though the symptoms diminished he was sad and unmotivated. Around age 23, he suddenly developed marked suspiciousness, conviction of controlled by the space people along with hearing threatening voices that makes him fearful and at times, he thought of committing suicide for which he was hospitalized. These symptoms gradually disappeared after a month but conviction of being harmed remains along with occasional derogatory voice.
a) Write your diagnosis mentioning differential diagnosis.
b) What will be your treatment plan for this case?

Given information

Demography and referral
Age- 28 years
Sex- Male
Marital status- Single
Occupational status- Unemployed
Accompanied by- Father

Chief complaints
- Low mood- 2 months

- Lack of energy- 2 months
- Diminished interest- 2 months
- Guilt feeling- 2 months
- Conviction of being harmed- 5 years
- Occasional hearing of unseen derogatory voice- 5 years
- Sad and unmotivated since early adulthood

Past psychiatric history
- Multiple mood episodes many times since early adulthood.
- Acute psychotic episode for 1 month at the age of 23 along with suicidal thoughts for which he was admitted in hospital followed by some residual features.

Extracted information

Current features clearly go in favor of major depressive episodes of 2 months duration.

Clear evidence of episodic depressive features with onset in early adulthood to date (about 10 years) and presence of sadness and amotivation in between the episodes or in other words all through.

Acute onset of psychotic features like delusion of persecution and control, auditory hallucination persisted without significant features of depression that persisted I month at the age of 23 and followed by attenuated form of persecution and derogatory voice.

Delusion of control is also of bizarre nature-controlled by space people.

Content of the auditory hallucination was derogatory and threatening and most likely third person or imperative type.

His suicidal thought is clearly explainable by his reaction to hallucination.

Assigned task

a) Diagnosis
From the given information and its extraction, the possible differential diagnoses are as followings:

Schizoaffective disorder
Features of schizophrenia (delusions and hallucination) present with depressive mood episodes. Uninterrupted period of active and residual symptoms of psychotic illness present for the last 5 years. Depressed mood present in majority of the period of illness. All such features suggest diagnosis of Schizoaffective Disorder.

Schizophrenia
Presence of delusions- persecutory, control, typical hallucination and negative symptoms (sad mood and amotivation) are diagnostic criteria for schizophrenia. Here, in this case, mood features appear before psychotic features and persist throughout the course with varied severity. In schizophrenia mood features, if present, present only for a short duration.

Major depressive disorder with mood congruent psychotic feature
In MDD with mood congruent psychotic features, delusion or hallucination present with depressed mood but their content goes with depression and subsides before mood features

improve. Here, psychotic features are more prominent and present in absence of depressive features. Moreover, the theme of delusion and hallucination are not congruent with the patient's mood. Delusion of control is a hallmark of schizophrenia/schizoaffective disorder.

Therefore, from the above discussion, it can be concluded that the final diagnosis is Schizoaffective disorder, depressed type.

b) Treatment plan
Hospitalization for thorough assessment and management

General management
Ensuring hydration, nutrition and personal hygiene
BDZ prn if sleep is inadequate.

Specific management
- Biological management- Antipsychotic drug (preferably Olanzapine/ Quetiapine/ Aripiprazole) keeping in mind the thorough drug history in previous episodes. Antidepressant may be needed if symptoms do not respond to antipsychotic alone.
- Psychological management- CBT, Cognitive remediation, family therapy.
- Social management- Social skills training, occupational therapy.

68. A 30-year-old sales executive attends a psychiatrist's chamber who becomes more active over 1 month. She sleeps less and recently does more shopping. She notices that her sexual urge has increased. She often starts a task but cannot finish it as she finds it hard to focus on the task.
a) What is the most likely diagnosis?
b) What will be your treatment plan?

Given information

Demography and referral
Age- 30 years
Sex- Female
Referred to- Psychiatrist's chamber

Chief complaints
- More active for 1 month
- Sleeps less
- Does more shopping
- Increased sexual urge
- Difficulty on focusing a task

Extracted information

Increased activity, decreased need for sleep, increased expenditure, increased sexual urge and easy distractibility (evidenced by difficulty focusing on tasks) all are diagnostic features of mania and hypomania.

In Mania, the symptom intensity is more, duration is 7 days or less if hospitalization is needed and psychotic features may be present. In hypomania, severity is less and hospitalization is not needed.

Here, the patient visits the doctors chamber and no functional impairment is reported. As no previous episode (manic/hypomanic/depressive) is mentioned, it can be said to be a case of hypomania.

Assigned task

a) Most likely diagnosis
From the logical extraction of given information, the most likely diagnosis is a Hypomanic episode.

b) Treatment plan

As the woman is in her child bearing age and probably it is her first episode, the choice of drug should be mood stabilizing antipsychotic (Haloperidol/ Olanzapine/ Quetiapine/ Risperidone/ Aripiprazole) rather than a mood stabilizer.

69. A 30-years-old married businessman appears in psychiatry OPD with elevated mood, marked over activity and excitement despite continuing medication. Three months ago, he was in a low mood with a lack of energy. He was admitted four times in the last year with alternate mood swings and associated features.
a) List the information you need to gather considering his diagnosis and treatment plan,
b) Outline the steps of a comprehensive treatment plan for this case.

Given information

Demography and referral
Age- 30 years
Sex- Male
Occupation- Businessman
Marital status- Married
Referred to- Psychiatry OPD
Reason of referral- Further treatment

Chief complaints
- Elevated mood
- Marked overactivity
- Excitement
- Under treatment

Past psychiatric history
Low mood and lack of energy- 3 months ago
Admitted 4 times in hospital due to alternate mood swings and associated features within last 1 year

Extracted information

Elevated mood, over activity and excitement indicates manic features.

Low mood and lack of energy are evidence of a depressive episode 3 months back.

Alternative mood swings, which includes manic and depressive episodes for which hospitalization needed go in favor of bipolar I disorder. Four episodes in 1 year specifies the course as rapid cycling.

Thus, the final diagnosis is bipolar I disorder with rapid cycling.

Though the onset of mood episodes is not mentioned, there could be history of more episodes in the past than other years as indicated by the number of episodes and hospitalization in one year. There could be a history of another episode, that the patient was not hospitalized due to so many reasons within the last and other years and patients and caregivers usually do not inform this to the physicians. Therefore, duration of the disorder is essential to clarify this.

Noncompliance or partial compliance is one of the main causes of poor response in bipolar disorder. The patient is continuing medication. Here, the patient's compliance status is essential to know. Another possibility is antidepressant-induced mania as it is common for rapid cycling disorder. Here, in this case, it could be, because the previous episode was a depressive one and the patient is in treatment. It is expected that he is getting treatment for a manic episode. It could be that the patient may still take antidepressant for his recent past depressive episode.

Other possibility of nonresponse is having acute or enduring stressors like problems in his business, financial issues, family issues, and other issues related to persistency of the illness and its adverse effects, comorbid psychiatric disorders, relevant general medical conditions that need exploration.

Poor response in increasing frequency of episodes is the nature of bipolar disorder and makes the case treatment refractory. This is likely more probable cause of nonresponse of treatment of current episode evident throughout in the information like typical presentation, increased frequency of episode and decreased inter-episodic period, enough severe evident by hospitalization, and possible long duration.

Assigned task

a) <u>Information need to be gathered</u>
   - Age of onset of the first mood episode.
   - Number, duration and interval between the episodes.
   - Precipitating factor of current episode especially substance abuse and drug or antidepressant treatment history.
   - Predisposing and perpetuating factors.
   - Comorbid psychiatric disorder with special emphasis on drug or alcohol misuse.
   - Comorbid medical illness especially thyroid dysfunction.
   - Thorough treatment history- the patient responds to which drug, what dosage, how long does it take to respond etc.
   - Current stressors including enduring and recent ones.
   - Assessment of impact of disorders.
   - Risk assessment.
   - Strength assessment.
   - Investigations
     - Baseline investigations.
     - Other first line investigations as indicated form the patient's clinical assessment including thyroid function tests.
     - Further specific investigation if required.

b) <u>Comprehensive treatment plan</u>

General treatment

- Explanation to the patient and caregivers on the illness status and treatment plan, support and advice.
- Hospitalization for thorough assessment and applying revving treatment with closed supervision.
- Ensuring hydration, nutrition and personal hygiene.

Specific treatment

*Biologica*l

- Stopping antidepressant drugs, if any.
- Protocol of treatment refractory bipolar disorder is likely to be implemented.
- If the patient is on a mood stabilizer, increasing the dosage considering blood level.
- Combination of mood stabilizers.
- Adjunctive aripiprazole/quetiapine/olanzapine/risperidone/haloperidol.

Psychosocial

- Psychoeducation to the family aiming to improve communication and reducing expressed emotions.
- Avoidance of stressors.
- Regular sleep.
- Avoidance of taking illicit drugs.
- Identification of early subjective signs of relapse.
- Psychotherapy- CBT, interpersonal and social rhythm therapy.

70. A 32-year-old clerk was referred to the outpatient psychiatry department by his GP of the office medical center, who has low mood and loss of libido. He feels tired all day, and finds it difficult to concentrate for a long time. These happen for 4 years and though the symptoms have ups and down but never go and he finds difficulties in his office work.
a) Mention your line of assessment keeping in mind the diagnosis.
b) What treatment plan will you adopt for this case?

Given information

<u>Demography and referral</u>
Age- 32 years
Sex- Male
Occupation- Clerk
Referred to- Psychiatry OPD
Referred by- GP

<u>Chief complaints</u>

- Low mood- 4 years
- Loss of libido- same duration
- Feeling tired all the day-same duration
- Difficulty concentrating long time-same duration
- Functional impairment as finding office work difficult-subsequent development

Extracted information

Low mood and other features are very much indicative of depressive disorder. Symptoms go up and down but never go away for a long 4 years duration.

The few symptom lists associated with mild impairment, particularly in his occupational domain, do not go for Major Depressive Disorder (MDD). To qualify the diagnosis of MDD, one should have other features of anhedonia, psychomotor retardation, feeling of inappropriate guilt and suicidality to make it total 5 features out of 9 diagnostic features. In this case, those features are not indicative.

Presenting symptomatology along with a long duration of 4 years and waxing and waning course of the features go in favor of a minor but persistent pattern of depression. The demographic profile strengthens it.

Patient has been referred by the GP, it can be expected that his problems are not due to any physical disorder that causes depression and can be assumed to be ruled out. However, it needs confirmation.

Thus, the most probable diagnosis is Dysthymic disorder/Persistent Depressive Disorder/Dysthymia.

Assigned task

a) Assessment plan
- Presence of other symptomatology of dysthymia.
- Through history about onset and course (patient not symptom free for more than 2 months at a time).
- Whether the loss of libido is for depression or antidepressant medication or for other issues.
- Overlapping symptoms of MDD any time during the course of illness including the present one.
- History of manic or hypomanic episodes.
- Presence of psychotic features during any point of illness.
- Comorbid history of substance abuse.
- Cooccurring medical illness.
- Etiological factors- predisposing, precipitating and perpetuating factors. Special emphasis on the presence of enduring stressors.
- Risk assessment- assessing suicidality.
- Impact of the disorder in social, occupational and other important areas of functioning.
- General, systemic and mental status examination.
- Baseline investigations including TFT if not done recently.

b) Treatment

The treatment plan should be comprehensive addressing the problems of depression, sexual dysfunction and functional impairment. Biopsychosocial models should be adopted.

Biological

If the patient previously responded to any medication, that should be reintroduced with optimal dosing.

If no history of antidepressant medication, SSRI can be used with low dosage and closely monitored for sexual side effects. If sexual problems worsen, the drug may be changed to mirtazapine or bupropion.

Low dose benzodiazepine can be used for short duration if sleep problems.

Psychological

Relaxation exercise

CBT
Graded exercise

Social
Active daily living program
Recreational and social activities

Chapter 2: Consultation liaison Psychiatry

1. A 44-year-old male admitted with CRF referred to you for psychiatric consultation. He was depressed during admission. Later, he developed irrelevant talks, excitement, violent behavior, sleep disturbances and loss of appetite.
   a) What areas do you need to assess to reach a diagnosis?
   b) What will be the management plan?

Given information

Demography and referral
Age- 44 years
Sex- Male
Referred to- Psychiatry department
Referred from- Inpatient care
Reason for referral-Psychiatric consultation

Chief complaints
- Irrelevant talks
- Excitement
- Violent behavior
- Sleep disturbance
- Loss of appetite

Psychiatric history
Depression during admission

Medical history
CRF

Extracted information

The middle-aged man has been referred for CRF which may either be from nephrology or internal medicine department. Reason for referral is psychiatric evaluation of sudden development of irrelevant talks, excitement, violent behavior, sleep disturbance and loss of appetite.

Incoherence, excitement and violent acts are features of cognitive impairment that indicate the possibility of developing delirium likely due to renal impairment.

Symptom progression is possibly toward depression; more & more symptoms are adding i.e. sleep disturbance, loss of appetite, psychomotor agitation. (agitation is more common in old age depression).

Assigned task

a) Areas need to be assessed
   - CRF status: S. electrolyte, S. creatinine, LFT, CrCl, whether dialysis ongoing or not (precipitates delirium before/after).

- Full assessment of higher cognitive function with special emphasis on level of consciousness and other features of delirium-behavioral, psychotic.
- Details of the recent history of depression and its severity and thorough psychiatric history including past history of depressive episode, family history of psychiatric disorder, history of substance abuse, current social circumstances and premorbid personality.
- Co-occurring general medical condition.
- M/S/E: with the aim of expected findings like disorganized speech and behavior, hallucination-visual and auditory, delusion-persecution, impaired consciousness and orientation.

b) Management plan

From the extraction of given information, most likely diagnoses are,

- Acute confusional state/Delirium
- Depressive Disorder

Acute confessional state
The general line of management for delirium is managing the patient with the following.

i. Calm and quiet room
ii. Bright light
iii. Similar staff
iv. Food, nutrition & electrolyte balance
v. Symptomatic management
vi. Short acting BDZ (lorazepam 1-2 mg)
vii. Low dose haloperidol 2-5mg

Depressive Disorder
Citalopram/Sertraline in optimum dose & duration.

2. A 40-year-old woman has been on disodium valproate for her bipolar disorder. Suddenly she developed acute abdominal pain and vomiting, and was brought to the intensive care unit in a semi-comatose state.
   a) What will be your role as a management team member in assessing and managing the case?
   b) What advice will you provide if she recovers from the present condition and while leaving hospital?

Given information

Demography and referral
Age- 40 years
Sex- Female
Admitted in ICU
Reason for admission- acute abdominal pain, vomiting
Current status- semi-comatose

Present psychiatric diagnosis
Bipolar Disorder

Treatment receiving
Disodium Valproate

Extracted information

Sudden onset of semi-comatose state in a middle-aged woman may be vascular, traumatic, infective, metabolic, inflammatory, neoplastic or drug induced. Apart from drug history no other relevant history is present.

Possible cause of semi- comatose condition is valproate induced hepatitis or pancreatitis. Though these two are rare, idiosyncratic but serious side effects. It usually occurs within the first 6 months of treatment.

Assigned task

a) Assessment and management

Assessment

- Exclusion of other causes of abdominal pain and vomiting.
- Dose and duration of Valproate.
- Whether the patient is taking any other mood stabilizer or not.
- Any other prescribed medication for comorbid medical illness.
- Clinical features of hepatotoxicity/pancreatitis- lethargy, malaise, anorexia, nausea, and edema.
- Re-examining the psychiatric diagnosis from caregivers if possible.
- Investigations
  CBC
  CRP
  SGPT, SGOT, Prothrombin time
  Serum amylase
  RBS
  S. Creatinine
  S. Electrolyte

Management

- Discontinuation of Valproate.
- Monitoring of amylase
- Other treatment as per standard protocol of hepatitis/pancreatitis.

b) Advice after recovery

- Not to start valproate again.
- Other mood stabilizers can be tried- Lithium/Carbamazepine/Lamotrigine.
- Atypical APD could be a better option if works- Olanzapine/Risperidone/Aripiprazole/Quetiapine
- If the patient is a valproate responder, challenge can be done with extreme precaution.

3. A 30-year-old man who is getting antipsychotics for his schizophrenia admitted in emergency with the complaints of rigidity, hyperthermia, autonomic immobility and confusion. For these, he got psychiatric referral.
   a) What diagnosis will you write? What are the first line biochemical tests you need to be checked or suggested?
   b) What major steps of the management plan will you share with the management team?

Given information

Demography and referral
Age- 30 years
Sex- Male
Psychiatric diagnosis- Schizophrenia
Admitted in emergency department
Referred to- Psychiatry department

Chief complaints
- Rigidity
- Hyperthermia
- Autonomic immobility
- Confusion

Extracted information

The young aged male is diagnosed with schizophrenia and on APD. Most likely he is on high potency APD. High potency drugs are most likely to cause NMS whereas low potency drugs have more anticholinergic adverse effects. APD with anticholinergic A/E are less likely to cause NMS.

Other possible causes of such presentation in this age group is meningoencephalitis and catatonia. As there is no history of infection, seizure or neck rigidity, so, meningoencephalitis can be ruled out. Features in favor of catatonia are not mentioned in the scenario. However, they should be thoroughly sought.

Assigned task

a) Diagnosis
From the logical extraction of given information, the best possible diagnosis is neuroleptic malignant syndrome.

First line biochemical tests
CBC with ESR- Leukocytosis is present
CPK- Raised
SGPT- Raised

b) Steps of management

Supportive measure
IV hydration
Cooling blankets
Ice packs
Ice water enema
Oxygenation
Antipyretics

Specific treatment
Dantrolene (1mg/kg/day for 8 days)
Bromocriptine (2.5 mg PO twice or thrice daily)

Levodopa/Carbidopa
Amantadine
BDZ (e.g. Lorazepam)
ECT

Psychoeducation about course and prognosis
Prevalence 2-2.4%, mortality 10-20%, course (onset 24-72 hours, but can occur at any time), prognosis (untreated symptom may last 10-14 days).

4. A 37-year-old woman who is getting imipramine for her depression admitted in the intensive care unit for overdosing with the medication. She is stuporus with unstable heart rate. You are requested to see this patient.
   a) How will you explain the case to your referring colleague?
   b) Mention the steps of the management from your part.

Given information

Demography and referral
Age- 37 years
Sex- Female
Admitted in ICU
Reason for admission- Overdosing of Imipramine

Chief complaint
Stuporus with unstable heart rate

Present psychiatric diagnosis
Depressive disorder

Treatment history
Tablet Imipramine

Extracted information

The young woman is a diagnosed case of depression and on medication. Most likely she has responded to the medication. She might have some recent life crisis for which she overdosed herself. Suicidal intent might be present as the incident is severe enough to get referred to ICU.

Stupor and unstable heart rate indicate hypotension and arrhythmia which is an adverse effect of imipramine.

Assigned task

a) Explanation to the referring doctors
   - The patient has been suffering from depression and was treated with imipramine.
   - The overdosing by the patient may be done with the aim of ending her life.
   - Imipramine is a tricyclic antidepressant which has cardiotoxic properties.

- The drug has good antidepressant properties but use has been limited due to its comparatively higher adverse effect burden than SSRIs.
- Probably the patient did not respond to SSRIs.
- Now imipramine should be stopped and the patient should be carefully monitored.

b) Steps of management
   - The patient must be treated empathetically.
   - Proper monitoring of the patient should be ensured.
   - Clear instructions regarding monitoring should be given to the nurse and supporting staff.
   - Proper handover during shift changes.
   - Harmful objects (e.g. knife, rope) should be kept away from the patient.
   - Drugs should be administered by a caregiver or nurse, not on patients own.
   - During discharge, antidepressants with a broad therapeutic index can be prescribed.
   - If imipramine has to be reinstituted, it should be in a non-dangerous dosage.
   - ECT may be planned.
   - Regular follow up and risk assessment.

5. A 34-year-old man presents with passage of mucus with stool and fullness of the abdomen. He says that he has "gastric" and "dysentery" that persist in the last 10 years despite several treatments. All investigations revealed no abnormality. He looks anxious and depressed and is surprised that he referred to psychiatry.
   a) What is your differential diagnosis?
   b) Make a checklist of your assessment areas to reach a diagnosis.

Given information

Demography and referral
Age- 34 years
Sex- Male

Chief complaints
- Passage of mucus with stool & abdominal fullness for 10 years
- Conviction that he has illness like gastric & dysentery
- Surprised about referral to psychiatry

Investigations
NAD

M/S/E finding
Mood- Anxious and depressed

Extracted information

The middle-aged man has been referred from non-psychiatric discipline. He has undergone massive investigations in the last 10 years to exclude medical conditions. However, the investigations fail to reveal any physical abnormality. Rather the origin of the problems is most likely to be psychosomatic.

Anxious and depressed mood are the core features of anxiety and depressive disorders respectively.

The person is preoccupied with illness related thoughts and performs extensive health checking behavior despite repeated negative findings. Such patterns of thought and related behavior is found in somatic symptom disorder, illness anxiety disorder, generalized anxiety disorder and depressive disorder.

In the above-mentioned scenario, persistent somatic symptoms, no finding despite multiple investigations and high levels of anxiety are very much suggestive of somatic symptom disorder.

Persistent thoughts of the person having a disorder goes in favor of IAD. However, the presence of real symptoms goes against the claim.

In GAD, the worry present is related to real life events rather than a single health-related matter. Thus, the worry about other day-to-day events including their severity and extent should be thoroughly sought.

Depressed mood indicates possibility of depressive disorder. Here depression can be present as a consequence of the illness related thoughts or it might be comorbidly present.

Psychiatric referral after long 10 years of investigations and follow up excludes the possibility of having a medical illness. However, the person's suffering is real and needs to be addressed properly.

Assigned task

a) Differential diagnosis

From the extraction of the given scenario, the possible diagnoses are,

i. Somatic symptom disorder
ii. Illness anxiety disorder
iii. GAD
iv. Depressive disorder

b) Other areas need to be explored to reach diagnosis

Premorbid personality to see whether the person is anxiety-prone and his pattern of cognition.
Level of impairment in social, financial, occupational and personal life.
Free floating anxiety to exclude GAD.
Presence of any somatic symptom and their nature and severity.
Somatic symptoms of anxiety present or not.
Thorough evaluation of mood (predominance, persistency, pervasiveness, mood reactivity).
Perception of the patient and his caregivers about the problems.
Expectation of the patient and the family from treatment.
Risk assessment including risk of suicide as the mood is depressed. Risk of financial exploitation should also be assessed.
Strength of the patient.

6. A 30-year old male patient in medicine OPD refuses to provide answers during initiating history taking like address, family information. When asked the reason for the refusal, he replies he does not see why the physician needs such irrelevant information and watches the physicians suspiciously. When pressed further, he asks angrily, "Are you going to treat me or my family? Should I complain to the authorities?" The surprised physician discussed the matter to you.

a) What is the most possible diagnosis?
b) What strategies will you advocate to the physicians to assess and manage such cases?

Given Information

Demography and referral
Age- 30 years
Sex-Male
Referred from- Medicine OPD
Advice send by- Attended physician
Reason for seeking advice- Patient's unusual behavior

Chief Complaints
- Refusal to give answer of the questions during clinical history as he thinks it irrelevant to his problem
- Suspiciousness about the physician's motive
- Unusual response to physician's interview in the form of threat

M/S/E findings
Appearance and behavior– Suspicious look, odd help seeking behavior

Extracted information

The young male is most likely referred to by self for his physical problems. However, initiation of history taking is not possible as he refuses to comply. On repeated asking, he becomes angry and suspicious. This pattern suggests his in general suspicious nature and mistrust toward the neutral physician.

Such a pattern of behavior is strongly indicative of paranoid PD. To qualify the diagnosis of PD, the onset must be in adolescence or early adulthood and behavioral problems present in a variety of contexts. Thus, these should be searched thoroughly in history.

Possibly this is not a case of paranoid schizophrenia because there is a general pattern of suspicious behavior and no indication of psychotic features.

Paranoid delusional disorder is also unlikely because there is no evidence of fixed and focused delusions.

Assigned Task

a) Diagnosis
From the given information and its extraction, the most likely diagnosis is Paranoid Personality Disorder (PPD).

b) Strategies of management

Following strategies for managing this case can be advised:
- Firm and assertive approach.
- Give him space to understand his odds.
- Enhance observational learning.
- Offer consultation when he requests or agrees.

- Develop trusted and empathic relationships.
- Refer to psychiatry after recognizing his problems subsequently.

7. A 48-year-old man referred from the palliative care inpatient unit of the hospital to the psychiatry department who has persistent denial of his terminal state, shows marked anger, refuses taking food and refuses to stay in the hospital.
a) Outline your assessment plan
b) Mention the major components of your management

Given information

Demography and referral
Age- 48 years
Sex- Male
Referred from- Palliative Care Unit
Referred to- Psychiatry department
Reason for referral-Psychiatric assessment and management

Chief Complaints
Denial of his terminal state- duration not mentioned possibly recent
Marked anger
Refuses taking food and
Refuse to stay in the hospital

Extracted information

This late middle-aged man has terminal illness for which he has been admitted to a palliative unit. Denial of his terminal illness at this age is likely due to psychological reaction in response to non-acceptance of his terminal condition. His marked angriness, food refusal and refusal to stay in the hospital are the sequential features of his initial denial.

It is likely that the patient might have or will be depressed in the course of time that needs to be addressed.

The psychological steps of death and dying are usually sequential but not always and have individual variation. This point must be kept in mind during assessing this case.

Here, for this patient, the key role of a psychiatrist is helping the patient in accepting the terminal condition and providing support for comfortable living for the rest part of life. For that, a psychiatrist will work as part of the wider palliative care supporting team.

Assigned task

a) Outline of the assessment plan
- Detail working out about the patient's illness, intervention and current situation and predicted end stage
- Details of the presenting and associated symptoms
- Assessing the patient in the light of psychological stages of death and dying
- Psychiatric history and mental state examination
- Assessing strengths and abilities of the patient
- Assessing supportive status of the family
- Assessing emotional and spiritual preparedness for the end of life stage

b) The major components of your management

- Managing his present symptoms efficiently with required drugs and psychosocial means
- Showing empathy, compassion and concerned involvement
- Encouraging the ventilation of his feelings
- Establishing effective communication with patient and family
- Encouraging family members and friends to visit him
- Providing coordinated support from family and team members
- Continuing feasible, persistent and consistent support
- Helping the psychological issues and challenges faced by other health care providers and family members in attending the patients
- Diagnosing and treating comorbid psychiatric disorders in patients

Chapter 3: Community Psychiatry

1. As a team leader to provide emergency mental health support to village people who are the victims of a terrible cyclone, you need to train your volunteers and supporting professionals first hand.
   a) Outline your educational contents of psychotrauma that you need to provide to the victims through your team.
   b) State the components of psychological first aid for their training.

Given information

Task
Ultimate- Offering emergency mental health support to the village people who are victims of a terrific cyclone.
Immediate- Train the volunteers and supporting professionals of the supportive team at the first hand.

Given responsibility
Team leader of a mental health support team.

Extracted information

Considering the ultimate task, main purpose will be providing psychological first aid to the victims of the village in most feasible and effective way

Therefore, educational contents should be goal oriented basic knowledge, skills, and attitude to meet the immediate purpose.

The composition of the team members seems to be a mixture of untrained volunteers and trained professionals. This point must be considered in designing training contents and techniques utilizing existing knowledge and experience of the professional members and self-motivated volunteers for creating the best possible stimulating learning environment.

The duration should be 2-4 hours using adult learning methods- like brief presentation, videos, group discussion, demonstration, simulation, psychodrama and practicum.

Assigned task

a)Educational content of psychotrauma for the team

Following contents are suitable for the competences of the team member. The contents will be customized considering their present abilities and level of understanding.

- Basic understanding about psychotrauma: crisis theory and phases of traumatic crisis,
- Traumatic stress and process of stress, death and grief, aims and principles of early interventions, psychological intervention methods in early interventions - psychological support, psychological first aid.
- Primary knowledge of: the disorders in the process, dissociation, developing psychic trauma, posttraumatic disorder, long term reactions after disaster, professional intervention methods, psychological defusing, psychological debriefing, long term collective support and activation of

the psychological working through process, screening those in need of crisis or trauma therapy, follow-up of the effects of interventions

- Some knowledge of Post trauma therapy - social and cultural factors and trauma, adaptation to trauma memory and its mechanism and process, development of psychological trauma, diagnosing psychological trauma, principles of trauma therapy, special trauma therapeutic intervention methods
- Competence of a worker in field of disaster, crisis and trauma:
  Stress tolerance, tolerance to be an object to strong emotions, talents on holding and storing of emotions. leadership and ability to organize action, good interaction skill
- Skill training on the task through group discussion, modelling, psychodrama, simulation etc.
- Identification of issues pertaining to psychosocial support in disaster management: brief information the cyclone and its effect, basic information including demography of the affected village and resultant crisis, statutes of disaster services, current need of the victims focusing psychosocial need.
- Stating action plan: individual and group role.

b) Psychological first aid for this training

It is the basic knowledge skills of traumatic crisis and psychosocial support. This is an integral part of the basic training of all those professionals who work with victims of disasters. The components are:

- Giving comfort and consolation
- Protecting the survivors from further threat and distress
- Giving immediate physical care
- Helping the survivors to reunite with the loved ones
- Sharing the experiences but not forced
- Linking the survivors with sources of support
- Facilitating the sense of being in control
- Identifying those who need further help

2. You are assigned to establish screening of depression during antenatal along with a referral system in a maternity center.
a) Outline your plan to establish this service in the center.
b) What could be your content of group psychoeducation for the attendees of the center?

Given information

Task

Establishing the process of screening depression in a maternity center along with referral system.

Extracted information

Screening of depression is a recognized component of maternity service as roughly 30% antenatal and postnatal attendees suffer from the depressive disorder.

This disorder has a significant impact on pregnant mothers before and after birth of their child.

If it is undefined and untreated, the consequences will likely be worse for both mother and child in many ways including suicide and infanticide.

Routine screening of mothers at the period of attendances with a valid and simple psychometric tool can identify the case with depression and intervention can be done including referral to the psychiatric facilities.

Assigned task

a) Establishment plan for screening and referral system in this maternity center

- Application of a screening tool for depression for all the attendees in the maternity center.
- Provision for identifying those who are vulnerable (personal or family H/O mental illness).
- Identifying those who are vulnerable due to their psychosocial adversities.
- Identifying those who need referral to a secondary center.
- Keeping a register for the entire patient that comes under screening service.
- Provision of education on good mental health.
- Making available the common psychotropic drugs that are safe in pregnancy.
- Initiation of training program for personal development (e.g. relaxation exercise, promoting recreational activities).
- Training the trainers.

b) Group psychoeducation for the attendees

- Rapport with the individual and the family attendees.
- Information on the clinical characteristics, incidence, prevalence, treatment and prognosis of the disorder.
- Early warning signs of the disease (e.g. mood change, lacking energy and enjoyment, change in eating and sleep pattern).
- Managing suicidal behavior.
- Improving communication skills (naming the emotions, expressing the pleasant and unpleasant feelings).
- Improving problem solving skills

3. A 22-year-old female who is in a safe house for her repeated suicidal acts for 10 days. At midnight, the warden of the house phones you for her severe agitated and suicidal behavior that she finds hard to control. As an on-call psychiatrist,

a) What will be your immediate action over the phone?

b) List the steps of your afterwards action for this woman.

Given information

Demography and referral

Age- 22 years

Sex- Female

Referred from- Safe house by phone

Referred by- Warden of the house

Referred to- On call psychiatrist in a psychiatric facility

Chief complaints

- Reputed suicidal acts- 10 days
- Severe agitation with and suicidal behavior that the warden finds hard to control- current duration

Extracted information

This young adult woman has repeated suicidal acts for which she is in a community safe house. It is likely she is a woman with high suicidal risk. Her present severe agitation with suicidal behavior certainly indicative of this high risk as well as her severe inner distress.

It can be expected that she has been shifted to a safe house for crisis intervention from any personal, family or environmental stressful event. She may have depressive, stress related, bipolar, and psychotic or personality disorder.

At this point at midnight, as an on-call psychiatrist, rapid tranquilization can be provided over phone and then immediate visit to the house is necessary.

Assigned task

a) Immediate action plan over phone

Giving an order for rapid tranquilization. Here, considering the severe and unmanageable condition of the woman, intramuscular haloperidol will be ordered initially with 5 mg. To prevent extrapyramidal side effects, additional procyclidine 10 mg will be advised. The process will be repeated after every 30-60 minutes if insufficient. If not adequately effective, diazepam 10 mg slowly over at least 2 minutes will be ordered with repetition after each 5-10 minutes for a maximum of 3 times.
Checking vitals- pulse, temperature, BP, respiratory rate in every 15 minutes for 1 hour.
Checking for any side effect- EPSE, pyrexia, hypoxia, hypotension, over sedation.
Maintenance of general physical wellbeing.

b) Steps for managing suicide

- Building up rapport with the patient.
- Expressing empathy.
- Thorough history including history of mental and physical illness, treatment history, family history of suicide and psychiatric illness, personal history, current social circumstances, premorbid personality and treatment history).
- Details history of suicidal acts (recent and past events).
- Treatment of the psychiatric disorder.
- Prescribing adequate and non-dangerous dosage of psychotropic drugs.
- Psychotherapy (problem solving therapy/interpersonal psychotherapy/CBT/DBT) as appropriate.
- Involving a family member or friend for keeping regular contact.
- Providing a helpline number for emergencies.
- Regular follow up.

[Note: For further reading, see the Child and Adolescent Community Psychiatry section in Part 2, Page – xxx. These are almost equally applicable in General Psychiatry.]

Chapter 4: Rehabilitation Psychiatry

1. A 24-year-old female with intellectual disability at moderate level has been brought by her parents to psychiatry OPD. The family is not in a position for special placement and seeks a home-based rehabilitation plan.

a) Prepare a checklist of your assessment for home-based rehabilitation.

b) Outline the contents of such a rehabilitation plan.

Given information

Demography and referral

Age- 24 years

Sex- Female

Referred to- Psychiatry OPD

Referred by- Parents

Reason for referral seeking for home-based rehabilitation plan

Psychiatric diagnosis

Intellectual Disability, moderate

Extracted information

This young female has intellectual disability at moderate level. It can be assumed that this woman has the problem since early life and has definite learning failure.

The parents express their inability to send their daughter in special placement. That indicated an earlier special intuitional based program is advised and it is not clear that this woman attended in special school or not.

Person with moderate intellectual disability is trainable in special settings. This includes life skill training, vocational training, and recreational activities.

As the parents seek home based rehabilitation programs, these components need to be incorporated in a feasible way. Here, it needs to be mentioned that in Bangladesh, traditionally a high degree of family cohesion exists. Measuring the family supports and strengths and present state of the patients and her abilities alternatively home-based learning program for this patient with ID is feasible and possible.

Assigned task

a) Checklist of assessment for home-based rehabilitation program

- Measuring her current level of adaptive behavior functioning in terms of independent and dependent activities, in conceptual, social and practical domains.
- Special abilities and skills and interest.

- Things she learned from the special schools or institution, if attended.
- Any comorbid psychiatric disorder or occurring physical illness including epilepsy.
- Level of functioning in all domains- personal, familial, occupational, social and recreational
- Strengths of the family and sources of support.
- Family- type, functioning status, socio-economic status, number of family members, attitude of the family members tars the patient.
- Key person and supportive persons of the family will be responsible for the home-based program.
- Neighborhood- neighborhood support, social, play and other recreational amenities.

b) Contents of rehabilitation plan

A booklet of home-based rehabilitation programs will be provided to the parents with adequate briefing. Thea main contents are:

- Health (promotion, prevention, medical care, rehabilitation, assisted device)- family members will be assisted and guided.
- Vocational training (according to patients' capacity and local availability)- she can be trained with unskilled, semi-skilled work with assistance based on family and local resources with the aim of possible employment.
- Livelihood (skill development, self-employment, social protection).
- Social (Relationship, marriage, recreation, leisure).
- Empowerment (Advocacy, communication, self-help groups).

2. A 37-year-old male lost his job due to her recurrent depression. Despite all modes of drug, ECT and psychotherapy, his depression persists with a waxing and waning course and most of the time he spends idle.
a) How will you assess his disabilities?
b) What steps will you take to overcome his disabilities?

Given information

Demography and referral
Age- 37 years
Sex- Male
Referred to- Psychiatric facilities
Reason for referral- Assessing and managing his disability

Chief complaints
- Persisting recurrent depression- duration not mentioned, likely long
- Spend time in idle-subsequent duration

Stressful events
Loss of job due to his persisting depression

Present psychiatric diagnosis
Recurrent depression, treatment resistance
Course of the disorder- waxing and waning
Treatment history
Nonresponsive to all drugs, ECT and psychotherapy

Extracted information

This middle-aged man has recurrent depression which is a treatment resistant with all modes of medication including ECT and psychotherapy. In case of major depressive disorder, at least 5% of cases are resistant to all forms of treatment. Unfortunately, he falls with this group. However, waxing and waning courses still are a good consideration to maintaining treatment that are relatively somewhat effective. It is evident that maintaining treatment at least prevent more worsening as the condition may end with committing suicide.

Along with a suitable rehabilitation program can prevent relapse and may contribute to further improvement.

This man lost his job as a consequence of his depression and spending time idle that will certainly be the cause of further worsening of his condition. On the other hand, maintaining a feasible daily life in all domains may help in improving his depression.

Considering all the factors this man needs a practicable rehabilitation program.

Assigned task

a) <u>Assessment of disabilities of this patient</u>
- Severity of depression
- Predominant depressive features
- Risk-Suicidal thoughts or ideas, attempt along with assessing all the predictors of suicide
- Treatment and response level
- Premorbid functioning
- Level of impairment in social, occupational and other areas of functioning
- Patient's view about self, world and future
- Adverse childhood experiences and presence of dysfunctional assumptions
- Stressors- predisposing, precipitating and perpetuating
- Effect of loss of job on him and family
- His burden of the family and burden of the family for him
- Sources of support including economic and social capital
- Applying WHO Disability assessment scale to quantify and qualify disability

b) <u>Steps for overcoming disabilities</u>

- Improving general health and well being
- Improving communication with family and friends
- Activity scheduling
- Regular exercise
- Balanced diet
- Regular sleep
- Nurturing hobbies
- Adherence to drug and psychotherapy
- Self-help groups
- Regular follow up

3. A 32-year-old man with schizophrenia remitted significantly with risperidone is on maintenance therapy. He lives in the coastal area from where attends psychiatry OPD for follow up. His father says that he does not want to do any work, is confined at home, and shows no willingness to talk with others. Your consultant asked you to apply to be an active daily living programmer for him.
a) What information do you need to gather for such a program?
b) How will you plan this program at home?

Given information

Demography and referral
Age- 32 years
Sex- Male
Referred to- Psychiatry OPD
Reason for referral- Applying daily life program
Accompanied by- Father

Chief complaints
- Does not want do any work- duration not mentioned, likely long
- Confined at home-same duration
- Shows no willingness to talk with others- same duration

Present psychiatric diagnosis
Schizophrenia

Treatment and outcome
Significantly responded with risperidone and, now under maintenance therapy

Additional treatment plan
Active daily living program

Extracted information

This early adult man is a case of schizophrenia. He responded well with risperidone and is now in maintenance therapy. It can be assumed that the disease course is active phase in partial remission. His current anhedonia, motivation, alogia—all are negative symptoms of schizophrenia.

There may be other negative symptoms with him and almost all drugs do not work in minimizing the negative symptoms. Social therapy in the form of an active daily life program is the basic first, and easy tool to minimize these symptoms as well as helps in the rehabilitating this patient.

Assigned task

a) Information need to be gathered

- Duration of Schizophrenia with predominant symptomatology
- Presence of negative symptoms
- Dose of Risperidone
- Adverse effect profile of Risperidone

- Use of other prescribed medications
- Any comorbid drug abuse- particularly cannabis
- Educational background
- Premorbid functioning level
- Current social circumstances
- Personal history- marital status, relationship with family members
- Sources of support
- Strength of the patient

b) Planning active daily life program

- Routine for feeding, bathing, dressing and grooming.
- Homemaking as he can do.
- Identifying his leisure activities and encouraging to practice.
- Regular exercise.
- Preparing the patient toward income generating activities.
- Communication and social skill development by improving communication with family and friends.

Chapter 5: Addiction Psychiatry

1) A 28-year-old man presents in psychiatry OPD with profuse rhinorrhea, agitation and piloerection. On examination, his pupils were widely dilated.
Based on your logical deduction of information form the scenario─
a) What is the single most likely diagnosis?
b) What is your immediate management plan for this case?

Given information

Demography and referral
Age- 28 years
Sex- Male
Admitted in hospital

Chief complaints
- Profuse rhinorrhea- duration not mentioned, seemingly present
- Agitation- same duration
- Piloerection-same duration

On examination
Pupils- widely dilated

Extracted information

Symptoms of rhinorrhea, agitation, piloerection and dilated pupils typically indicate opioid withdrawal.

Other features of withdrawal like intense craving for drugs, insomnia, pain in muscle and joints, abdominal cramp, vomiting and diarrhea, and fever are likely present with this man.

Assigned task

a) The most likely diagnosis
From the above extraction of the given information, for this case the most likely diagnosis is Opioid withdrawal

b) Immediate management plan
Quick assessment of
- Signs and symptoms of opioid withdrawal including cognitive state and behavior.
- Information of opioid misuse duration, frequency, daily dose, formulation, route of administration.
- Comorbid other drugs of abuse or dependence.
- Any co morbid mental illness- mood disorder, psychosis, personality disorder.
- Any co occurring physical illness.
- Prior history of substance misuse, treatment and outcome.

- Family and social support.
- Risk assessment.

Treatment
At this point, hospitalization, stabilization and detoxification are the main lines of treatment.

- Checking and monitoring and monitoring vital signs.
- Maintenance of fluid, nutrition.
- Alternative replacement therapy.
  Methadone (liquid) 20 mg, with a supplemental dose of 5-10 mg, 4 hours later if necessary.
  Alternatively, buprenorphine 4-8 mg, with a supplementary dose 12 hours later if necessary
  If methadone or Buprenorphine is not available, any opioid can be used in acute settings i.e. morphine sulphate 10-20 mg as an initial dose with an extra dose of 10 mg if needed.
  Alpha receptor agonist clonidine or lofexidine.
- Symptomatic treatments for withdrawal effects-
  Loperamide or Metoclopramide if GIT upset
  NSAIDs for body ache.

2) A 55-year-old man was admitted in the orthopedic department for a fracture femur after RTA and necessary operation has been done. On the 3rd postoperative day he develops tremors, sweating and confusion and starts picking on his bed sheet and complains of seeing spiders all over. For that he has got psychiatric referral. He has alcohol dependence. He is apprehensive and fearful.
Based on your logical deduction of the given information─
a) What is the best possible diagnosis?
b) What is your assessment plan for this case?
c) What is your immediate treatment for his problems?

Given information

Demography and referral
Age- 55 years
Sex- Male
Admitted in- Orthopedic department
Orthopedic Diagnosis- Fracture of the femur by RTA
Treatment received- Operation done 3 days before
Referred by- Inpatient orthopedic department
Referred to- Psychiatry department

Chief complaints
- Tremor and sweating - 3 days (on the 3rd POD)
- Confusion- same duration
- Picks bed sheet and sees spider all over- same duration

Psychiatric history
Alcohol dependence

M/S/E finding
Appearance- Apprehensive and fearful

Extracted information

This late adult man has confusion along with relevant emotional and behavioral symptoms clearly indicative of acute confessional state

This confessional state may arise in postoperative condition. However, it develops on the 3rd POD. He has alcohol dependence. Due to his sudden fracture by RTA, he has been hospitalized and operated accordingly. In this period, certainly, he did not take alcohol and withdrawal symptoms appear after recent cessation of alcohol. These withdrawal symptoms are increasingly severe enough to cause delirium at the 3rd day after operation. Withdrawal features become most prominent in 24-48 hours. It is usually more severe in persons with heavy alcohol use, medically compromised patients with a long history of dependence.

Here, in this case, the core feature of delirium- impaired consciousness has been present. Other associated features like anxiety, apprehension, visual hallucination, and disorganized behavior are also present. Therefore, this case is Delirium due to alcohol withdrawal.

As a rule of thumb, the majority of the patients with substance misuse usually have one or more other substance misuse. In that case, that will add more in manifestation of the features making the condition worse. This area needs exploration.

There is the possibility of having comorbid psychiatric disorder and other physical illnesses at this age that also need exploration.

Assigned task

a) <u>The best possible diagnosis</u>

From the above logical deduction of the given information, the best possible diagnosis is Delirium due to alcohol withdrawal.

b) <u>Assessment plan</u>

- Searching other features of alcohol withdrawal delirium
  - Marked autonomic hyperactivity- tachycardia, sweating, fever, anxiety or insomnia.
  - Associated features- vivid hallucinations that may be visual, tactile or olfactory; delusions; agitation; tremor; fever and seizures or the so-called rum fits (if seizures develop, they always occur before delirium).
  - Typical features- paranoid delusions, visual hallucinations of insects or small animals, and tactile hallucinations.
  - Sub syndrome of alcohol withdrawal- Delirium tremens (running amok); Wernicke's encephalopathy; Tremulousness; Alcoholic hallucinosis; Withdrawal seizures.
- Severity of withdrawal (rapid fall of BAC leads to disequilibrium of brain function).
- Any other drug misuse or addiction, withdrawal.
- Any other psychiatric comorbidities- personality disorder, mood disorder, psychosis.
- Any co-occurring physical illness.
- Mental status examination with special emphasis on cognitive function, delusions and hallucinations.
- Risk assessment – possibility of impulsive act, self-harm and excitement.
- Checking records of his fracture, treatment, current medication, investigations and general health status. Particularly any possible other causes of confusion- commonly, electrolyte

imbalance, and effect of medication. If necessary, lab investigation can be done particularly, S. Electrolytes including S. Ca and Mg, Vit. B12, Folate, LFT- SGPT, Bilirubin, PT, albumin, HBSAg, S. creatinine, FBS, Serum amylase, ECG.

- Urinalysis for alcohol, and other drug soft misuse.
- Blood analysis for alcohol level.

c) Immediate treatment

- Taking vital signs every 6 hours
- Continuous observation
- Decreasing stimulation
- Precautionary measures for possible harm, excitement, impulsive act out of blue
- Correction of electrolyte imbalance and treating co existing medical problems
- Rehydration
- Chlordiazepoxide- 25-100 mg orally every 6 hours; other BDZ can be used (oral/IV, never IM)
- Thiamine- 100 mg orally 1-3 times/day
- Folic acid- 1 mg orally/day
- One multivitamin/day
- MgSO4 -1g IM every 6 hours for 2 days if post withdrawal seizure
- After stabilization, tapering of chlordiazepoxide by 20% every 5-7 days
- Maintenance of adequate sleep
- Antipsychotics should not be used unless otherwise needed as they precipitate seizures. If patient is agitated and psychotic and signs of BDZ toxicity (ataxia, slurred speech), then haloperidol/fluphenazine can be used (less likely to develop seizure)
- Planning long term prevention- acamprosate, naltrexone

3) A 32-year-old man complains of episodes of hearing music and sometimes threatening voices within a couple of hours of heavy drinking.

Based on the deduction and interpretation of the given information─

a) What is the most likely diagnosis?
b) Outline the management plan.

Given information

Demography and referral
Age- 32 years
Sex- Male

Chief complaints

- Hearing music and sometimes threatening voices, episodic occur within a couple of hours of heavy drinking- duration not mentioned, likely long.

Extracted information

Symptoms start within 2 hours of heavy drinking. Such type of auditory hallucinations is more common in Alcohol hallucinosis which is alcohol induced.

Alcohol hallucinosis occurs within 2 days of reduced alcohol concentration in a dependent person (usually at least 10 years of dependence).

In alcohol withdrawal delirium (Delirium Tremens), there are also hallucinations which are mostly visual and extremely terrifying.

Again, the hallucination occurs within several hours of cessation of or reduction of prolonged heavy alcohol consumption.

Assigned task

a) <u>The most likely diagnosis</u>

From the above discussion, the most likely diagnosis is Alcohol induced psychotic disorder.

b) <u>Management of this case</u>

Assessment

- Detection- application of AUDIT questionnaire.
- General at-risk association: relationship within family, work, finance or law.
- Medical at-risk association (alcohol related physical and psychiatric disorder).
- Drinking history- a typical day's drinking, prevalence of withdrawal symptoms in the morning or after abstinence, previous attempts at treatment, physical health problems, patient's attitude towards drinking.
- Lab investigation-
  - CBC with ESR (macrocytic anemia)
  - GGT >30 U/L
  - MCV >91 um3
  - Uric acid >6.4 mg/dL
  - AST >45 IU/L
  - ALT >45 IU/L
  - TG >160 mg/dL
  - Breath alcohol conc.

<u>Treatment</u>

- Management of hallucination with Lorazepam 1-2 mg/ Diazepam 5-10 mg/ Haloperidol 2-5 mg.
- Detoxification with BDZ- preferably with chlordiazepoxide.
- Treatment of co-existing mental disorder when the patient is sober.
- The ultimate goal is the prolonged maintenance of total sobriety.

4) A 26-year-old male presents in psychiatry OPD who had been arrested for the charge of snatching an act with a gang. After getting bail, he has been forcefully confined at home. Since then he has developed insomnia, low mood and bad dreams. Parents report his long-lasting challenging, aggressive, demanding behaviors. He had previously been treated for opiate misuse.

Based on your extraction of the given information─
a) What could be your best possible dual diagnosis?
b) Make a checklist of your assessment plan.

Given information

Demography and referral
Age- 26 years
Sex- Male
Referred to-Psychiatry OPD

Chief complaints
- Insomnia- duration not mentioned, probably recent
- Low mood- same duration
- Bad dreams- same duration

Psychiatric history
Opiate misuse and treated for this.
Long-lasting challenging, aggressive, demanding behaviors.

Forensic history
Arrested for the charge of snatching an act with a gang; now on bail and confined at home.

Premorbid personality
Challenging, aggressive, demanding behaviors.

Extracted information

This young man has insomnia, bad dreams and a low mood that starts after recent confinement at home. Insomnia, low mood and bad dreams are the key features of Amphetamine withdrawal.

These are also features of depressive disorder. However, it is less likely because of the pattern of onset and lack of evidence of other features of depression including duration. However, it needs to be mentioned here that depressive disorder is one of the comorbidities of both SUD and antisocial personality disorder and that may be developed in course.

Long duration of having challenging, aggressive, demanding behavior along with the charge of snatching and confinement in the jail clearly indicative of having antisocial personality disorder as continuum of conduct disorder. The common comorbid of antisocial personality disorder is substance use disorder.

Prior opioid addiction and its treatment further support antisocial personality disorder and addiction. The type of addiction may by polysubstance either co or continuum.

Assigned task

a) The best possible dual diagnosis

   From the above logical deduction of the given information, the best possible diagnosis is Amphetamine withdrawal and Antisocial personality disorder.

b) Checklist of assessment

- Other features and dope test for confirming diagnosis of amphetamine withdrawal.
- Searching for other features of antisocial personality disorder.
- Any other features of depression along with the duration of his low mood.
- Details of drug misuse- prior or present SUD.
- Searching for the ODD-CD continuity to antisocial personality disorder.
- Inquiry about possible other psychiatric comorbidities.
- Any features of co-occurring physical illness.
- Etiological assessment, particularly family factors.
- Impact of the disorder over the patient and degree of burden.
- Psychosocial stressors- enduring, recent and circumstantial.
- Risk assessment- self-harm and harm to others.
- General health and mental health status- general, systemic and mental state examinations.
- Laboratory investigations
  - Routine: to check general health status
  - Toxicological test: for other substances
  - Other relevant tests: LFT, RFT, VDRL, ECG
- Psychometrics
  - Validated MMPI- for personality assessment
  - Validated BDI- for depression
  - DSS-A for assessing stressors

5. A 28-year-old man is being treated for his hypomanic episode in psychiatry OPD. On subsequent follow up, it was explored that he misuses amphetamine and cannabis.
a) Mention the assessment areas that you need to explore.
b) How would you manage this case?

Given information

Demography and referral
Age- 28 years
Sex- Male
Referred to- Psychiatry OPD
Reason of referral- Follow-up

Chief complaints
Abuse of amphetamine and cannabis- duration not mentioned, explored during follow-up

Present psychiatric diagnosis
Hypomanic episode

Treatment
Received and now under follow-up

Extracted information

This mid adult man has a hypomanic episode and has been treated on an outpatient basis now in follow-up. Most likely, he is a case of Bipolar II Disorder, most recent episode hypomanic. Therein mentioned a prior history of bipolar disorder. A patient with bipolar one can be changed to bipolar II and reverse is also true.

During follow-up, it has been explored that the man is misusing amphetamine and cannabis. It is well known that substance misuse and psychiatric disorders are closely related to each other. This relation is mainly three kinds- firstly, substance misuse can cause psychiatric disorder, secondly, psychiatric disorder can cause substance misuse and thirdly, both may exist as comorbidity.

In a manic or hypomanic episode, substance misuse can be the cause of substance misuse as part of his elated mood, inflated self-esteem and excessive involvement in activities. This patient might have substance misuse in the past, and current misuse is the continuum of that. As the patient is a diagnosed case of hypomanic episode independently, misuse of these two drugs is likely additional problems.

Substance misuse can cause precipitation, perpetuation and exaggeration of her present hypomanic state and can lead to a manic episode. Furthermore, it can cause mixed presentation of mood features and substance withdrawal, intoxication and hampers current treatment mainly due to poor compliance due to drug related maladaptive behavior thus worsening the outcome and can alter the course of bipolar disorder in a more negative direction.

Assigned task

a) Areas of assessment

Bipolar Disorder

- Reassessing the present state of his hypomanic episode and reviewing the ongoing treatment.
- The age of onset of the first episode of the bipolar disorder and nature of the episode (manic, hypomanic, mixed or depressive).
- Total number of episodes.
- Interval between episodes.
- Presence of any psychotic feature.
- Treatment history including number of hospitalizations.

Substance misuse

- Duration, quantitate, frequency of each substance misuse- amphetamine and cannabis. A typical drug use day or week's pattern may be present.
- Any other additional misuses currently have.
- Whether the patient is dependent on any of the drugs or on both the drugs.
- Any history of intoxication, withdrawal or substance induced disorder.
- Treatment or rehabilitation history.

Temporal relation between bipolar disorder and SUD

The relation between substance abuse and episodes of mood disorder. Whether substance precipitates the mood episode or mood disorder precipitates or perpetuates substance abuse.

Any forensic history?

Risk assessment.

Recovery capital of the patient (personal, familial and social, financial)

Impact and burden

Level of functioning of the patient in all domains of daily life and degree of burden to the family for individual and combined effect of the both problems.

Etiological assessment

- Causal relation between the two disorders.
- Predisposing, precipitation and perpetuating factors- family history of bipolar spectrum disorder, prior psychiatric history, presence of any other psychiatric disorder including personality disorder, any co-occurring general medical condition.
- Psychosocial stressors- familial, occupational, economic or socio-environmental.

Clinical Examination

- General, systemic and mental state examination.

Investigations

- Baseline investigations.
- Toxicology screening along at this point.
- Other relevant investigations will be done as required.

b) Management

Managing the current episode

- Patient needs hospitalization if his hypomanic status changes to manic, or if he has amphetamine and cannabis dependence or other dependence, withdrawal or intoxication or both.
- Psychoeducation to the patient and the caregiver emphasizing the need of abstinence from substance abuse.
- If the patient is already on a mood stabilizer, it should be continued (checking the blood level if appropriate).
- Addition of an atypical antipsychotic preferably olanzapine, if necessary.

Managing the substance abuse

- If the patient is dependent on amphetamine and cannabis, abstinence is the usual goal.
- Patient should be motivated for change.
- BDZ for acute distress associated with severe withdrawal symptoms.
- Psychosocial management: CBT, Contingency management.
- Rehabilitation planning as necessary.

6. A 58-year-old man has been admitted to the medicine ward for hepatomegaly and jaundice. Subsequently he develops excessive sweating, agitation, tremor, sleep disturbances and thereby psychiatric referral is given for him.

Doing logical extraction of the given information, answer the following.

a) What is the single most possible diagnosis?

b) Prepare a checklist of your assessment to confirm the diagnosis and interventional plan.

Given information

Demography and referral
Age- 58 years
Sex-Male
Referred from- Medicine ward
Refereed to- Psychiatry department

Chief complaints
- Excessive sweating- duration not mentioned, likely recent as starts after admission
- Agitation- same duration
- Tremor- subsequent duration
- Sleep disturbances- same duration

Reason for admission
Hepatomegaly and jaundice

Extracted information

This late adult man has been admitted into the medicine ward for his hepatomegaly and jaundice. After admission, these symptoms appear. The cluster of symptoms like excessive sweating, agitation, tremor, sleep disturbances with sudden onset clearly indicative of substance withdrawal as it can be expected that after being admitted in hospital, he has to be abstinent for substance. These withdrawal features allowed with his hepatomegaly and jaundice clearly indicates that this man is a case of Alcohol withdrawal due to long standing alcohol misuse.

This type of withdrawal symptoms can be due to sudden absence from opioid dependence. Here, the presence of hepatomegaly and jaundice and absence of other typical features of opioid withdrawal does not support this diagnosis.

By nature, usually multiple drugs of abuse are present in such case with this age and sex. Therefore, mixed features of withdrawal may be present that need exploration.

Presence of comorbid other psychiatric disorder, behavioral addiction, personality disorder is possible with the case that also needs exploration.

Assigned task

a) Most possible diagnosis

Based on the above logical extraction of the given information the single most possible diagnosis is Alcohol withdrawal.

b) The checklist of assessment

- State of his hepatomegaly, jaundice, diagnosis and treatment.
- Inquiry about alcohol misuse
  - Current and other features of alcohol withdrawal.
  - Autonomic features (palpitation, pulse >100 bpm, raised BP, dyspnea, muscle cramp).
  - Delirium tremens (tremor, confusion, hallucination), acute onset, cause is outside the brain.
  - Psychotic feature- hallucination (tactile, visual); illusion (micro/macroscopic).

  - Features of Wernicke's encephalopathy and Korsakoff psychosis- ataxia, ophthalmoplegia, confusion and other related symptoms.
  - Features of agitation.
  - Seizure (could be single/repeated).
  - Onset and frequency of alcohol intake.
  - Effect of alcohol misuse over physical health- relation with hepatomegaly and jaundice.
- Any other substance misuse- if present, details along with withdrawal features.
- Presence of any comorbid psychiatric disorder- mood disorder, behavioral addiction like gambling, personality disorder.
- Any co-occurring general medical condition.
- Investigations
  - Evaluating the reports that have already been done, especially liver function tests.
  - Dope test both urine and blood for alcohol, and also for other common drugs of misuse.
  - Vitamin B12 and thiamine assay-if not done.
  - VDRL, HIV test.

Chapter 6: Geriatric Psychiatry

1. A 82-year-old man has been brought to the psychiatry OPD who recently sees that snakes and strangers are moving around him that make him fearful and suspicious. Gradually he develops fluctuating consciousness, mood lability, incoherence and excitement. He is a known case of HTN, DMT2, CAD and CKD and has been under treatment for a long time and has no remarkably psychiatric history.
Based on this information, answer the following by doing logical deduction.
a) Best possible differential diagnosis.
b) Provide your assessment plan to reach the causal diagnosis and immediate treatment.

Given information

Demography and referral
Age- 82 years
Sex- Male
Referred to- Psychiatry OPD

Chief complaints
- Sees snakes are moving around and known and unknown people around him, which, the other family members cannot see-recent onset
- Fearfulness and suspiciousness that other people might harm him-same duration
- Fluctuating consciousness
- Mood lability
- Incoherence } very recent onset
- Excitement

Current physical illness
HTN, DMT2, CAD, CKD- since a long, under treatment

Extracted information

Seeing snakes and known & unknown people around him without their presence as others do not see are clearly visual hallucinations that makes him fearful and suspicious. Suspiciousness could be delusional; here it is better explained by the fearful reaction of these hallucinations.

Fluctuating consciousness, mood lability, incoherence and excitement indicate that the older man is in a confusional state and that causes other features. Likely, the confusional state starts at the beginning and is noticed later due to increased severity along with other features.

Confusion, perceptual disturbances like visual and possible auditory hallucinations, disorganized speech and behavior, mood lability with recent onset and rapid progression clearly indicates that this patient has delirium.

Here, in this case at this age, most possible causes of delirium are general medical conditions as the patient already has long lasting multiple major systemic disorders as mentioned and possibility of adding other problems like electrolyte imbalance, effect of ongoing medications. Other common causes like substance-induced delirium that are less likely in this context. TBI could be possible at this age by falling, delirium could be superimposed with dementia or age-related cognitive decline, therefore thorough medical and neurological evaluation is necessary.

All the features go to the favor of psychosis that are explainable as behavioral features of delirium. This patient has no remarkable psychiatric history and new onset of primary psychotic disorder is unlikely at this older age. However, this area should be rechecked.

Assigned task

a) Best possible diagnosis
On the basis of above logical deduction of given information, the best possible diagnosis is Delirium due to GMC.

b) Assessment plan to reach the causal diagnosis and immediate treatment

Enquiry about other features of delirium
Details of the present and other expected features-attention and additional disturbance of cognition particularly disorientation, memory, language, visuospatial ability and perceptual disturbances.
Onset and progression, distress and impact.

Assessment of cognitive decline
Checking the progression of ARCD, and possible features of dementia.

Causal assessment
Examining present status of existing medical conditions as mentioned in the scenario and ongoing treatment, including drug-drug interaction and possible adverse effect on brain function.
Emergence of new general medical conditions-commonly hyponatremia, hepatic and head trauma.

Detailed psychiatric assessment
Systematic clinical assessment including MSE particularly for sleep deprivation, change of sleep schedule- night time awakening, presence of other delusions and hallucinations, pattern of incoherence and abnormal behavior, depression, psychosis –primary or secondary.

Risk assessment
Particularly risk of suicide and self-harm as fearful and impulsive reaction the hallucinations, delusions, and possible depression, head injury in face of movement effort.

Living condition
Room status, caring status and level of family support.

Physical examination
Chekiang vitals, nutritional status/weight loss, eyes, mouth, skin for any poor hygiene, thyroid, liver, and mobility.

Neurological examination
Details of higher brain function, gait, frontal release sign, focal neurological deficit, movement disorders and sensory function.

Laboratory investigations
Baseline investigations- to see his general health status.
Test related to his present illness-HTN, DMT2, CAD, CKD.
Test for other possible causes- S. electrolyte, S. Calcium, S. Creatinine, VitB12, folic acid.

Neuroimaging-preferably CT scan for ARCD, TBI, and dementia.

Neuropsychiatric testing
GCS-for assessing level of consciousness
MMSE- for neurocognitive status and severe

[**Note:** The causes of confusional state and delirium must be remembered to answer the alternative questions of similar nature]

2. A 65-year-old man presented with the complaints of forgetting day-to-day events, cannot dress, do prayer properly, low concern of self since last 2 years. The problems are gradually deteriorating and very recently, he is getting lost when out of home.
a) List the first line investigations and psychological testing you need to perform for this case.
b) What will be the contents of your family psychoeducation including the role of the family members?

Given information

Demography and referral
Age- 65 years
Sex- Male

Chief complaints
- Impaired memory-2 years
- Cannot dress
- Low self-care } same duration
- Lost when out of home-recent addition

Course
Gradually progressive and deteriorating in nature

Extracted information

The concerned complaints of this old man-impaired memory, inability to perform known act like dress up and performing prayer, low self-concern since a long period clearly indicates significant impairment of higher cognitive function with the presence of hallmark features like amnesia, apraxia and impaired executive functioning and possible existence of attention deficit and deterioration of personality.

Furthermore, the event of loss from home clearly indicates visuospatial deficit impairment of functioning blended with other features of cognitive deficit as mentioned.

Symptoms gradually increased in severity with addition of new symptoms indicating steadily progressive cognitive decline.

Overall pictures with a pattern of deficit, it is likely that this person has major neurocognitive disorder most probably Alzheimer's disease.

This cognitive deficit can happen in a confusional state. The patterned presentation and progression and lack of such information as main complaints, it can be summed up that problems are not due to it. Here confirmation is required by excluding the causes of confusion related to delirium particularly substance misuse.

There is no mention of other features of psychiatric disorders particularly, pseudodementia (most commonly depression) or any other physical condition for better explanation. Here, the thorough psychiatric and medical assessment is necessary for exclusion as well as having possible comorbid psychiatric disorder and co-occurring systemic disease that are usually present at this age.

Assigned task

a) First line investigations and psychological testing

The aim of first line investigations is to confirm the diagnosis and common and reversible causes of dementia, to know the patient's general health status for making treatment plans at this point. For this purpose and on the basis of above extraction, these are:

For general health status
Routine: CBC with ESR, Urine R/E, and CXR, ECG at this age is part of the routine exam.)

For the exclusion of other conditions and checking co-occurring illness
LFT
RFT
Serum electrolyte
Vitamin B 12 assay
TFT
CXR (mentioned routine CXR will help to exclude infection, metastasis)
Toxicology screening- Urine for opiates, cannabinoid, alcohol
VDRL, TPHA
MRI of brain (preferably) or CT scan of head

Neuropsychiatric testing: for status of severity and effected cognitive domain
Validated MMSE
Validated Alzheimer's diseases Scale

Psychometrics: to exclude pseudodementia
Geriatric Depression Reading Scale (GDS)/ BDI (validated Bangla version available)

b) Contents of family psychoeducation including role of the family members

Environment
- Sufficient light, balanced sound.
- Calendar, clock for reality orientation.
- Minimum furniture in the room.
- No hazardous instruments should not be kept around.
- Main door should be locked after evening.

Caregiver
- Not to argue or confront when a patient expresses mistaken ideas or facts.
- Changing subject or gently reminding patient of an inaccuracy.
- When speaking to the patient, speaking slowly, using simple words, making eye contact.

- Sharing responsibilities of caregiving.
- Maintaining a simple daily routine.

[NTK- The common reversible causes of dementia are

- Vitamin B12 or folate deficiency
- Syphilis
- Hypothyroidism
- Normal pressure hydrocephalus
- Subdural hematoma
- Benign tumors (frontal)]

3. A 75-year-old man brought by his only daughter to a psychiatric OPD whose wife died 6 months ago. Since then, he becomes isolated, talks little, low food intake, spends time with things related with spouse's memory, and cries and talks to himself. Gradually, he feels guilty and becomes agitated that the daughter becomes more worried. Recently he says that he is dead and should be buried at the earliest. The man is cachectic and looks anxious and distressful.
Based on your logical extraction from above information, answer the following.
a) What is the best possible diagnosis?
b) What is your treatment plan?

Given information

Demography and referral
Age- 52 years
Sex- Female
Marital status- Widower
Refereed to- Psychiatry OPD
Refereed and accompanied by- only daughter

Chief complaints
- Isolated, talks little, low food intake- 6 months
- Spends times with activates related to wife's memory- same duration
- Self-crying and talking- same duration
- Guilt feelings and agitation-subsequent onset
- Conviction that he is dead and should be buried- recent addition

M/S/ E findings
Appearance and behavior- below average nutrition
Affect-anxious, distressed

Recent life events- death of wife 6 months back

Extracted information

Initial features of self-isolation, retarded speech, low food intake, preoccupied with wife's memory, self-crying and talking clearly expression grief reaction. As the duration is 6 months and persisting with addition of other features, it seems that the grief process is abnormal.

This abnormal bereavement becomes more complex with the addition of feeling of guilt, psychomotor agitation (event from agitation plus anxious and distressful effect) that further progresses with conviction to be deed and asking for quick burial that is nihilistic delusion.

Present of all these features only can be explained best with psychotic depression that starts initially with grief reaction.

Psychotic features like idea/delusion of guilt is likely mood congruent and at this age onset of primary psychotic disorders is very unlikely.

Other secondary causes of depression include substance misuse, and relevant general conditions could be present at this age. In addition, evidence of increasing loss of weight plus possibility of having other systemic disorders in old age warrants detailed medical assessment.

Loss of spouse is the highest level of stressful events. Subsequent development of stressors expected in his overall living situation that needs exploration.

Possibly this old man has a lack of family support. He has only one daughter who brought him for consultation in face of increasing problems that made her worry. In the cultural context, accompanying other caregivers is usually expected, which is very much indicative of lack of family and social support.

Persistent severe depression with psychomotor agitation and psychotic features (guilt and nihilistic), loss of spouse, loneliness, poor family and social support, the age, possible comorbidity---all are strong predictors of suicide and needs special attention.

Assigned task

a) The best possible diagnosis

From the above extraction from given information the best possible diagnosis is, Depressive disorder, severe with psychotic symptoms/MDD, Severe, with anxious distress, With psychotic features.

b) Treatment plan

General
Explanation advice and support to the patient and her daughter.
Hospitalization- as strongly indicative of having suicidal risk as well as lack of feasibility in home treatment.
Measures to prevent possible suicidal risk- 24 hours monitoring.
Maintain adequate fluid and nutrition-Nasogastric intubation if necessary, checking vitals.
Treatment for any associated physical illness.

Specific
Biological
MDD with psychotic features:
Applying management protocol of major depression in old age.
SSRI (sertraline or fluoxetine) with atypical antipsychotic (olanzapine) is preferable in the first step.
If treatment refractory, such protocol to be followed:
Lithium is useful but closed monitoring is necessary at this age of compromising renal function.

ECT- as per indication (ECT is comparatively safe in old age than drugs especially when associated with one or more major medical illness–cardiac, renal, hepatic, endocrine, respiratory, musculoskeletal)

Psychosocial- after workable recovery
ADLP- Slow increasing activities
Bereavement management psychotherapy
CBT- with the aim of cognitive restructuring
Stress management
Support groups- for old bereaved people

4. A 62-year-old male attends in psychiatry OPD for his forgetfulness in minor matters that makes him worry for 2 months. His wife says his daily performance is poor, has slow verbal fluency and increased unwillingness in day-to-day activities. He appears retarded.
a) What is the best possible diagnosis drawing logical deduction of the given information?
b) Highlight the treatment plan.

Given information

Demography and referral
Age- 62 years
Sex- Male
Referred to- Psychiatry OPD

Chief complaints
- Forgetfulness in minor matters -2 months
- Worry about forgetfulness-same duration
- Poor daily performance } - subsequent duration
- Verbal fluency is slow
- Unwillingness in day-to-day activities

Course
Gradually increasing

M/S/E finding:
Appearance- Retarded

Extracted information

This early older man has memory impairment for whom he is worried. Though there is no information on depressed mood, slow in fluency of speech, poor performance, anhedonia, retardation, age and onset indicates this man is severely depressed.

At this age, development of dementia is also usual and here features of mild cognitive impairment in the form of amnesia, impaired executive function, and slow verbal fluency are present.

Mild form of cognitive impairment is usual as part of normal aging. Here, in this case, cognitive features are mild, enhanced mainly due to his depression and associated anxiety. Patient is well concerned about his forgetfulness, which is evidenced by his worry about the matter and explainable by impaired and ill-sustained attention, inner distress, and increased anhedonia and impact. Clinically this state is called pseudo dementia or dementia syndromes of depression.

However, existence of both depression and dementia or other neurocognitive disorders at this age is not unlikely and that needs thorough assessment.

Depression in older age may be secondary to physical disorders that also need exploration. Assessment and management of co-occurring physical illness and possible other illness that cause depression needs to be explored

Increased anhedonia in daily activities and psychomotor retardation and seeking professional help at this stage clearly indicates that this old man has significant functional impairment and overall impact and burden is severe.

Depression at this age with increased retardation and severity with possible co-occurring physical disorder are prone to suicide. Risk assessment and precautionary measures are essential.

Referral indicates the patient and his family are concerned about the matter and that is why they sought psychiatric help.

[NTK:
All the qualitative changes of NCD are also found in normal ageing. It is the quantitative change that makes them different.
In NCD there is severe cognitive decline and aphasia, apraxia and agnosia are associated with memory loss. In ARCD only mild memory loss, no other feature of cognitive decline.]

Assigned task

a) Best possible diagnosis

Based on the above extraction of given information, the best possible diagnosis is Severe depressive disorder/ MDD, Severe.

b) Highlights of the treatment plan

General

- Explanation, support and advice,
- Psychoeducation on normal aging & cognitive decline in aging, deference of depressive disorder and NCD at this age, treatment of his depression and expected outcome.
- Management of co-occurring physical illness.

Specific

Biological

Antidepressant:

- SSRI -sertraline, fluoxetine, citalopram.
- SNRI-venlafaxine or desvenlafaxine (keeping in mind the possible hazards).

Sedative-hypnotics (if additionally required for the management of anxiety and insomnia):

- BDZ- clonazepam for both anxiety and sleep.
- Short acting BDZ lorazepam or non BDZ- Zolpidem, zaleplon for sleep disturbance

If treatment refractory, such protocol suitable for him will be applied:

- Lithium is useful but close monitoring is necessary at this age of compromising renal function.
- ECT- as per indication (ECT is comparatively safe in old age than drugs especially when associated with one or more major medical illness; increment of dose and combination is not practical).

Psychosocial

After workable recovery following is to be applied:

- ADLP- slow increasing activities. It minimizes retardation and facilitates recovery.
- CBT- with the aim of cognitive restructuring.
- Stress management- for possible enduring and acute stressors related to old life.
- Support to the family in management and minimizing their burden.

5. A 67-year-old man is brought to the psychiatry outpatient department who recently suspects that strangers frequently enter his house, steals his valuable things and tries to move them out angrily. For the last one year, he forgets things and becomes tempered when asked about forgetting matters. He is euphoric and occasionally does silly behavior that does not go with him.

Based on your logical deduction,

a) Write your differential diagnosis.
b) Mention the areas of your assessment to confirm the diagnosis for your treatment plan.

Given information

Demography and referral

Age- 67 years
Sex-male
Referred to- Psychiatry OPD

Chief complaints

- Forgetfulness -1 year
- Tempered if he is confronted with his forgetfulness- same duration
- Suspiciousness that strangers enters into house and steals; with anger behavior to expel them out
- Euphoria }- recent onset
- Silly behavior

M/S/E findings

Appearance- Silly behavior inappropriate to his and characters
Mood- Euphoric

Extracted information

This old aged man comes with persistent forgetfulness with tempered behavior if confronted and recently additional features of marked changes of his emoting and behavior inappropriate in his context of age and characters and odd in nature. Here the focus of complaint is forgetfulness along with problems with thought behavior and emotion, deteriorating nature. Considering the presentation, clearly these are signs of cognitive deficit indicative of dementia.

Considering only 1-year duration, the nature of progression and cognitive deficit in the course of the disorder is certainly relatively rapid, evident from the recent development of odd behavioral features of dementia.

Rapid progression of dementia usually associated with slow viral disease, causes related with ICSOL unidentified and unaddressed earlier. There may be other remote causes of rapid progression.

Conviction of stealing her thing by strangers and related angry efforts of expelling them from home is the evidence of having persecutory delusion and explainable at this advanced stage of dementia. However, it could be part of primary psychotic disorder- commonly delusional disorder at this older age. Furthermore, euphoria and odd and silly behavior may be due to primary or secondary bipolar disorder. Detailed psychiatric assessment is required on these issues.

Persistency dementia may be superadded with the causes outside of the brain than cause of recent added features particularly causes related with delirium. This old man might have such causes and there may be impaired consciousness that causes visual and auditory and hallucination. Therefore, thorough medical assessment is essential.

Assigned task

On the basis of above logical deduction in extraction, the answers are as followings:
a) Differential diagnosis

i. Dementia/ Major Neurocognitive Disorder, With behavioral disturbance, severe
ii. Delusional disorder
iii. Psychotic disorder due to GMC

b) Areas of Assessment:
The areas of assessment to confirm the diagnosis and treatment plan are as follows:

Cognitive Deficit
Other features of dementia, severity, persistency, course, and pattern of progression, impact on patients including level of impairment in all domains, daily functioning, and degree of burden to caregiver.

Neurological assessment
Detailed assessment for possible features, cause- includes gait, frontal release sign, focal neurological deficit, movement disorders and sensory function.

Thorough psychiatric assessment
To see her long lasting HTN status and to find any primary or secondary psychiatric disorders for these features with special emphasis on delusional and bipolar disorder with the aim of exclusions or having comorbidity.

Thorough medical assessment
General medical plus neurological assessment for the possible cause of rapid progressive dementia (viral, ICSOL), any cause of possible delirium and secondary causes of psychiatric disorder. If necessary, gathering more information through referral to neurology and relevant discipline are required.

Laboratory investigations
Routine for understanding general health status
Test for diagnostic confirmation and finding causes
LFT, RFT, TFT, S Electrolyte, Calcium and Phosphate, B12 & Folate assay
CSF- for amyloid aß & tau protein
Neuroimaging-EEG, MRI/ CT scan. SPECT
Syphilis serology
HIV test

Neuropsychiatric testing
To assess severity and possible area of cognitive impairment: MMSE

Psychometrics
Validated ADS- for assessment of severity
Validated BPRS- for assessment psychosis

[NTK-
Course of dementia: Amnesia---apraxia---agnosia---executive function. Ultimately leading to behavioral problems.
End result of dementia is either loss of executive function or psychotic features.
In extreme forms of dementia, the patient cannot recognize their own self.
Euphoria in dementia is called fatuous euphoria that is associated with disinhibited behavior.]

6. A 62-year-old man brought to the outpatient department who recently feels insects are crawling over his skin that she weeps frequently. Gradually he sees many known and unknown people sit and walk in front of him but others at home do not see. These types of visions extend to scenic manners. He becomes fearful and suspicious that some group of people are trying to harm him. He is hypertensive and diabetic controlled with medication.
a) What are the areas you need to explore to reach the diagnosis?
b) What investigations do you want to do at this stage?

Given information

Demography and referral
Age- 62 years
Sex- Male
Referred to- Psychiatry OPD

Chief complaints
- Feels insects are moving over his body that he frequently weeps-recent onset
- Sees that known and known and unknown people around him, which, the other family members cannot see- subsequent duration
- Visions extended to scenic manner- additional subsequent duration
- Fearfulness and suspiciousness that other people might harm him- subsequent duration

Existing medical illness
HTN, DM; both controlled with medication

Extracted information

The problems are of recent onset.

Feeling insects are crawling either somatic hallucination or somatic delusion, further added with suspiciousness and fear of harm are likely persecutory delusions. These delusions at this age indicate that this man has delusional disorder.

Seeing people without their existence is visual hallucination extending to scenic hallucination. This type of hallucination can happen with old age delusional disorder. Furthermore, the content is related to persecutory delusion.

Presence of delusions and hallucination could be features of schizophrenia. However, at this age with short duration this is less likely.

This visual hallucination and delusions, particularly insects crawling could be features of confusional state or delirium. Here, in this context of the stable status of his co-occurring HTN, DM it is less likely. However, emergence of any new cause of GMC, adverse effect of medication or substance is possible and therefore needs evaluation.

NCD could be another possibility at this age, and these types of features are found in severe and advanced stages. Here, no such information of gross cognitive deficit is present.

Assigned task

On the basis of above logical deduction in extraction, the answers are as followings:

a) Differential diagnosis
   i. Delusional disorder-Mixed (Persecutory, Somatic)
   ii. Psychotic disorder due to GMC

b) Areas of Assessment

The areas of assessment to confirm the diagnosis and treatment plan are as follows:

Thorough psychiatric assessment
Detailed present and other features of delusional disorders.
Checking impaired consciousness and related behavioral features of delirium.
Other possible primary or secondary psychiatric disorders with special emphasis with the aim of exclusions or having comorbidity.

Thorough medical assessment
General medical assessment for the possible secondary causes of delusional disorder, any cause of delirium and cognitive deficit of NCD.

Lab investigations
Routine for understanding general health status.
Test for diagnostic confirmation and finding causes.

Thorough neurological assessment
Systemic assessment with special emphasis on test of higher brain function clinically along with relevant laboratory and neuropsychiatric testing, and psychometrics to know his cognitive status for any cause related to delirium, secondary cause of delusional disorder or NCD.

7. A 61-year-old woman appears to a psychiatrist's chamber referred by an internist with her spouse who has palpitation, chest compression, and feeling of restlessness, low mood, and sleep disturbances. These problems started after the leaving of her daughter and son in law who moved abroad 1 month back. The husband informed that this relocation was planned and expected since. She appears worried about her symptoms and fear of possible physical cause for that and has no other significant features of depression. She is diabetic for the last 10 years and is under treatment.
Based on your analysis and logical interpretation of the given information─
a) What is the single most possible diagnosis?
b) Provide your treatment plan for this case.

Given information

Demography and referral
Age- 61 years
Sex- Female
Referred to- Psychiatrist
Referred by-Internist

Chief complaints
- Palpitation and chest discomfort -1 months
- Feeling of restlessness }same duration
- Low mood
- Sleep disturbances
- Worries about the existing symptoms and fear of any physical cause for these

M/S/E finding
Appearance- anxious
No significant features of depression

Associated stressor
Relocation of the daughter and son in law abroad 1 month back, planned and expected.

Extracted information

This early older woman has somatic anxiety symptoms- palpitation, chest compression, sleep disturbances associated with psychic anxiety symptoms – like anxiety and restless feeling indicative anxiety disorder. However, these features are minor and rational, not seems excessive, with short duration lack of evidence of significant unusual distress and impact do not support this diagnosis.

The symptoms happen immediately after relocation of her intimate family members. This event acts as a precipitating factor. Here, both the relocation event that was planned and expected, and the consequence of the events in the form of emptiness cause the symptoms. The temporal relationship between the event and these symptoms along with the month duration goes in favor of adjustment disorder, clearly related to old life crisis and the woman has failed to adjust with the new situation.

Here, added anxiety is clearly for the persistency of the problems probably due to lack of understanding of somatopsychic relationship that is usual and expected and not likely hypochondriacal in nature.

Any form of loss events can precipitate depression. Here, the relocation was planned and expected and can be explained as a normal psychological reaction to the event. She has no significant features of depression other than low mood and possibly has some minor symptoms related to both anxiety and depression that are expected and inseparable.

Furthermore, these problems are likely not due to any physical illness evident from her referral from an internist.

Assigned task

a) The single most possible diagnosis

Based on above extraction and logical interpretation of the given information, the best possible diagnosis is Adjustment disorder with anxiety.

b) Treatment plan for this case

General
Explanation, support and advice.
Psychoeducation on normal psychological reaction to stress, old life crisis and effect on coping failure. Somatic manifestation of psychological illness and addressing her idea about possibly having physical illness.
Maintaining sleep hygiene.
ADLP with the aim of maintaining her usual daily life.
Specific

Biological
Anxiolytic- beta-blocker(propranolol), BDZ
Hypnotic- if significant sleep problem - melatonin can be chosen alternatively other non-BDZ, BDZ for short duration if necessary.

Where there is possibility of dependency and strong predictors of anxiety and depressive disorders present, antidepressant can be chosen.
SSRI–sertraline or citalopram in low dose. Alternatively,
Low dose of mirtazapine can be good choice for both anxiety and depressive symptoms with sleep problem.

Psychosocial
Relaxation. Breath holding exercise could be the best choice considering her symptoms.
Stress management- for current stressors and anticipatory coping for future stressors.

8. A 77-year-old woman appears in the psychiatry OPD referred by GP who easily forgets since last six months that is gradually aggravating. Recently, she cannot recognize his close relatives, cannot dress properly and perform prayer and even cannot do own basic activities. Very recently, she developed speech difficulties and had five convulsive fit attacks in the last 10 days. She is hypertensive for the last 25 years. The woman appears jovial and disinhibited.
Give the answer of the following doing logical deduction of information from the above scenario.
a) Specify your diagnosis as much as possible.
b) What is your assessment plan to confirm the diagnostic specifications?

Given information

Demography and referral
Age- 77 years
Sex- Female
Referred by- GP
Referred to- Psychiatry OPD

Chief complaints
- Persistent forgetfulness that gradually aggravates in rapid fashion-6 months
- Cannot recognize close relatives-recent development

- Cannot dress properly and perform prayer- recent addition
- Difficulty in speech-very recent addition
- Five convulsive fit attacks in the last 10 days
- Cannot do own basic daily activities

Course
Rapidly progressing

Existing physical illness
HTN-25 years

M/S/E finding
Appearance and behavior- Jovial and disinhibited

Extracted information

This older woman has clear-cut features of dementia evident from significant features of cognitive deficit like amnesia. Agnosia, apraxia, dysphasia and impaired executive function are associated with remarkable behavioral disturbances related to dementia along with gradual and progressive deterioration.

The patterned behavioral disturbance like disinhibition, mood changes and dysphasia are very much indicative of frontotemporal dementia

Rapid progression, gross personality deterioration, and expected significant functional impairment indicates her basic activities indicate that the disorder is severe enough.

Recent fit attack and rapid progressing is very much indicative of etiology and/ or co-occurring condition-ICSOL, possibly a tumor that may be unidentified and unaddressed. Other causes of rapidly progressing dementia like viral infection affecting the brain also need to be considered.

Sudden onset of repetitive convulsive fit attack in the last 10 days is certainly not seizure disorder. Most likely it is the effect of gross degeneration of the frontotemporal region or additional pressure effect of any ICSOL. Therefore, thorough neurological assessment and neurological referral is necessary.

Disorganized speech, disinhibition and euphoria may be due to primary or secondary bipolar disorder though less likely considering the overall scenario. However, detailed psychiatric assessment along with general medical is required on these issues.

General medical assessment is also necessary in this old age for the possible causes of rapid progressive dementia and any possible secondary causes.

Assigned task

a) Diagnostic specification

Frontotemporal dementia/ Major Frontotemporal Neurocognitive Disorder, with behavioral disturbance, Severe.

b) Assessment plan to confirm the diagnostic specifications

Cognitive Deficit

Other features of dementia along with features of frontotemporal dementia, severity, persistency, course, and pattern of progression, particularly

- Presence of recent or remote, single or multiple, possible or confirmed cerebrovascular event (e.g. stroke) prior to the dementia symptoms.
- Progression of symptoms (stepwise that is acute decline followed by plateau in vascular dementia; very slow progression in Alzheimer's disease).
- Personality changes from baseline.
- Level of executive functioning.
- Language- expressive and receptive aphasia or dysphasia.
- Perceptual motor function.
- Other features- mood, anxiety, apathy more common in vascular dementia; euphoria more common in FTD.
- Gait impairment.
- Level of functioning- basic activities (ADLs), Instrumental activities (IADLs).
- Impact on patients including level of impairment in all domains daily functioning, and degree of burden to caregiver.

Systemic neurological assessment

Detailed assessment for possible features, cause- includes gait, frontal release sign, focal neurological deficit, movement disorders and sensory function.

(A visual field defect or parkinsonian features may suggest a non- Alzheimer NCD such as vascular or Lewy body NCD type).

Thorough psychiatric assessment

For any primary or secondary psychiatric disorders for these features with special emphasis on delusional and bipolar disorder with the aim of exclusions or having comorbidity. In MSE special attention required as follows:

General appearance- elements of executive functioning, self-care.

Mood- Apathetic, depressed in Alzheimer's, vascular dementia; euphoric in FTD.

Speech and language- comprehension, fluency, grammar, phoneme, paraphrasing, repetition, reading, writing.

Thought- delusion (paranoid), depressive thoughts, disorganized thoughts –concreteness.

Perception- hallucination of any modality (usually in DLB, may occur in vascular dementia).

Cognition- impaired or distorted

Judgement and insight-whether grossly impaired

Thorough medical assessment

To see general medical status, to see her long lasting HTN status plus neurological assessment for the possible cause of rapid progressive dementia (viral, ICSOL), any causes of possible delirium and secondary causes of any psychiatric disorder. If necessary, gathering more information through referral to neurology and relevant discipline.

Laboratory investigations

- Routine for understanding general health status
- Test for diagnostic confirmation, specification and finding causes:
  LFT, RFT, TFT, S Electrolyte, Calcium and Phosphate, B12 & Folate assay
  CSF- for amyloid aß & tau protein
  EEG-to see seizure status and also for generalized atrophy and ICSOL
  Neuroimaging-MRI/ CT scan. SPECT-for diagnosis and diagnostic specification. Here gross degeneration in frontotemporal region and possible ICSOL are expected
  Syphilis serology
  HIV test

Neuropsychiatric testing (to assess severity and possible area of cognitive impairment that support severity and specification of dementia):
MMSE
MoCA (Montreal Cognitive Assessment tool)
Others- Clock drawing test; verbal fluency test (Semantic-animals or fruits, Phonemic- words beginning with letter 'F')

Psychometrics
ADS- for assessment of severity
BPRS- for assessment psychosis

[NTK:
ADLs: (BEAT HD) bathing, eating, ambulance/walking, toileting, hygiene, dressing
IADLs: (FAST MD) food preparation, accounting, shopping, telephone, medication use, driving]

9. A 72-year-old male presents with self-talk, incoherence, forgetfulness, lack of interest, irritability and cannot perform usual activities, lack of self-care and urinary incontinence for 3 years. His wife died four months back. Since then he has been increasingly sad and tearful. He is diabetic and hypertensive. Based on logical deduction from the scenario,
a) What could be the most likely diagnosis?
b) Make a checklist for assessing this case.

Given information

Demography and referral
Age- 72 years
Sex-Male

Chief complaints
- Self-talking
- Incoherent speech
- Forgetfulness
- Lack of interest
- Irritability } 3 years
- Lack of self-care
- Urinary incontinence
- Increasingly sad in tearful- 4 months

Stress- Death of wife 4 months back

Present physical illness
HTN and DM

M/S/E finding
Appearance: Sad and tearful

Extracted information

This old man has persistent remarkable cognitive deficits in the form of amnesia, apraxia, speech difficulties, and impaired executive function evident with poor daily performance and self-care since 4 years is clearly indicative of having dementia.

Considering the pattern of progression, his dementia is likely due to degenerative, vascular or mixed cause. Alzheimer's disease is a likely possibility. However, the patient has HTN and dementia due to stroke (commonly infarct/multi infarct) is possible. History of stroke is not present in the information and no step ladder pattern deterioration is evident. Next expected is mixed type as both Alzheimer's and vascular type share common features. Other degenerative, and other common causes are also equally important for evaluation.

Presence of behavioral features like incoherence, irritability and mood features indicates that above cognitive deficit is with behavioral disturbance. At this stage, other behavioral features like delusions and hallucination may present.

The pattern of persistency, and progressive deterioration, inability to self-care and urinary incontinence indicate the severe stage of dementia.

This old man has depressive features like anhedonia, irritability, reduced daily functioning, depressed mood, crying spell. However, these are or are not mainstream features of cognitive deficit and can be explained by the effect of it. Further sad mood and crying spell developed immediately after the death of his wife which was the highest form of stressful life event. In old age, features of dementia sometimes represented as features of depression. This condition in clinical practice is known as pseudo-pseudo dementia. However, this old man might have comorbid major depression that is also common in this age.

Incoherence is a hallmark of schizophrenia and self-talking is indirect evidence of auditory hallucination that has been present since 4 years. Along with these, motivation, underactivity, and poor self-care represent negative features of schizophrenia. First onset of schizophrenia at this age is unlikely and features that are best explainable by dementia excludes its possibility and other primary psychosis.

Urinary incontinence is possibly impairment of the brain's control over the micturition center due to brain degeneration commonly happening in advanced stages of dementia. However, thorough medical assessment is necessary to exclude other causes of incontinence, causes of dementia, to see the status of his HTN, diabetes and possible co-occurring GMC likely at this age.

Assigned task

a) Most likely diagnosis

On the basis of above logical deduction the most likely diagnosis is Dementia/ Major Neurocognitive Disorder, With behavioral disturbance, Severe.

b) Checklist for assessment

The checklist of assessment in the following areas is as follows:

Detailed assessment of dementia and its specification

- Other features of dementia and its dominance- At this stage, other behavioral features are likely present along with the incoherence that will strengthen 'with behavioral disturbance' subtyping. Clear evidence of memory and learning decline in Alzheimer's and prominent decline in complex attention, frontotemporal executive function in vascular type.
- Onset-gradual onset in Alzheimer's. If vascular, onset of neurocognitive symptoms will be temporarily related with stroke events.

- Chronology of symptom appearance-to understand the psychopathological process.
- Progression- Slow or rapid, linear or plateaus: steady progressive deterioration in Alzheimer's and step ladder pattern of deterioration in vascular.
- Impact on patients including level of impairment in all domains of daily functioning.
- Degree of burden to caregiver- with the aim of understanding the disorder and possible cause.
- Etiology: family history of dementia, NCD or neurological disorder that causes NCD ; in Alzheimer's type and no evidence of mixed etiology, on the other hand HTN,CVD in vascular type.
- Risk of self-harm.
- Living condition, family and social level support.
- Specifications need to be strengthened by indicated laboratory and psychological testing and using apological tools as mentioned below.

Thorough psychiatric assessment
- Bereavement- Onset stages and present status-persistent or resolved
- Depression- features of depression since onset to the present, severity, persistency, prior history, treatment-if any, associating with dementia and bereavement.
- Possible other primary or secondary psychiatric disorders.

Thorough medical assessment
- Present general health status.
- Status of HTN and DM and possible causes of dementia.
- Other GMCs.

Thorough medical assessment
- Presence of other neurological signs of dementia.
- General and neurological examination.

Laboratory investigations
- Routine for understanding general health status.
- Test for diagnostic confirmation, specification and finding causes:
  Structural neuroimaging (CT, MRI)–to see degeneration, infarct and other events and its pattern to an extent.
  Functional neuroimaging (fMRI, PET, SPECT where available and feasible) provides specific findings for NCD including extent of functional damage.

Neuropsychiatric testing (to assess severity and possible area of cognitive impairment to support the mentioned severity and specification of dementia):
MMSE, ADS, MoCA.

Psychometric:
Validated BPRS-for psychotic features
Validated BDI-for depression

[**Note**
The causes of dementia and NCD must be remembered to answer the alternative questions of similar nature]

10. A 72-year-old man brought by his family members in psychiatry OPD who exhibits disinhibited sexual behavior at home for 6 months that is increasingly odd, pervasive. The female members, particularly the family, are scared after a recent incident when he tried to do a sexual act with his wife in front of others. He has a long h/o HTN & a stroke. After that his forgetfulness, change in his mood and behavior developed that is increasingly worse. He is euphoric, overfamiliar and talks spontaneously.

Based on deduction of the single most likely diagnosis
a) Make a checklist of your assessment plan.
b) What treatment will you offer for this case?

Given information

Demography and referral
Age- 72 years
Sex-Male
Referred to- Psychiatry OPD
Referred by- Family members

Chief complaints
- Forgetfulness- uncertain but prolong duration
- Changes in mood and behavior progressively deteriorating- subsequent duration
- Disinhibited sexual behavior increasingly odd and pervasive-6 months
- Tried to do sexual act with his wife in front of others- very recent event
- Impact: family members, particularly female are scared

Existing medical illness
HTN-long standing with one past stroke event

M/S/E findings
Appearance & behavior- overfamiliar (exaggerated social behavior)
Affect- Euphoric
Speech- Spontaneous

Extracted information

Acute onset of cognitive deficit evident from forgetfulness, mood and behavioral change with progressive deterioration after stroke, clearly indicates this old man has dementia and likely due to stroke severe in nature with gross deterioration of personality.

At this age, expected degenerative change is likely blended with other features and enhances the downward progression of his dementia.

His unusual sexual behavior is part of behavioral features of the disorder resulting from disinhibition and marked deficit of executive function at this stage.

His changes in mood and behavior with recent hypersexuality could be part of primary or secondary mood disorder. The long-lasting persistency of these features along with the features of cognitive deficit and its progressive deteriorating course do not support this possibility.

His status of long lasting HTN and effect of stroke need assessment to strengthen the diagnosis and its cause. Other co-occurring systemic or neurological illnesses can be present at this age. Therefore, thorough medical and neurological evaluation is necessary**.**

Family members are distressed, particularly female members are scared about his disinhibited sexual behavior, and this is certainly the main reason for seeking consultation and indicative severe family distress.

Assigned task

a) The assessment checklist

Based on the deducted, single possible diagnosis of severe vascular dementia, the checklist of the assessment plan is as follows:

• Cause of deterioration of overall cognitive deficit (slow/stepladder) with special attention on the following features:
Complex attention
Executive function
Learning & memory
Language
Perceptual motor
Social cognition
• Status of HTN- how long; controlled or not, cause and effect to the other systems, and treatment.
• Stroke- onset throughout the disease, types-hemorrhagic or infarction-single or multiple, area involvement, effect- immediate and persistent, residual features.
• Function of other lobar areas.
• Family H/O NCD, CVD.
• Details of behavioral disturbances- cognitive, non-cognitive.
• Psychiatric evaluation for exclusion of possible mood disorder and comorbid other disorder primary or secondary.
• Medical and neurological assessment for other possible physical disease (other neurological, renal, cardiac, hepatic impairment; electrolyte status).
• Risk assessment (harm to self & others; decision for admission and treatment planning).
• Disability-physical, psychosocial and level of dependency.
• Impact and burden on family for his odd sexual behavior and overall condition.
• Burden of caregivers.
• Investigations:
Laboratory investigation- General and specific with the aim of assessing health status and confirming diagnosis, severity, areas of deficit and comorbid physical illness.
Neuropsychiatric–MMSE.
Psychometrics- validated MMPI for assessing personality deterioration
Zarit burden Disability scale (validated Bangla version is available).

b) Treatment plan

General

Explanation advice and support to the caregivers.
Family education- with special emphasis on nature, course, prognosis and on their changing role at present and near future.
Hospitalization, if his behavior is uncontrolled, repetitive, unmanageable at home and causes home life crisis and if it is necessary for executing the assessment and treatment plan.
Rapid tranquilization- if excitement and uncontrolled violent behavior.
Maintenance of proper nutrition, hygiene and monitoring vitals.
Maintenance of ADLP as feasible- particularly proper sleep schedule and leisure activities.
Ensuring adequate sleep and wakefulness.
Treating his long lasting HTN and stroke and any other co-occurring illness.
Referral to internal medicine, neurology and other disciplines as necessary.

Specific

Biological

Antipsychotic- for behavioral problems.

Sedative hypnotic- lorazepam, melatonin.
Mood stabilizer-addition may be necessary for managing his disturbed behavior and emotion; CBZ is preferable; alternatively, valproate could be the option.
Anticholinesterase- at this stage of severe cognitive deficit there is no possible indication for it.

Psychosocial
Behavioral modification technique.
Support group involvement.
Rehabilitation-preparing a program either home or community based as feasible.

11. An 80-year-old male has been admitted for his uncontrolled diabetes. He frequently takes high doses of insulin beyond prescription that caused hypoglycemic state on several occasions since the last 4 months. On some occasions, he takes excessive food after overdosing on insulin in many ways. For these behaviors, he has been referred for psychiatric evaluation. Based on your logical deduction of the given information--
a) What is your differential diagnosis
b) Outline your assessment plan for confirming diagnosis and making treatment.

Given information

Demography and referral
Age- 60 years
Sex- Male
Referred to- Psychiatry department
Refereed from-An inpatient department
Reason for referral- Psychiatric evaluation

Chief complaints
- Taking high doses of insulin beyond prescription on several occasions- last 4 months
- Taking excessive food after overdosing of insulin

Medical diagnosis
Uncontrolled DM

Treatment receiving
Insulin

Extracted information

This older man was admitted for his uncontrolled diabetes who takes by himself high doses of insulin beyond prescription on several occasions followed by excessive food intake. This clearly can be described as abnormal illness behavior that caused uncontrolled diabetes and put him in a risk - last 4 months.

Referrals from other departments, possibly from internal medicine or endocrinology indicate his unusual and incompatible behavior in contrast to desired illness behavior resulting from uncontrolled status of his illness is related to psychiatric domain.

His abnormal illness behavior at this age and 4 months duration is likely related with mood disorder either primary or secondary.

The first possibility is bipolar disorder because high mood, inflated self-esteem and excessive activities without thinking about its consequences in a manic episode can cause such disinhibited and risk-taking behavior.

Major depression is the possibility because persistent severe low mood, pessimistic thought, psychomotor agitation can exert such behavior. Such frequent overdosing of insulin may be suicidal behavior.

Other possibilities are impulse control disorder and personality disorder.

At this age, it could be a case of neurocognitive disorder and common degenerate types of NCD like Alzheimer's disease usually starts at this age. However, the duration of the problems in only 4 months is insufficient for such behavioral features explainable by gross cognitive skills. However, presence of NCD due to causes related to rapid deterioration may present.

Assigned task

Based on the above extraction and logical deduction of the given information

a) Differential diagnosis
   i. Bipolar Disorder
   ii. Depressive disorder
   iii. Neurocognitive disorder (60 years is the starting age of Alzheimer's)

c) Assessment plan
   For confirming diagnosis and making a treatment plan.

   Thorough psychiatric assessment for bipolar disorder, depressive disorder and other impulse control disorder as per protocol of general psychiatric assessment.
   Neuropsychiatric assessment for excluding NCD.
   Etiological assessment- whether the disorder is primary or secondary. In this issue, GMC can cause bipolar disorder and depression or any other impulse control disorder and personality disorder. Here, syndromal psychiatric disorder can be present with PD.
   Stressors. Persistent uncontrolled DM itself is an enduring stressor caused by his restricted and undesirable life that could be a precipitation factor. Others stress in this stage of life is likely. Thorough assessment of stressors during history taking and applying stress is one of the components of assessment.
   Checking the medical record and if necessary, medical assessment will be carried out for any GMC that can cause assigned psychiatric disorder.
   Risk assessment-for suicide and intent behind the behavior.
   Assessment of family support.

12. A 67-year-old male presents in psychiatry OPD with forgetfulness for 4 months. On questioning, he says that he forgets names of the people and tries to recall. If fails, he feels marked distress and that persists unless he knows the name either by recall or any other ways. This happens many times in a day despite his unwillingness. His wife informs that he shows marked restless behavior, preoccupied with recurring thoughts of remembering names and sleep disturbance.
Answer the following by doing logical extraction from the given information.
a) What Is your best possible diagnosis?
b) Make a checklist of your assessment plan.

Given information

Demography and referral
Age- 67 years
Sex- Male
Referred to- Psychiatry OPD

Chief complaints
- Forgetfulness especially the names of people- 4 months
- Distress if names cannot be remembered- same duration
- Restless behavior, preoccupied with thoughts of remembering names and sleep disturbance- reported by wife

Extracted information

Patient's forgetfulness seems to be of recent onset.

Factually, this is intrusive in nature, senseless and associated with compulsive searching of name either by recall or other sources.

S/S is related to anxiety, distress and its expression through agitation and sleep disturbances.

No reporting of any remarkable impairment of higher brain/cognitive function.

These features cannot be explained by ARCD or Neurocognitive disorder either (Dementia or equivalent) as forgetfulness does not encompass other areas except names.

Assigned task

a) The best possible diagnosis

Based on the information and its extraction, the best possible diagnosis is OCD.

b) Checklist of the assessment
- General assessment protocol application.
- Whether it is the first onset or recurrence of OCD.
- Clinical examination-General, neurological and mental status.
- Lab investigations-Using first line investigation protocol of assessing causes of neurocognitive disorders, with special emphasis on brain tumor if it is first onset.
- Psychometric assessment
  Neuropsychiatric
  MMSE for cognitive status
  Psychometrics
  For OCD- YBOCS (validated Bangla version available)
  For Anxiety- HAM-A, HADS, DU Anxiety and Depression Scale
  For Depression- HAM-D, BDI, MADRS
  For Stressors- Dhaka Stress Scale- Adults–DSS-A

Chapter 7: Forensic Psychiatry

1. A 30-year-old man referred to you from prison for psychiatric assessment for his repetitive violent behavior. He has several convictions, has been imprisoned several times, and breaks up with his family.
Based on your logical deduction of the given information in the scenario─
a) What is the best possible diagnosis?
b) How will you assess this case?

Given information

Demography and referral
Age- 30 years
Sex- Male
Referred to- Psychiatric facility
Referred from- Prison
Reason of referral- Psychiatric assessment

Chief complaints
- Repetitive violent behavior-not mentioned, possibly long
- Forensic history- Several convictions, has been imprisoned several times
- Stressful events- Broke up with family

Extracted information

For such forensic referral, two things must be accessed and communicated. Firstly, whether the person is suffering from a psychiatric disorder. Secondly, if so, whether he needs treatment.

This early mid adult man is referred for his repetitive violent behavior in prison. He has been accused of law-breaking activities and imprisoned several times. He has broken up with family members. Persistent aggressiveness, frequent law-breaking behavior, imprisonment and poor interpersonal relationship is clearly indicative of antisocial personality disorder.

Aggressiveness, ill-sustained relationships are also common features of borderline, schizoid and paranoid personality disorders that need further inquiry.

This person may be a case of psychosis because of his repetitive violent behavior that may result either from delusions or hallucinations or expression of his disorganized behavior. There is no mention of such features of psychosis and needs exclusion.

Though there is no information mentioned, bipolar disorder sometimes presents with violent behavior that needs exclusion.

He could be a case of any other impulse control disorder. However, his frequent law-breaking behavior and poor interpersonal relationship do not support this.

Assigned task

a) The best possible diagnosis

From the above deduction of the given information, the best possible diagnosis is Antisocial Personality Disorder.

b) Assessment of this case

- Onset, nature, severity, frequency, persistency and pervasiveness of violent behavior with anticipated event-provoked, unprovoked and consequences. For personality disorder, this must be from the late adolescent period and pervasive in nature.
- Other features of antisocial personality disorder- nonconformity to social norms deceitfulness, impulsivity, recklessness, irresponsibility, lack of remorse of his act.
- Any features of other personality disorders.
- Evidence of conduct disorder. Here, age of onset of conduct disorder before 15 years of age and antisocial behaviors since age 15 years is crucial. Other features of conduct disorder need to be enquired.
- Prior history of oppositional defiant disorder and its continuity to conduct disorder.
- Any features of other personality disorders related to aggressiveness and unstable interpersonal relationships.
- Features of schizophrenia or bipolar disorder whether present or not.
- History of substance misuse.
- Family history of psychiatric disorder including antisocial PD.
- M/S/E: with particular emphasis on the following points
  Mood/Affect- irritable/indifferent/withdrawn
  Perception-any hallucination
  Thought- distorted cognition, callous lack of empathy and delusions
- General medical assessment for any possible secondary cause.
- Investigations
  Routine for general health status
  Specific investigation -Dope test if history suggests.
- Treatment needs and options.

2. An 84-year-old man donates his valued land to his distant relative by registration. His sons challenge this registered document on the ground of his insane mind. This old man has been sent by the court to assess his capacity of giving his property by registration.
a) What are the areas you need to assess for his testamentary capacity?
b) Outline the contents of your court report for this case.

Given information

Demography and referral
Age- 84 years
Sex- Male
Referred to- Psychiatric facility
Referred from- Court
Reason of referral- To assess his testamentary capacity

Chief complaints
Insane mind as his sons challenged for- duration not mentioned

Extracted information

For such referral, the main course of action will be task oriented. Here the task is to test his testamentary capacity.

With this view, the points related to his testamentary capacity need to be assessed and thereby communicated in the report form.

Confirming an appointment arrangement including identifying the person, appointment date, time and location. Any special arrangements such as the need for an interpreter, disability access, communication tools, such as a voice amplifier need to be made if necessary, along with the assigned person responsible for making the appointment.

Checking personal background, records of legal proceedings and current order, records of general medical and psychiatric conditions are the crucial issues.

Conducting psychiatric interview, mental state examination for any psychosis, mood disorder, neurocognitive disorder with special emphasis on cognitive state and judging her testamentary capacity.

Recording of the assessment procedure and sending the report to the court with confidentiality are essential.

Assigned task

a) Testamentary capacity

The following points have to be considered to assess his testamentary capacity

- Whether the testator is capable of understanding the nature and consequences of making the will.
- Whether he is capable of understanding the extent of his assets.
- Whether he understands the claims of those who might expect to benefit from his will (both those being included in, and being excluded from, the will).
- He should not have a mental illness that influences him to make bequests (dispositions) in the will that he or she would not otherwise have included.

b) The contents of the court report

- Reference of the court-number and date.
- Identifying points- Name, age, and identifying persons.
- Place, date and time of the assessment.
- Summary of assessment procedure- based on history and mental state examination. Only relevant points should be mentioned. Specifying the type of assessment required and the questions that need to be addressed are necessary. For example: does the person suffer any cognitive impairment, and if so, what is the nature and extent of that impairment; and does the impairment affect the person's ability to make reasonable decisions in relation to his or her financial and legal affairs; and his or her personal affairs.
- Opinion- The person has or has not the testamentary capacity.

- Signature with date, full name and designation.

3. A 40-year-old man appears in psychiatry OPD who believes that his wife has sexual relationships with multiple men that cause persistent discord between them. The man is repeatedly violent to his wife and pressurizes her to confess her sin. Collateral information does not support his belief. In one to one interview, he expresses his firm determination that he will kill her wife.
Based on your extraction of the given information─
a) What will be your decision on the grounds of protecting confidentiality?
b) What will be your steps of managing this case?

Given information

Demography and referral
Age- 40 years
Sex- Male
Marital status- Married
Referred to- Psychiatry OPD

Chief complaints
- Conviction that his wife has sexual relationship with multiple men despite no such evidence- duration not mentioned, possibly long
- Repeated violent behavior to wife and pressurizes her to confess her sin- subsequent duration

M/S/E findings
Thought- homicidal, expressed his firm determination to kill her wife

Related stressor
Persistent marital discord

Extracted information

This mid adult man has a conviction of wife's sexually unfaithfulness that has no evidence. This belief is clearly irrational and delusional. Subsequent marital discord, his violence towards wife and homicidal thoughts are clearly this delusion related behavior. All these indicate this man is suffering from delusional disorder of the jealous type.

This man can be a case of schizophrenia and this delusion may be one of the features of this disorder. Here, such other features of schizophrenia like other delusions, hallucinations, disorganized speech or behavior are not mentioned here that need exploration.

This type of delusion also can be the expression of substance use disorder like cannabis, alcohol either as primary or as comorbidity that need to be assessed. At the same time, any primary organic disease like intracranial space occupying lesions needed exclusions.

Confidentiality is the core part of medical ethics that binds the physicians to hold secret all the information given by the patient. The circle of confidentiality does not only include the physician, but encompasses all staff members, clinical supervisors, and consultants involved in the patient care. Sharing of information only can be done with the permission of the patient. In certain circumstances particularly in suicidal or homicidal intention, part of legal proceedings and emergency this confidentiality can be breached but should be in a restricted way. Here, in this case, the man has firm determination of homicide and breaching of confidentiality is necessary.

Assigned task

a) Decision on the ground of protecting the confidentiality

In this case confidentiality of the patient's homicidal thought needs to be breached and will be done in following ways-

- Asking the patient for permission to disclose it. Many patients with psychosis usually agree.
- If he does not agree, breach of confidentiality will be made.
- Relevant statement of the patient needs to be recorded and keeping all documents in confidential
- The information release will be limited as possible in order to carry out intervention.
- Debriefing the patient about the breaching confidentiality in a suitable time.

b) The steps of managing this case

This patient with the most possible diagnosis of delusional disorder with violent behavior and homicidal thought needs hospitalization at a psychiatric facility for intervention. The necessary steps will be as follows.

- Process of voluntary admission will be tried at the first step.
- Process of involuntary admission will be applied if it fails.
- The police officer in charge of the area will be notified and the wife and accompanying responsible caregivers and the treating team members will be informed about his homicidal thoughts.
- Antipsychotics and other medication will be stated and adjusted accordingly.
- Close surveillance of the patient will be maintained.
- Frequent assessment will be done.

4. A 32-year-old man has been brought to psychiatric emergency by the police who has been found in front of the prime minister's office with irrelevant talks, excitement and started a grandiose conversation with the guards. The man is highly elated and excessively talkative. When asked for hospitalization, he aggressively refuses.
Based on your logical deduction of the given information in the scenario─
a) What is the most likely diagnosis and his state of mind?
b) Describe your steps of action for admitting the patient.

Given information

Demography and referral
Age- 32 years
Sex- Male
Referred to- Psychiatric emergency
Brought by- Police

Chief complaints
Irrelevant talks, excitement and grandiose conversation- duration not mentioned

M/S/E findings
Appearance- Aggressive
Mood/Affect- Highly elated
Speech- Excessively talkative
Thought- Grandiosity
Insight- seemed absent evident in admission refusal

Extracted information

This early mid adult man has irrelevant talks, excitement and grandiose conversation. He has a highly elated mood, pressure of speech and possible flight of ideas. All these features are indicative of a manic episode.

This man has excitement, irrelevant talks and possible grandiose delusion. The excitement and irrelevant talk can be the expression of disorganized speech and incoherence therefore this patient may be a case of schizophrenia. There is no clearly mentioned other delusions, hallucinations, disorganized speech or behavior. Further, other features are very suggestive that this irrelevant talk is likely the expression of pressure of speech and flight of idea and excitement is expression of his excessive goal directed activities and in face of any situational provocation. Therefore, these symptoms are possibly mood congruent.

This feature may happen in substance intoxication, withdrawal, or any primary general medical condition that needs exploration.

It seems that he has no or poor insight that is evident with his loitering state, illogical appearance in front of the highly important office with grandiose talks, and refusal of involuntary admission.

Assigned task

a) The most likely diagnosis and his state of mind

From the above logical deduction of the given information the most likely diagnosis is Manic episode/ Bipolar Disorder, current episode manic. His state of mind is lack of insight to give consent for voluntary admission.

b) The steps of action for admitting the patient

Here, the steps of action will be as per involuntary admission. The process is as follows.

- The attending police officer will apply for admission or medical officer on duty will either apply or give consent for admission and the admission will be done through a prescribed form of involuntary admission initially for 24 hours.
- The admission period can be extended for another 28 days with the consent of the consultant either for treatment or for assessment.
- This period further can be extended for another 60 days either by the consent of the treating consultant or by a Mental Health Review and Monitoring Committee for the same purpose
- The Mental Health Review and Monitoring Committee will extend the admission time for another 120 days and if necessary, for another 180 days
- The Mental Health Review and Monitoring Committee can further extend the period of admission considering the treatment needed.

5. A 28-year-old woman with mental disorder has been sent to the psychiatry department from the court for assessing fitness to stand trial as her lawyer claimed that she has no such fitness and submitted relevant supportive documents to the court.
a) Outline the steps of your assessment of this woman.
b) What are the points you need to mention in the court report?

Given information

Demography and referral
Age- 28 years
Sex- Female
Referred to- Psychiatry department
Referred by- Court
Reason of referral- assessing the fitness to stand trial

Present psychiatric diagnosis
Mental disorder, not specified

Forensic issue
Assessing the woman's fitness to plead

Extracted information

This woman with late early adulthood has been sent from the court to the psychiatric facilities who has mental disorder and her lawyer claims that she is not fit for trial.

For such referral, the main course of action will be task oriented. Here the task is to test her competence to stand trial

With this view, the points related to her competence to stand trial need to be assessed and thereby communicated in the report form.

In severe mental illness, neurodevelopmental disorders and neurocognitive disorders can lose the fitness to plead. However, it is not the question of having only such disorders; rather the person's insight is important during the time of assessment because many persons may have such fitness despite the presence of such disorder.

The criteria of such competence are, in presence of a mental disorder, the defendant understands the charges against him or her and can assist in his or her defense.

Assigned task

a) Outline of the steps of your assessment of this woman

- Going through the court order and attached documents.
- Confirming the appointment of assessment.
- Checking the identity.
- Checking the medical records including psychiatric diagnosis and treatment.

- Conducting psychiatric assessment with gathering history and along with informants and conducting mental state examination and reaching the diagnosis.
- Assessing specific points reacted to competence for fitness to plead. These are the ability to-
  - understand the nature of the charge
  - understand the difference between pleading guilty or not guilty
  - instruct counsel/legwear
  - challenge proceedings
  - follow the evidence presented in the court.
- Recording the assessment procedure.
- Writing a court report and sending the report to the court with confidentiality.

b) <u>The points need to be mentioned in the court report</u>

- Reference of the court-number and date.
- Identification of the woman- Name, age, and identifying persons/documents.
- Place, date and time of the assessment.
- Sources of information.
- Summary of the psychiatric assessment including history and mental state examination and diagnosis.
- Summary of the specific findings related to her competence to stand trial.
- Opinion- Whether she is fit or not fit to plead.
- Conclusion- any treatment recommendation.
- Signature with date, full name and designation.

6. A 31-year-old male has been sent from the court for psychiatric assessment who is under trial prisoner for the charge of murder. The defending lawyer demands that the man is insane and the trial should be suspended on this ground. His psychiatric documents say that the person is a diagnosed case of long-standing schizophrenia currently in relapsing state and under treatment.
   a) What are the areas you need to assess for this purpose?
   b) How will you proceed for such assessments?

Given information

<u>Demography and referral</u>
Age- 31 years
Sex- Male
Referred to- Psychiatric facility
Referred by- Court
Reason of referral- Psychiatric assessments

<u>Present psychiatric diagnosis</u>
Schizophrenia as mentioned, long lasting

<u>Treatment history</u>
Under treatment, not specified

<u>Forensic issues</u>
This man is an under-trial prisoner

Charge- Murder
Defending lawyer demands suspension of trial in the ground of insanity
Sent for psychiatric assessment by the court order

Extracted information

This under trial prisoner is in charge of murder sent form the court for psychiatric assessment. Documents show that he is a case of long-lasting schizophrenia with a recent relapsing state and was under treatment.

For this prisoner, his lawyer demands for suspension of trial due the ground of insanity.

On the grounds of insanity of such a major offence, the court may apply McNaughton rule that the person is not guilty as he did not know the nature and quality of the act he was doing or if he did not know what he was doing was wrong. Alternatively, the court can apply diminished responsibility by virtue of having illness. In both conditions the trial can be suspended with issuing orders for treatment detaining in hospital indefinitely. The person may be returned for trial considering his condition.

Here, in such a case, duty of a psychiatrist is conducting psychiatric assessment, specially the person's mental state at the time of act, sending reports to the court mentioning his mental state, illness and treatment required or not. The comment about not guilty due to insanity or diminished responsibility is not the concerned part of the psychiatrist.

Assigned task

a) <u>The areas need to be assessed for this purpose</u>

- Current mental illness- Assessing the diagnostic status of schizophrenia- onset, duration, course and its type, early presenting features, current features, treatment and outcome including any ongoing treatment. Here pass history of violent or aggressive behavior, excitement, any homicidal or suicidal behavior are necessary.
- Mental state during the time of act- this area is crucial and highly important. In the current psychiatric diagnosis that will be more likely in the active phase—in reaction to derogatory voices, paranoid delusions, delusion of control or as part of disorganized behavior that usually happens all on a sudden. Inquiry needs to be conducted for such evidence.
- Past or comorbid substance misuse- particularly intoxication or withdrawal state of drugs and alcohol.

- Pat and present comorbid psychiatric disorder- particularly depressive disorder.
- Forensic history.
- Personality state- both premorbid and comorbid personality disorder.
- Mental state examination- It could be one or more as necessary. Details of every point particularly his delusion, hallucinations, cognitive state and insight are crucial. Findings along with examples should be recorded.

b) <u>Proceeding of the assessment</u>

Before assessment

Going through the court order and attached documents with special emphasis on prior diagnosis of schizophrenia and treatment.

Setting an assessment session in a particular period and time. This needs to be fixed with concerned persons and agencies. One or subsequent series of assessments may require settings.

Source of gathering information- In this case, the information needs to be gathered from the prisoner, family members, prison personnel (warden, prison doctors). All sources of information are to be noted. Direct observation may be required either in the prison or in the prison cell of the hospital.

Confirming the identity- recording identifying persons and checking necessary documents, particularly name and age

During assessment
Interviewing the person for necessary history taking, confirmation of the early gathered information and mental state examination.

Mental state at the time of the act-special query is to be done on this issue along with reacted symptoms, possible cause of the act. Person's own statement on the background of gathered information is particularly helpful.

Recording all findings of each examination.

After assessment
Writing court report with the following components

- Reference of the court-number and date.
- Identification points- Name, age, sex mentioning identifying persons/documents.
- Place, date and time of the assessment, who were present.
- Sources of information.
- Summary of the psychiatric assessment including history and mental state examination.
- Mental state at the time of the act.
- Conclusion- Diagnosis, treatment.
- Signature with date, full name and designation.
- Sending the court report to the competent authority confidentially.

[NTK
The court report should be in plain language avoiding any medical jargon. Diagnosis reacted to the forensic category should be used. For specific diagnosis, it must be assigned as ICD classification]

Chapter 8: Psychiatry of Learning Disability

1. A 36-year-old man is brought by his father to a psychiatric OPD who suddenly disappeared from the home. He has no academic achievement due to mental incapability. After one year, he returned home with the help of local volunteers who found him wandering riverside. He is cachectic, not communicative, disheveled and marked incongruous.
Doing logical deduction by analyzing the scenario─
a) What will be your best possible differential diagnosis?
b) Outline your assessment plan to confirm the diagnosis and make an interventional plan.

Given information

Demography and referral
Age- 36 years
Sex- Male
Educational status- No academic achievement
Referred to- Psychiatry OPD
Referred by- Father

Chief complaints
- Academic failure due to mental incapability- life span duration
- Disappeared suddenly from home and returned recently after one year
- Wandering riverside
- Not communicative

M/S/E findings
Appearance and behavior- Cachectic, not communicative, disheveled
Mood and affect- Markedly incongruous

Extracted information

This man has no academic achievement due to mental incapability. It is most likely that he has intellectual impairment.

It is known that mild ID patients can carry on study in normal school whereas moderate ID patients can study in special school. In this case, the patient has no academic achievement. It is more likely that he has severe intellectual impairment.

Wandering behavior is one of the important signs of psychosis. It can also occur in cognitive impairment. Intellectual disability patients may exhibit wandering behavior more likely due to psychosis or part of its behavioral manifestation.

The man is non-communicative. It indicates he was communicative before his disappearance. Though use of language is limited in intellectually disabled patients, nonverbal communications usually remain normal. In this case, the person becomes noncommunicative which is a clear deviation from his baseline functioning and likely due to withdrawal state of psychosis and most possibility as part of positive or negative symptoms of schizophrenia.

Cachectic body, disheveled appearance and marked incongruity are clearly suggestive of psychosis. At the same time, inability to care for oneself in intellectual disability also can be explained in part by impaired adaptive behavior likely in almost all domains.

There is a strong possibility of having physical disorder due to malnutrition and self-neglect due to consequences of psychiatric disorders. Another medical condition that causes intellectual disability and schizophrenia or schizophrenia-like symptoms may be present, especially related endocrine, genetic and neurological disorder. Therefore, physical assessments are required.

Assigned task

a) <u>The best possible differential diagnosis</u>

From the logical deduction through analysis of the given information, best possible differential diagnosis are—

Intellectual Disability- The patient has intellectual deficits throughout his life mainly evident by academic failure. Deficit in adaptive behavior functioning is also evident as stated in case description and extraction. Both components are in severe form.

Schizophrenia- Disorganized behavior expressed as long away from home, wandering, withdrawn, disheveled appearance, and lack of self-care. Though any direct features for delusions and hallucination are not mentioned, withdrawal active phase symptoms are indicative of such symptoms. It is evident that these problems are of long duration at least one year.

Other neurodevelopmental disorder- The features of intellectual disability can be blended with other neurodevelopmental disorders like Autism Spectrum Disorder, Communication Disorder. However, no such clear evidence is present.

Substance induced psychotic disorder- Not unlikely both with intellectual disability and with schizophrenia. Noncommunicating and possible cognitive impairment may be either intoxication or withdrawal. However, there is no straightforward evidence of substance misuse.

From above extraction and discussion, this patient has at least dual diagnosis of Intellectual Disability and Schizophrenia.

b) <u>Assessment plan for confirming the diagnosis and making an intervention plan</u>

History
- Birth and development history.
- Level of intellectual and adaptive functioning before disappearance and current level.
- Extent and severity of presenting symptoms. It is usually difficult to elicit psychotic features like delusions and hallucination in patients with intellectual disability. Therefore, extensive collateral information and observation are required.
- Inquiry about existence of other neurodevelopmental disorders specially, Autism Spectrum Disorder, speech and language disorder.
- Interview with significant others for collateral information.
- Observation of the patient over time.
- Changes in the presentation of symptoms over time or in different places/situations.

Physical examination
General physical examination to rule out any deformity.

Features of endocrine disorder- particularly hypothyroidism.
Features of genetic disorder (Velocardiofacial syndrome, Klinefelter's syndrome, Prader-Willi syndrome, PKU).
Features of neurological disorder- Tuberous sclerosis, Wilson Disease.

Mental State Examination
Special technique needs to be adopted and a series of MSE may be required to elicit psychotic features. Special emphasis needs to be given on elicit cognitive function.

Lab Investigations
Routine-CBC with ESR to know his general health status
Special- to know systemic status- RBS, liver and renal function tests, serum electrolytes
Dope test if history or examination suggestive
Tests for any other comorbid disorders and that will be according to clinical assessment

Psychological testing
Validated WAIS for assessing his level of intelligence.
Validated Vineland Adaptive Behavior Scale for assessing his adoptive behavior.
Validated BPRS for measuring psychosis.
Other psychometrics for assessing neurodevelopmental status can be applied as required.
The use of psychometrics is required mainly to support diagnoses, its severity and area of deficit.

2. A 28-year-old man attends psychiatry OPD with his father. Father says that his son has low intelligence as he observed from early life, failed to get education, cannot understand simple matters, doing nothing and becoming a burden to his family. He seeks a certificate of mental disability for getting financial support from the social welfare department. He also asks for any possible treatment for his son.
a) How will you proceed to help this father for expected financial benefit?
b) What management plan will you design if the father's assumption is correct?

Given information

Demography and referral
Age- 28 years
Sex- Male
Referred to- Psychiatry OPD
Accompanied by- Father
Reason of referral- Getting mental disability certificate and possible management

Chief complaints
- Low intelligence- since early life
- Learning failure-same duration
- Marked lack of understanding- same duration
- Marked functional impairment that makes family burden- subsequently going on

Extracted information

The problems described by parents reflect the son's inability to achieve age-appropriate intellectual and adaptive functioning that clearly goes in favor of intellectual disability.

The level of learning failure, occupational failure and high family burden are severe and the man is more likely dependent to family. All these are very much indicative of severe intellectual development disorder.

It should be mentioned here that as per provision of the social welfare department, confirmation of certain disability diagnoses must be endorsed by a physician in a prescribed form of that department for getting financial benefit, and intellectual disability falls within the list of disabilities.

Thorough assessment is necessary for confirmation of the diagnosis, finding any physical and psychological comorbidity, intellectual level, adaptive behavior, degree of burden, etiological issues and any form of previous treatment and outcome to design a feasible management plan.

Assigned task

a) Proceeding to support for expected financial benefit

Initial task

- For such benefit, signing on a prescribed form is required, that works as a certificate.
- Inquiry about the father's understanding about mental disability, the process of getting such financial benefit and what he means about the term "certificate." It may be that the father does not know the procedure and got the impression that such a certificate is necessary. Alternatively, it could be that father comes for signing but mistakenly says.
- Explaining to the father about the process of getting such benefits.
- Asking for any identifying document of the son for identity check.
- Following assessment process will be carried out-

Gathering necessary information

- Intellectual functioning level (reasoning, planning, problem solving, abstract thinking, judgment, academic learning and learning from experience).
- Adaptive functioning level (communication, social participation, independent living across multiple environments).
- Onset of the problem (in the developmental period).
- Educational history including details of parent's effort and outcome.
- Presence other comorbid disorders like other neurodevelopmental disorder ASD, Speech and language disorder. Psychiatric disorder commonly, disruptive behavior, impulse control disorder, depression, psychoses and addiction, genetic and endocrine disorders that cause intellectual disability, any other physical disorder.
- Any law breaking behavior.
- Birth history, especially perinatal infection.
- Level of impairment of functioning, degree of burden to others and overall need assessment.
- Family history: particularly, consanguinity of parents, intellectual disability and other neurodevelopmental disorders.
- Strength of the patient and family.

Physical examination

Careful physical examination, particularly for neurological signs, dysmorphic features and the skin signs of the neurocutaneous syndromes (neurofibromatosis, tuberous sclerosis).

Investigations
Psychometric tools:
Validated Wechsler Intelligence Scale for measuring both verbal and performance intelligence, Validated Vineland adaptive behavior Scale to assess adaptive behavior functioning
Lab investigation: particularly for fragile X syndrome, chromosomal abnormalities and metabolic disease.
Psychometrics- WAIS, Adaptive Behavior Scale for intellectual disability,

After confirmation of diagnosis, if the father brings the form that will be duly signed and sealed. If he does not bring it, information will be offered to get such a form advised to come another day along with the form and it will be signed and sealed.

b) Designing a management plan considering possible diagnosis

The above-mentioned assessment will guide the management plan. Considering main diagnosis of Severe Intellectual Disability, the structure of management plan for this case will be as follows: Biopsychosocial approach through multiagency (health, educational and social) involvement and multidisciplinary team are required.

- Explaining the problems to the father and informing possible treatment options.
- Psychoeducation to the father along with fact sheets for family education.
- Psychiatric intervention: for managing any emotional, behavioral features of intellectual disability and other comorbid psychiatric problems or disorders if any.
- Periodic follow-up assessment is an essential component because any form of developing psychiatric disorder is likely with the intellectual disability patients. Regular review of treatment plan and necessary modification usually required. Therefore, they will be advised to come at regular intervals and when necessary.
- Other medical treatment: for treatment of causal factors if found. In that case, liaison and referral will be made according to the nature of the cause.
- Helping the family to reduce their burden by providing necessary advice and extra assistance and support. For that referral to the appropriate social agency(s).
- Training: This patient is likely trainable. If so, referring to the appropriate Severe Learning Disability facility for achieving personal, social and occupational skills.
- Vocational Training: Providing advocacy and information for acquiring suitable occupational activities from such a center or alternatively sheltered workshop.
- Residential care: Placement in group home, or other LD community facilities if the family burden is heavy and possible for the family.

3. A 36-year-old female with moderate Intellectual Disability and Down syndrome referred to psychiatry OPD from a community residential care due to increased verbal aggression, refusing to engage in activity & personal care and banging on door, window, and repetitive behavior over the last 6 months. There has been noticeable change in mood within the same period. She is obsessed with certain people and wants to live with that person. She lacks energy and needs prompting to engage in activity. She cries most of the day and stays in her bedroom. Always, wanted to talk about that person and want to live with her.

Now the patient is overtly attached to her personal career, she showed this type of behavior with her teacher in childhood but it was not persistent and serious as present.
a) Make a checklist of further information to understand her problem
b) How will you explain this problem to prepare your interventional plan?

Given information

Demography and referral
Age- 36 years
Sex- Female
Referred to- Psychiatry OPD
Referred from- Community residential care

Chief complaints
- Increased behavioral problems expressed as verbal aggression, refusing to engage in activity and personal care, banging in door and window
- Repetitive behavior
- Noticeable change in mood
- Lacks energy and needs prompting for engaging in activity
- Cries most of the day and stays in her bedroom
- Overt attachment with personal career
- Duration- 6 months

Present psychiatric diagnosis
Moderate Intellectual Disability and Down's syndrome

Extracted information

The patient is a case of Down's syndrome. Intellectual disability is invariably present in such cases and in mild to moderate severity.

Down syndrome is frequently associated with mental and behavioral disorders, most commonly depression, anxiety, fear-related disorder, impulse control disorder and psychotic disorders. Comorbidities are typically detected when a patient shows any change from his/her baseline behavior, mostly disruptive behavior.

This patient has challenging behavior increasing in nature evident by verbal aggression, refusing to engage in activity & personal care and banging on door, windows.

It can be assumed that challenging behavior already exists and the patient is referred to psychiatric facilities due to its increasing nature and possibly unmanageability in community facilities.

Challenging behavior can be present as part of both the disorders. However, recent deterioration along with other remarkable features-repetitive behavior, mood changes, persistent cry, anhedonia, lack of energy, patterned clinginess are very much indicative of having major depression.

There is a possibility of having disruptive behavior disorder due to the presence of challenging behavior. Disruptive Behavior is classified as:
i. the presence of challenging behavior that is not associated with a mental disorder
ii. the presence of challenging behavior that is associated with symptoms that meet
iii. the diagnostic criteria for a mental disorder

iv. the presence of challenging behavior that is associated with some psychiatric symptoms that do not quite fulfil the diagnostic criteria for a mental disorder

Here in this case, recent increased and noticeable behavioral changes are most likely due to depressive disorder. In the patient with intellectual disability, depression can be expressed through behavioral problems and severe enough to cause functional impairment. In ID patients, due to their poor communication skills, emotional problems like depression or anxiety are often expressed as a challenging behavior. Overt attachment to and separation anxiety from the caregiver explainable by her recent mood change.

The change in behavior may also occur if there is physical discomfort, environmental changes or communication difficulties. However, here the patient's age and other presenting features rule out the physical causes.

Assigned task

a) Checklist of further information

From above information and extraction, additional diagnosis of Major Depressive Disorder needs to be confirmed considering other possibilities that need exclusion. Necessary information also required for revising treatment plans. The farther information checklist are:

Gathering required information

- Other features of depression along with extent, severity, duration of symptoms and impact of the disorder
- Any change in patients' environment prior to behavioral change
- Recent stress
- Physical discomfort
- Any specific reason behind the overt attachment with the caregiver
- Severity of Down's syndrome
- Any previous episode of depression or other psychiatric problem

Assessment

- Mental status examination
- Functional behavioral analysis
- Risk assessment, particularly suicidality
- Strengths assessment-creative, recreational skills and desires

Investigations

Baseline investigations to know his general health status

b) Explaining the problems to prepare an intervention plan

The emotional and behavioral symptoms exhibited by the patient are due to the existence of a separate psychiatric disorder more likely MDD rather than expression of intellectual disability. In this point of view, the intervention plan will consist of biological, psychological and social elements.

Psychosocial

ADLP- a routine of daily activities incorporating desired recreational activities.
Wellness treatment- Group play, physical exercise.
Contingency management program on the basis of functional analysis of behavior.

CBT depends on the capacity of the individual to understand the relationship between internal states, behavior and cognitions.

Biological
For depression- SSRI can be prescribed.
For behavioral disturbances- Low dose clonazepam for short duration.

4. A 28-year-old male patient with severe learning disability, autism and pica was referred to psychiatry outpatient department from community care for running up and down in the stairs and banging the doors forcefully and insomnia. He had two episodes of tonic-clonic seizures last month. After that he started showing such behavior and suffering from poor sleep. He had previous episodes of seizures but did not show this type of behavior.
a) Mention the specific areas that you need to assess.
b) What treatment will you offer this patient?

Given information

Demography and referral
Age- 28 years
Sex- Male
Referred to- Psychiatry OPD
Referred from- Community care

Chief complaints
- Running up and down in the stairs and banging the doors forcefully-2 months
- Poor sleep- same duration

Precipitating factor
Two episodes of tonic-clonic seizure last month

Present psychiatric diagnosis
Severe Intellectual Disability, ASD, Pica

Past history
Previous episodes of seizures but did not show challenging behavior that time

Extracted information
ASD has frequently been associated with intellectual disability. Among them, 40% of cases suffer from severe intellectual disability. The communication difficulties faced by this group of patients leads to frustration and behavioral disturbance.

Running up and down in the stairs and banging the doors forcefully clearly indicates the challenging behavior of this patient. This behavior may be a part of ASD or ID. Reasons behind challenging behavior could be to reduce boredom, to attract attention, for understandable frustration, for sensory deprivation, for physical disorder or a response to mental phenomena.

In this case, the patient exhibiting the behaviors just after episodes of tonic-clonic seizure. Epilepsy or tendency to have recurrent seizure has been associated with mental disorder, pre-ictally, ictally, postictally or inter-ictally. Among them, post ictal and interictal psychiatric disorders are common. Anti-seizure medication can also trigger depression. As the patient's behavioral changes become

apparent after seizures, the relationship between seizure, its etiology and impact of its management should be sought with caution.

Assigned task

a) Specific areas of assessment

- Assessment of ID- intellectual and adaptive functioning level, any physical disorder or deformity.
- Assessment of ASD- level of communication, speech problem, non-verbal communication, restricted repetitive behavior pattern, other stereotyped behavior.
- Assessment of mood- present mood state, change from baseline functioning, sleep disturbance and eating pattern (before/now).
- Assessment of seizure- onset, duration, precipitating factor, pre and post ictal phenomena, details of previous episode, medication and response to medication, associated features to exclude other causes of epilepsy.
- Assessment of challenging behavior- by conducting functional behavioral analysis (antecedent-behavior-consequence).
- Risk assessment-risk of aggression, harm to others and harm to self.
- Direct observation of the patient in different setting aided by the video recording
- Investigations

  Routine- CBC with PBF, Urine R/E, Stool R/E, CXR to know his general health status and to exclude iron deficiency anemia (one of the causes of pica).

  Other investigations: LFT, RBS, serum creatinine, EEG, CT/MRI scan of the brain to exclude any possible systemic diseases and state of epilepsy.

b) Treatment will be offered

Psychosocial

- CBT
- Mindfulness
- Applied behavioral analysis and positive behavioral support

Medication

- Atypical antipsychotic- Risperidone can reduce the arousal and anxiety associated with challenging behavior.
- Antidepressant- SSRI for depression.
- Adjusting AED for managing seizure.

Chapter 9: Psychotherapy

1. A 36-year-old schoolteacher who is diagnosed with OCD and receiving 250 mg sertraline per day. She has extensive thought of dirt and contamination that results in severe cleaning, washing that is poorly responsive to medication. Recently, she avoids bathing and performing prayer and appears to be marked distressful.
Answer the following by doing logical deduction from the scenario.
a) What are the areas you need to assess?
b) Make a psychotherapeutic intervention plan.

Given information

Demography and referral
Age-34 years
Sex- Female
Occupation-School teacher

Present psychiatric diagnosis
OCD under treatment

Chief complaints
- Contents of OCD- Obsession: dirt/contamination; Compulsion: cleaning and washing persistent and severe form-duration not mentioned, likely long.
- Avoids bathing and performing prayers-recent features.

Treatment and outcome
Getting sertraline 250/day with poor response

Additional treatment plan
Psychotherapeutic intervention

Extracted information

Middle aged school teacher who is a diagnosed case of OCD who has obsessive dirt contamination and compulsive washing and cleaning.

She is getting sertraline in adequate doses but the outcome is poor.

Here recent avoidance of bathing and praying indicates it has become more worsen. Possible explanation of such avoidance behavior is her own way of neutralizing behavior to prevent compulsion and minimize her distress.

Abstinence from prayer is likely related with dirt/contamination, as doing 'wudu' (ablation) is necessary for the prayer. Religious contents of obsession in the form of obsessional doubt about her religious performance may present separately that it needs exploration.

All these features could be blended that can make the psychopathology more complex.

Though the duration is not mentioned here, likely it is long as per treatment history, and recent addition of new features.

It seems that the impact of the disorder on her is significantly high evident from the persistency. Severity of the disorder and recently added additional features.

Depressive features can be present with her due to frustration, poor treatment outcome, and possible significant adverse impact on her life.

Though the outcome of drug treatment is poor, adding psychotherapeutic measures at this stage will help for a better outcome.

There are many effective options of psychotherapy for this case. As the patient is a schoolteacher, it is expected that necessary measures will easily be applicable. However, relevant assessment of the problem area and patient's need is necessary before selecting particular options.

Assigned task

a) The assessment areas

Full assessment of OCD- onset, duration, contents, severity, persistency, prior treatment and outcome, distress and impact with present functional levels in all domains.

Through psychiatric assessment for possible comorbid psychiatric disorders or symptoms, partially other impulse control disorders related to OCD, anxiety and depression.

Etiological formulation including psychopathology.

Assessing extent of support of the patients, particularly from family.

Level of understanding of the patient and caregivers about the disorder along with their expectation from the facilities.

b) Psychotherapeutic intervention plan

Usually, this intervention is offered on an OPD basis. Sometimes hospitalization is required for feasibility and very practical reasons.

Psychoeducation to the parents and family- nature, course, prognosis, psychotherapeutic provisions and possible outcome.

Relaxation- any form of relaxation technique is applicable ranging from breath holding exercise to applied relaxation technique as appropriate. With the aim of reducing her anxiety and distress as well as an ingredient of other form of therapy, particularly in ERP for extinction of obsession and compulsion

Exposure with response prevention (ERP)-This will be helpful to reduce compulsion of such nature. Reduction of compulsion can help in reducing obsessive thought.

Cognitive behavioral therapy (CBT)-with the aim of reducing her repetitive thought, her minimizing neutralization, avoidant behavior and associated depression, if any.
Combined ERP and CBT- will be more effective if the patient is suitable for such a combination.

Family therapy- for supporting the family, reducing any marital discord and family dysfunction.

2. A 31-year-old man who has had a long history of anxiety and depression. For this disorder, he is getting antidepressants and has shown a partial response. He remains anxious and is very negative, avoidant, and uncomfortable in his thinking. Your consultant has suggested you apply cognitive behavioral therapy.
a) Mention the cardinal points of your assessment before applying this therapy.
b) Outline the content of your therapy.

Given information

Demography and referral
Age-31 years
Sex- Male

Present psychiatric diagnosis
Mixed anxiety and depressive disorder

Chief complaints
Persistent anxiety and depression- long duration

M/S/E Findings
Mood- Anxious
Thought- negative, avoidant, and uncomfortable

Treatment and outcome
Getting antidepressants with partial response

Additional treatment plan
Cognitive behavioral therapy (CBT)

Extracted information

This patient had persistent anxiety and depression for a long duration and got the diagnosis of MADD.

Antidepressant treatment responded partially and still he has marked anxiety and negative thoughts that he avoids, as he feels uncomfortable and it is likely that he is in distress.

Adding CBT with this state will likely enhance the positive outcome. Assessment of the problem area and patient's need is necessary before starting CBT.

Assigned task

a) Cardinal points of the assessment before applying CBT

Full assessment of MADD- onset, duration, contents, severity, persistency, prior treatment and outcome, distress and impact with present functional levels in all domains. If an adequate record is kept, going through this and gathering information for better clarification.

Through psychiatric assessment for possible comorbid psychiatric disorders or symptoms, Assessment of personality traits- anxious, avoidant.

Etiological assessment including - especially ACEs, enduring and acute stressors,

Psychopathology of negative thought- types, number, interacting nature, effects on behavior and emotion
Assessing extent of support of the patients, particularly from family.

Level of understanding of the patient and caregivers about the disorder along with their expectation from the facilities.

b) Outline of the content of your therapy

Explaining CBT in this context

- Types of therapy-psychological or talk therapy.
- Basic Principles-it focuses on his present problems and its adverse effect, recognizing that negative thoughts can affect mood negatively.
- Encouraging looking at different ways of thinking.
- Structure of Therapy-Usually on a one-to-one basis, typically occurs once-a-week for a few months (8-12 sessions), problem-solving strategy is used, he has to do feasible homework.
- Expected outcome-Good for particular aspects of Depression, better when combined with medication, can help to prevent relapse.
- Other-Usual treatment including medication often requires to continue, the therapist undergoes supervision, ethical issues including ensuring confidentiality.

Applying the following cognitive components

- Cognitive restructuring-for restoring positive thought instead of distorted thought.
  Understanding his negative cognition- for example: over generalization, selective abstraction, arbitrary inference, magnification/minimization, disqualifying positive thought overgeneralization.
  Cause and effect of such negative cognition.
  Applying suitable methods of reasoning- e.g. Socratic question.
- Thought challenging- particularly addressing anxiety provoking thoughts.
- Practicing assigned behavioral tasks.
  - Activity diary keeping
  - Thought diary keeping

3. A 26-year-old woman has an intrusive thought of contamination with menstrual blood and repetitive washing that turns into a never-ending task for 1 year. Her daily life has markedly disrupted and family members are critical and annoyed to her. She becomes severely distressful and attends psychiatry OPD for treatment. After getting fluvoxamine 200 mg/day in a divided dose, she improves a little but cleaning behavior remains the same.
a) What psychotherapeutic measure do you need to apply at this point to this patient?
b) Prepare an action plan to implement the measures.

Given information

Demography and referral
Age- 26 years
Sex- Female

Referred to- Psychiatry OPD
Reason of attending – Follow-up review and further treatment

Chief complaints
- Persistent thought of contamination with menstrual blood- 1year
- Persistent repetitive washing-same duration
- Marked distressfulness- same duration
- Marked disruption of daily activates- subsequent duration

Treatment and outcome
Getting fluvoxamine 200 mg/day for related diagnosis and insignificant response

Extracted information

This patient is clearly a case of OCD evident by persistent obsession of dirt/contamination and washing compulsion. This diagnostic assumption is further supported by treating her with fluvoxamine and subsequent plan of adding psychotherapy.

Patient's severe distress are likely due to persisting nature of the symptoms, poor drug response, marked disruption of daily life that is further reinforced by annoyance and critical comments of the family members.

Assigned task

a) Psychotherapeutic measure needed to be applied at this point

In light of the extraction, the most suitable first line psychotherapeutic intervention is Exposure and response prevention (ERP).

b) Action plan for ERP
- Making a list of obsessions thoughts of menstrual blood) and compulsions (repetitive washing).
- Grading them according to severity.
- Making a chart with columns of obsessions, compulsions and their percentage according to severity.
- Following 15-minute-rule technique (when obsessive thoughts come, delaying the response of washing for 5 minutes for one week, then 10 minutes and then 15 minutes delaying until distress is reduced by 50%).
- Practicing relaxation technique when feeling distressed while performing ERP.

4. A 28-year-old male patient with schizophrenia attends in psychiatry OPD as part of regular follow-up review. He is getting clozapine finally to manage his refractory condition. However, he still hears voices occasionally that are derogatory in nature. At this point, your consultant decides to apply psychotherapy and asks you to work out for it.
a) Outline your assessment plan for first line psychotherapy for this patient.
b) Mention the steps and expected outcome of such psychotherapy.

Given information

Demography and referral
Age- 28 years
Sex- Male
Referred to- Psychiatry OPD
Reason for referral- Follow-up review

Present psychiatric diagnosis
Schizophrenia, refractory in nature

Chief complaints
Hearing derogatory voices

Treatment history
Clozapine, partially responded

Extracted information

Cognitive behavior therapy (CBT), cognitive remediation therapy (CRT) and family interventions (FI) are potentially effective therapies to be considered in the treatment of patients with schizophrenia. For this patient of schizophrenia with partial remission, CBT is the first line psychotherapy. At this stage, CBT work will be focused on psychoeducation, accepting the present state of hallucination symptom, neutralizing of his negative emotional reaction to derogatory voice, destruction, and behavioral tasks are possible.

Assigned task

a) Assessment plan for first line psychotherapy

Following states will be assessed before providing CBT.

- Status of hallucination- content, frequency, reaction of the patient both before treatment and after treatment.
- Presence of other symptoms- delusion, disorganized thoughts, speech and behavior and negative symptoms.
- Presence of mood and anxiety features.
- Assessment of suicidality.
- History of substance use.
- Current level of functioning of the patient.
- Impact of the problems in the patient's life and burden to the caregivers.
- Sources of support of the patient.
- Perception and expectation of the family.

b) Steps and expected outcome of psychotherapy

Steps of CBT in Schizophrenia

Engagement stage

- Warmth, genuineness, empathy and humor for developing rapport.

- Identifying the causes of distress.
- Identifying the patient's own understanding of his situation and ways of coping with it through a process of guided discovery.
- Empathizing with the patient's unique perspective and feelings of distress and showing flexibility at all times.

Analyzing behavior ABC model (activating event, beliefs, consequences)
- Based on a scale 0 to 10, the patient rates the intensity of distress.
- The consequence(C) is assessed and divided into the emotional (e.g. sorrow, depression, loneliness, desperation) and behavioral (e.g. isolation) part.
- The patient gives his own explanation as to what activating events (A) seemed to cause C; and the therapist ensures that the factual events are not contaminated by judgments and interpretations.
- Assessing the patient's own belief, which is actually causing C, is then discussed; often this can be rationalized, and a B such as "nobody will like me if I tell them about my voices" can be disputed and changed to "I can't demand that everyone likes me. Some people will and some won't." That may change C, i.e., less sadness and less isolation.

Goal setting
Measurable, realistic and achievable goals will be set early in the therapy and discussed with the patient.

Normalization
- A normalizing rationale is helpful in decatastrophizing psychotic experiences.
- Education regarding the fact that many people can have unusual experiences in a range of different circumstances.
- Placing heard voices in a continuum of normal perception, the patient can be made feel less alienated and less stigmatized.

Critical collaborative analysis.

Developing alternative explanations

Expected outcome of CBT
- The patient will accept the present hallucinatory status
- Will feel less distressed about psychotic experiences
- Can feel less anxious and depressed
- Can reduce alcohol or drug consumption, if any
- Can handle suicidal thoughts, if any
- Can overcome feeling of hopelessness
- Reduce further drug requirement
- Engage with active daily life
- Prevent relapse

5. A-32-year-old computer analyst has major depressive disorder in moderate level. She has inappropriate thoughts that she made many mistakes in the past act, conviction of not being understood by others, worthlessness, pessimistic thoughts about her career and future, and finds it hard to make any decision. Considering her state CBT is a plan for her.
a) Outline the contents of the CBT.

b) Mention the steps of problem solving that will help her in regaining healthy cognition.

Given information

Demography and referral
Age-32 years
Sex- Male
Occupation- Computer analyst

Present psychiatric diagnosis
Major depressive disorder, Moderate

List of mentioned cognitive distortions
- Did many mistakes in the past
- Conviction of not been understood by others
- Worthlessness
- Pessimistic thought about her career and future, and
- Find hard to make any decision

Treatment plan
Cognitive behavioral therapy (CBT)

Extracted information

This mid adulthood patient has been diagnosed as major depressive disorder with moderate severity for which CBT has been planned.

Assessment of the problem area and patient's need is necessary before starting CBT.

A primary objective of CBT is to change her negatively distorted thinking to more positive and realistic thinking. This woman has many negative cognitions that need restructuring. It is likely that she may have other distorted cognitions. She also has problems with decision-making. Therefore, CBT for her needs to be customized incorporating necessary components along with building problem solving ability.

To accomplish this objective, the first step is identifying the core beliefs that underlie her pessimistic thoughts and then develop a plan for providing the women with corrective learning experiences that help her to evaluate and change dysfunctional beliefs. Here, the core beliefs or schemas underlying depression include "I made many mistakes in the past", "I'm not understood by anyone "and "My career and future are dark" and "I can't take decisions."

Though it is not mentioned here, it can be expected that the woman is getting other measures for managing her depression at this point with this diagnostic status.

Assigned task

a) Outline the contents of the CBT

How many sessions will be required depend upon the level of task and desired outcome. However, on an average 10 sessions are usually required. Preliminary work, like a building report, explaining the purpose of CBT and its basic framework, session duration, expected outcome and other contractual points will be made.

Conceptualizing her problems
This conceptualization includes hypotheses about possible core beliefs. To determine which belief or beliefs are operating for her, listening to her self-references and the meanings that she draws from daily experiences. The beliefs are reflected in the themes and consistencies found in her thoughts. The meanings of events can be deduced from the discussions and by asking deductive questions and by following up with additional similar questions until the most basic meaning is uncovered by downward-arrow technique.

Restructuring
Negative thoughts will be restructured directly and indirectly throughout treatment. During the first few sessions, her negative thoughts will be challenged by the questions that lead to cognitive restructuring.
Direct restructuring of negative thoughts will be done through teaching her to identify, evaluate, and then replace their own negative thoughts with more realistic and positive thoughts.

Indirect restructuring will be made by teaching her cognitive restructuring later in treatment sessions because it requires them to become more self-focused and to focus on negative thoughts that can exacerbate depressive symptoms. For example, one of the woman's underlying core beliefs is "No one understands me," She will follow the events that happened between meetings expectedly will hopefully get more evidence against her belief. Thus, she will manage the upset that comes with an increased self-focus.

The cognitive restructuring will help to start the shift in thinking, and it will serve as a model for how to do it. With the improvement in mood and symptoms, the therapist-led cognitive restructuring will provide her with some cognitive distance from her depressive thoughts and beliefs that will help her to restructure her own thoughts. To accomplish this, discussion will be made on how to recognize negative thoughts.

Subsequently, she will be asked to catch and record her own negative thoughts on homework forms and bring it in subsequent sessions for restructuring. Thus, she will learn the question that is best suited for transforming negative thoughts to generate alternative, plausible, and positive thoughts for a distressing situation.

Encouraging her to depersonalize the negative thinking, creates emotional distance between her and her depressive thinking, and creates a concrete opponent to defeat. Subsequently learn how to restructure their negative thoughts between the subsequent sessions and termination.

Maintaining a cognitive workbook by her. She will be instructed to complete a cognitive diary. It will contain the list of her negative thoughts and work done for changing these thoughts and the outcome. This diary will guide her through the process of catching, evaluating and replacing negative thoughts, for her belief that she is not understood by anyone would be asked to develop a list of other behaviors that demonstrate that she is understood. She will be instructed to monitor the occurrence of these behaviors using the diary between the sessions. As they occur, she will check them off in her diary, and the outcome of the assignment will be processed during the next meeting.

Building a Positive Sense of Self
The primary objective of cognitive restructuring is to help build a positive self-schema. During the last few sessions additional activities will be used to support this positive sense of self. This treatment component appears last because all of the other skills will be used during the process of working toward self-improvement and recognizing positive aspects of the self. During this process, she will learn to recognize their positive attributes, outcomes and possessions.

Self-mapping

It is composed of multiple circles. Each circle within the figure represents an area of her life and an aspect of self-definition. Overall, the "self-map" helps the girls to broaden their self-definition and to recognize more strengths than she was previously aware of.

Personal pleasure activities and mindfulness
Instructing her for doing personal pleasure be will emphasized with keeping best possible concertation

Therapeutic Homework
Therapeutic homework is an integral part of CBT. Homework assignments will be designed to help her apply skills that she will learn in the sessions to real-life situations that occur outside of treatment. Each assignment will be designed to support application of the skill that was taught during that session.

b) <u>The steps of problem solving training that will help her in during regaining healthy cognition</u>

Steps of problem-solving training are based on the following "5P"
- Problem—Problem definition
- Purpose—Goal of problem solving
- Plans—Brainstorming solution generation
- Predict and pick—Consequential thinking
- Pat on the back—Self-evaluation of progress toward the goal and self-reinforcement for effort

6. A couple appears to a psychiatrist with persistent discord for which they become sick and tired. They married 10 years back after 5 years of relationship. Since early in their marital life, they usually have differences of opinion and pass critical comments that end with verbal abusive talks, blame each other and have self-reproach. They are worried for their son and daughter as their children are increasingly emotionally and behaviorally disturbed. Despite all these odds, both are willing to sustain their relationship in a healthy way.
a) What are the points you need to clarify before starting conjoint marital therapy?
b) What techniques do you need to apply here for this therapy?

Given information

<u>Demography and referral</u>
Age of the couple- not mentioned, likely mid adult
Attends to- Psychiatrist
Reason of attending- Persistent marital discord

<u>Chief complaints</u>
- Persistent difference of opinion, passing critical comments- around 10 years
- Verbally abusive- subsequent duration
- Blaming each other and self-reproach-same duration
- Worry for their children's mental health- subsequent duration

<u>Impact</u>
Their son and daughter increasingly emotionally and behaviorally disturbed
They become sick and tired with the conflict

<u>Strength</u>
Desire to keep the marital relationship in a healthy way

Extracted information

This mid adult couple has persistent marital conflict expressed in the form of difference of opinion, critical comments, verbal abuse, blaming each other. However, they have self-reproached for their act.

There is a strong possibility of having anxiety, and depression of either couple or both that could be a symptom or syndrome as they are sick and tired with their conflict for a long period. This conflict is expected to be the continuum of their 5 years premarital relationship and probably that was in low intensity they were not concerned.

They worried about the adverse effect of their conflict on their son and daughter. Therefore, it is likely that they have emotional and behavioral problems that are increasingly worsening.

The children are the sufferers from their conflict as they already recognize that their son and daughter have emotional and behavioral problems. This could be in the form of a disorder.

They have a willingness to continue their marital life in a healthy way at this stage. Probably, this willingness was present for the last 15 years but they failed to manage their conflict. Certainly, there exists strong conflicting traits in their personality.

Assigned task

a) <u>The points need to clarify before starting conjoint marital therapy</u>

- Premarital relationship- nature, intensity, details of positive behaviors, any discord at that time, if present, nature of discord, efforts taken by them, level of understanding and expectation for marriage.

- Present conflict- details of conflicting behavior- antecedent-behavior- consequences, level of tolerance, effects of conflict in their daily life.

- Marital relationship- degree of intimacy, level of understanding and expectation form each other, empathy, need fulfillment, common areas of mutual interest.

- Sexual life including level of participation and satisfaction, any sexual dysfunction.

- Social life- whether their disruption of social life for the conflict.

- Psychosocial stressors- family conflicts, trouble with in-law's family, financial stressors, any circumstantial environmental stressor or any other stressor.

- Assessing their level of distress- anxiety or depressive disorder or any other psychiatric disorder exists in either partner.

- Premorbid personality- list of incompatible traits, individual traits, any existence of personality disorder.

- Past history of psychiatric disorder including their family history.

- Information related to the emotional and behavioral problems of their children, presence of any disorder among the children- particularly disruptive behavior, anxiety, depressive and somatic symptom disorder.

- Assessing impact of the conflict over them and children and degree of burden to the family.

- Family assessment- level of family functioning, any features of disorganized family, parental attitude and behavior towards children, any involvement of the children in their conflict, scapegoating, enmeshment, pattern of hierarchy. Overall assessment for the need of family therapy.

- Assessing their nature of willingness to maintain a healthy conjugal life-reason- whether it is their own interest or for the interest of children or both, any other reason, level of motivation of each partner behind this desire.

- Assessing their expectation from the psychiatric consultancy.

b) <u>The contents of this therapy in this regard</u>

The basic goal of the therapy is to resolve their conflict by modifying their interaction. Considering the variety of parameters of their conflict and possible psychiatric problems, this therapy will be mixture of different types of couple therapy chiefly;

Emotionally focused therapy (EFT): EFT focuses on improving the attachment and bonding between you and your partner. The therapist helps you understand and change patterns that lead to feelings of disconnection

Behavioral couple's therapy (BCT), this form of therapy involves shaping behavior by reinforcing positive behaviors that promote stability and satisfaction, while discouraging behaviors that foster negativity.

Cognitive behavioral couple's therapy (CBCT) involves identifying and changing thought patterns that negatively influence behavior.

The main techniques will be applied are:

- Getting to know self: The therapist creates a sense of safety by getting to know each partner. They work actively and collaboratively with the therapist.
- Identifying feelings: The therapist helps the partners to identify feelings and put them into words to one another.
- Exploring the past: Therapist involves exploring the client's past, since that can help the client better understanding of own fears, motivations, and behaviors in a relationship. It can also help the partners to address unresolved conflicts that affect their present.
- Focusing on solutions: Therapist works with the client and partner to resolve issues, correct negative behavior patterns, and focus on positive aspects of the relationship.
- Teaching skills: Therapist teach the partners' anger management, problem solving, and conflict resolution skills. The aim is to equip the couple with tools to help them to deal with issues as they crop up.

It needs to be mentioned here, if they have any psychiatric disorder including personality disorder, that is likely to hamper the therapeutic process and need to be addressed accordingly.

Similarly, if the children have psychiatric disorders a necessary arrangement is to be made. For the above reasons, conjoint couple therapy could be started in appropriate workable time. Additional family therapy may be necessary if indicated.

[Note: For further reading, see the Child and Adolescent Psychotherapy section in Part-2 on page: xxx. These are equally applicable in general psychiatry.]

Chapter 10: Exercise for self-practice

1. A 30-years-old man brought to a psychiatric emergency who is mute and stupor. On examination, marked negativism was found.
   Applying your clinical judgment, answer the following.
   a) Make a list of points for quick assessment of this case.
   b) What treatment will you provide in this state?

2. A-50-year-old man attends for psychiatric consultation who has marked sleep disturbances, amotivation, disengagement, inattention, difficulty in completing normal tasks and marked irritability. He had suffered with COVID 19 and was hospitalized for 2 months.
   Based on your logical deduction of the given information─
   a) What is your differential diagnosis that explains best his condition?
   b) List the information you need to gather for diagnostic confirmation and treatment planning.

3. A-40-year-old male appears for psychiatric consultation who is a case of schizophrenia in a burned-out state. Despite long treatment, he responds poorly. He shows incongruous affect and incoherent speech.
   a) Mention your core assessment plan.
   b) What possible treatment options will you offer for this case?

4. A 26-year-old woman brought to you who is violent, refuses to take food, and lacks sleep and self-care. Parents report that she has suddenly broken off her long relationship one week back. Three days back, she blames her mother for her misfortune and repeatedly utters to her father to divorce her mother at once. Father is surprised by her talks and tries to make her calm. She becomes furious and has started breaking household things. Subsequently, they find it too difficult to control her. She has a younger brother with schizophrenia.
   a) How would you proceed to assess this case?
   b) Outline the management plan with explaining the reason for compulsory admission for this case.

5. A 29-year-old male has been brought to psychiatry OPD by family members who suddenly became apprehensive one month back. Subsequently he develops frequent excitement and lack of self-care. He has OCD with religious obsession and rumination for 3 years. The man continuously mutters with low pitch speech.
   Based on your logical deduction of the given information ─
   a) What is the best possible differential diagnosis?
   b) Make a checklist of information and investigations for diagnostic confirmation and intervention planning.

6. A 24-year-old woman presents with marked incoherence, fit, odd behavior and outgoing tendency for 6 weeks immediately after her marriage developed in the face of attempting sexual act; The symptoms are rapidly increasing with addition of incongruous mood and total lack of self-care.
   Answer the following based on your logical deduction of the given information.
   a) What is the most likely diagnosis?

b) What information do you need to gather for a comprehensive treatment plan?

7. A 36- year-old male has been admitted for his recurrent manic episode despite continuing treatment. During the phase of increasing good response, he becomes confused and restless for 2 days that are worsening. Urgent investigation revealed HB- 10mg/dl, ESR 47 mm Hg after 2 hours, TLC 4,000/cumm, Na+ 128 mmol/L, Cl- 82.3mmol/L and K+ 3.4 mmol/L.
   a) What is the best possible explanation of this condition?
   b) List steps of your action plan.

8. A 44-year-old male with schizophrenia in partial remission was under clozapine therapy is admitted in a psychiatry unit due to relapse. Gradually, this dose has been increased to 600/day. After 2 weeks, he develops fever, tachycardia, chest pain and dyspnoea.
   a) What is the single most appropriate diagnosis that explains the condition?
   b) What steps will you take at this point?

9. A 56-year-old woman with a long history of bipolar disorder who was admitted in the University hospital for electrolyte imbalance and subsequently that was corrected. She also has hypertension, renal impairment and receiving treatment. Recently, she appears with fluctuating confusion, excessive talkativeness, restlessness, insomnia, and occasional excitement. For that reason, she has been referred for psychiatric consultation.
   a) How will you proceed to assess this case?
   b) What investigations are required at this stage?

10. A 20-year-old female who is a victim of acid burn, currently stays in a community support center for such victims after discharge from hospital. She has second-degree burns on face, trunk and hand. Presently, she develops persistent insomnia, food refusal, and marked lack of self-care. For these, the center seeks psychiatric evaluation.
    Considering differential diagnosis based on your extraction from the given information—
    a) Make a checklist of information for the assessment.
    b) What treatment will you offer this woman?

11. A 48-year old man has been admitted in emergency after a road traffic accident. Three days later, he developed tremor, agitation and generalized seizure.
    Based on your analysis of the scenario—
    a) What is the best possible diagnosis?
    b) Outline the management plan.

12. A 22-year-old man is brought to emergency by his father because he is mute and doing abnormal behavior. He is drowsy with slurred speech. On examination, wide pupillary dilation was found.
    a) Based on this presentation what is the most possible diagnosis?
    b) Mention your steps for diagnostic confirmation and immediate management.

13. A 46-year-old is persistently engaged with gambling that he cannot control in any way. Gradually, he falls into huge debt for which her family is the worst sufferer.
    a) Make a checklist of information for your assessment.

b) Summarize the treatment plan.

14. A 66-year-old man presents himself for psychiatric consultation who has forgetfulness and inability to perform his daily schedule. These problems are gradually increasing and he becomes depressed and hapless about that.
    a) Prepare a list of information with the aim of etiological formulation.
    b) What scales do you need to use as part of your assessment?

15. A 22-year old student has been in psychiatric facilities with lack of interest in studies since the last 6 months. He also has frequent quarrels with his parents and headaches.
    a) What could be the differential diagnosis?
    b) What other things do you need to rule out?

16. A 35-year-old man, admitted in a psychiatric ward who suddenly became violent at his office and assaulted his boss. He talks incoherently and poorly. Your consultant asks you to evaluate the patient.
    Considering your differential diagnosis from above information, answer the following.
    a) What are the areas you need to explore to reach a diagnosis?
    b) What investigations do you need to do in the first step?

17. A 20-year-old female has been referred form an acid-burn survivors' center to psychiatry OPD who had been hospitalized for 1 month due to acid attack as revenge for rejecting proposal of marriage. She has marked fear, anxiety, impaired sleep, headache, tightness of the chest, weakness of the limbs, partial amnesia of the event, poor engagement with the daily activities and hopelessness. She looked retarded and depressed.
    Based on your logical deduction of the given information─
    a) What is the best possible single or multiple diagnosis?
    b) What information do you need to gather to confirm the diagnosis and make the treatment plan at this stage?

18. 17. A 28-year-old man is being treated for his manic episode in psychiatry OPD. On subsequent follow up it has been explored that he misuses amphetamine and cannabis.
    a) Mention the areas that you need to explore as part of your assessment.
    b) How would you manage this case?

19. A 44-year-old male referred from emergency suffering from head trauma following an automobile accident. Over the next week, he develops hallucinations, delusions, incoherence and poor verbal comprehension.
    a) What is the single most likely diagnosis?
    b) Map your management plan.

20. A 28-year-old woman appeared in psychiatry OPD with her family members who recently gave birth to a male child. She is nearly mute, takes little food, and does not sleep. She is always holding her baby in her womb and does not allow anyone to take her child from her but cares for

the child very little. She appears untidy. Considering your differential diagnosis, answer the following.

a) How would you proceed to reach a diagnosis?
b) Outline the management plan.

21. A 32-year-old man has a known case of schizophrenia for the last five years. He responds well with antipsychotics but relapses since last one month after noncompliance. He also has a similar prior history of response and relapse on several occasions.
    a) Make a checklist of the assessment areas.
    b) How will you treat this case?

22. A 28-year-old female who was delivered 6 weeks ago feels sad and has no interest in feeding the baby. She has been eating poorly and having difficulty sleeping. She feels weak throughout the day and has stopped going out of the house. She also says that the baby has evil eyes.
    Based on your logical extraction from the given information─
    a) What is the most likely diagnosis?
    b) Specify your management options.

23. A 27-year-old man was admitted to the cardiology department complaining of severe chest pain. He reports tenderness during auscultation and dizziness. All forms of cardiac examination are unable to explore any underlying cause for his pain. The medical record shows that this is the third time in the past three years he appeared for medical help at the end of Eid festival. On each previous occasion, no identifiable medical problem could be uncovered. Now, he has been referred for psychiatric evaluation.
    Based on your logical analysis and interpretation of the given information─
    a) What will be the possible preliminary diagnosis that explains best his condition?
    b) What are the areas you need to assess?

24. A 39-year-old man attends in psychiatry OPD forcefully by his wife and family members who are suspicious and increasingly violent for the last 5 years. He says that wife has intense sexual relationship with his 14-year old son that he knows from hearing the repetitive erotic conversations spreading through the sound of moving ceiling fan. As he is vocal about the matter wife tries to damage him in all ways and cleverly convinces his family members. Ultimately, all are involved in plotting against him for their gains and now want to prove him “mad”. Family members say that he drives his elder son from the house, does not sleep, beats wife, shouts and now threatens that everything must end. He looked very irritable and resentful.
    Doing your logical deduction form the scenario ─
    a) What is the single most likely diagnosis?
    b) What information you need to gather for the management of this case.

25. A 26-year-old woman has been referred from the victim support center for psychiatric assessment, who recently has been raped by her two friends 1 month back and criminal proceedings are going on. She has severe numbness, unresponsive to surroundings, nightmares, low food intake and marked lack of self-care. The girls looked fearful and depressed.
    Considering her features and the circumstantial situations in the scenario─

a) What is the single most likely diagnosis?
b) Outline your assessment with the aim of her treatment and possible court reporting.

26. A 28-year-old woman presents in psychiatry OPD accompanied by her husband who has an intrusive thought and image of husband's love relationship with a woman who has been their distant relative for the last four months. Husband disapproves of the fact saying that he has had some casual meeting and telephone conversation with his sister like a relative. The woman is worried with fearful anticipation, depressive and has repetitive suicidal thoughts.
    a) What could be the single most appropriate diagnosis?
    b) Make a treatment plan for this case.

27. A 28-year-old man attends psychiatry OPD by his parents who have autism, low intelligence and marked disruptive behaviors. Parents are sick and tired of him asking for help in any way.
    a) How will you assess the family burden for his condition?
    b) What will be the contents of your advice to the parents?

28. A 21-year-old woman with intellectual disability brought to psychiatry OPD by her father who recently becomes irritable, defiant and shows little interest in her work. Earlier, she had been sent to special school and achieved some basic vocational skills.
    Analyzing the scenario, answer the following.
    a) What is the best possible explanation of her presenting features?
    b) Outline your rehabilitation plan.

29. A 23-year-old man presents himself to a psychiatrist's chamber for his persistent feeling of detachment from surroundings, palpitation and sleep disturbances for the last 3 years. Despite all his effort, symptoms remain that make him worry and sad. Recently he had shortness of breath, and fear of losing that increased his worries.
    Based on logical deduction of the given information─
    a) What is the most likely diagnosis?
    b) Provide your treatment plan.

30. A 44-year-old woman appeared in the psychiatrist's chamber who is marked irritable, frequently outburst with tempers and has discorded relationships with almost all and prefers leaving alone. She thinks that no one loves her. She has no issue yet, has hypothyroidism and is under treatment.
    Doing logical extraction from the given information─
    a) What is the most likely diagnosis?
    b) Make a list of information required to make a treatment plan.

31. A 36-year-old married banker who diagnosed a case of OCD getting a maximum dose of fluvoxamine. She has pervasive rumination of sexual issues blended with unholy thought that result in long lasting cleaning behavior. Recently, she avoids sexual acts and becomes severely depressed.
    a) What psychotherapeutic options will you consider for her at this stage?
    b) Outline your assessment plan with the aim of selecting such options.

32. A 48-year-old man admitted in psychiatry word with major depressive disorder with catatonic state for 6 weeks. He is also a treatment refractory and nonresponsive to the main line options of medication rather deteriorating. It has been decided by the treating team to give him ECT at this state. The patient's caregivers are not giving informed consent for ECT despite repeated efforts. Answer the following providing logical deduction from the scenario—
    a) What will be your plan of action in this regard?
    b) How will you explain your action based on ethical principles?

Part 2: Child and Adolescent Psychiatry

Chapter 1: General Child and Adolescent Psychiatry

1. A 10-year-old boy appears for psychiatric consultation who refuses to go to school due to breathing difficulties and chest pain. His parents consult with several physicians including cardiologists but the problems remain. The child is clingy to his mother, increasingly fearful and feels better staying at home.
Considering the best possible differential diagnosis-
a) What information will you gather to reach a diagnosis?
b) What could be the psychopathology of his condition?
c) Outline the treatment plan.

Given information

Demography and referral
Age- 10 years
Sex- Male
Referred to-Psychiatric facility
Accompanied by- Parents
Referred for-Psychiatric consultation

Chief complaints
- Breathing difficulty and chest pain that are persisting in nature- recent onset
- School refusal due to his above-mentioned difficulties-same duration
- Marked fear and clingy to mother- subsequent duration

Extracted information

The boy's problem possibly starts during going school followed by school refusal.

His chest pain and breathing difficulty are nonorganic in nature evident by remaining of the problems despite many consultations. Rather the problem is more likely the manifestation of somatic anxiety.

The boy must have anxiety or fear related to school that manifests through school refusal and somatic anxiety symptoms.

Clingy behavior to mother, school refusal, and feeling comfort to stay at home along with child's age is very much indicative of having separation anxiety disorder.

The boy might have a fear of the classroom and school environment where she has to perform in front of others. Therefore, social phobia is another possibility. However, there is no information of such type of fear.

Any school factor can make the child fearful followed by school avoidance. Therefore, specific phobia is another possibility.

Any form of other anxiety can be the cause of his school refusal and clingy behavior. Therefore, he might be a case of another anxiety disorder that needs to be ruled out.

The boy might have a genuine cause of school refusal, like school factor- bullying, fear of a particular teacher, home factor, parental illness, stressful family event, and boy's own physical illness that need exclusion.

Assigned task

a) Information need to be gathered

From extraction of possible differential diagnoses, the following information is necessary to reach a diagnosis.

- Exploring the child's specific fear and anxiety.
- Whether the child worries that something worse will happen to either parents, particularly mother and shows distress during separation or anticipating separation-Separation Anxiety disorder.
- Whether the child is anxious in different social situations and avoids such situations-Social Phobia.
- Whether the child has any other one or more fear and anxiety provoking events.
- Whether a child is a victim of bullying in the schools or way to and from the school or any other events, whether anxiety is likely and rational to his age.

b) Psychopathology of this condition

- Anxiety provoking events causes the child's somatic anxiety symptoms like chest pain and breathing difficulties. Possibly that happens during separation with mother during school. This causes school refusal and increased clinginess to mother. As a child's principal anxiety, possibly separation anxiety persists and undresses, so symptoms persist.

- Frequent consultations ranged from GP to specialist further added distress anxiety and fear, particularly in this age and acted as a perpetuating factor.

- Parental over reaction and pattern of actions, particularly consulting cardiologist to manage the problem is very much indicative of overanxious parental attitude and child's school refusal could be strengthened by withholding.

- Persistency of the symptoms make the situation worse that cause confinement at home and disruption of usual life.

b) Treatment plan

- Explanation support and advice to the child and parents about the overall situation with special emphasis on the nonorganic nature of the symptoms and its reasons in their understandable ways.
- Explain to the parents about their role in the interventional program.
- Breath holding exercise training.
- SSRI like sertraline 25 mg can be given to reduce anxiety.
- Advice to adopt, implement feasible daily life programs.

- Adopting a back to school behavioral program, preferably direct exposure is preferable at the earliest possible time.
- Wellness treatment-peer play, home based recreational activities like drawing, reading books, watching favorite programs on the TV.
- Parenting training if the abnormal parental attitude, particularly parental overprotection is found.

[NTK
In child and adolescent clinical practice, syndrome diagnosis is not enough for effective intervention. Multiaxial consideration of related other issues like developmental, medical disorders or problems, associated abnormal psychosocial stressors or situation, disability shall be counted for the personalization of treatment plan. Further, dual or more psychiatric diagnosis is also common among children and adolescents in clinical practice that must be considered carefully. Therefore, the treatment plan for each individual case must be unique. For that multinformant, multisetting, multidimensional assessment sees necessary and intervention is likely multiprotection with multiagency involvement]

2. A 9-year-old boy became fearful and senseless after exposure to thunder 5 days back. Worried parents consult with a neurologist who refers the boy to a child and adolescent psychiatrist. Parents say that a similar event first happened 6 months back in the face of thunder. Gradually the child fears storm, cloud, loud sound, and noises and avoids such situations. Parents close doors and windows particularly during storms and thunder and give earplugs to block the noise with the aim of reducing his fear. However, these efforts do not work and the child is increasingly fearful and unwilling to go school though he is a studious boy.
Considering the most likely diagnosis based on logical extraction from the scenario ─
a) Explain the psychopathology of this case.
b) Outline the treatment plan.

Given information

Demography and referral
Age- 9 years
Sex- Male
Referred to- Child and adolescent psychiatrist
Referred by- Neurologist
Accompanied by- Parents

Chief complaints
- Fear and senselessness on exposure to thunder- 6 months
- Fear of storm, cloud, loud sound, and noises- subsequent development
- Avoidance above mentioned fearful objects and things- same subsequent duration
- Marked fear and fit on exposure to thunder-5 days
- Does not his work and unwilling to go school- recent development

Extracted information

The boy has an irrational fear of thunder and other objects and things of similar or nearly similar nature along with avoidance behavior that indicate the boy has specific phobia.

His senselessness is one of the expressions of high-end fear along with other features of psychic and somatic anxiety that are misinterpreted as fit attack by the parents. Further, these two events

senselessness resemble a collapsing state of sudden fear and there is no record of any independent fit or such history in the scenario that nullifies seizure attack further strengthened by neurologist's referral.

This fainting could be a feature of panic attack that may happen with specific phobia in face of intensive fear. As the main presentation and concern are specific phobia not the panic attack, it can be considered as a symptom of specific phobia rather than panic disorder.

Parents' anxiety about the child's problems and their subsequent help seeking behavior acts as a perpetuating factor.

Furthermore, parents' way of reducing a child's fear is inappropriate and increases both fear and avoidance behavior.

Avoidance of school and work suggestive of child's significant distress and functional impairment.

Assigned task

a) Psychopathology

- Natural unconditioned stimulus-response of thunder-fear pairing becomes conditioned.
- Stimulus generalization causes subsequent fear of storm, cloud, loud sound, and noises.
- Fear-avoidance is negative reinforcement further increased by positive reinforcement by parental over concerned behavior.
- Inappropriate help seeking behavior and medical intervention further reinforced the child's behavior.
- Strong possibility of having cognitive distortion about the overall situation.

b) Outline the treatment plan

- Explanation support and advice to the child and parents with emphasis on the nature of the disorder and reason of his senselessness, impact and intervention.
- Defining the role of parents to alleviate problems.
- Relaxation- Breath holding exercise training.
- Systematic desensitization followed by in vivo exposure.
- Wellness treatment-pear play, home based recreational activities.
- Reinstating the child's normal life.

[NTK
Psychopathology is the science and study of psychological and psychiatric symptoms. It has two major components:
i) Descriptive psychopathology or phenomenology or signs and symptoms in psychiatry
ii) Analytic psychopathology.

Descriptive psychopathology is the precise description, categorization and definition of abnormal behavior (overt or covert) of the patient. It is concerned with the selection, delimitation, differentiation and description of particular phenomena of experience, which through the use of accepted terminology become both defined and capable of repeated identification. Descriptive psychopathology is the

fundamental professional skill of the psychiatrist and possibly, the only diagnostic skill unique to the psychiatrist and provides the foundation of clinical psychiatric practice.

Explanatory psychopathology is explanations of such sign symptoms according to theoretical models such as biological (pathophysiology), psychodynamic, cognitive, behavioral perspectives and in an interrelated and interactive way. A sign or symptom either is explainable by one or by more or combined theoretical viewpoint or by can be drawn by constructing evidence based findings.

A clear understanding of psychopathology is the heart of effective and appropriate conclusions of the problem and intervention]

3. A 14-year-old boy appears in CAMH OPD who has palpitation, dyspnea, chest compression, and sweating and sleep disturbance for 9 months. Mother says that he worries for his mother and does not want to go to school for the last one month. In the last 3 weeks, the boy repetitively thinks about his past acts and upsets to find his possible faults. He worries about future events, cannot concentrate on his work and performs badly in class tests. Recently, he has been frequently irritated.
Based on your logical deduction and interpretation of the given information─
a) What is the best possible diagnosis?
b) Outline the psychopathophysiology of the disorder.

Given information

Demography and referral
Age- 14 years
Sex- Male
Occupation-Student
Referred to- CAMH OPD
Accompanied by- Mother

Chief complaints
- Physical symptoms like palpitation, dyspnea, chest compression, sweating and disturbances of sleep- 9 months
- Increased worries about many things and objects- same duration
- Not going to school - 1 month
- Poor performance in test - more or less same duration

Extracted information

This mid adolescent boy's presenting physical symptoms seem to be associated with anxiety and representative manifestation of anxiety. These symptoms are explainable as somatic anxiety.

Core feature is worriedness of diverse things later added with inattention followed by irritability. These features are the manifestation of psychic anxiety.

Worry for the mother is the recent development and not in favor of separation anxiety. Rather it can be explainable as his gradual increase of overall anxiety and might be associated with any stressors.

Intrusive thought about the past fault again part of progressive heightened anxiety and could be the real fact, not OCD features.

Worries about the feature are linking anxiety and rational not like patterned features of depression. Persistency of the present state may lead to depression.

Evidence of significant academic impairment and possibility of impairment of functioning in other domains.

Assigned task

a) Diagnosis

From above extracted information from the given information, the best possible diagnosis is Generalized Anxiety Disorder (GAD).
The key supporting information in favor of this diagnosis are:

- Free-floating anxiety of multiple events is present.
- Somatic symptoms of anxiety are present.
- Apprehensive thoughts.
- Lack of concentration.
- Sleep disturbances.
- Functional impairments present.
- Duration is almost a year.

b) Psychopathophysiology

- Activation of hypothalamo-pituitary-adrenal axis leads to somatic anxiety symptoms and psychic anxiety symptoms.
- Perceptual feedback increases further both types of anxiety.
- Persistency of the anxiety stress and possible psychosocial stressors initiates stress reaction and rerelease of stress hormone mainly cortisol and its effects over body and mind.
- Progressive heightened anxiety caused distorted cognition.
- Increasing functional impairment added more insult to the overall process.

4. A 13-year-old boy appears in CAMH OPD with his parents who has marked fear and avoid talking in the classroom for 5 months. He avoids the contact of strangers either at home and other situations. The problem is gradually increasing and he stammers in conversation with such people. Now he is very unwilling to go school and prefers studying at home. Class teacher calls on the parents and advises them to consult a psychiatrist for his problem.
Answer the following doing logical deduction from the given information.
a) What is the most likely diagnosis?
b) Prepare a checklist of information required for confirming diagnosis and making a treatment plan.

Given information

Demography and referral
Age- 13 years
Sex- Male
Occupation-Student
Referred to- CAMH OPD

Referred by- Class teacher
Accompanied by- Parents

Chief complaints

- Marked fear and avoidance of talking in classroom- 5 months
- Avoidance of the contact with strangers both at home and other situation - subsequent development
- Stammers during talking in such situation- recent development
- Unwilling to go school and prefers studying at home- most present development

Extracted information

The boy has a fear of talking in the classroom and recently has avoided going to school. He also has avoidance of strangers both at home and other situations indicate the boy has social anxiety.

His recent stammering is likely an expression of heightened anxiety during conversation with people with such fear-provoking situations rather than primary stuttering.

It is assumed that the boy has no such problem with family members at home as prefers doing his work at home. However, information is required for confirmation.

Boy possibly has no other developmental problems related with social interaction or speech as the duration of the problem is 5 months. The boy might have some temperamental traits related to these problems that need exploration.

His fear and avoidance may be associated with bullying, discord with peers or any other stressful events that needs to enquire about.

His problems and worries are gradually increasing, evident from his unwillingness to go school and the recent appearance of stammering that causes significant distress and impairment of functioning at least in his academic and social domain, further strengthened by the class teacher's concern.

Assigned task

a) The most likely diagnosis

From the above logical extraction of the given information most likely diagnosis is Social Phobia.

b) Checklist of information required for confirming diagnosis and making a treatment plan

- Onset-acute, gradual with or without any event.
- Features: Pattern, frequency, persistency, dominance, extent, and severity of presenting symptoms; other features of social anxiety- particularly places and pattern of fears- fear of performance, being observed.
- Inquiry about the causes of unwillingness to go to school- refusal (other emotional problem, avoidance, disruptive behavior).
- Any features of other anxiety disorders and depression, substance misuse-particularly sedative-hypnotics.
- Any neurodevelopmental problems associated with this feature.
- Temperament- any particular traits like shy, timid, socially inhibited.

- Psychosocial stressors- discord with peers, teachers, academic underachievement, any environmental stress.
- Efforts taken: by self, family, and school (teachers and peers).
- Impact: Distress, level of functioning in main domains of daily life- particularly, academic, peer relations and play & recreational activities and degree of burden to family.
- Risk: predictable risk of self-harm.
- Strengths: abilities and skills usable in treatment.
- Overall physical and mental health status.
- Relevant psychological testing-
  Validated Kutcher Generalized Social Anxiety Disorder Scale for Adolescents (K-GSADS-A)
  Dhaka Stress Scale- Adolescent (DSS-Ad)

  [Note: Any rating scale should not be used without adoption and validation]

5. A 6-year-old girl presents with her parents to a psychiatrist's consultation center who has not spoken at school for the last 7 months. She talks freely at home and with well-known persons. She participates in school activities and her performance is satisfactory. Despite the efforts of the teachers and parents, the problem remains.
Drawing logical deduction from the scenario─
a) What is the best possible diagnosis?
b) Outline your assessment plan for diagnostic confirmation and intervention.

Given information

Demography and referral
Age- 6 years
Sex- Female
Occupation-Student
Referred to- Psychiatrist
Accompanied by- Parents

Chief complaints
- Does not speak at school but participates in activities and talks freely at home/well-known people -7 months
- The problem persists despite of efforts of parents and teachers- same duration

Extracted information

This girl in early childhood appears not talking at school but participating in school activities. She talks freely at home and well-known people indicate she has selective mutism.

Her not talking at school may be due to social anxiety. Here, she participates in school activities and there is no school or social avoidance.

She talks freely at home and with known people and the duration of the problem is 7 months, good school performance. This information excludes the possibility of ASD, ID or language or communication problems.

It is not unlikely that the girl might have some temperamental features like shy, sensitive, and easily anxious that need exploration.

Her problem may be precipitated by any stressful life events like abuse, discord with peers or any family events that she could not cope with.

Parents and teachers are engaged to resolve that certainly a strength for intervention.

Assigned task

a) The most likely diagnosis

From the above logical extraction of the given information, most likely diagnosis is Selective Mutism.

b) Outline of the assessment plan

- Details of her mutism at school- onset, pattern, frequency, persistency, extend, and severity of presenting symptoms
- Family assessment- level of talking with family members, any recent association with the problems, family history of social anxiety, selective mutism, parental personality problems or psychiatric illness.
- School assessment- school environment, level of her participation in school activities including play, any stressful events in school, level of teachers 'understanding of the problem and willingness to support her.
- Assessment for exclusion of social anxiety or other anxiety and stress related disorders.
- Checking the milestones of all dimensions of development, any delay, catch-up for any neurodevelopmental problems.
- Temperament- any particular traits like shy, sensitive, anxiety prone.
- Psychosocial stressors- any ACEs particularly sexual abuse, enduring and recent events.
- Details of efforts taken by self, family, and school (teachers and peers).
- Impact- Distress, level of functioning in main domains of daily life- particularly, academic, peer relations and play & recreational activities and degree of burden to family.
- Strengths- abilities and skills useful in treatment.
- Overall physical and mental health status.

6. An 11-year-old girl appears in the CAMH OPD with her parents who are worried about her repetitive thoughts against God for 2 months. These problems start during reading Arabic books that makes her fearful and despite all her efforts, she cannot control the thoughts, which rather increasingly worsen. Parents say she constantly utters holy verses, begs pardon to God and frequently asks parents whether she is seen and God forgives her. On asking her parents, she says that someone in her mind tells her to think so. Anxious parents bring her to a religious healer, and after herring and seeing her, he comments it is not the act of any evil spirit, and advises to visit a mental doctor. The girl is tearful and mutters continually.
Based on your deduction forum the given information─
a) What is the most likely diagnosis?
b) What treatment will you offer to manage her problems?

Given information

Demography and referral
Age- 11 years
Sex- Female
Referred to- CAMH OPD
Referred by- Religious healer
Accompanied by- Parents

Chief complaints
- Persistent and repetitive uncontrolled thought against God- 2 months
- Persistent fear and worries about her thought- same duration
- Frequent utterance of lines from holy books, begging pardon to God, asking parents about her possible sin, and getting God's pardon- subsequent duration
- Says that she thinks so by the talks of someone in her mind- subsequent duration

Course
Acute, increasingly worse

M/S /E findings
Appearance and behavior- tearful, constant self-muttering

Extracted information
This early adolescent girl's persistency, repetitive, intrusive thoughts against God despite all of her efforts to control is likely obsessive in nature.

Her repetitive act of holy recitation, begging God's pardon is her obsessional act.

Frequently asking parents about her possible sin and receiving God's pardon are explainable as her assurance seeking behavior and her doubt about this matter as she repeatedly thinks so.

Apparently, the conviction of someone's existence in her mind with instruction like voice seems like delusion- control in nature and auditory hallucination-command in nature along with self-muttering, sudden onset with fearful reaction--all are indicative of psychosis. Her sudden appearance of obsession triggered during her reading Arabic book is not uncommon in pediatric OCD. The girl's statement of the existence of someone in her mind who tells her to think so is likely that she does not want to recognize this thought of her own, tired with inner fight and displacing this to someone else that is not unlikely at this age. Her self-muttering is explainable by covert expression of her compulsion and associated with her distress.

Jinn position state (a variant of hysteria) sometimes presents in this fashion. However, lack of other criteria and culturally explainable associated features added with religious heeler's observation do not support this diagnosis.

The girl is severely anxious and distressful of her increasingly worsening of her very sensitive and awkward thoughts which are out of her control that possibly make her helpless expressed through her tearful appearance. However, at this stage thorough checking for depression is necessary.

Checking of a prior medical condition, particularly streptococcal infection is also necessary to rule out the secondary cause of OCD.

It seems that there is a significant impact on a girl's daily life as she is most of the time preoccupied with this for the problem and burden to possibly worried and possibly puzzled parents.

Assigned task

a) The most likely diagnosis

Based on the above logical deduction of the given information. The most likely diagnosis is OCD.

b) Treatment needed to offer

General

- Explanation and reassurance to the parents and the girl in their understanding level, particularly diagnosis, nature of the disease, assessment and intervention plan.
- Hospitalization- if the problem is severe, have comorbid depression, needs crisis intervention and practicability (if they live in a rural area, difficult to stay in the city for quick follow-up).
- Maintaining adequate hygiene, diet and sleep.
- Relaxation- Breath holding exercise to reduce his inner distress.
- Active daily life programming.

Specific

- SSRI- preferably fluvoxamine (best if associated with sleep disturbances), sertraline or fluoxetine is required at this severe state, starting with low dose with gradual optimization.
- ERP- will starts after reduction of symptoms at working level
- CBT- particularly to strengthen the outcome, prevent relapse.

Working with family

Particularly helpful if such ritualistic behavior is the family religious practice.

- Establishing effective communication among family members.
- Engaging a family member as a therapist.
- Encouraging follow-up to prevent possible relapse.

7. A 12-year-old girl attends the CAMH OPD who witnessed the sudden death of her father at home 5 weeks back. Since then he has developed marked fear, irritability, bad dreams and poor sleep. Considering the most likely diagnosis—
a) Prepare a checklist of information that you need to gather during assessment.
b) Outline the contents of communication with family.

Given information

Demography and referral
Age- 12 years
Sex-Female
Referred to- CAMH OPD

Chief complaints

- Marked fear
- Irritability
- Bad dream
- Poor sleep

Duration of all the symptoms are 5 weeks following witnessing the sudden death of the father at home.

Extracted information
The symptoms of this mid adolescent girl started immediately after witnessing the death of the father that must be horrific and extraordinary stress particularly at this age.

Irritability, sleep disturbance (hyperactive arousal symptoms), negative alteration of mood persistent fear, sleep disturbances (mood symptoms) and intrusion of bad dreams (re-experiencing Symptom) are clearly indicative of acute or posttraumatic stress disorder. Considering the pattern of symptom clusters, there is a strong possibility of having avoidance symptoms.

The duration is 1 month. The diagnosis of acute stress disorder is considered up to 1 month and that for PTSD is more than one month. Therefore, considering duration, this girl is most likely a case of Post-traumatic Stress Disorder.

Assigned task

a) <u>Checklist of information for assessment</u>

- Other symptoms of PTSD

  Avoidance to the thoughts or external reminders of father
  Dissociative features
  Persistent distorted cognition
  Feeling of inappropriate guilt
  Lack of mood reactivity
  Recklessness
- Risk assessment including thoughts of joining the deceased.
- Impact of the event on other family members.
- Level and domains of impairment in comparison with her premorbid functioning level.
- Premorbid temperament.
- Strength of the girl.
- Family and other support.

b) <u>Contents of communication to the family</u>
- Intrusive thoughts are not a sign of 'madness'.
- Reassuring the child that these are normal responses to abnormal experiences.
- Other family members will be helped to acknowledge what has happened and comfort the affected individual.
- The girl should be gradually encouraged to share her memories with father (but not forced).
- She should not be forced to talk.
- Gradual resumption of normal life activities, specially schooling and academic work.
- Explaining other option of treatment:
  Drugs are not first line treatment. However, it will be given if anxiety, depression or sleep disturbance is present. Non-pharmacological measures for sleep will be applied first.
  Talk therapy- individual and family counseling, relaxation. High level of therapy like CBT- will be given if necessary
- Informing the possible outcome and comorbidity.
- Making them aware of possible risks.
- Responding to their any queries.
- Summarizing and communicating the importance of follow-up.

8. A 14-year-old boy attends CAMH OPD who presents with marked irritability and resentful. His parents say the boy is defiant, refuses to go school and does not study for 2 months. He keeps himself most of the time in his room and increasingly assaultive and destructive with minor matters. Sometimes he looks tearful and it seems to them that he does not sleep well.
Considering the most possible diagnosis through logical deduction of the given information─
a) Mention the areas you need to explore to confirm the diagnosis.
b) Outline the treatment plan.

Given information

Demography and referral
Age- 14 years
Sex- Male
Referred to- CAMH OPD
Accompanied by-Parents

Chief complaints
- Refuse to go school and do study- 2 months
- Stays in his room most of the time-same duration
- Resentful, assaultive and destructive with minor matters- subsequent duration
- Tearful sometimes- recent development
- Does not sleep well as assumed by parents- same duration

M/S/E findings
Appearance and behavior- marked irritability and resentful

Extracted information

This mid adolescent boy is persistently irritable for nearly around 2 months. Irritability is one of the presenting features of child and adolescent depression. It can also be present in any form of disruptive behavior, psychosis, anxiety and other disorders. In this case, irritability along with other related features like keeping himself confined in the room, sleep disturbance, inactivity and tearful appearance, marked functional impairment particularly in the educational domain with recent onset supports the diagnosis of major depressive disorder.

Assaultive and destructive behavior in minor matters along with irritable mood in absence of other defiant behavior indicates disruptive mood dysregulation disorder (DMDD). However, onset of DMDD is earlier, usually before the age of 10 years. Furthermore, the patterned features of depression are more dominant than disruptive behavioral features.

Resentfulness is the part of defiant behavior. Along with this, other symptoms like irritability, assaultive and destructiveness are features of oppositional defiant disorder. Here, all these are associated with minor provocation not like patterned behavior of vindictiveness and recent onset seems to be associated with mood features.

School refusal and study refusal is unlikely due to any behavioral disorder rather goes with depression and its impact evident by its association of other features of depression, recent onset at the age of 14 years.

Therefore, from above deduction and depending on the duration and other diagnostic features, the best possible diagnosis is major depressive disorder.

Assigned task

a) Areas need to be explored to confirm the diagnosis

Other features of major depression, its severity, extent and duration with special emphasis on suicidal thought for confirming MDD and its severity.

Any possible features of DMDD with special emphasis on relation between irritable mood and behavior as in this disorder, irritable mood presents between episodes of temper tantrum.

Any other emotional features particularly anxiety

Enquiry on presenting and other possible features of disruptive behavior along with its severity, extent, duration, and relation with emotional features.

Confirming onset of the symptoms that is essential to assigning particular diagnosis.

Risk assessment with special emphasis on suicidality and harm for others.

Impact assessment- level of functional impairment in all domains of everyday functioning specially with special emphasis on educational domain.

Etiological assessment- existence of any recent or enduring stressor like academic failure, school and peer factors, problems with parents, any family issues, any past emotional and behavioral problem, family history of mood disorder, substance misuse, any co morbid physical illness, premorbid temperament, parenting style.

Strengths of the boy and family.

Patient and caregivers' perception about the problems, efforts taken by them with outcome and their expectation from the facility.

b) Treatment plan

General

- Explanation support and advice to the patients and parents.
- Hospitalization, if suicidal thoughts or attempts, food refusal, needs crisis intervention or extensive assessment required.

Specific

- Drug- SSRI-Fluoxetine/sertraline/ citalopram.
- Sedative-hypnotics for short duration, Melatonin is preferable in mild levels of insomnia.
- Psychological: CBT or IPT as preferable from the assessment outcome. Others include relaxation techniques, behavior modification therapy, implementing a back to school program after significant remission.
- Social management- active daily living, stress coping, social skill training. wellness activities-like exercise as game as appropriate in mild to moderate depression or partial remission of severe depression, remedial teaching if necessary.

9. A 15-year-old girl attends Psychiatry OPD with her parents. She believes that her face has been gradually going deformed since the last three years. She does not go to school and avoids social situations as she thinks that she looks ugly and others talk about the matter. Gradually, she keeps herself confined in her room, checks her face frequently on mirrors and asks mother several times in a day despite reassurance. She shows two photos of her from her mobile captured in different time intervals in favor of her statement but no significant difference and deformity observed. She looks anxious and distressed.
Considering the most likely diagnosis─
a) Outline the assessment process to confirm diagnosis.
b) What will be your treatment plan?

Given information

Demography and referral
Age- 15 years
Sex- Female
Occupation- Student
Referred to-Psychiatry OPD
Accompanied by- Parents

Chief complaints
- Conviction and worries of gradual deformity of face despite of no such-3 years
- Avoiding school and social situation due to fear of being criticized for her ugly face as she thinks-nearly same duration
- Confined at home most of the time- subsequent duration

M/S/E findings
Appearance- anxious and distressful

Extracted information

The girl's belief of deformed and ugly face seems not to be true, evident by her two photographs of different time intervals. Psychiatric referral strengthens it further.

The girl is preoccupied about the deformity that is evident from repetitive thinking, checking on the mirror and asking mother. At this age, this type of preoccupation goes in favor of body dysmorphic disorder (BDD).

The avoidance of school and social situation can be explained by her belief, preoccupation and anxiety.

Confined at home and distress indicate increased severity of problems and disruption of daily life.

This conviction might be delusional, and can be a symptom of schizophrenia. However, any other features of schizophrenia since the last 3 years are not mentioned in the given information and her behavior, anxiety and distress can be explained by her main concern of body deformity.

This dysmorphophobia could be the expression of delusional disorder. However, at this age the onset of this disorder is unlikely.

Assigned task

a) Assessment outline

The main assessment is required confirming diagnosis. The outline of assessment areas is:

- The child's belief is confined as an intrusive thought or delusional in nature for confirming.
- Onset, duration and types of persistency of repetitive behavior.
- Level of insight about the imagined deformity.
- Checking for any other symptoms of psychosis, depression, social anxiety, OCD and related disorders for exclusion or comorbidity.
- Suicidal risk assessment- rate of suicide is high in BDD.

b) Treatment plan

Biopsychosocial approach is applied here. The components are:

- Explanation, empathy and advice to the patient and caregivers.
- Psychoeducation with special emphasis on the nature of the disorder treatment and outcome in their understandable ways.
- Relaxation Therapy- preferably Breath Holding Exercise for reducing anxiety and distress.
- Drugs- First line-SSRI preferably sertraline or fluoxetine starting with low dose and gradual optimization to highest recommended dose, if failed then another SSRI or combination with a non-SSRI.
- If not effective, then augmentation with clomipramine.
- In refractory cases augmentation with antipsychotics are indicative.
- Exposures and response prevention (ERP)- tailored to the girl's BDD symptoms. For example, exposure like going to social settings and prevention being resistant to mirror checking.
- Cognitive Behavioral Therapy (CBT) mainly with cognitive restructuring.
- Inference Based Therapy.
- Implementing a feasible active living program.
- Treating comorbid disorders, if any.

[NTK: SSRIs plus CBT is proved to be more effective treatment for BDD]

10. A 16-year-old girl attends in a psychiatrist's chamber for her worries of losing memory. She has chest compression, body ache, increased frequency of micturition and interrupted sleep for one year. Mother says she worries more for the parents and family. On questioning, the girl says she is over concerned about making and keeping friends. She worries about her past acts and future events that are intrusive in nature that she cannot avoid and cannot concentrate in her study and performs poorly in class tests. She becomes less confident and hopeless, and recently annoyed and restless.
Drawing logical points from the given information, answer the following.
a) What is the single most likely diagnosis?
b) Make a treatment plan for this case.

Given information

Demography and referral
Age-16 years

Sex- Female
Occupation- Student
Referred to- a psychiatrist
Referred by- Self and mother
Accompanied by- Mother

Chief complaints

- Palpitation, chest compression, body ache, increased frequency of micturition and interrupted sleep-1 year
- Worries of multiple activities and events predominantly memory impairment, study, past and future- same duration
- Lack of confidence and hopelessness-subsequent duration
- Annoyance and restlessness – recent development

Extracted information

The cluster of somatic symptoms seem to be associated with anxiety and certainly manifestation of somatic anxiety.

Worries many things later added with inattention followed by irritability expressed through annoyance and restlessness. All these features are a presentation of psychic anxiety.

There is enough evidence of significant distress of the girl and academic impairment and possibly impairment of functioning in other domains.

These persistent excessive worries of multiple things for one year along with associated somatopsychic features of anxiety and significant impact on the girl clearly goes in favor of generalized anxiety disorder.

The main anxiety and concern related with study and poor performance in exam. and possible worse impact in future need special attention.

Excessive preoccupation with anxiety provoking thought causes lack of attention and concentration in study that interrupts registration process. That gives her an impression of memory impairment.

She has hopelessness, lack of confidence, annoyance and restlessness. These are not the main line features and can be explained by her persistent severe anxiety and concern about poor school performance, failure to concentrate in her task and its possible worse effect in future. Furthermore, some features of depression are common with persistent anxiety at this age and anxiety disorder can be superseded by depression. This needs to be ruled out.

Intrusive and unavoidable thoughts about the past and future can be better explained by her persistent anxiety and its adverse impact over her life and not obsessive in nature.

Assigned task

a) Diagnosis

From the information of the case scenario and extracted information, the single most likely diagnosis is GAD.

b) Treatment plan

Biopsychosocial approach will be applied here. The components are:

- Explanation, support and advice to the patient and caregivers.
- Psychoeducation on the presentation, causes, treatment and outcome with special emphasis on the failure to memorize not the actual memory impairment.
- Encouraging parents for active communication with the girl, performing a daily program and providing encouragement.
- Relaxation Therapy- preferably progressive muscular relaxation alternately breath holding exercise.
- Drugs- Sertraline 25-50 mg or mirtazapine 7.5-15 mg in low dose.
- Implementing a feasible active living program.
- Encouraging wellness activities including brief physical exercise, peer play and preferred healthy recreational activities.
- CBT-if necessary

11. A 10-year-old boy referred from pediatric OPD who has acute lymphoblastic leukemia and is under treatment for the last 9 months. Mother says he gradually becomes worried, restless, defiant, argumentative, tempers, sleep disturbances, frequently complaints of chest pain, and repetitively denies going to school. The boy looks irritable.
Giving logical points for the given information─
a) What are the best possible diagnoses?
b) Prepare a list of information that you need to confirm diagnosis and treatment planning at this point.

Given information

Demography and referral
Age-10 years
Sex- Male
Occupation- Student
Referred by- Pediatric OPD
Accompanied by-Mother
Referred to- Psychiatric facility

Chief complaints

- Worries, restlessness, sleep disturbances and frequent chest pain- 9 months
- Defiant, argumentative, tempers- same duration
- Denies going to school- subsequent duration

Co-occurring physical illness
Diagnosed case of ALL, under treatment- 9 month

Extracted information

This boy of late childhood has ALL and is under treatment. At this age with this diagnosis, it is likely that this diagnosis and treatment will have an impact on a child's emotion and behavior.

His worries, restlessness, sleep disturbances and frequent chest pain clearly indicates the boy has persistent anxiety since the diagnosis of ALL. The anxiety is expected to be pervasive- like about the

illness, treatment & outcome, study, peer relations, play, future as it is expected that the boy's life will be restricted with impaired independence due to his ALL and its interventional measures where significant adjustment in daily life will be necessary. In this view, most likely the boy is a case of generalized anxiety disorder.

Gradual development of persistent defiance, argumentativeness, and tempered behavior, denial to go to school indicates the boy has oppositional defiant disorder.

The frequent complaints of chest pain along with anxiety could be features of panic disorder. However, there is no mention of such intense anxiety along with related features of panic attack.

His irritable mood and affect sleep disturbances may be the features of depression. His unwillingness to go to school may be the expression of his lack of interest and pleasure. However, no other specific features of depression are mentioned here and main line features are predominantly anxiety and disruptive behavior. Irritability is equivalent to a depressed mood in this age and can present with this child as the psychological reaction to ALL. Here, it can be considered as part of his anxiety and expression of his distress. Subsequent development of full-fledged depression can be predicted by considering all these factors.

Overall, the features indicate that there is significant impairment of boy's daily functioning, particularly in school life and peer relationship. The denial to go to school possibly due to the mixture of her internalizing and externalizing problems along with combined impact physical and mental illness on him.

Assigned task

a) <u>The best possible diagnosis</u>

Based on the above extraction of the given information the best possible diagnoses along ALL are ODD and GAD.

b) <u>List of information needed to confirm diagnosis and treatment planning at this point</u>

- Checking the documents related to ALL and its treatment including hospitalization, effects and side effects of medication to know the present status of these.
- Going through the referral note to know the boy's psychiatric status as noted and the specific reason for the psychiatric referral.
- The list of the events, activities and situations that the boy worries about and its sequential development; frequency, severity, persistency of the worries.
- Identifying the somatic symptoms of anxiety that are expected to be present along with presence of unexplained somatic symptoms.
- Inquiry about any feature of panic attack, especially the boy's statement about chest pain.
- Any feature of depression, particularly onset, frequency and persistency and reason of his irritability and if any frustration and discouragement related to outcome of ALL treatment, school, peer relationship difficulties.
- Listing the features of ODD /CD and its sequential onset, frequency and persistency.
- Enquiry about the boy's denial to go to school- whether it is part of defiance or has any other reason.
- Assessing the impact of the problems on the child, particularly in learning, peer relaxations, any imposed restriction, home life.

- Burden to family due to his ALL along with emotional and behavioral problems. Temperament of the child and any recent changes in temperament- like isolation, easily stressed, withdrawal from new things.
- Strengths of the child in the form of specialties, abilities and skills that are usable in the treatment.
- Perception of the child and parents about the problems and their expectation for the facilities.
- Level of family support.

12. A-14-year-old girl attends a child and adolescent psychiatrist's consultation center who has persistent irrational thoughts of her past and future act and possible worse versus good consequences to her and family for 9 months. It becomes so worsen and uncontrolled that she feels extreme worries and doubt about her acts, does revised acts several times and she fails to pay attention in her work and that makes her very anxious about her academic career. Scene 1 month the girl is depressed, finds no interest in anything and becomes hopeless. Her mother informs she does not sleep well, takes little food and has a persistent headache.
Based on the logical analysis and interpretation of the given information─
a) What is the best possible dual diagnosis?

b) Prepare your interventional plan.

Given information

Demography and referral
Age- 14 years
Sex- Female
Referred to- Child and adolescent psychiatrist
Referred by- Parents
Accompanied by- Mother

Chief complaints
- Persistent irrational and uncontrolled thought of her past and future act and possible worse and good consequences to her and family - 9 months
- Persistently increased doubt her acts and repetitive revisions of that- subsequent duration
- Persistent increase of worries with the thought and act that becomes worsening- same subsequent duration
- Failure to focus attention in her work that makes here marked anxious about her academic career- subsequent duration
- Depressed, lack of interest in anything, hopelessness, decreased sleep and appetite and headache- 1 month

Course
Gradual, increasingly worse

Extracted information

This mid adolescent girl's persistent, irrational and uncontrolled thought of her past and future act and possible worse and good consequences to her and family is clearly obsessive thought rumination in nature that further added with doubt about her past act.

Repetitive revisions of her performed act come from her doubt blended with initial rumination of possible consequences of her act is her cardinal compulsion.

Persistent increase of worries with the thought and act most possibly due to her increased failure to control her irrational thought for that she is compelled to revise her act.

Certainly, she is increasingly preoccupied with this obsession and compulsion that is time consuming; therefore, she fails to concentrate on her task that makes her more and more worried and distressful.

All these clearly indicate that the girl is a case of OCD severe in nature

Along with these worries, she is also worried about her academic career. Multiple worries and impaired attention are indicative of generalized anxiety disorder. However, her initial and subsequent worries are best explainable by her obsession and subsequent compulsion and its consequences and her further added worry about career is rational and expected.

Persistent anxiety is usually associated with some features of depression as its part or consequences. For one month, she has had a low mood, lack of interest in anything, hopelessness, decreased sleep, and decreased appetite- all are clearly indicative of having major depressive disorder in severe form rather than associated features of OCD or anxiety. Her headaches are explainable by her persistent anxiety or manifestation of her depression or both. Therefore, MDD warrants additional as well as presciently first diagnosis.

Here it needs to mention that at this age, common comorbidity of untreated and unresolved OCD is major depression.

Though it seems that it is not the case of stress related disorder, stressor(s) related to family or any other acute or enduring stressors can trigger OCD and perpetuate it and can lead to depression that needs exploration.

The OCD and depression may be secondary to streptococcal infection or any other GMC that needs to be assessed.

Clearly, this girl has severe distress and remarkable functional impairment and family burden.

Assigned task

a) <u>The best possible dual diagnosis</u>

Based on above logical analysis and interpretation of the given information, the best possible dual diagnosis is MDD Severe and OCD, Severe.

b) <u>Intervention plan</u>

Immediate

- Explanation and reassurance to the parents and the girl in their understanding level, particularly dual diagnosis, nature and relation between two disorders and added impact, assessment and intervention plan and possible outcome.
- Hospitalization- as both the disorders are severe enough, and if suicidal risk, poor nutritional status and or needs crisis intervention.
- Monitoring the vitals.
- Maintenance of adequate nutrition and sleep and hygiene

- SSRI- preferably fluvoxamine (effective for sleep), sertraline or fluoxetine with adequate dose and duration as it works both OCD and MDD.
  TCA- alternatively, clomipramine starting with low dose with gradual optimization.
- Sedative-hypnotics- if required or as adjunct.

Subsequent
Psychosocial intervention-will start after reduction of symptoms at working level
- ADLP- initially low followed by increased responsibility.
- Relaxation- Progressive muscular relaxation is the choice to reduce her anxiety and headache.
- CBT- will be most effective in both the disorders.
- Extended CBT by incorporating ERP will be applied if necessary.
- Stress management- for resolution of existing any stressors and increased coping ability.
- Problem solving skills- if necessary.
- Family counselling- for increasing support and effective communication.
- Family therapy- if indicated.
- Planning for rehabilitation including remedial teaching.

13. A 18-year-old-boy was diagnosed with schizophrenia 3 months back in psychiatry OPD. His symptoms are significantly reduced with risperidone 6 mg/day. During follow-up, his father reported gradual reappearance of symptoms for the last 2 weeks.
a) Mention the areas with reasons you need to assess for further treatment planning of this case.
b) Specify your intervention plan.

Given information

Demography and referral
Age- 18 year
Sex- Male
Attends to- Psychiatry OPD
Reason of attendance-Follow-up
Accompanied by- Father

Chief complaints
Reappearance of his schizophrenia symptoms despite achieving good response under treatment- 2 weeks.

Present psychiatric diagnosis
Schizophrenia, diagnosis assigned 3 months back
Treatment
Getting risperidone 6 mg/day, is in the state of remission, now relapsing

Extracted information
Considering the age of the boy, the disorder can be said to be early onset. Possibly this is the 1st episode.
Course is an acute episode with partial remission & again relapsing.
Reappearance may be due to the normal course of schizophrenia, truer for early onset.
Having good family support as evident from initiation of early treatment and adherence to treatment.
Strong possibility of having one or more stressors with the boy.

Possibility of having significant impact on academic, family and social domain.

Assigned task

a) Areas need to be assessed

- Checking whether a patient is adherent to treatment; especially who is assigned for the task and whether the patient takes drugs on his own.
- Finding out any continuing or new psychosocial stressors with the child, particularly about study, exam, high expressed emotional effect, stigmatizing insulting comments.
- Assessing the nature, severity, extent of the recurring symptoms and any anxiety or depressive symptoms usually develop at the time of remission. Sometimes behavioral symptoms can appear as a consequence of dealing with a patient.
- Reassessing the severity, extent & pattern of symptoms. Which symptom appears first? Comparing current symptoms with previous symptoms.
- Assessing for any possible side effect profile for that there may be noncompliance.
- Reviewing the diagnosis- in first episode diagnosis may change in many cases (e.g. bipolar disorder, conversion disorder as psychotic presentation).
- Assessing for any psychiatric co-morbidity and co-occurrence of physical disease.
- Any current substance abuses. e.g. hallucinogen, cannabis, amphetamine, ecstatic.
- Pattern of active daily living- under or over stimulating environment.
- Reassessing patient's strengths for utilizing these in intervention.
- Reassessing the patient's state of impairment & burden on the family.
- Listing the bad & good prognostic, risk & resilience factors.

b) Intervention plan

- Explaining the overall situation with special focus on the reason for recurrence of symptoms and informing that it could have happened as part of the course of the disease. Informing interventional plan.
- If non-adherence, applying means for improving compliance with the same dose.
- Resolving identified stressors if any along with providing anticipatory coping technique.
- If adverse effects are bothering the patient, managing accordingly.
- If good compliance, increase the dose of risperidone gradually to maximum therapeutic dose and monitor adverse effect profile. Sometimes, adolescents need greater doses along with individual variation of response.
- Switching to other medication will be considered as per protocol if there is no adequate response.
- Addressing the issues of comorbid substance misuse, any other comorbidity or co-occurrence.
- Psychological management: psychoeducation, family therapy, CBT, cognitive remediation.
- Social management: active daily life programming at optimum level, social skill training if appropriate.

14. A 12-years-old boy referred to psychiatry OPD from medicine OPD with the complaints of persistent episodic cough and dyspnea. A series of consultations done from GP to specialists. He has been treated with O2 inhalation and a number of oral and inhalers bronchodilators and steroids but

there is no response. The boy is not going to school but is studying at home. The episode particularly started when he was asked to go school.
Considering possible diagnosis on the basis of your logical deduction form the given information─
a) What are the areas you need to assess?
b) Make a treatment plan for this boy.

Given information

Demography and referral
Age- 12 years
Sex- Male
Occupation- Student
Referred from- Medicine OPD
Referred to- Psychiatry OPD

Chief complaints
- Persistent but episodic cough & dyspnea- possible long duration
- Impairment: not going to school-subsequent duration

Treatment history
Seen by many physicians ranging from GP to socialist. Received oral & inhaled bronchodilators & steroids, O2 inhalation, no response

Extracted information

Patterns of many consultations and received treatment resemble that initially the boy has been considered to have respiratory disease. Possible absence of organic pathology, non-response to treatment, and nature of the episodic cough and dyspnea that particularly start during going to school generates the conclusion of the problems as functional.

These symptoms are likely non-organic supported by referral from medicine. The symptoms persist due lack proper intervention and reinforced by a series of long medical consultation and intervention and possible reinforcing behavior of the parents.

The nature of symptoms is likely the manifestation of his persistent inner distress, and the boy has a motive (possibly in unawareness) to avoid school as symptoms appear more during going school. Therefore, causes of school refusal need to be explored.

The most possible disorder with these symptoms and expected associated is conversion disorder. Other possibilities are somatic symptom disorder and anxiety disorder- particularly specific and social phobia. Other stress related disorders, disruptive behavior disorder, and early onset depression also need to be considered for exclusion.

Assigned task

a) Assessment areas

- Confirming school avoidance as school refusal or part of truancy.
- School factor- specific phobia from peers, teacher; bullying, school environment.
- Parental attitude & behavior towards the child (particularly overprotective, reinforcing undesired behavior of the child)

- Academic performance (before/now).
- Treatment history.
- Level of impairment.
- Etiological formulation
  Predisposing- academic consideration.
  Precipitating- stressful life events-relocation, change of school, family event.
  Perpetuating- persistent sign/symptoms; impairment; treatment; parental attitude.
- Temperament of the boy-easy or difficult.
- Strengths of the boy.

b) Treatment plan

General
Explanation and reassurance to the parents and the boy, particularly nonorganic nature of the symptoms, possible cause, assessment and intervention plan.
Active daily life programming.

Specific
Symptom reduction by suggestion.
Relaxation- Breath holding exercise to reduce his inner distress.
Explorative psychotherapy for identification of the causal stressor(s).
Core intervention- resolution of stressor- removal/modification or acceptance.
Behavior modification therapy- encouraging desired behavior and discouraging undesired behavior by applying or withdrawing reinforcement.
Implementing a back to school program by gradual desensitization.
Particular treatment for conversion disorder or any existing psychiatric disorder.

Preventive strategy
Improving stress coping ability of the boy.
Positive parenting with establishing sharing and effective communication among family members.

15. A 18-year-old college student has been referred to psychiatry OPD by a GP who recently becomes frightened and expresses suspicious belief. He has no previous psychiatric history. He appears bewildered and partially withdrawn.
On the basis of your logical deduction from the scenario─
a) What is the best possible differential diagnosis?
b) Prepare a list of laboratory investigations that you would consider in the first step.

Given information

Demography and referral
Age- 18 years
Sex- Male
Occupation- Student
Referred from- GP
Referred to- Psychiatry OPD

Chief complaints
- Bewildered and fearful- recent onset
- Suspicious belief-same duration

M/S/E Finding
Appearance: Bewildered, partially withdrawn

Extracted information

This late adolescent college student has a recent history of fearfulness, persecutory belief; bewilderment and partially withdrawn state indicate he has persecutory delusion and possible hallucination. As he has no past psychiatric illness, this condition is likely first episode psychosis (FEP).

At this age with recent onset, most possible causes of FEP are substance withdrawal or intoxication, schizophrenia spectrum disorder, and substance induced psychotic disorder. Psychotruma could be another cause. Secondary psychosis due to TBI or any general medical condition is also possible,

Here, history of substance misuse, pattern of onset, stressful life events, head trauma and family history of psychosis are necessary.

For the diagnostic specification, duration is the most important for schizophrenia spectrum disorder and temporal relationship between substance misuse and psychotic features or stressful life events are crucial for other disorders.

Assigned task

a) The best possible differential diagnosis
Based on above logical deduction in extracted information, the best possible differential diagnosis are:
   i. Substance withdrawal or intoxication
   ii. Schizophrenia spectrum disorder (Brief psychotic disorder/Schizophreniform disorder)
   iii. Psychotic disorder due to TBI or another medical condition
   iv. Trauma and stressor related disorder (acute stress disorder/ PTSD).

b) First line Investigations
Routine: to know the general health status
- CBC with ESR, CXR, Urine R/E
- Dope test-Urine for cannabinoids, opiates, amphetamines, alcohol
- LFT
- RFT
- Imaging of brain (to exclude TBI, organic disease if history suggests)

[NTK: D/D of bewilderment or perplexity- extreme anxiety, PTSD, acute onset psychosis]

16. A 12-year-old boy was referred to CAMH OPD from Medicine OPD for his multiple aches and pains, a few weeks after a short febrile illness. Investigation does not reveal any continuing organic pathology. The boy has been transferred to a new school shortly before illness 2 months back and because of his continuing symptoms has not yet attended school and the parents are worried about.
Considering possible explainable cause─
a) What could be the psychopathology of this case?
b) Outline the management plan.

Given information

Demography and referral
Age- 12 years
Sex- Male
Occupation- Student
Referred from- Medicine OPD
Referred to- CAMH OPD
Reason of referral- Psychiatric assessment

Chief complaints
Multiple aches and pain few weeks after a brief febrile illness- around 2 months

Treatment
Attends medicine OPD, investigation done, no abnormality detected.

Medical history
Short febrile illness few weeks before the symptoms, slightly more than 2 months back

Stressor
Transfer of school

Impairment
The boy not yet attends his new school after transfer due to his present complaints

Extracted information

This early adolescent boy has multiple aches, pain has no organic etiology, and at present, no pathological abnormality detected. His problems are likely nonorganic, further strengthened by psychiatric referral from medicine.

Her brief febrile illness happened more than two months back and symptoms developed a few weeks after the illness. There is no temporal relationship with the febrile illness and his aches and pains. His onset and continuing of S/S are less likely with febrile illness possibly that was usual sickness because of significant time elapsed after fever. Rather, the symptoms have a strong temporal relationship with transfer of school and are very indicative of nonorganic somatic symptoms of somatoform problems.

Transfer of school is usually related with other pre and post stressors like job transfer of parents, relocation, loss of previous school teachers, and friends, and of course living environments, fearful anticipation of new school and places and so on and that require coping and adjustment. Further non-school attendance of about 2 months can be the cause of his academic backwardness. With this view, the boy is most likely a case of adjustment disorder.

The boy's school avoidance is likely school refusal related to distress and other possible emotional problems, not defiance or truancy as there are no mentioned behavioral symptoms.

Other than school abstinence, engaging with medical help with the problems likely disrupts his usual activities and parental worries could be more as his complaints are not remitting and for that, and as no organic cause is identified.

Assigned task

a) Psychopathology of the case

Change of school- facing a new environment as well as absence from school for a significant period is the main stressor that causes the problems. Other possible pre and post circumstantial stressors mentioned in the extraction have cumulative effect.

The boy could not cope with the stressor(s). In childhood, any unbearable distress can either be internalized or externalized that causes emotional and behavioral problems respectively. Here, the boy's distress has been internalized.

This internalization is further expressed through the process of somatization where negative emotions or psychological distress are expressed through physically unexplainable somatic symptoms; here these are aches and pains.

Unresolved stress, medical consultation, lack of proper identification and intervention in time, possible reinforcement from parental worries are maintaining the problems.

b) Outline of management plan

Here liaison between home, school and CAMH service is required.

General

- Explanation support and advice to the child and parents about the nonorganic nature of the symptoms and its reasons in their understandable ways.
- ADLP- feasible, minimum initially gradually towards his premorbid level.
- Decreasing any reinforcement related to perpetuating the symptoms.

Specific

- Progressive muscular relaxation to reduce his pain and aches and distress.
- SSRI like sertraline 25 mg/day to reduce anxiety.
- Adopting a back to school behavioral program, preferably direct exposure is preferable at the earliest possible time.
- Support and encouragement from school to cover his academic backwardness if present. Remedial teaching- if necessary.

Preventive

- Wellness treatment-peer play, home based recreational activities like drawing, reading books, watching favorite programs on the TV.
- Stress coping- to increase the stress coping abilities of the boy.
- Parenting training if the abnormal parental attitude, particularly if parental overprotection exists.

[NTK:
In the process of normal cognitive development, stages of somatization in childhood mainly due to low verbal expression turns into the stage of desomatization at adolescence that usually persists into adulthood. In face of adverse experiences, rationalization happens in any age particularly who has less stress coping ability.
Common pathological coping: conversion, somatization, dissociation]

17. A 8-year-old boy appears with his mother to CAMH OPD who has persistently angry, resentful, and argumentative since the last three years. He does not want to go school and is reluctant to study. Mother tries to fulfil his demands and father frequently beats him to control his troublesome behavior. However, nothing works and the boy is now out of control. Very recently, he stole money from home and beat his friend.
Based on your logical analysis and interpretation of the given information, answer the following.
a) What is the most likely diagnosis?
b) Make a checklist of the areas that you need to assess to confirm the diagnosis and initiate treatment.

Given information

Demography and referral
Age- 8 years
Sex- Male
Referred to- CAMH OPD
Referred by - Mother
Accompanied by- Mother

Chief complaints

- Angry, resentful and argumentative – 3 years
- Unwilling to go school and reluctant in study- same duration
- Mother's efforts of fulfilling his demand and beating do not work- subsequent duration
- Problems are out of control of parents- subsequent duration
- Stealing money from home and beating friend- very recent development

Extracted information

Age of onset of the problems is 5 years of his age.

Angry and argumentative behavior, persistently and pervasively present in one or multiple settings for 6 months, is diagnostic criteria for oppositional defiant disorder (ODD).

Stealing and beating indicates that the boy may be developing childhood onset conduct disorder. However, stealing happens at home and beating friends occurs on one occasion, and explainable by extended features of ODD. However, this area needs exploration.

The parents show opposite reactions to the child's behavior, which is inconsistent parenting and an etiological factor for developing disruptive behavior.

Assigned task

a) Most likely diagnosis

Based on the above logical deduction of the given information, most likely diagnosis is Oppositional Defiant Disorder.

b) Checklist for assessment diagnostic confirmation and initiation of treatment

- Details of the present and other features of ODD- severity, persistency and context.
- Circumstantial information and explanation of his conduct like features.
- Enquiry about the predictors of future development of conduct disorders.
- Birth and development history- particularly level of intelligence and any learning difficulties, speech and language difficulties, hyperactivity, brain disorder.
- Temperament- difficult, socialized/unsocialized.
- Family-Child rearing practice
  Family environment (organized or disorganized), parent child interaction
  Parental attitude & behavior (authoritarian, harsh, rejecting, inconsistent, permissive)
  Parental psychiatric disorder and substance use, physical disorder-chronic, severe
  Parental criminality.
- School and peer factors- school and classroom environment, play facilities, level of boy's participation and teacher's supervision.
- Psychosocial stressors- any ACE, maltreatment, abuse or bullying, family events-domestic violence, parental discord,
- Strengths of the child- social, recreational, creative abilities or skills
- Level of family, school and neighborhood support

[NTK: four **'D's** in family history should be sought- **D**eviance and criminality of father, **D**epression in mother, **D**rug misuse by either parent, **D**omestic violence between the two]

18. A 13-year-old boy recently tried to jump from the school rooftop two times. School authorities find it hard to manage him and he has been suspended from school. Parents inform he has a fit attack 6 month back for which he has been treated but doctors find no cause for it and the attack persists on and off. Subsequently he exhibits a tendency of harmful acts but never performs any such act and becomes calm if they fulfil her need and desire. Occasionally, he lies, does not want to perform schoolwork, and is increasingly tempered.
Considering the most likely diagnosis on the basis of your logical deduction and interpretation─
a) What information do you need to confirm the diagnosis and make a treatment plan?
b) Provide your treatment plan.

Given information

Demography and referral
Age- 13 year
Sex- Male
Occupation- Student
Accompanied by- Parents

Chief complaints
- Sudden fit attack, episodic that persists on and off- 6 months
- Exhibits tendency of frequent self-harm act at home but never does act when needs fulfilled- subsequent duration
- Tries to jump from the school rooftop two times for which he is suspended- recent onset
- Occasional lying, unwilling to perform schoolwork, increasingly tempered- subsequent duration

Extracted information

This early adolescent boy has sudden fit episodes that persist on and off and for which no explainable pathology as consulting physicians says.

His subsequent tendency of exhibiting a self-harm act that he never does and managed by parents by full filing his needs and desires clearly requires attention seeking behavior and persistency for the positive reinforcement given by the parents and not actual self-harm or suicidal behavior.

This tendency of act becomes dominating and pervasive as he shows such behavior in school two times and has been suspended. This suspension may act as a further reinforcer as he now does not need to go school and that may be her desire-conscious or unconscious. This area needs exploration.

All the features indicate that the boy is a case of Dissociative disorder/Conversion Disorder.

The boy is suspended from school and has lying, unwillingness to perform schoolwork, increasingly tempered behavior---features of disruptive behavior (optional/conduct) disorder. All these are recent onset, the lying is occasional and likely confined at home and explainable as part of continuous reinforcement of parents by his demand fulfillment. However, it indicates the development of disruptive behavior disorder.

There is no such mentioned features of specific emotional disorder. Conversion disorder itself is one kind of emotional disorder and usually stress related. Here, the gradual increased pattern, severe and pervasive nature of his self-harm tendency are indicative of her persistent distress, the possibility of having any emotional problem or disorder-like anxiety and depression and development of such disorders.

His persisting nature of symptoms and subsequent added symptoms is clearly indicative that the boy has an underlying psychological distressful factor or event that is not yet resolved or addressed rather he is continuously receiving reinforcement in an increased fashion.

Clearly, there is evidence of impact of the problems to the boy at least in his educational and home life domains and likely in recreational, peer relation domains and caused significant burden to parents.

Assigned task

a) <u>Areas need to be assessed to confirm diagnosis and making treatment plan</u>

- Checking the medical record and videos and if necessary, doing medical assessment to confirm the nonorganic nature of his recurrent fit.
- Nature, types along with ABC analysis of this behavior, with particular emphasis on his recent attempt of jumping at school and clear reason for his suspension.
- Assessing to exclude any emotional (anxiety, depression) and behavioral disorder (optional and conduct) and predictors of possible developing such disorders.
- Risks-Assessment for the possible risk for the boy, family and school
- Psychosocial stressors- Identifying the main stressful event and circumstantial stressful events at home (family conflicts, abuse) and school factor (teacher's attitude toward symptoms, bullying, academic underachievement or failure) or environment.
- Reinforcement- what kind of reinforcement is the child receiving, who is giving, what is the consequence etc.
- Parental attitude and behavior, particularly the existence of overprotective parents who are giving excessive attention to the symptoms, any inconsistency between instructions to the boy or between their thought and action.
- Temperament- adaptability, peer relations, social skill and stress coping ability of the child.

- Strengths of the child in terms of special skill or abilities.
- Level of support of the family, school and neighborhood.

b) Treatment plan

General
Explanation, support and advice to the patient and caregivers.
Psychoeducation- explaining the nature of disease, cause, planned treatment and outcome in their understandable ways.
Reducing secondary gain or reinforcement by showing affection and with firm determination.
Managing over concerns and worries of caregivers, and their overprotective behavior if any.
ADLP- as feasible and targeted towards the normal level of his functioning.

Symptomatic
Suggestion- to manage his fit. Encouraging the patient if he/she does the task. Suitable relaxation techniques can be added. Here the role of the parents will be instructed.
Behavior modification therapy-for alleviating behavioral problems by using and withdrawing reinforcement.
SSRI-preferably sertraline to reduce anxiety and depressive features, if any.
Back to school behavioral program with the support from school.

Specific
Resolution of stressor(s):

Identification and resolution of conflict by removal, modification or acceptance. Helping parents and the boy in selecting a suitable option by providing problem-solving strategies, counselling.
Applying stress management techniques for other circumstantial stressors.

Preventive Measures
Providing stress coping techniques to manage any anticipatory stressor.
Social skill training.
Family counseling- for managing unhealthy parental attitude and behavior, family conflicts.
Family therapy–if indicated particularly for dysfunctional family, parental discord, ineffective sharing and communication among family members.

19. A 12-year-old boy refuses to go to his new school one month after admission. The change of school is due to family relocation from a district town to Dhaka city. The boy has good scholastic performance. He is sociable, obedient to parents. Recently, he appears to be in a low mood and finds little interest in his usual activities.
a) Mention the most likable differential diagnosis with highlighting reasons.
b) How will you manage this case?

Given information

Demography and referral
Age- 12 years
Sex- Male

Chief complaints
- Refuses to go to new school after one month of admission- 1 month
- Low mood, little interest in usual activities- recent development

Stressor
Relocation of family from district town to Dhaka city prior the complaints

Personal history
Good scholastic performance

Premorbid temperament
Sociable, obedient to parents.

M/S/E findings
Mood- Depressed

Extracted information

This early adolescent boy has school refusal after admission to a new school. There is a clear temporal relationship between the relocation and school refusal. This relocation is expectedly highly stressful because of the changing environment as well as the proportionately different environment between a small district school and school of metropolitan city added with circumstantial stressors like loss of friends, teachers, and neighborhood and that the child fails to cope.

This school refusal is likely for his emotional problems rather than his willful absence from school supported by no mention of any behavioral symptoms and his obedient, sociable temperament.

The school refusal started immediately after relocation, the duration is 1 month and his depressive feature is the recent development. All these clearly indicate that the boy has adjustment disorder with a depressed mood.

The subsequent development of low mood and marked lack of interest and pleasure indicates the boy is depressed due to the effect of adjustment failure and persistent school refusal further adding worries and disappointment for possible academic backwardness as the boy is a good student evident by his past scholastic performance. However, having full-fledged depression associated with school refusal at this age is the strongest possible diagnosis as he has two cardinal symptoms of depression and presence of other features is likely.

There is a possibility of existence of initial anxiety about all the things related with relocations before developing depression and persistency of anxiety for anticipatory things. This area needs exploration.

It is evident that the boy has significant distress and impairment of his daily functioning, clearly in his academic domain, likely in peer relations, free time activities and whole life.

Assigned task

a) The most likable differential diagnosis

Based on above extraction most likable differentials are
i. Adjustment disorder with depressed mood
- Relocation from district town to Dhaka city is a stressor
- Clinically significant depressive features
- Significant functional impairment
- Symptoms occurring within 3 months of stressor

ii) Major depressive disorder
- Low mood
- Lack of interest in usual activities
- Significant functional impairment
- Duration one month
- Stress present and likely unresolved

b) Management

Here, liaison approach of work with family, school is essential and effective.

Psychosocial
- Explain the problems to the boy and parents, providing assurance and support.
- Helping the child to understand and cope with the stress.
- Explaining the role of parents and school in this situation.
- ADLP- as feasible.
- Back to school behavioral program- gradual exposure at this point with these symptoms.
- Reducing ongoing adversities (contracting teachers to tackle bullying).
- Promoting protective factors (encouraging the child to join extracurricular activities).

Biological
Only if psychological management fails to reduce his anxiety and depression.
SSRI- Sertraline starting with low doses as required.
Applying full-fledged protocol of treatment of depression if the child has depressive disorder.

20. A 14-year-old girl comes with her mother who recently starts wetting the bed at night. Gradually, it happens most nights in a week and increases into daytime wetting. Her parents recently reconciled 1 month back after a long period of separation. Mother is anxious about her daughter's problem. Routine urine analysis reveals that the pus cell was 10-15/rph.
Drawing logical points from the given information—
a) What will be the most possible diagnosis?
b) How will you manage this case?

Given information

Demography and referral
Age- 14 years
Sex- Female
Accompanied by- Mother

Chief complaints
- Wetting bed at night, most the nights in a week- possibly 1 month
- Day time wetting- subsequent development

Recent life event
Parents reconciled 1 month back after long period of separation

Investigation
Routine urine analysis- pus cell 10-15/rph

Extracted information

This mid adolescent girl has loss of acquired bladder control at nighttime wetting followed by daytime wetting is secondary enuresis.

There is no evidence of having any physical disease, as routine urine tests are normal at this age for this enuresis or effect of medication like diuretics. There is strong indication of the nonorganic nature of this neurosis.

There is a clear temporal relationship with her neurosis and parental recompilations as both happen around the same time. Onset at this age and rapid progression from nocturnal to diurnal is certainly related to each other. However, the reconciliation of parents after prolonged separation seems like a very good entry event, which appears to be stressful for the girl and she fails to cope with it.

It is likely that during the period of prolonged separation of parents, the girl and mother developed an intimate relationship that has been disrupted after reunion of parents and their daughter does not accept it. That creates distress and as an expression of protest, the bed-wetting starts through an unaware process. Therefore, this is likely the case of dissociative/conversion disorder leading to secondary enuresis.

Apart from enuresis, the altered home environment where the girl needs to accept and adjust likely plays a critical role in causation.

It is expected that the girl should have emotional problems mostly anxiety and depression around one month and this neurosis is just a symptom of such problems or disorders. This area warrants full exploration.

Assigned task

a) <u>The most possible diagnosis</u>

Secondary enuresis / Enuresis, Nocturnal and Diurnal due to possible emotional disorder.

b) <u>Management</u>

- Explanation and reassurance to the patient and parents with special emphasis on explaining the possible underlying cause and intervention plan.
- Parent training by informing that punishment and disapproval are inappropriate and to reward her successful efforts without drawing attention to failure will be effective.
- Restricting fluid before bedtime, voiding at daytime intervals and before bedtime, taking the child to the toilet at night at regular intervals.
- Medication- Imipramine 50-75 mg maximum 3 months.
- Identifying and managing stressor related to parental separation and reconciliation is the focus of treatment. This needs to be discussed thoroughly with the girl and parents. Father needs to be involved actively with the aim of creating a healthy family environment.
- Family therapy is required in this regard.
- Specific treatment of emotional disorder- conversion disorder, anxiety and depressive disorder

21. A boy of 15 years presents in outpatient department with the conviction that he belongs to opposite sex and wish to be a girl. His parents informed that their son behaved like a girl and used to wear girl's dresses in his room.
Considering the best possible diagnosis from the given information─
a) List the areas of information you need to gather to confirm the diagnosis and make a treatment plan.
b) What laboratory investigations and rating scales do you want to do and apply at this point?

Given information

Demography and referral
Age- 15 years
Sex- Male
Referred to- Psychiatry OPD

Chief complaints
- Conviction that he belongs to opposite sex- unspecified duration
- Wish to be a girl- subsequent duration
- Behaves and dress like a girl in his room as reported by parents- same duration

Extracted information

From the above information, it is clear that the boy has strong conviction and wishes to be a girl along with related girl-like activities. These indicate the diagnosis is Gender Dysphoria.

The boy's cross-dressing may be due to getting sexual excitement as expressed as transvestism. His core belief and desire related to gender do not support this diagnosis. However, it may be present as a comorbid diagnosis that needs exploration.

It is likely that the boy has distress, possibly ego-syntonic in nature due to getting adverse responses from home, and other immediate social environments. Therefore, associated emotional symptoms related with anxiety and depression are likely.

If it was caused by genetic, chromosomal or hormonal disorder, the parents would have been reported and dysfunctional primary or secondary sexual characteristics would have been apparent.

Assigned task

a) Areas to be assessed to confirm the diagnosis and making a treatment plan

Considering this case as gender dysphoria following areas need to assess at this point.
- Onset and duration of problem.
- Clinical features
  - Marked incongruence between experienced and assigned gender
  - Strong desire to get rid of his primary/secondary sex characteristics and preference for the opposite one
  - Strong desire to be of other gender
  - Strong desire to be transfer as the other gender
  - Strong conviction that he has typical feelings and reactions of the other gender.
- Whether he gets sexual excitement or gratification in cross dressing.
- Assessing for any anxiety, depressive or disruptive behavioral symptoms or disorder.

- Level of impairment in personal, social and academic life and degree of burden to family.
- Any physical disorder (Congenital adrenal hyperplasia, Androgen insensitivity syndrome).
- Risk assessment- for possible self-harm and suicidality.
- Motivation of the boy behind the wish.
- Strengths- talent, special abilities and skills.
- Parents' perception and expectation.

b) Investigations and rating scales

Laboratory
Routine- to know his general health status
Serum Testosterone level- low level can caused increased feminine behavioral pattern

Rating scale
Will be used for assessing severity of the problems
For gender dysphoria-Validated Utrecht Gender Dysphoria Scale
For assessing anxiety- Anxiety section of DAWBA (Bangla version available)
Assessing depression-Depression section of DAWBA (Bangla version available)

[Note: Alternative validated rating scale can be used here]

22. A 10-year-old girl refuses to go to school due to breathing difficulties and chest pain. His parents consult with several physicians including cardiologists but the problems remain. The child is clingy to his mother, increasingly fearful and feels better staying at home.
Considering the best possible differential diagnosis on the basis of your extraction of the given information─
a) What information will you gather to confirm your diagnosis and to plan a feasible treatment?
b) Provide your treatment plan.

Given information

Demography and referral
Age- 10 year
Sex- Female

Chief complaints
- Breathing difficulties and chest pain
- Refuses to go to school
- Clingy to her mother
- Increasingly fearful and feels better staying at home

Duration
Not clear, seems considerably long

Treatment received
Seen by several physicians including cardiologist, no response

Extracted information

This girl with the age of late childhood has persistent breathing difficulties unexplained by the organic pathology evident from multiple consultancy and likely the somatic symptoms of anxiety.

The main problem of the girl is school refusal. Here, recurrence or first onset of separation anxiety is the most possible cause of school refusal as the girl is clingy to mother, increasingly fearful and feels comfort staying at home. Here, the girl's worry and fear related to parents needs exploration.

At this age, the most common cause of school refusal is phobia, either social or specific, related to school. Here no such type of fear is mentioned that also needs to be examined.

Adjustment disorder is another possibility due to acute stressor(s) related to family, school and immediate environment. Her inner distress is expressed in the form of somatic (dyspnea, chest pain) and psychic anxiety (fear). Here, no such stressors are mentioned.

Assigned task

a) Information need to gather to confirm the diagnosis to plan a feasible treatment

- Other symptoms of anxiety--both physical, psychological.
- Other features of separation anxiety.
- Any feature of social anxiety.
- Any specific fear in school and the way to/from the school.
- Stressors related to school factors, academic performance, peer factor, any form of abuse, bullying and school's perception about her problems.
- Any physical illness or psychiatric disorder of parents.
- Any ACE or early physical or sexual abuse.
- Any physical illness.
- Home factors- home environment, parental attitude and behavior-particularly overprotective, overconcern, nature and level of parental reinforcement for persisting the problems, parental relationship, family stressors.
- Gains-primary, secondary; any conscious motive.
- Efforts taken by parents and school to manage her problem, particularly school refusal.
- Level of support from family and school.

b) Feasible treatment plan

General
Explanation, assurance and support to the girl and her parents with special emphasis on informing treatment plan and role of parents to combat the problems.

ADLP- Starting with minimum and gradual increased responsibilities.

Minimizing any undue reinforcement particularly form parents.

Specific
Relaxation- Breath holding exercise for reducing dyspnea and chest pain.

Anxiolytic- Here peripheral anxiolytic is preferable like-propranolol- 10 to 40 mg in divided dose.

SSRI- Effective if significant somatic and psychic anxiety. Sertraline 25-50/day in starting.

Back to school behavioral program- here graded approach is likely preferable in this age and longer duration added with permanent technique of reinforcement (e.g. star chart for the present days of a week).

Reducing ongoing adversities if any with the help of family and school. Managing stressors if any.

Parental counseling- for minimizing their over concerns and perception and establishing effective communication with their daughter.

[NTK- Masquerade syndrome- intentional production of symptom related to some gain like school refusal]

23. A 14-year-old boy presents in CAMH OPD with intensive fearfulness after being violently beaten by a peer group in the school hostel one day back. After returning home, he is nearly mute except for saying that he does not want to go back to school. Mother says he stopped doing his usual activities and did not sleep last night. He is nearly non-responsive, apathetic and becomes distressful when he is asked about the event.
Based on the logical deduction of the above information in the scenario—
a) What is the best possible diagnosis?
b) Outline the management plan.

Given information

Demography and referral
Age- 14 years
Sex- Male

Chief complaints
- Intensive fearfulness after violent beating by peer group-1 day
- Nearly mute, only says, he does not want to go back to school- subsequent duration
- Stops doing usual activities- same duration
- Does not sleep last night- same subsequent duration

M/S/E findings
Appearance and behavior- apathetic, non-responsive
Mood- distressful

Extracted information

The symptoms of this mid adolescent boy started immediately after violent and brutal gang violence done by his peers in school is a severe extraordinary stressor.

He is withdrawn from usual activities and nearly mute that are dissociation and numbness or detachment. He has marked fear and he shows avoidance behavior as evidenced by his utterances that he does not want to go back to school hostel. His sleep disturbance likely part of arousal symptoms are clearly indicative of acute and severe stress related.

Other features of severe and acute stress disorder are likely present and need exploration.

The duration is 1 day. The diagnosis of acute stress disorder is considered up to 1 month. Therefore, this boy is certainly a case of Acute Stress Disorder.

Severe panic attack, state of dissociation/conversion, severe depression and acute psychotic episodes can be present with such features that need exclusion. Further, substance intoxication or withdrawal is not unlikely at this age and gender with living in a hostel with peer group involvement. Here, the confusional state can resemble extreme fear, numbness and detachment. Furthermore, substance misuse can be present as comorbidity. All these along with the cause of violent beating by peers need to explore.

Such types of problems can be caused by TBI or it can be associated with TBI, as the stress is a physical violence. Bruise or laceration may be present. Therefore, physical and neurological assessment may be required.

Assigned task

a) <u>The best possible diagnosis</u>

Based on the above extraction of the given information, the best possible diagnosis is Acute Stress Disorder.

b) <u>Outline of Management</u>

- The first step of management is crisis intervention. As the patient is unable to face the situation, he should be reassured that he does not have to go back to the school.
- Hospitalization-for crisis intervention, necessary referral for any injury or TBI, and management.
- Ensuring the safety of the patient.
- Sedative-hypnotics- for induction of sleep and tranquilization.
- SSRI- Sertraline or paroxetine is the first line drugs to reduce the symptoms will be given initially with low dose and gradually will be increased for optimization. It will also be helpful to reduce associated fear, anxiety or depression.
- Psychotherapy- after getting workable recovery, followings are the options.
  Individual psychotherapy; if the patient is prone to develop PTSD.
  Prolonged exposure therapy.
  Trauma- focused CBT can be considered.
  EMDR- alternatively it can help to prevent developing PTSD.
- Treatment of underlying substance use or other disorder as necessary.

24. Tanzila, a 15-year-old girl attends with her father and aunt who recently refuses her identity and utters by mentioning her name, “I am not Tanzila, I am another girl.” Her aunt says that for the last three months she is marked irritable, does not sleep well, take care of her very little and markedly retarded. She does not want to go school and do study saying that nothing will be gained from doing so. She is a student of a reputed school, lives with aunt’s house after the death of her mother one-year back. The girl looks tearful and is unwilling to talk.
Based on your logical interpretation of the given information─
a) What is the most likely diagnosis to explain these features?
b) How would you manage this case at this stage?

Given information

Demography and referral
Name- Tanzila
Age- 15 year
Sex- Female
Occupation- Student of a reputed school

Chief complaints
- Irritable- 3 months
- Sleep disturbance- same duration
- Poor self-care- same duration
- Retardation with scanty speech- same duration
- School refusal- subsequent duration
- Hopelessness about future- same subsequent duration
- Refuses her identity by denying her name- recent onset

M/S/E findings
Tearful, unwilling to talk

Stressor
Death of mother 1 year back

Living circumstances
Live with aunt's house after the death of the mother

Extracted information

This mid adolescent girl's complaints of irritability, sleep disturbance, retardation, and marked hopelessness and lack of self-care, pervasive anhedonia are clearly indicate that she has severe depression. Her school refusal is likely for that.

Refusal of her own identity seems that she is a case of dissociative identity disorder. In that case, dissociation one type of identity replaced by one or more types of identity. She has no such displaced identity or evidence of memory gap as she denies her identity by mentioning her name and that means she knows her identity. This denial can be explained by her extreme depression and hopelessness with the perception that she is now in a worst position that is not expected. This denial also can be the expression of nihilism and existence of mood congruent psychotic features could be possible.

Here, it can be mentioned that at this age and gender, the most common cause of school refusal is depression. Death of her mother is the highest form of stressful event for children adolescents that she experiences one since one year and her depression is possibly the continuity of initial bereavement.

She could be a case of abnormal bereavement. Here, the full-fledged depressive features develop after 3 months and that supersedes any other possibility.

Secondary depression due to general medical conditions, as hypothyroidism is not unlikely. Therefore, medical assessment is necessary.

Assigned task

a) Most likely diagnosis

From the above logical deduction of the given information, the most likely diagnosis to explain the features of this girl is Severe depressive episode/Major Depressive Disorder, Severe .

b) Management

General

- Explanation, assurance and empathic support to the girl and caregiver.
- Hospitalization- necessary at this severe state, retardation, lack of self-care with possibility of having mood congruent psychotic features, and suicidal risk.
- Maintenance of adequate nutrition, hydration and sleep and if necessary- sedative-hypnotics as PRN basis.
- Monitoring vitals, weight.
- Checking general health status- particularly for anemia, blood sugar.
- Systemic assessment for excluding any GMC particularly hypothyroidism.
- Precautionary measures for possible suicidal acts.

Specific

- Biological- here depression is severe enough with marked retardation and antidepressant should be the first step.
- SSRI is the drug of choice- fluoxetine with adequate dose and duration. Here, careful monitoring is necessary for possible side effects in the form of increased suicidal risk. Alternatively, other SSRIs, SNRIs can be given at this age.
- Antipsychotic- preferably olanzapine, if psychotic features are present.

Psychosocial

CBT is the choice because of the presence of marked negative cognitive features.
ADLP as feasible.
Managing abnormal bereavement if it persists.
Stress management- if other circumstantial stressors exist.
Back to school behavioral program- here graded approach is preferable.
Remedial teaching if necessary.
Wellness treatment- physical exercise, group play, recreational activities.
Support to family-family counseling.

[NTK:
Pediatric depressive disorder differs from adult depression in presentation. Irritable mood instead of depressed mood is common in addition somatic, anxiety and dissociative symptoms are common. Fluoxetine is the only approved drug for child & adolescent depression by USFDA. Combined antidepressants and CBT proved more effective for immediate as well as sustained effects that can prevent relapse or recurrence.]

25. A 14-year-old boy attending CAMH OPD who is defiant, frequently tempered, and impulsive, does not show any attention and interest in his work, and is recently unwilling to go to school. He steals money from home, beats younger sisters and is aggressive to parents if they try to control him. His school performance gradually became poor in the last few years and teachers complained several times about inattentiveness, restlessness and creating disturbances in the classroom. The boy says nobody likes him either at home or in school and feels sad.
Giving logical points from the given information answers the following.
a) What are the most likely diagnoses?
b) Map your treatment plan.

Given information

Demography and referral
Age- 14 years
Sex- Male
Occupation-Student
Referred to- CAMH OPD

Chief complaints
- Inattentive, restless and creates disturbances in classroom - for few years
- Defiant, frequently tempered, and impulsive-subsequent duration
- Steals money from home, beats younger sister, aggressive to parents- subsequent development
- Does not show any attention and interest in his work unwilling to go to school- recent development
- Progressively deteriorating of academic performance- for few years

M/S/E findings
Mood- Depressed
Thought- says nobody loves him at home and in school

Extracted information

Persistent inattentive, restless and creating disturbances in the classroom and inattentiveness in his work and impulsive behavior at home for possibly many years clearly indicates the boy has hyperactive disorder in early life, severe in nature.

Subsequent complaints of defiance, frequent tempered behavior, impulsivity show that the boy has oppositional defiant disorder results from externalization of his ADHD.

Added disruptive behavioral symptoms of impulsivity, stealing money from home, beating younger sister, aggressiveness to parents, unwillingness to go to school apparently indicative of conduct disorder. Impulsivity is also a cardinal feature of hyperactive disorder. Here, the stealing is only at home, beating sister is likely his annoyance and aggression to parents clearly due to parental efforts to control him and the expression of his argumentative and impulsiveness rather than deliberate awkward behavior exclude the diagnosis of conduct disorder. However, there is a strong possibility of developing conduct disorder in the near future.

His unwillingness is likely due to persistent failure to concentrate on his task and progressively poor performance that explain his recent loss of interest in academic activities and going school added with possible rejection by peers and teachers due to his hyperactivity and other troublesome behavior.

His recent loss of interest in his work, sad mood and belief that nobody like him are the features of depression. There are other symptoms of depression. Because of his persistent hyperactive and disruptive behavior, these features are expected. His lack of interest is only with his academic activity, as he cannot perform, his belief unlinking by others clearly related with resultant negative attitude of others about him that makes him sad. The combined and cumulative effect and impact of both disorders and negative reaction persistently ongoing vis a vis that corner the boy and directs towards internalization. Here, there is a curtained possibility of developing full-fledged depression.

Though there is no such evidence, the boy might have any associated learning disabilities- like dyslexia, or low intelligence that need exploration.

There is clear evidence that a child has severe distress and functional impairment almost in all domains, particularly in his academic domain.

Assigned task

a) Most likely diagnoses

On the basis of above extraction and given information the most likely diagnoses are dual diagnosis: ADHD and Oppositional Defiant Disorder

b) Mapping of treatment plan

To implement an effective treatment plan, the liaison among home, school and CAMHS is essential. With this view, mapping of the treatment is as follows:

General
Explanation, support and advice to the child and parents and teachers (here, organizing meeting with the teachers is necessary)

Psychoeducation- nature course and prognosis of both disorders, with special emphasis on combined effect, impact of the disorders on the child, burden to caregivers and teachers, and possible future comorbidity and adulthood continuity, planned treatment and outcome. It is expected that the boy at this already understands the existence of possible problems and will be able to understand clearly.

Regular school attendance with the support of parents and teachers.

Specific

The boy focused
Stimulant- to manage his ADHD. First line-methylphenidate is the choice- initially shot acting followed by long acting. Alternatively, mixed salts of amphetamine and dexamphetamine.
As second line- atomoxetine, bupropion, venlafaxine, clonidine.

Maintenance of feasible daily routine with joint agreement with parental supervision and support.

Behavior modification therapy-for reducing his oppositional features.

Problem solving skill training and social skill training- for increasing sustained relationship with his peers, teachers, parents and siblings.
Individual psychotherapy with mixed ingredients of CBT, stress coping, mindfulness.

The family focused
Family counseling- for increasing desired parental attitude and behavior, effective communication and sharing among family members.
Positive parenting- is the primary treatment utilizing child management skills and careful assessment of family interaction.

Family therapy- if family are dysfunctioning or has other indications.

The school focused
Increased supervision and encouraging regular school attendance and engaging in school activities

Applying management strategies by teachers through positive reinforcement.
Preventing measures for peer rejection in the classroom or playground.

26. A 13-year-old boy attends CAMH OPD with his parents. Parents say that the boy leaves home without informing parents for one day on the first occasion and 65 days on the second occasion. Parents also informed that though he has good intelligence he is reluctant to study. He has no friends and becomes isolated. The boy says his parents give excessive pressure for study that he cannot carry out.
a) What are the differential diagnoses?
b) What information do you need to gather for the diagnosis?

Given information

Demography and referral
Age- 13 years
Sex- Male
Referred to- CAMH OPD

Chief complaints
- Stays outside home without informing parents
- Reluctance in doing study

Premorbid temperament
Has no friend and becomes isolated

Intelligence
Good

Extracted information

Possibilities are Conduct disorder, oppositional defiant disorder or intellectual disability. However, as the parents claim the boy is intelligent, ID can be ruled out after having other relevant history. Again, as law breaking activity is present, ODD can also be ruled out.

Assigned task

a) Differential diagnosis

1) Conduct disorder (unsocialized) because the child has stayed outside home on 2 different occasions (once for 65 days), reluctance to do study which signifies disobedience and he has no friend which indicates unsocialized behavior.

2) Oppositional Defiant Disorder.

b) Information need to be gathered

- Age of onset
- Other problematic behaviors- defiance, argumentative, vindictiveness, predominant mood

- Persistency of behavior
- Situation specific behavior
  Home- stealing, lying, disobedience, verbal or physical aggression
  School- truanting, delinquency, vandalism and recklessness
- H/O drug abuse
- Aggression to people and animals
- Destruction of property
- Deceitfulness or theft
- H/O serious violations of rules
- Lack of emotion
- Family type and pattern of interaction in family
- Family H/O psychiatric disorder

27. A 15-year-old girl is heavily engaged with adult internet chatting and left home with one of her boyfriends with handsome stole money. Her mother died two years back and caregivers try to provide her maximum comfort in all the ways. She gradually becomes impulsive, irritable and does as she likes. Her school performance has been downgraded significantly.
Considering the most possible diagnosis on the basis of your extraction─
a) Provide your assessment to reach the diagnosis and treatment planning.
b) What management will you provide for this girl at this point?

Given information

Demography and referral
Age- 15 years
Sex-Female

Chief complaints
- Heavily engaged with adult internet chatting- duration not mentioned, possibly long
- Left home with one of her boyfriends with good amount of stole money- same duration
- Impulsivity, irritability, stealing, does whatever she likes- subsequent duration
- Significant down gradation of school performances- gradual onset

Associated main stressor
Mother died 2 years back

Extracted information

This late adolescent girl has impulsivity, irritability, stealing, reckless behavior, adult internet chatting, and left home two times with her boyfriend and likely engaging in sexual acts clearly indicates that this girl is most likely a case of conduct disorder. Further information of the onset, types, and frequency of troublesome behavior along with clear duration is necessary to confirm the diagnosis. Because at least 12 months duration of troublesome behavior and 6 months persistency of awkward behavior is necessary for the diagnosis.

This girl could be a case of oppositional defiant behavior as she has marked defiance, evident from ‘does what she likes’ behavior, engaging in internet chatting, annoyance in the form of irritability, possibly stealing happened from home. However, her internet chatting with adults, stealing handsome money purposefully, leaving home with her boyfriend, and possible sexual activity are clearly violations of social norms thus, nullifies this diagnosis.

This case may be an internet use disorder, as she is heavily engaged with the internet and possibly most of the times in a day. However, this engagement is related to adult chatting as part of her serious disruptive behavior.

Heavy internet chatting is also indicative of her group involvement and strong possibility of having substance misuse at this age, gender and circumstances as a comorbidity.

It could be that after mother's death two years back, father and family members fail to care, share and guide and supervise her appropriately and this severe stress and post stress matter caused them to develop conduct problems. With this view, the onset and duration of these symptoms could be within a maximum of 2 years.

Her irritability, bereavement, and possible loss of interest at least in school work are also indicative of her depression. This area needs thorough exploration.

There is clear evidence of gradual impairment of her academic functioning and likely in her daily activities and home life.

Assigned task

a) Assessment plan to reach the diagnosis and treatment planning

Details of onset, types, frequency, severity and persistency of her present and other disruptive behaviors.
Inquiry about her internet chatting behavior.
Checking for grief reaction, complex bereavement and features of depression.
What is the reason behind recent deterioration?
At this point, who are the main caregivers and main attachment figures and details of their attitude and behavior including their efforts to control her behavior?
Medico legal issues- Information about the boyfriend, how the girl left home, how long she stayed.
Other behavioral problems requiring attention (e.g. substance abuse, promiscuity, sexual act).
Past and current academic performance social circumstances.
Risk assessment- risk of suicide & self-harm and further promiscuity, and harm for others.
Strengths assessment- abilities and skills, extracurricular activities.

b) Management will you provide for the girl at this point

General
Explanation, support and advice to the girl and her caregivers about the nature, course and outcome of the disorder and its combined effect over the girl and family, planned treatment and possible outcome and role of the caregivers at this point and future.

Alternative living placement – in a community safe house if crisis intervention and safety of the girl require. Hospitalization is necessary if there is suicidal risk.

ADLP- as feasible gradually incorporating her academic and healthy peer relations and free time activities.

Specific

The girl focused

Management of internet misuse- by applying restrictive schedules with encouragement and reinforcement.
Anger management training.
Individual psychotherapy focusing on positive behavior.
Atypical APD for reactive aggression. Alternatively, preferable mood stabilizer.
SSRI for depression or mixed features of conduct and emotion.
Treatment of substance misuse if present.

The family focused
Family counselling for providing support for them, encouraging effective communication and creating a desired attitude and showing such behavior to her.
Caregiver training program- educational and behavioral approach.

28. A 17-year-old boy attended CAMH OPD by his father who was charged for snatching 2 months back. From his early life, he is increasingly defiant, argumentative and unwilling to do his work. The parents frequently beat him to control his behavior. Gradually, he starts lying, often steals money and items of peers, becomes aggressive, and threatens others, left form class several times for that suspended from school and parents fail to do anything. For the last 6 weeks, he keeps him isolated in his room, does not sleep, talks and eats very little, lies in bed. Very recently, he attempted suicide by hanging.
Based on your logical extraction and interpretation, answer the following.
a) What are the most possible dual diagnosis?
b) What treatment will you offer for this case at this point?

Given information

Demography and referral
Age- 17 years
Sex- Male
Occupation-Student
Referred to- CAMH OPD

Chief complaints
- Increasingly defiant, argumentative and unwilling to do his work-long duration from his early life
- Persistent lying, stealing from school, aggressive, threats others, deliberate living from class- subsequent duration
- Suspended from class- subsequent event
- Charge for act of snatching- 2 months
- Keeps him isolated in his room- 6 weeks
- Does not sleep, eats little- same duration
- Talks little, lies in bed- same duration
- Attempted suicide by hanging- very recent event

Parental attitude and behavior
Harsh, ineffective to manage his behavior

Impact
Significant impairments of functioning

Extracted information

This late adolescent boy has persistent defiance, argumentative and unwilling to do his work for his early life clearly indicative of having oppositional defiant disorder.

Subsequent gradual increased symptoms of lying, stealing, aggressiveness, bullying, truancy, and recent snatching acts are the features of conduct disorder developed as a continuum of his ODD. Here, ODD diagnosis superseded the diagnosis of CD.

His self-isolation, insomnia, psychomotor retardation, pervasive anhedonia since last 6 weeks added with and very recent suicidal act by hanging indicate that this boy has major depressive disorder with enough severity.

The boy might have a stress related disorder, like acute stress disorder or PTSD. However, lack of evidence of such mentioned symptoms do not support such diagnosis.

At this age and gender with severe disruptive behavior there is a strong possibility of having substance misuse that needs exploration.

Though there is no such evidence, the boy might have additional learning disabilities that need exploration.

There is clear evidence that child has severe distress and functional impairment almost in all domains,

The efforts taken by parents are hostile that likely do not work and the boy is now out of their control. Suspension of school also did not work. All these are related to aetiology.

Assigned task

a) Most possible dual diagnosis

On the basis of above extraction and given information the best possible diagnosis are dual diagnosis: Conduct Disorder and MDD, Severe.

b) Treatment plan at this point

General
Explanation, support and advice to the child and parents about the nature, course and outcome of this disorders and its combined effect on this boy and family.

Hospitalization- necessary at this severe state of depression with retardation and dangerous suicidal attempt with inadequate sleep and diet intake- sedative-hypnotic is required here.
Precautionary measures for any further suicidal attempt.

Twenty-four hour direct and video monitoring of his behavior.

Monitoring vitals and body weight.

Checking general health status- and if necessary IV infusion.

Checking for excluding any GMC particularly hypothyroidism.

Specific

Biological- here depression is severe enough with marked retardation and antidepressant shall be the first step.

SSRI is the drug of choice- fluoxetine with adequate dose and duration. Here, careful monitoring is necessary for possible side effects in the form of increased suicidal risk. Alternatively, other SSRIs, SNRIs or TCA can be given at this age in hospital setup.

Psychosocial
The measures will be applied after remission of symptoms in a workable state.
ADLP as feasible.
CBT or IT as indicated.
Family counseling- for supporting the family, changing their hostile attitude and behavior, and establishing effective communication and sharing with the boy.

29. A 15-year-old girl appeared in a child and adolescent psychiatrist's consultation center who has had a headache for the last 3 years with waxing and waning courses that have no explainable pathology. For the last 3 days, her headache has been intense followed by repetitive fits when she saw her father slap her mother during a row.
Considering the most likely diagnosis based on your logical deduction of the given information─
a) Make a checklist of content of assessment of this case.
b) Outline the treatment plan.

Given information

Demography and referral
Age- 15 years
Sex- Female
Referred to- Child and adolescent psychiatrist's consultation center

Chief complaints
- Headache with waxing and waning course with unexplained pathology -3 years
- Intense headache followed by repetitive fit attack- 3 days

Precipitating factor
Witnessing father slapping her mother

Extracted information

This late adolescent girl has waxing and waning headaches for long 3 years without no known organic pathology clearly indicates that the girl has somatic symptom disorder likely predisposed, precipitated and perpetuated by persistent family conflicts.

Here, recent intense headache immediately followed by repetitive fit attack during witnessing harsh parental discord 3 days back indicates the addition of the diagnosis of conversion disorder and most likely not an epileptic fit or having any explainable organic pathology.

Here, the main issue is the family factors added with possible girl's temperamental factors that cause the internalization of her distress need to explore and manage.

In this long duration, there may be any anxiety disorders, particularly generalized anxiety disorder and depressive disorder that need exploration.

Certainly, there is significant functional impairment particularly in her academic domain and burden to parents that needs thorough assessment.

Assigned task

a) Checklist for assessment

Considering above diagnoses and etiological factors from the extraction,

- Detailed history about her persisting headache and treatment, recent intense headache and repetitive fit attack to confirm its nonorganic nature.
- Detailed description of the immediate stressor and pre-post events.
- Searching for features of anxiety and depressive disorder.
- Presence of any ongoing stressor- parental discord, unhealthy parental attitude and behavior, parental physical or mental disorder, any academic stressors of the girl.
- Level of impact of the problems over the girl and family.
- Premorbid temperament of the girl- sensitive, poorly expressive, peer relationship, and low
- stress coping ability.
- Family structure and dynamics.
- Relationship between child and parents and with other members.
- Child's social circumstances (e.g. school, peer group, any relationship issues).
- Presence of perpetuating factors and secondary gains.
- Patient and the family's perception about the disease.
- Expectation of the patient and the family.
- Strengths of the child-special abilities and skills.

b) Treatment plan

General
Explanation, reassurance and empathic support to the girl and parents, particularly informing cause and effect of the unbearable psychological factors and progression of somatic symptom disorder to conversion disorder, impact and burden, treatment and outcome.
ADLP- as feasible towards normal level.
Minimizing undue reinforcement- Encouraging desired behavior and discouraging undesired behavior by applying principles of behavioral therapy.
Relaxation- for decreasing her inner distress, anxiety.

Specific for conversion disorder
Symptom reduction by suggestion.
Core management- explorative psychotherapy for identification of the stressor and removal/modification or acceptance of the stressor by the patient.

Specific for Somatic Symptom Disorder
Cognitive behavioral therapy
- Cognitive: Patient will learn how stress and conflict translate into somatic illness. Negative thoughts about disease will be examined and altered.
- Behavioral: relaxation and biofeedback techniques.

Others
Back to school behavioral program if school refusal.
Treatment of any other anxiety or depressive disorder, if any.

Preventive strategy
Improving stress coping ability of the patient.
Family Counselling- for creating healthy home milieu, parental attitude and behavior, effective sharing and communication among the family members.
Family therapy- for persistent parental discord, and dysfunctional family.

30. A 4-year-old boy is referred to CAMH OPD from pediatric neurology OPD for stunted growth and marked language backwardness inappropriate to age for which no organic etiology was identified. Considering most likely cause of the child's problem on the basis of your logical deduction of the given information─
a) Outline your assessment plan.
b) What intervention will you offer for this case?

Given information

Demography and referral
Age- 4 years
Sex- Male
Referred to- CAMH OPD
Referred from- Pediatric neurology OPD
Reason for referral-likely psychiatric evaluation of the problems and management

Chief complaints
- Stunted growth- possibly long duration
- Marked language backwardness inappropriate to age- possibly subsequent duration
- No organic etiology found for these problems

Extracted information
As the child is stunted and has delay in speech development without apparent organic cause strengthened by pediatric neurology referral, the most probable diagnosis is psychological short stature syndrome (PSSS). Non-organic failure to thrive (NOFTT) is diagnosed when the onset is before 3 years. Therefore, onset and exact duration need confirmation.

This child may have associated attachment problems or disorder due to the strong possibility of having insecure attachment that needs exploration.

It is likely that there is a serious problem in child rearing and signs of child neglect. Here, the mother possibly has either physical or psychiatric problems.

Though it is nonorganic, persistency of the reasons and lack of intervention will certainly make the condition irreversible at this age and has serious adverse impact on brain and physical, social and cognitive development.

Assigned task

a) Assessment plan

Child

- Birth and developmental history (cognitive, motor, social, emotional and speech).
- Rechecking body weight, height and growth chart plot (usually the PSSS children are below 5th centile for weight and height).
- Rechecking the child's speech and nonverbal communication.
- Checking for other neurodevelopmental problems or disorders.
- Checking for any emotional and behavioral symptoms for reactive attachment disorder or disinhibited social engagement disorder.
- Eating and sleep patterns.
- Pattern of play.
- Any history or sign of physical abuse.
- Temper tantrum and any other emotional and behavioral features.
- Temperament- difficult or easy.

- Risk assessment-possible immediate and ultimate impact.

Family

- Details of caregiver and child rearing practice.
- Attachment- primary attachment features, type of attachment- secure or insecure, other attachment figures and degree of attachment.
- If the mother presents- physical or mental illness of the mother, her attitude and behavior- rejecting, hostile.
- Checking for the existence of child abuse and neglect.
- Family environment- structural and functional- disorganized.
- If a child in institutional, foster care or adaption- details of the averment, caring style.
- Level of social capital- social and neighbor support.
- Needs for alternative care.

b) Intervention plan

Here, multi-agency and multiprofessional involvement are required. With this view interventional plan is as follows:

Decision of child staying and placement

- Home with caregivers-with home support.
- Alternative care. If the child is not safe at this point, a case conference is necessary by relevant agencies.
- Community safe house –on a temporary basis.
- Hospitalization- in pediatric care with psychiatric support if needed particularly for malnutrition, the child's safety and feasible treatment planning.
- Permanent alternative living arrangement like foster care – if necessary.

Parent focused intervention

- Home based interventional program- it is the best possible intervention- help the parents and family for changing the pattern of parenting or rearing by the involvement of child and family social worker.
- Domiciliary support.
- Parent/caregiver counselling.

- Parenting training.
- Treatment of parental psychiatric disorder-if present.

Child focused intervention
- Nutritional catch up and ensuring adequate nutrition.
- Play and recreational activities.
- Behavioral therapy.
- Speech therapy.
- Treatment of neurodevelopmental disorder or attachment disorder, if present.
- Arranging treatment of psychiatric disorder of the parents, particularly mother, if any.
- Peer involvement-day care admission if required.

31. A 9-year-old boy presents with multiple recent bruises who has been referred by GP for psychiatric evaluation. The child looks sad, socially withdrawn but has frozen watchfulness.
Considering the best possible explanation of his problems through your logical deduction from the scenario─
a) What are the areas you need to assess?
b) What is your intervention plan?

Given information

Demography and referral
Age- 9 years
Sex- Male
Referred by- GP
Referred to- Psychiatric facility
Reason of referral- psychiatric evaluation

Chief complaints
Multiple recent and old bruises- uncertain duration, possibly longer

M/S/E findings
Appearance and behavior- Sad, socially withdrawn but had frozen watchfulness

Extracted information

This boy with late childhood has multiple recent and old bruises associated with sad mood, socially withdrawn but having frozen watchfulness clearly indicate he is a case of child maltreatment-certainly with physical and likely other types of abuse and neglect.

Assigned task

a) Areas of Assessment

Thorough general assessment of the child
- All members of the household should be seen.
- Reports from GP should be assessed including rechecking his bruises and any other injury, types, duration of abuse- oldest to newest bruises.
- School reports, if any.

- The child should be seen alone.
- Psychometric test (if school performance falls significantly).
- Physical examination-general physical exam and screening for suspected sexual abuse.
- Checking photographs, videos, if any.
- Investigations- Routine for general health status, CT scan for any subdural hemorrhage.

Psychiatric assessment of the child

- Emotional and behavioral and cognitive status of the boy for any definite psychiatric problems or disorder.
- Daily life pattern.
- Schooling and peer relations and free time activities.
- Developmental history- checking milestones of physical, emotional, cognitive and social developments for any delay or deficit or any neurodevelopmental disorder.
- Temperament- difficult or easy checking for other.
- Risk assessment-possible immediate and ultimate impact
- Strengths of the child.

Family assessment

Here, assessment of the parents, particularly the mother is prime important.

- Parental explanation about the injury- usually inconsistent, anomalous and unexplainable to accident, or acknowledgement of the mother for doing such injury.
- Parental help seeking behavior- any delays or failure to seek medical help, indifferent effect of parents.
- Pattern of child rearing-details of attachment- attachment figures, types of attachment or attachment failure, types of rearing practice, caregivers' attitude and behavior-hostile or rejecting.
- Family structure and dynamics- any dysfunctional family environment.
- Psychiatric assessment of parents, particularly mother- possible presence of Munchausen syndrome by proxy, PD or any other psychiatric disorder.
- Ability of the mother/ parents to protect the child and to prevent further abuse

b) Intervention plan

- Inpatient admission- either in psychiatric or pediatric facilities.
- For any physical problem or head trauma- appropriate referral and liaison work.
- Informing senior colleagues, pediatrician, casualty, police, and relevant social agencies.
- Management of specific psychiatric disorders, if any.
- Doing child protection referral (e.g. to social agency).
- Using option for custodial order- if required.
- Using option for care order providing opinion of such order if it is asked.
- Home visiting program if necessary.
- Assessing special needs.
- Alternative care- if it is necessary-passing such opinion to the relevant agencies.
- Child protection conference- organizing or attending.
- Being an expert witness.

[NTK
Inpatient admission in a stable unit is mandatory for all cases of child maltreatment. If required, admission by safety order needs to process]

32. A 3-year-old child admitted in the pediatric department with the complaints of bleeding from the rectum and mouth. Subsequent examinations and investigations are normal except inflicted injurious marks in and around anus and mouth. The mother who stays in the ward with the child, denies any cause of bleeding or illness. She repeatedly asks for more investigations and diagnosis but shows no expected distress. The child has been referred for psychiatric evaluation in this conflicting situation.
Answer the following on the basis of your extraction and logical interpretation of the given information.
a) What is the most likely diagnosis?
b) Outline your assessment and management plan.

Given information

Demography and referral
Age- 3 year
Sex-not mentioned
Referred by- Consultant in pediatrics
Referred from- Pediatric inpatients department
Referred for- Psychiatric consultation

Chief complaints
Bleeding from the rectum and mouth for which mother denies to know any cause- unmentioned duration possibly recent

Physical examination findings
Inflicted cut marks in and around the anus and moth

Investigations
All relevant investigations done and no abnormal report found to explain the bleeding

Mother's behavior
Unusual help seeking behavior who stays with child and reputedly ask for investigations in reaching a diagnosis despite all normal investigations.

Extracted information

Doing these types of injuries are not possible by the 3-year-old child, the nature of injury is inflicted that certainly is done by someone.

Mother denies knowing any cause of bleeding. It is very unlikely that injury has been done and mother knows nothing. Therefore, the mother's statement is inconsistent and the most possible explanation is that the mother is lying and she herself has done it.

Hospital admission and repetitive asking of mother for more investigations and a diagnosis is pathological knowing that the child's relevant investigations are found normal and no diagnosable illness of the child was found.

The mother's concern for her child is clearly inconsistent with her emotion, as she has no misery.

All these logical deductions indicate the child's injury due to her mother's illness imposed on the child. This is well known in clinical practice as Munchausen Syndrome by Proxy.

Malingering of mother is another possibility due to conscious symptom production but here no conscious gain is observed.

The mother may have a deviant personality problem or disorder or other major psychiatric disorder for the inflicting injury of her own child.

Assigned task

a) The most likely Diagnosis
On the basis of the above logical deduction of the given information, the most likely diagnosis is Factitious disorder by proxy because this disorder is characterized by conscious symptom production and unconscious motivation. Here the symptom production of the mother is projected to the child.

b) Assessment and management outline
- Assessing for the criteria confirmation of the diagnosis.
- Confronting mother for acknowledging her act and knowing the details of the current and any previous act in a face-saving manner.
- Assessing the child in the line of child abuse protocol with special emphasis on risks for the child including assessing risk factors of recurrence of child's harm.
- Assessing the mother's mental state and possible psychiatric disorders, especially any personality disorder.
- Assessing mother's home environment.
- Treating psychiatric illness of the mother if any.
- Parenting training and periodic home-based observation where it seems to be applicable.
- Applying child abuse and protection processes involving relevant agencies if necessary.
- Communicating the referred consultant with necessary notes and action plan.

33. A 14-year-old boy who has repetitive thoughts of having an infectious disease and is convinced he acquires it by infiltration through mouth. He spits in an effort to clean his mouth almost within every minute and washes his hands several times. Subsequently, he develops fear of illness, and death and repetitively begs pardon to Allah. He becomes sad and finds no interest in work and stops going to school. His sleep is remarkably interrupted and weight reduces significantly. On questioning, he says that he finds no way to come out. His appearance was disheveled and dirty and he was muttering constantly.
Based on the logical deduction from the scenario─
a) What is the most possible dual diagnosis?
b) Outline the treatment plan.

Given information

Demography and referral
Age- 14 years
Sex- Male

Chief complaints

- Repetitive thought of having infectious disease followed by fear of illness- duration not mentioned
- Frequents spitting and hand washing as efforts of eliminating infection- same duration
- Persistent fear of illness and repetitive begging pardon to God - subsequent duration
- Low mood and loss of interest in activities, loss of weight- subsequent duration
- Stop gang school- subsequent duration

M/S/E findings
Appearance- disheveled, self-muttering
Thought- pessimistic, hopelessness

Extracted information

This late adolescent boy has repetitive thoughts of infection that seems obsessive in nature. Best possible explanation of frequent spitting, hand washing and begging pardon is compulsion. His self-muttering is likely a covert compulsion of begging pardon and might be an expression of pessimistic thought.

The boy is convinced that he has infective disease, possibly his colluding error from circumstantial evidence that comes from his repetitive thought of having infection that further leads to fear of death. Poor insight about illness is not uncommon in this age and not as impaired insight in psychosis.

The sad mood, anhedonia, pessimistic thought, weight loss possibly due to decreased appetite- all are certainly indicative of major depression that leads to significant functional impairment in the academic domain. Most likely, these depressive features develop as the consequences of increased, uncontrolled and persistent obsession-compulsion.

Fear of illness could be a part of illness anxiety but no such conviction of having illness is evident and related illness behavior is not evident. Rather, these can be explained by obsessive thought and depressive cognition.

There is clear evidence of marked impairment daily functioning in all domains markedly in his academic domain.

Assigned task

a) The best possible dual diagnosis

On the basis of the above logical extraction of the scenario, the best possible dual diagnosis is Major Depressive Disorder and Obsessive-Compulsive Disorder. The diagnostic formulation has clearly mentioned in the extraction section of information.

b) Treatment outline

Based on detailed assessment, the following treatment outline can be adopted.

- Explanation, support and advice to the patient and caregivers about the nature, course, treatment and outcome.
- Selecting SRRI preferably Fluoxetine, Sertraline or Fluvoxamine that is effective in both OCD and Depression in an adequate dose and duration.

- Relaxation therapy with the aim of reducing distress and as a component of behavioral therapy.
- Maintenance of an active daily living program with minimum activity that will gradually be increased according to degree of remission.
- Applying ERP followed by CBT when the patient is prepared to receive it.
- Remedial teaching to catch up with his academic backwardness.
- Periodic follow-up for further action.

34. A 13-year-old girl is brought to psychiatry OPD. The girl vomits immediately after taking food that has been developed two weeks after the recovery from her chikungunya fever. However, she can drink liquids without the consequences of vomiting. A series of exhaustive investigations and consultations reveal no abnormality and she is not responding to antiemetic or any form treatments related to peptic ulcer disease. She is not going to school and parents are worried about her condition. Considering the most likely diagnosis by drawing logical points from the given information─
a) What information do you need to gather to confirm the diagnosis and make a treatment plan?
b) Outline the treatment plan.

Given information

Demography and referral
Age- 13 years
Sex- Female
Occupation-student
Referred to- Psychiatry OPD

Chief complaints
- Vomiting immediately after taking food but no such after drinking for which no organic cause was found- not mentioned but long as considerable time elapsed.
- Nonattendance in school- subsequent duration.

Medical history
Chikungunya fever- recovered and vomiting appears after 2 weeks of recovery.

Lab investigations
Many investigations done- Normal, symptom unexplained.

Treatment received
Antiemetic and antipeptic ulcer disease - no response

Extracted information

This early adolescent girl has persistent vomiting immediately after taking food and not associated with drink intake seems anomalous and does not indicate any possible physical illness.

The girl has recovered from Chikungunya fever and it is unlikely any recurrence of such noticeable symptoms.

Case information indicates that the girl is medically assessed for these symptoms and no abnormality was found in investigations and more likely in clinical examination to explain the symptom. Non-

responsiveness to antiemetic and psychiatric referral by attending physician strengthen the nonorganic nature of vomiting traditionally known as psychogenic vomiting.

The girl's stopping of going to school is either school refusal or withholding from school by anxious parents. This clearly indicates that academic backwardness during Chikungunya happens due to her absence from school and inability to do day-to-day study for a considerable period and girl's inability to cope with this situation after restarting. Therefore, absence from school and not doing study can act as primary gain. There is a strong possibility of having secondary gain either as medical consultation or as over care of the parents. All this deducted information strongly suggestive of having Dissociative/Conversion disorder.

Alternatively, she may be a case of Somatic Symptom Disorder because of her very specific symptom of vomiting. However, anomalous symptoms, existence of gain and absence of worries and thoughts related to symptoms do not support this diagnosis. Here, parents are worried. Their worriedness along with a pattern of help seeking behavior clearly act as reinforcement for persisting in her symptom.

She may be a case of adjustment disorder as acute physical illness of such rare variety is certainly a stressor. However, adjustment disorder is a diagnosis of exclusion and the features go in favor of conversion disorder.

Assigned task

a) Necessary information needed to confirm the diagnosis and making a treatment plan

From the above extraction, the girl likely suffers from Psychogenic Vomiting due to Conversion Disorder.

Necessary other information required for diagnosis are:

- Whether the symptoms happen unintentionally or in unawareness will go in favor of Conversion disorder.
- Whether child in anxious and preoccupied with the symptom
- Whether the academic factor or any other stressor is the primary reason of this situation and the girl cannot cope with it is necessary to identify primary gain.
- Nature and degree of secondary gain and pattern of the girl's response. Particularly the reason for school nonattendance- whether a child is unwilling or withholding by parents.
- Whether the child has significant emotional and behavioral symptoms in response to associated stressors like academic backwardness, or having severe illness like Chikungunya necessary to exclude other anxiety disorder and adjustment disorder.
- Though less likely, if the symptoms are produced intentionally to avoid going school or doing study, happens only at that time that could be malingering which is also known as Masquerade Syndrome.
- Level of impairment of the girl's functioning and burden to parents and family.

b) Outline of the treatment plan

- Explanation assurance and support to the patient and her anxious parents with special emphasis on informing that the vomiting is not due to effect or after effect of Chikungunya or any other physical illness rather it's the physical manifestation of psychological factors like academic stress. Also informing that this can be happened restarting of going after absence from school for a considerable period of time
- Continuing normal daily life as much as possible through a program. Parents should be encouraged and monitored to do that.
- Relaxation training in the form of breathing exercise.

- Sertraline 25-50mg after food or nortriptyline 10-30 mg before taking food could be helpful and that will be optimized as required.
- Individual psychotherapy for resolving stressors and increasing the coping ability, acquiring interpersonal skills.
- Adopting a back to school behavioral program within the earliest possible time.
- Remedial teaching to cover up any academic backwardness.

Family counselling to support the family and encouraging parents to show desired attitude and behavior, establishing effective communication with their daughter to resolve any problem and maintain normal life.

35. A 12-year-old boy attends CAMH OPD who suddenly starts fasting almost every day as part of religious activities and becomes violent in response to the refraining efforts of his parents for three weeks. On asking, he says that he gets signals from God to do so through a flying bird in one day. He does not sleep and goes to school rather than moving around. He refuses to take medicine from the GP as he fasts. The boy looked restless and he was meaninglessly talking with self loudly.
Based on your logical deduction form the given information─
a) Mention the best possible diagnosis with reason.
b) Prepare a checklist of your assessment with the aim of conforming the diagnosis and making a treatment plan.

Given information

Demography and referral
Age- 12 years
Sex- Male
Occupation-Student
Referred to Psychiatry- CAMH OPD
Referred by- More likely Consulting GP

Chief complaints
- Odd religious behavior like unusual fasting-3 weeks
- Conviction of getting signals from God though a flying bird- around the same duration
- Violent if parental efforts to refrain from doing fasting- subsequent duration
- Lack of sleep – same duration
- Stop going school- same duration

Onset
Acute

M/S/E findings
Appearance and behavior- Restlessness and loud self-muttering
Thought- Possible incoherence as expressed in meaningless talk
Insight-Grossly impaired evident by his fasting refusal and medicine refusal

Extracted information

This early adolescent's conviction of getting the signal of God through sudden flying of a bird is clearly indicative of primary delusion in the form of delusional perception. This delusion is persisting in nature and the base of his other abnormalities.

As the boy told that his fasting behavior is due to God's will, a subsequent self-muttering is strongly indicative of having auditory hallucination. Incoherence is certainly part of disorganized speech. His wandering behavior is possibly part of his disorganized behavior.

Sleep disturbances and restlessness may be due to the effect of acute unusual experiences in this mid childhood.

All these cardinal psychotic features indicate that the boy is suffering from acute psychosis. Here, total duration is necessary to assign the specific psychotic disorder. Apparently, it is clear that the duration is at least around 3 weeks. Therefore, he can be assigned as Brief Psychotic Disorder. However, from the symptom pattern, particularly, primarily delusion it can be predicted that the boy is going to be a case of schizophrenia.

There is no such indication of any possible physical illness or drug misuse but the existence of drug misuse could be possible in this age and intoxication and withdrawal can produce psychotic symptoms.

These problems caused significant distress and gross functional impairment being evident in his restlessness, school nonattendance and moving around.

Assigned task

a) <u>The best possible diagnosis</u>

From the above extraction, the best possible diagnosis is Brief Psychotic Disorder. So many criteria exist but strong indications of having delusional perception and related behavior make a great difference from acute psychosis due to drug intoxication and withdrawal.

b) <u>Checklist of the assessment to confirm the diagnosis and making a treatment plan</u>

Assessing is necessary in the following areas along with general assessment.

- Severity, frequency and persistency of existing and other symptoms, with special emphasis on accurate duration of illness.
- Extent of distress and impact of the illness to the boy and family.
- Any h/o drug misuse, if present details of lists, dose, frequency, effect.
- Any possibility of physical illness associated with psychosis like Wilson disease.
- Thorough physical examination with special emphasis on neurological examinations.
- Etiological factor assessment predisposing like odd temperament, positive family history of psychosis, precipitating like existence of any stressors, perpetuating like any maltreatment.
- Strengths of the child and family that will be helpful for managing the cases.
- Routine lab investigations to know the boy's general health status, dope test for possible substance misuse, serum ceruloplasmin for Wilson disease and CT scan or MRI of the brain for possible brain pathology.
- Applying validated BPRS to assess the types, frequency and severity of psychotic features

36. A 17-year-old girl comes with her parents to a psychiatrist's consultation center who does not do her study and wants to change her subject of study as per instruction of the voice. Parents say that she does not sleep well and spends time on the internet in her room closing the door, showing marked anger if she is interrupted. She is very imaginative, creative since early life, selectively social and has an excellent academic record. The girl smiles and talks with herself and on questioning she replies

that she does so as she visualizes many people around her who talk with her. When the consultant asks her whether these people control her, she promptly replied, “Oh, you’re thinking I am schizophrenic. I also have mood swings.
Analyzing and interpreting the above given information, answer the following.
a) What is the most likely single diagnosis to explain her problem?
b) How will you manage this case?

Given information

Demography and referral
Age- 17 years
Sex- Female
Occupation-Student
Referred to- psychiatrist
Referred by- self and parents
Reason of referral- psychiatric consultation

Chief complaints
- Excessive use of internet keeping herself in her room-uncertain, possibly long
- Impulsive in face of any interruption of her internet use and other activities- subsequent duration
- Wants to change her study subject as per instruction of voice- subsequent duration
- Irregular daily life maladaptive in nature-subsequent development

Recent life event and conflict
Want to change her subject of study

Temperament
Imaginative, creative, selectively social, have excellent academic record

M/S/E findings
Appearance and behavior- smiling, talked with herself, good rapport
Talk- fluent, explained reason of smiling
Insight- seemingly intact event by her response to consultant’s question of being controlled

Extracted information

This late adolescent girl has excessive internet use closing the door in her room, impulsive if interrupted or in face of parental efforts to refrain her from internet use, possibly deliberate sleep deprivation as part of her maladaptive behavior are clearly indicative of having internet addiction.

She experiences the voice and vision of many people around her. The said auditory and visual hallucination and pattern of smiling and self-talking are very inconsistent for psychosis and can be better explained by the effect of her excessive internet use colored with her imaginative and creative nature.

There may be associated drug addiction with the girl at this age and gender particularly, hallucinogens and ecstasy where visual hallucination usually happens.

The girl is intelligent and knows the symptoms of schizophrenia possibly through the internet or by any other means evident by her prompt reply of the consultant's question and pattern of expression of her will of changing subject of study though voice.

Changing the subject of study is likely her own desire as she does not like her current subject and parents do not agree with her in this issue, and the clever girl wants to execute it by creating the story of the instruction of voice.

Imaginative, creative, selectively social temperamental characteristics of the girl and her clever expression of her intention by psychotic-like symptoms requires thorough checking of any of his ongoing deviant personality traits or disorder.

Assigned task

a) Diagnosis

From the above extraction, the most likely single diagnosis to explain her problem is Internet Dependence.

b) Management

- Explaining the problems, encouragement and support to the patient and her parents.
- Hospitalization- mainly because she is willing to change her subject and because it seems that parents have lost their control. Hospitalization is also necessary for confirming the diagnosis as the girl mentioned about psychotic symptoms.
- Applying sleep hygiene with a fixed sleep schedule. If necessary, sedative-hypnotic as required for adequate sleep and restoration of sleep schedule.
- Applying internet addiction treatment protocol including controlling or abstinence of internet, using alternate healthy recreational activities, motivational psychotherapeutic work.
- Treatment of any other drug addiction or psychiatric disorders like anxiety, depressions and personality disorder.
- Maintaining a feasible active daily living program.
- Encouraging utilizing her creative and imaginative characteristics in positive ways by discussing with the girl.
- Parental counselling particularly how to deal with their girl effectively.
- Discussing with the girl and her parents about her academic problems particularly her desire of changing the subject of study.
- Individual psychotherapy- for applying healthy problem solving techniques, learning stress coping strategy, managing any odds in her temperament, increasing ability to utilize her imaginative capacity in creative ways.

37. A 10-year-old boy has been marked irritable for the last three months. Gradually, he becomes defiant, impulsive, does not go school, studies, argues, and tempers with mother if he is asked to do so. He also has headaches and sleep disturbances. Presently, he stays most of the time at home in his bed and does almost nothing.
Deducting points from the given information in the scenario—
a) What is the single most possible diagnosis?
b) Prepare a checklist of information necessary for confirming diagnosis and planning treatment.

Given information

Demography and referral
Age- 10 years

Sex- Male
Occupation-Student

Chief complaints

- Marked irritability-3 months.
- Headache and sleep disturbances-same duration
- Behavioral change like defiant, impulsive and argumentative and tempered- subsequent development
- Most of the time confined in bed and doing nothing-recent development.

Extracted information

The pattern of appearing symptoms of this late childhood boy ranged from irritability, sleep disturbances to lying in bed most of the time is very much indicative of depressive features. Considering his marked irritability, pervasive anhedonia and severe functional impairment, the boy is likely a case of major depression severe in nature.

His subsequent defiance, impulsivity, unwillingness to go to school, argumentativeness resembles oppositional defiant disorder. The onset of primary disruptive behavior at 10 years of age is uncommon.

Recent onset of his interim disruptive behavior and gradual decline is possibly the expression of his irritable mood and can present in childhood depression.

Headache can be the somatic symptom of depression and anxiety and his inner distress as somatization of depression and inner distress is common among children and adolescent population.

This child could be a case of DMDD due to the existence of a combined picture of disruptive behavior and depression. However, his tempered bevor is not the main feature, happens only with mother as part of argumentativeness and expression of his inner distress. Further age of onset of DMDD is before 10 years with more than 1-year duration. Above all, the diagnosis of MDD supersedes any other related diagnosis.

Assigned task

a) The single most possible diagnosis

Based on above logical extraction of the given information from the scenario, the single most possible diagnosis is Major Depressive Disorder.

b) Checklist of information to confirm the diagnosis and making treatment plan

Clinical assessment of disorder
Onset, types, frequency, severity and persistency of his depressive features and disruptive behavior feature with special inquiry about onset, severity and persistency of his irritability and tempered behavior.
Level of impact and burden- particularly in his academic domain, peer relation, and basic personal activities.
Risk assessment- risk of self-harm or suicide.

General, systemic and mental status examination for any other comorbid psychiatric disorder-phobia, anxiety disorder, ADHD, general health status possible secondary cause of his depression and co-occurring physical illness.

Child factor
Temperament- shy, timid, anxious, cognition-like rumination, negative inferential style, behavioral inhibition, biased attention to negative emotional cues.
Stressors- Any Adverse childhood experiences- Abuse, neglect, any toxic stressors or acute or enduring traumatic life events, domestic violence, loss, bereavement, bullying including cyber bullying.

Parent/Family factor
Parental anxiety, depression or any acute or chronic medical condition.
Parental efforts of combating child's problems.
Parental perception about the child's problem.
Family- structure, pattern of family functioning, parental attitude and behavior, communication style.

School factor
School environment and teacher's supervision level, child's participation in classroom, play and other activities, performance level, peer relationship
Bullying happened or not. If it happened, reason, types, child's reaction, parents know or not, measures taken by school.

38.A 9-year-old boy presents with vomiting and headache for two months and no organic etiology was found to explain these symptoms. His mother says that the boy recently discloses that persistent thoughts and images of love and loving behavior with two of his girl classmates come into his mind that make him very distressed. The boy has a tendency to worry about any minor matter for 10 months.
a) What is the best possible diagnosis?
b) What treatment will you offer for this case?

Given information

Demography and referral
Age- 9 years
Sex- Male
Occupation-Student
Accompanied by- Mother

Chief complaints
- Worries about any matter- 10 months.
- Persistent intrusive thoughts and images of love and related behavior with girl peers – duration not mentioned, subsequent duration
- Distressed about the thoughts and images-2 months
- Vomiting and headache-2 months

Extracted information

This boy with late childhood has persistent thoughts and images of love and related behavior that may extend to sexual one is indicative of unwanted and uncontrolled evident with his distress (ego dystonic) and clearly obsessive in nature. There is a strong possibility of having overt or covert

compulsion with this type of obsession that needs to be explored. As there is no clear duration of obsession given, duration of somatic symptoms and early worries indicate duration will be at least 2 months or more. The boy's marked distress indicates the disorder is severe.

The boy's recent disclosure of these thoughts and images means that the boy knows these are awful and shareable, but as the problems persists, uncontrolled and difficult to bear its distress he discloses to mother. Alternatively, he discloses the secret in face of mother's queries for his vomiting and headache.

The vomiting and headache can be explained as a somatic expression of his inner anxiety and distress.

The tendency of worries in any matter before this problem indicates that the boy possibly has generalized anxiety of 10-month duration. If that exists his preoccupied obsessive thought could be the part of that However, the tendency of worries does not ensure excessive and uncontrolled worries about a number of events and activities. Further, subsequent development of OCD features appears to be prominent and the main issue. One possible explanation could be that the obsessive thoughts and images start at this time but the boy kept these within him. Alternative explanation could be that his tendency of worries is part of his temperament or response to associate other stressors.

Assigned task

a) <u>The best possible diagnosis</u>

From the logical deduction of the given information from the information of case scenario the best possible diagnosis is Obsessive-Compulsive Disorder.

b) <u>Treatment</u>

General

Explanation, reassurance and support to the boy and the parents.

Psychoeducation- stating the nature, course, treatment plan, and expected outcome along with role of the boy and parents in the treatment.

Nutritional care, hydration, personal hygiene.

Relaxation exercise- progressive muscular relaxation will be better for his headache and possible aches and pains Alternatively, breath holding exercise will be applied.

ADLP- as feasible with progressive increasing activities towards premorbid state.

Specific

SSRI is necessary due to the severe nature of the disorder with marked distress. Sertraline (fluvoxamine will be selected if marked insomnia present)) initially low dose followed by slow and gradual increasing the dose after assessing response.

Exposure and Response Prevention Therapy- here parents or senior siblings will be incorporated as therapists and help the boy in implementing home practice. Extra addition of effective reinforcement can accelerate the process.

If the boy is suitable for CBT- it will be provided after reduction of his anxiety and distress in a workable state.

[NTK

Any SSRI at this age is proved more or less safe and effective with moderate effect size. If the condition is mild to moderate, initial treatment should be combined. If the child is suitable for CBT then it is the first choice of intervention Combined SSRI and ERP is more effective for sustained effect]

39. A 13-year-old girl brought to the CAMH OPD by police for psychiatric assessment who is a victim of rape 7 days back.
a) Make a checklist of your assessment plan.
b) Outline the contents of your expected management for this case.

Given information

Demography and referral
Age- 13 years
Sex- Female
Referred to- CAMH OPD
Referred by- Police
Reason of referral- Psychiatric assessment

Psychiatric issue
Victim of rape- 7 days back

Extracted information

As the mid adolescent girl is a rape victim, and brought to the psychiatric facility, it is obvious that the girl has remarkable psychiatric problems.

The problems are likely associated with stress related disorders more likely Acute Stress Disorder or Conversion/Dissociative Disorder. Therefore, features of these disorders are expected.

The incidence is medico legal and therefore psychiatric opinion, and reports are expected from relevant agencies and caring facilities.

Assigned task

a) Checklist of assessment of the case

In general, the assessment of such victims is multidisciplinary, multilevel, multi-informant and interlinked. Here, a child and adolescent psychiatrist will do psychiatric assessment and intervention and do liaison work with pediatrician, police and judicial system and inform casualty officers if required.

With this point,

- Checking record of information from- family, school, GP, Police
- Careful history taking by very sympathetic/ empathetic approach
- No direct question
- Encourage to child to tell what has happened
- Act- duration, severity, nature, dangerousness
- Predisposing/subsequent event

- Whether immediate protection is needed-
  Is she safe at family/ any dangerousness to stay with family?
- Assessment/ interview of child
- Medical/physical examination
- Immediate psychiatric risk assessment-
  Assess significant harm of mental health
  Acute Stress Disorder
  Self-harm, suicide
- Assessment of the family
- Assessment of circumstantial environment
- Assessment of risk of further abuse
- Mental state examination of child and parents
- Social investigation-
  Information/ materials collected by social worker

b) Contents of expected management

General

- Safety of the child to prevent further harm. If necessary, alternative care.
- Immediate relief of effects of abuse that already happened/ minimize effects of abuse.
- Hospitalization- if suicidal risk, needs elaborative and collaborative intervention, or constant observation.

Specific

Psychological

- Psychoeducation that fault is not her rather the perpetrator(s).
- Preventive measure of self-harm, suicide, PTSD.
- Measure to hide identification of person.
- Applying treatment protocol of conversion disorder, if present.
- Applying treatment protocol of acute stress disorder, if present.
- CISD- Critical Incident Stress Debriefing.
- Prolong exposure therapy.
- Trauma focused CBT.
- Relaxation exercise.
- Mindfulness training.

Drugs

Short-term sedatives but drugs in safe custody with full supervision of parents/family.
If suspected for development of PTSD, give SSRI- sertraline 25 mg, 1 tab in morning after meal.

Others measures

Meeting the child's needs to reduce the effects of maltreatment.
Prepare the child to cooperate with a legal agency.
Counselling of family members to avoid critical comments, blaming, encourage doing normal activities.

Legal proceedings

- Use of legal agencies, police
- Help from human right agencies
- Child protection services

- Social services
- Preparing court report if asked for

40. A 16-year-old girl appears in CAMH OPD with repetitive self-injurious behavior mainly in the form of multiple superficial cut injuries for 3 years. She says she does this when she is upset. Mother says she is very emotional, difficult to predict and always falls into trouble with maintaining her relationship. She does whatever she wants and becomes angry, threats to commit suicide if she is not allowed to. Her daily life is disrupted, mostly engaged with mobile phones and poorly performing in examinations. The girls looked sad.
Based on your logical extraction and interpretation form the scenario─
a) What could be possible diagnoses?
b) Mention your treatment plan.

Given Information

Demography and referral
Age- 16 years
Sex-Female
Occupation-Student
Referred to- CAMH OPD
Accompanied by-Mother
Reason for referral-Psychiatric assessment and treatment

Chief complaints
- Repetitive self-injurious behavior mainly in the form of multiple superficial cut injury-3 years
- Emotional instability expressed through unpredictable mood change- upsets, angers, and suicidal threats-same duration
- Angriness, does as she like and impulsive if not allowed doing so- subsequent duration
- Engages with mobile most of the time- subsequent duration
- Disruption of daily life and poor academic performance- subsequent duration

Premorbid temperament
Very emotional, impulsivity, mood changes, unstable relationship

M/S/E finding
Affect- Sad

Extracted information

This late adolescent girl's emotional mood, mood changes, easily upsetting, angriness, and sad mood are the main emotional symptoms that play a critical role in her overall condition.

The girl has significant behavioral problems in the form of anger, impulsive and defiant behavior and possibly reckless behavior indicates the girl has disruptive behavior. This behavior starts at early adolescence and does not fulfil the full criteria of either oppositional defiant disorder or conduct disorder as these are strongly related and explainable with her predominant emotional symptoms and temperamental components. However, these futures cause significant distress and impairment of her academic, social and home functioning and for that want a diagnosis. Detailed inquiry about the onset, frequency and persistency of disruptive features is essential.

Repetitive self-injurious behavior in face of upsetting, suicidal threats, low mood is very much indicative of having depressive disorder. These features are also related to her unpredictable emotion, anger, and impulsive act. The pattern of self-harm seems non-suicidal, evident by her superficial cut and other circumstantial evidence. However, thorough assessment of features of depression and suicidal risk assessment is essential.

Internet dependence may be another possibility as the girl engages with mobile most of the time and has an eruptive daily life indicative of maladaptive lifestyle. However, her emotional and behavioral features are prominent and an area of main concern. Here, excessive mobile use is explainable by her depressive and disruptive features.

Possibility of having substance misuse is also possible at this age and gender with this kind of emotional and behavioral problems and maladaptive temperamental traits that need exclusion.

This feature seems to be more or less 3 years along with ill sustained relationship is clearly persistent and possibly maladaptive go in favor of inflexible temperamental traits more as borderline traits and depressed mood usually associated with this in reaction to frustration as she expressed in word "upsets". She has manipulating behavior as evident by giving suicidal threats in face of unmet goals and might have attention seeking behavior that usually happens in histrionic traits, but this can be better be explained as part of borderline traits and goes with other features.

Her enduring pattern of conduct problems, mainly impulsivity, anger, manipulative behavior and possible reckless behavior, failure to make stable relationships indicative of antisocial temperamental traits but clearly not socially deviant in nature rather can be explainable as her own pattern of sense of self. The onset of the girl's maladaptive temperamental traits is thought to be in mid adolescence within her 16 years of age.

Disruption of daily life and poorly performing in examinations is clearly indicative of functional impairments and has a possible significant burden to the parents.

Assigned Task

a) <u>The best possible diagnoses</u>

From the given information and its extraction, following could be best possible diagnoses.

- Mixed disorder of conduct and emotion /Disruptive Behavior Disorder
- Major Depressive disorder
- Alternatively, Borderline Personality Disorder is the more likely diagnosis because the entire features onset, duration and predictable enduring and maladaptive nature and its impact on the child and family goes in favor of this diagnosis except required age (18 years and above). However, personality disorder among children and adolescent can be diagnosed when:
  -fulfils all criteria of PD
  -long duration (at least 1year)
  -predictive evidence of persistency, pervasiveness, and longitudinal continuity
  -not confined with any mental disorder
- There is also the possibility of having other comorbid diagnosis as mentioned above along with BPD.

[Note that answering of only BPD, only other disorder, and dual diagnosis all are correct but needs logical arguments of justification of diagnosis]

b) <u>Treatment plan</u>

Prerequisites for treatment are
Commitment from the patient and the parents, commitment from the therapist and not to withdraw treatment from treatment prematurely.

General

- Explanation, reassurance, and empathic support to the girl and the family.
- Building a rapport with the patient and his/her family.
- Psychoeducation- based on the provision of clear information about the pathology and its treatment, an evaluation of the adolescent's level of commitment and the establishment of realistic treatment objectives.
- ADLP- Maintenance of daily life with a feasible and agreed schedule towards normality.

Specific

- Acting on the suicide crisis.
- Act on the ongoing disorders and problem- depression, disruptive behavior, BPD, internet misuse and its impact
- Dialectical Behavioral Therapy (DBT) targeted for
  - Distress tolerance
  - Emotion regulation
  - Interpersonal effectiveness
  - Mindfulness

- Working on persistency factors like parental behavior, behavior of siblings, peer relationship, any confined relationship by changing the disabling immediate environment (i.e., the interactions with not only parents but also with siblings and peers).
- Acting preventively on family risk factors by working with family.

Chapter 2: Neurodevelopmental Child and Adolescent Psychiatry

1. A 12-year-old boy has difficulty in expressing himself in writing and makes frequent spelling mistakes. He passed his exams with poor marks. However, his mathematical ability and social behavior are age appropriate. He is termed lazy by his parents and teachers.
Based on the above information and its logical deduction─
a) What is the most likely diagnosis?
b) Provide the treatment plan.

Given information

Demography and referral
Age- 12 years
Sex-Male

Chief complaints
- Difficulty expressing himself in writing, makes frequent spelling mistakes but having good mathematical ability and social performance- not mentioned, considerably long
- Poor academic performance for that labeled as lazy by teachers and parents - subsequent duration

Extracted information

This late childhood boy has a problem writing, especially spelling mistakes. Despite his good mathematical ability, he gets poor marks in tests due to mistakes in writing numbers or symbols as part of his spelling mistake. This boy clearly has a learning disorder of written expression. As the problem is specific developmental, certainly it has been expressed in the early period of his learning and longtime has already elapsed.

Though it is not mentioned, developmental reading problems may be associated with this writing problem that needs exploration and exclusion.

His mathematical ability and social skills indicate this child has no intellectual problem, autism, or problem is speech and language.

Spelling mistakes may be due to inattentiveness that is a cardinal feature of ADHD. Absence of any feature in the given information on over activity do not support this diagnosis. However, inattentiveness may developed secondarily form his frustration about poor performance

The child is termed as lazy and possibly considered as inattentive boy with poor interest in his work and certainly, his learning difficulty in the form of spelling error is undiagnosed and unexplored. Rather, he is criticized and humiliated and possibly bullied.

Expectedly the child is in distress due to poor performance for which possibly he does not find any reason added with his cornered situation both at home and in school. If this disorder remains undiagnosed and treated there is a strong possibility of developing emotional and behavioral problems and will have adverse impact on his academic and social life despite having good intelligence and social skill.

Assigned task

a) The most likely diagnosis

From the above extraction of the given information, the most likely diagnosis is Specific spelling disorder/Specific learning disorder with written expression.

b) Treatment plan

Here, active involvement of teachers and parents are essential. Combined efforts of school, parents and the boy with the CAMH service can ensure the best possible outcome. With this view, the treatment plan for this boy is as follows:

General
Explanation, assurance and empathic support to the boy, parents and teachers with emphasizing their need and role in the treatment plan.
Psychoeducation- explaining the nature, developmental origin, course, treatment and expected outcome. Along with clearly informing them, that is not autism, ADHD or intellectual disability and the child has adequate abilities to do better and he needs normal schooling with some special support.

ADLP- Encouraging the boy to perform his daily activities with home and school support and supervision

Acting for alleviating negative attitude and behavior of the parents and teachers and preventing any abuse- emotional or physical and neglect.

Wellness activities- encouraging the boy in-group play, peer reactions, preferable free time activities

Specific
Instruction of lesson-Clear outline of each lesson in unambiguous language with a variety of forms is to be given by teachers in classroom activities. Here, supervision for the boy's involvement in individual and group work is necessary. At home, similar support and supervision is required in his homework.

Spelling practice with applying behavioral modification therapy-this should be done at both home and school with the following measures.
Spelling-rule training- systematic instruction about letter-sound and sound-letter correspondences, letter-syllable-morpheme synthesis, and sound-syllable-morpheme analysis. Spelling performance will be reinforced with appropriate reward.

To facilitate the outcome, active involvement of school psychologists and/or developmental psychologists is required.

Follow-up
Periodic follow-up is necessary for evaluating the outcome, further necessary measures and preventing additional psychiatric, home or school problems.

2. A boy of 6 years has developed marked hyperactivity and lost previously achieved skills after encephalitis.
Drawing points form the given information─

a) What is your diagnostic impression that explains the child's condition?
b) Prepare a checklist of your assessment.

Given information

Demography and referral
Age- 6 years
Sex-Male

Chief complaints
- Marked hyperactivity- not mentioned possibly long
- Loss of previously achieved skill-same duration

Onset- after encephalitis

Extracted information

This boy of mid childhood developed hyperactivity and loss of previously achieved skill after encephalitis. As he has no such problems before, it is likely that these are due to encephalitis.

The first possibility is that the boy has ADHD. Though features related to inattention and impulsivity are not mentioned, likely are present with this boy.

His loss of previously achieved skills indicate acquired intellectual disability from brain insult that is irreversible.

This post encephalitic condition can be the cause of cognitive impairment at this age. If so, it will likely be considered as part of intellectual disability considering his developmental period.

The child might have other acquired neurodevelopmental problems, including epilepsy that needs enquiry.

It is expected that the boy has significant deterioration of global functioning.

Assigned task

a) Diagnostic impression that explains best the child's condition

From the above logical extraction of the given information, the best possible diagnosis is dual-Intellectual Disability and ADHD due to encephalitis.

b) Checklist of the assessment

- Checking the documents related to diagnosis, investigation, treatment to know his status of encephalitis.
- Details of the features of ADHD-onset, types, frequency, severity, persistency of hyperactivity, impulsivity, and inattentive domains.
- Level of intelligence and adaptive functional deficits in conceptual, social and practical domain plus assessing for any cognitive deficit.

- Checking for any other neurodevelopmental deficit and epilepsy.
- Level of impairment in his personal, familial, educational, social and recreational functioning and degree of burden to the caregivers.
- Premorbid intellectual level, activity and functioning level and full developmental history.
- Lab investigations- Routine, CSF study, EEG, MRI of brain, if recently not done.
- Psychometrics

  Validated parent version of Conner rating scale for ADHD.
  Validated WISC III Revise for measuring IQ.
  Validated Vineland Adaptive Behavior Scale- for assessing adaptive behavior.
  WHO-DAS- for assessing degree of disability.

  [NTK
  Adapted and validated scales must be used in any case for a particular purpose for which the scales have been designed. Overall, clinical judgement is the final interpretation of the test results.]

3. A 16-year-old boy with autism attends CAMH OPD with his puzzled parents who recently appears to be extremely hyperactive, frequently violent to others as well as has severe self-injurious behavior including dangerous repetitive head banging and marked sleep disturbances. The boy goes to a special school and is relatively stable with risperidone 6 mg per day for his hyperactivity and unpredictable disruptive behavior.
Considering best possible comorbid diagnosis on the basis of logical interpretation of the given information─
a) Make a checklist of information for assessing the boy's problems for a feasible intervention.
b) Outline the interventional plan.

Given information

Demography and referral
Age- 16 years
Sex- Male
Occupation- Student of special school
Referred to-CAMH OPD
Refereed and accompanied by-Parents

Chief complaints
- Extreme hyperactivity- recent onset
- Frequently violent to others- same duration
- Severe self-injurious behavior like repetitive dangerous head banging- same duration
- Sleep disturbance- subsequent duration

Psychiatric diagnosis
ASD with severe hyperactivity and disruptive behavior

Ongoing treatment
Receiving risperidone 6 mg/day and was relatively stable with it

Extracted information

This late adolescent boy has a primary diagnosis of ASD. He has severe hyperactivity which is one of the associated common features in the course of ASD. As his hyperactivity is severe enough and considered for treatment for that he is likely to have a comorbid diagnosis of ADHD. The boy also has disruptive behavior frequently found with ASD children and considered for treatment. Hence, he also has the diagnosis of disruptive behavior disorder.

The boy goes to a special school. That indicates the boy possibly has low functioning or mid functioning autism. In that case, another diagnosis of ID may be presented with the boy.

His recent frequent violent behavior to others and self like dangerous repetitive head banging is due to severe form of disruptive behavior and stereotyped behavior of autism respectively. These are possibly interacting with each other and could be the expression of his inner distress and emotional problems, like anxiety and depression. As a rule, frustration leads to aggression.

Excitement could be the part of catatonic feature that can happen with ASD particularly at this age. This also needs exploration.

Assigned task

a) <u>Checklist of information for assessing the boy's problems for a feasible intervention</u>

- Full features of ASD and comorbid ADHD, disruptive behavior disorder and possible ID.
- Details of the recent development of violence to self and others-
  - Onset
  - Types
  - frequency
  - persistency
  - severity
  - pre and post event (antecedent and precedent)
- Reason of violence. Whether there is
  - Change in early routine/ disruption
  - Over and under stimulation
  - Scholl factor-bullying, change of teacher, routine, vacation
  - Recent stress- family, neighborhood
  - Attention seeking behavior/ demand fulfilment
  - Frustration and inability to communication
  - Physical discomfort
  - Psychiatric disorder
  - Integral part of the ASD and its course
- Risk assessment- risk for others particularly family members and risk for the child specially degree of dangerousness his self-injurious act including possible head trauma.
- Full psychiatric assessment for any emotional disorder-anxiety and depression, or specific and nonspecific disruptive, impulse-control disorder, and catatonia.
- Full medical assessment for general health status and possible physical disorder.

b) <u>Outline of the interventional plan</u>

Some problems are manageable, some are modifiable.
Bio-psycho-social approach for management should be adopted.

- Hospitalization and rapid tranquilization if needed.
- Use of a helmet.
- Referral for possible TBI or other brain disorder.
- Drugs- increasing the dose of risperidone or considering other alternatives- quetiapine, olanzapine.
- Addition of a mood stabilizer, preferably Lithium.
- ECT if needed, particularly if the patient has catatonia and non-responsive to usual treatment Alternatively, other brain stimulation therapies, if available or hyperbaric chamber if indicated and available.
- Behavior modification therapy at workable condition-contingency management is helpful in combination and for sustained effect.
- Acting on minimizing the cause as explored during assessment.

[NTK:
Comorbidity is usual in ASD both in children and adolescents. Low function ASD is usually associated with other developmental disorders including co-occurring seizure disorder. In contrast, high functioning autism has more emotional disorders like anxiety and depressive disorder. The behavioral problem or disorder usually presents with autism of all types more specified in high functioning and unspecified form in low functioning autism. Other than this, frequency of any psychiatric disorder is equally prevalent with ASD at any age and sex.
Most common comorbidities are-

- ID (low IQ 100%; ID is also higher)
- ADHD (30-60%) & ODD
- Disruptive behavior disorder- intermittent explosive disorder, Impulse control disorder in the form of violent aggression
- Any form of anxiety disorder especially specific phobia & social phobia

Regular psychiatric evaluation is necessary for ASD children and adults for its lifelong continuity and expected psychiatric comorbidity.]

Key role of a child and adolescent psychiatrist in autism.

- Diagnosis, treatment planning, necessary treatment and follow-up
- Treatment of comorbid psychiatric condition
- Appropriate referral and educational placement
- Helping the family and working for protecting the rights of ASD children
- Advocacy

Major indications of hospitalization in child and adolescent psychiatry

- NDD with behavioral disturbance
- High level of conduct problems
- Major depression and self-harm
- Early onset psychosis]

4. A 3-year-old child is referred to CAMH OPD by a pediatrician who is not talking and said to appear not to understand what his parents say.
On basis of your extraction of the given information─
a) What is the best possible differential diagnosis?
b) Outline your assessment necessary to clarify the diagnosis.

Given information

Demography and referral
Age- 3 years
Sex- Male
Referred by- Pediatrician
Referred to- CAMH OPD

Chief complaints
- Not talking- duration not mentioned
- Does not understand what his parents say- same duration

Extracted information

This boy of early childhood cannot speak and understand his parents' speech. These problems become apparent by the age of 3 which indicates the onset is earlier and developmental in origin.

Most common causes of absence of speech and comprehension at this age are ASD, ID/GDD, and Communication disorder.

The boy has problems in communication in the form of absence of speech and comprehension. Lack of understanding of others' talk is very much indicative of having social impairment. Therefore, the most likely cause is ASD. Here other features of ASD need exploration.

The child may be a case of intellectual disability, as he may not understand others' talk due to low intelligence and poor adaptive behavior. Language delay or deficit is often a presenting feature of ID in early periods and may present with ID as comorbidity.

His deficit of production and comprehension of speech at this age is also indicative of developmental speech and language disorder /communication disorder. In that case, age appropriate social interaction and intellectual abilities will remain normal though it may be limited due to impaired communication.

The child may be a case of global developmental delay considering his 3-year age. Some children have delay in all spheres of development and can catch up within the age of 5 years. In that case, there will be a deficit in motor and other areas of development along with communication. However, there is no such information of deficit in other areas and likely no such as the main concern of the parents that they noticed the child's communication problem.

There is also the possibility of having all these disorders as comorbidities. As the majority of ASD, patients have ID and a significant number of children with ID have comorbid communication disorder. Further, there is the possibility of having ADHD, other learning disorders and other neurodevelopmental disorders that need exploration.

These problems can happen due to congenital dumbness, deafness, or brain disorder. Referral to psychiatry indicates that the child has no such problems that have been ruled out.

It is clearly indicative that the boy has impairment of expected learning and parents are concerned about the problem.

Assigned task

a) The best possible differential diagnosis

From above extraction and logical interpretation of the given information, the best possible differentials are:

- Autism Spectrum Disorder
- Intellectual Disability
- Speech and language disorder/Communication Disorder

b) Outline of the assessment necessary to clarify the diagnosis

- History

  Other features of autism
  - Core features evident from neurodevelopmental period
  - Language deficit- complete lack of speech
  - Non-verbal communication deficit
  - Deficits in developing, maintaining and understanding relationships
  - Restricted repetitive activities or interests

  Feature of intellectual disabilities
  - 90% ASD has low IQ
  - ID may present with or without features of autism
  - Intellectual and adaptive functioning deficits

- Observation

  Direct observation in clinical settings, home and playground particularly aloofness, nonverbal communication, social interaction, restrictive & repetitive behavior and movement, hyperactivity or deficit in motor skills. Here, video monitoring & watching records and parents report and record will be additionally helpful.

- Medical assessment

  Checking all medical records and examination of hearing organs.

- Psychometrics

  Following validated tools will be applied:
  M-CHAT (Modified Checklist for Autism in Toddlers)
  Diagnostic Interview for Social & Communication Disorders (DISCO)
  Dimensional & Diagnostic Interview (3di)
  Vineland Adaptive behavior Scale

5. An 11-year-old girl is brought to CAMH OPD for her increasingly poor academic performance. Her worried parents report that she makes silly mistakes and forgets immediately after learning schoolwork. Schoolteachers most of the time censured her and parents called on for her poor performance.

Analyzing the scenario─

a) What is the most likely diagnosis?

b) What are the areas you need to explore for confirming the diagnosis and making an intervention plan?

Given information

Demography and referral

Age-11 years
Sex- Female
Occupation- Student
Referred to-CAMH OPD
Referred by-Parents

Chief complaints

- Does silly mistakes in school work-duration not mentioned, likely long
- Forgets immediately after learning- same duration
- Increasingly poor academic performances- subsequent duration
- Frequently ensured by school teacher and parents called on for that-subsequent event

Extracted Information

This early adolescent girl has increasingly poor academic performance for a long period despite the girl's own and joint effort of teachers and parents clearly indicates this girl has a learning disorder and likely is a case of intellectual disability. Her disability is likely at a mild level as she goes to mainstream school, no remarkable problems and concerns are mentioned in her social and personal caring and because up to a certain age parents and teachers could not understand the problem. Rather, teachers frequently censure her and parents are called several times, possibly because they think that the girl is reluctant to concentrate on her work. When the demand of the environment exceeds the capacity of the child, the diagnosis becomes apparent.

The girl could be a case of a specific learning disorder because in such cases the child makes silly mistakes, forgets, and performs poorly. It is usually apparent from early years in particular areas like reading, spelling, and calculating. In this case, it can be assumed that her learning impairment is global rather than in a specific area.

She may be a case of ADHD where there is poor academic performance, forgetting school work. However, inattention, hyperactivity or impulsivity is not reported, rather it seems that the girl tries her best but to perform better.

It is likely that the girl is distressed as she fails to fulfil the expectation of teachers and parents rather than verbally abused by teachers that she perceives.

Parents are concerned and supportive, now worried about her problems and seeking medical support.

Assigned task

a) Most likely diagnosis

From the above extraction, the most likely diagnosis is Intellectual Disability, Mild.

b) The areas need to be explored for confirming the diagnosis and making an intervention plan

- Details of her academic performance- onset, nature, efforts of the girl, teachers and parents and the outcome.
- Confirming the level disorder of deficit in intelligence and adaptive behavior functioning.
- Checking for the features of any specific learning disorder, ADHD or any other neurodevelopmental disorder.

- Enquiry for anxiety, depression or any other emotional and behavioral problems.
- Checking the milestone for all dimensions of development- for any delay, catchup, or residual problems.
- Temperament of the girl- easy or difficult.
- Level of the girl's impairment of functioning in all domains with special emphasis on her personal skills, peer relations.
- Parental attitude and behavior, level of family support.
- Perception of teachers and parents about the problem and their expectations.
- Strengths of the girl- special abilities and interest.

6. A 17-year-old boy appears in CAMH OPD with an irritable mood for the last 3 months. Subsequently, he has developed mild hand tremor and spastic gait that are gradually increasing. History reveals that parents have consanguinity. On examination, cogwheel rigidity was found.
Considering differential diagnosis from the above information─
a) What is the most possible diagnosis to explain his condition?
b) What essential steps will you do to confirm the diagnosis?

Given information

Demography and referral
Age- 17 years
Sex- Male
Referred to- CAMH OPD
Chief complaints
- Irritable mood- 3 months
- Mild hand tremor and spastic gait gradually increasing - subsequent duration

Family history
Consanguinity of marriage

Clinical exam findings
Cogwheel rigidity

Extracted information

This late adolescent boy has irritable mood and clear neurological features-tremor, spastic gait and cogwheel rigidity. With this features the best possible differentials are:

1) Wilson's disease- due to neuropsychiatric presentation, consanguinity of marriage.
2) Neuroleptic induced Parkinson's disease – The boy has tremor, rigidity. Though he has spastic gait but possible reason of getting neuroleptics are not mentioned in history.
3) Conversion disorder- manifestation of this disorder is usually with neurological symptoms and irritability may be present. However, the symptom cluster does not seem anomalous or inconsistent and no other associated features are mentioned here.
4) MDD- This boy may be a case of major depression as he has an irritable mood at this late adolescence age. However, no other features of depression are evident. Furthermore, Wilson disease can present with emotional and behavioral symptoms and the first neuropsychiatric manifestation of this disease can be mood change like irritability, depression.

Assigned task

a) <u>The most possible differential diagnosis to explain his condition</u>

From the above extraction, the best possible diagnosis is Wilson's disease.

b) <u>Essential steps to confirm the diagnosis</u>
- Taking family history of Wilson's disease
- Medical history of jaundice
- Physical examination- Slit lamp examination of eye for K-F ring
- First line investigations

  CBC with PBF
  24 hours urinary copper
  24 hours urinary copper with penicillamine challenge (gold standard)
  Serum ceruloplasmin
  MRI of brain (Panda sign)

7. A 7-year-old male child brought by his mother in the CAMH OPD for periodic follow-up who has autism spectrum disorder and marked hyperactivity. The drugs work a little and the mother is tired with the boy. The mother also brings her another 5-year-old child for consultation who is gradually doing similar behavior of her older.
Providing logical deduction of the given information─
a) What is the best possible explanation of the problem of her younger child?
b) What are the points you need to consider in assessing the situation of the family as a whole?

Given information

Indexed child

<u>Demography and referral</u>
Age- 7 years
Sex- Male
Reason for visit- follow up
<u>Chief complaints</u>
Persisting symptoms of autism of hyperactivity- not mentioned, expectedly long
<u>Psychiatric diagnosis</u>
ASD, ADHD
<u>Treatment</u>
Getting some drugs, improved a little

Second child

<u>Demography and referral</u>
Age- 5 years
Sex- Female
Referred to- CAMH OPD
Referred by- Mother
Reason of referral- psychiatric consultation
<u>Chief complaints</u>
Behavior similar to elder brother increasing in time- not mentioned likely recent onset

Extracted information

Indexed child
This boy with mid childhood is a diagnosed case of ASD and ADHD. He is getting treatment with drugs and likely combined with other measures and response is poor, possibly having more externalizing behavior for that the mother is frustrated and tired with the boy.

Younger child
Behavior of the younger child is certainly externalizing in nature and she is unlikely a case of ASD and ADHD as these disorders usually cannot start at this age unless the ASD is extremely atypical and ADHD with very secondary cause. Such information does not exist at all. This child is either possibly normal or may have some behavioral problems.

The best possible explanation is that her problem at least in part develops through observational learning of her elder brother and its consequences and puzzled mother perceives it as the same problem as her brother. Father, the behavior of the first child can cause a chaotic family environment, and influences negatively on parental attitude and behavior. Here, assessing the mother's perception is essential along with her mental health state. As having two children below the age of 7 years of which one has persisting two disorders are certainly a serious stressor for the mother who expresses in the word 'tired'.

The individual and combined impact on these children are likely severe, which is possibly a big barrier to manage them and expectedly burden to the family, particularly the mother.

Assigned task

a) The best possible explanation of the problem of the younger child

From above extraction and logical deduction, the best possible explanation is, this girl is normal and her some behavioral problems are through observational learning and imitation reinforced by the family factors.

b) The points need to be considered in assessing the situation of the family as a whole

Here, thorough family assessment is necessary with the following points.

- State of adherence to the treatment of the indexed child and level of execution for reviewing his treatment and necessary changes.
- Examining the onset, types, frequency, persistency, impact of problems of the second child.
- Impact on the individual child and individual and combined burden to mother and family.
- Mother's perception about the problems of the first child and treatment outcome, and the recent problems of the second child along with identifying the reason for her assumption of her behavior similar to the first child. Possible reason could be that she is helpless and needs support, overburdened that she cannot share or is sick mentally (commonly depressed)or physically or both.
- Expectation of the mother from the CAMH facility.
- Family factor
    - Family type- joint/nuclear, organized/disorganized
    - Family functioning level—quietly functional/ dysfunctional
    - Attitude and behavior of the parents- overprotective or hostile/rejecting, any change in negative direction as reaction to the children's behavior added with their own frustration

- Other caregivers' attitude and behavior- particularly important for joint family
- Level and source of family support
- Strengths of the family and individual child
- Family history of psychiatric illness
- Interaction among the family members- adult-adult, adult-child

[NTK: 20-40% mother of autistic child is depressed]

8. A 14-year-old boy with ADHD is under treatment. Since one year, he has been increasingly demanding. He is unwilling to go school and study. Though he is meritorious, he fails in all subjects and is thereby not promoted. He does not want to go out of home, rather disturbs his parents and elder sister with very negligible matters and becomes verbally and physically abusive to them. His parents try to manage him by fulfilling his demands and undue desires. Very recently, he becomes violent and takes a knife to kill his mother and sisters.
Considering the best possible comorbid condition on the basis of your extraction of the given information─
a) Prepare a checklist of information for assessing this boy.
b) What will be the treatment plan for his present conditions?

Given information

Demography and referral
Age- 14 years
Sex- Male

Chief complaints
- Increasingly demanding- one year
- Unwilling to go to school and doing study, thus not promoted- subsequent duration
- Disturbs parents and elder sister and verbally and physically abusive to them- subsequent development
- Violent attack with knife to kill his mother and sisters- recent onset

Present psychiatric diagnosis
ADHD, under treatment.

Extracted information

ADHD is a neurodevelopmental disorder having problems of hyperactivity, impulsivity and inattention. This mid adolescent boy is a diagnosed case of ADHD and receiving treatment. As there is no indication of symptoms in chief complaint, it can be assumed that with treatment his hyperactivity has been managed sizably. Inattention and impulsivity persist as evident by his refusal to study and abusive behavior respectively.

Challenging behavior as expressed through defiance to do academic work, deliberate annoyance, impulsive, abusive and violent behavior, clearly indicate that the boy has disruptive behavior and this is the main problem and cause of seeking consultation.

This disruptive behavior is most likely explainable as part and as consequences of ADHD, or comorbid disruptive behavior disorder or blended with the both.

Disruptive behavior either ODD or CD is a common comorbidity of ADHD. The most disruptive behavior of this boy goes in favor of oppositional defiant disorder. His recent violent behavior with using weapons is the symptoms of conduct disorder. However, this happens on one occasion at home indicating that at present likely he is not a case of conduct disorder. However, the features indicate the continuity of behavioral problems towards this disorder.

This challenging behavior happens at home towards family members and is increasing day by day. In the face of such behavior, the parents fulfil his undue demands. Such kind of reinforcement helps to maintain the behavior.

Unwilling to go to school and work, disruption of home life clearly indicates that this boy has gross impairment of all domains of daily life.

Assigned task

a) Checklist of information

Assessment of ADHD symptoms
Hyperactivity, inattention and impulsivity- severity and pervasiveness of each symptom.
Age of onset (preschool year indicates early onset and poor prognosis).
Impact of the problems in social, academic and other important areas of functioning.

Assessment of disruptive behavior
Apart from aggressive behavior towards family members, other areas should be sought. Aggression outside family and towards animals, destruction of property, deceitfulness or theft and serious violation of rules are diagnostic features of conduct disorder.

- Problems with social relationships (e.g. peer relationship)
- Birth and developmental history (e.g. delay in speech or language acquisition)
- Parenting style (mostly indifferent or permissive)
- Level of intelligence with psychometric tools

b) Treatment plan

Continuing ongoing ADHD medication as the boy has been responding to it. Advising periodic follow-up to review treatment.

Psychosocial management
Family focused
Parental Counselling- to support them, expressing desired behavior, taking active participation in the intervention, creating a healthy family environment.
Parent management training- parents will be taught about effective techniques for handling undesired behavior. Positive aspects of parent- child relationships will be promoted.

Adolescent focused
Behavior modification therapy.
Problem solving skill.
Social skills training.
Individual psychotherapy.
Drugs- SSRI for anxiety and depression, Low dose antipsychotics- for uncontrolled violent behavior.

9. A 12-year-old boy attends the psychiatry OPD with his parents. Parents say that the boy is very restless and inattentive in study. Teacher complains that he disturbs in class, makes silly mistakes and never finishes his task. The boy is fidgeting most of the time.
Considering most likely diagnosis based on logical deduction of the given information─
b) List the information you need to gather for confirming diagnosis and making a treatment plan.
a) What treatment will you offer for this case?

Given information

Demography and referral
Age- 12 years
Sex- Male
Referred to- Psychiatry OPD
Referred by- Parents

Chief complaints
- Very restless
- Inattentive to study
- Disturbs in class
- Does silly mistakes in class work
- Never finishes his task

M/S/E finding
Appearance- Fidgeting most of the times

Extracted information

The boy with early adolescent period exhibits symptoms of inattention (inattentive to study, makes silly mistakes, never finishes tasks), hyperactivity (fidgeting, restlessness) and impulsivity (disturbs in class). The symptoms are the diagnostic criteria for Attention-Deficit/Hyperactivity Disorder (ADHD).

As the boy is 12-years-old, it can be assumed that the symptoms have onset before that.

Symptoms are present at home and in school, setting indicates both perversity of the problems.

Complaints from teachers and psychiatric consultation by parents indicate functional impairment.

Considering all these facts, it can be said that symptom criteria, duration criteria and impact criteria of ADHD have been met.

Assigned task

a) Information need to be gathered for confirming diagnosis and treatment planning

Considering the most likely diagnosis of ADHD the following information will be gathered to confirm the diagnosis and make a treatment plan.
- Age of the child from when the symptoms have been apparent.
- Chronicity of the symptoms (present for 6 consecutive months).

- Extent of symptoms (other symptoms according to DSM-5 or ICD-10).
- Perversity of the symptoms in different settings especially in the playground.
- Presence of features of disruptive behavior like defiance, aggressiveness and antisocial behavior.
- Level of impact of the problems on the child and degree of burden to the family.
- Birth and developmental history of the child.
- Comorbid other neurodevelopmental (especially ASD, ID, specific learning disorder) or psychiatric diagnosis (e.g. mood disorder, psychotic disorder).
- Co-occurring medical disorder (e.g. epilepsy).
- Family factors-parenting style and relationship between parents, family size, number of siblings, family history of psychiatric disorder.
- Efforts taken by the parents and its outcome including past treatment history.
- Perception and expectation of the family about the problems.

b) Treatment plan

For making a feasible and effective treatment plan involvement of the boy, parents, teachers are necessary. With this view treatment plan will be as follows:

General

- Explanation, reassurance and support to the boy and parents.

- Psychoeducation- nature, presentation, comorbidity, impact and burden, intervention and possible outcome. This should be explained to the boy, parents and teachers in their own level of perception and understanding.

- ADLP- through a structured routine prepared jointly by the boy, parents and teachers with mutual understanding and joint consent. Feasibility should be the main consideration rather than ideality. Supervision, monitoring and on time feedback to the boy is essential. After review, necessary change in the routine is to be made. Reinforcement can be added with this ADLP for better outcome. For that, keeping a clear performance record is essential.

- Wellness activities- physical exercise, play, creative and other recreational activities as the boy preferred

Specific

- Medication- at this severe and chronic state medication is necessary.
  First line- Methylphenidate- initially shot acting followed by long acting.
  Switching to lisdexamphetamine if methylphenidate fails after 6 weeks of trial.
  Second line- Atomoxetine
  Other option- Clonidine, atypical APD (Risperidone, Aripiprazole).
- In treatment refractory condition, using deep brain stimulation (if available) as combination, alternative or adjunct.
- Back to School behavioral program- for regular school attendance.
- Behavioral modification therapy by palling and withdrawing reinforcement of increasing his targeted desired behavior and decreasing undesired behavior.
- Parental counseling- to support the family, exerting desired behavior to the boy, establishing effective communication
- ADHD focused group parent training program.

- School based program.
- Providing stimulating classroom activities with closed teachers' supervision.
- Engaging the boy with group play and encouraging effective peer relationships.
- Prevent him from bullying others and being bullied.
- Praising his desired performance, creative activities and skills.

10. A 2-year-old girl has speech difficulty as his parents observed and concerned parents bring this child to a child and adolescent psychiatrist for this problem. The child is smiling and has a good response.
a) Mention your differential diagnoses extracting points from the above scenario.
b) List the information you need to gather during evaluation of this child.

Given information

Demography and referral
Age- 2 years
Sex- Girl
Referred by- Parents
Referred to- Child and adolescent psychiatrist
Reason for referral- assessment and intervention

Chief complaint
Speech difficulty- not mentioned

Extracted information

By the age of 12 months children start saying a word or two and by 2 years of age more words and can put two words together to make meaningful sentences. Considering this milestone, this child has speech difficulty.

The possibilities range from complete absence of speech leading to social impairment to minor speech delays or articulation problems without significant impairment.

As the parents are concerned, it can be inferred that the boy has a significant problem.

Child having intellectual disability may have speech difficulty as a part of the ID and explainable to her mental age. The child has a good social response. Whether it is age appropriate needs exploration.

Autism Spectrum Disorders characteristically involve language delay or deviance. However, full-fledged clinical features of ASD are usually expressed after the age of 3. Here this child has good social and nonverbal communication evident by her smiles and response to the environment therefore, possibility of ASD is less likely. However; here is a strong possibility of catching up through appropriate environmental stimulation.

Global developmental delay is another possibility. Here no such indication or evidence of having delay in her milestones of development in any other domains.

Hearing impairment is the most important reason behind speech and language disorders. Here, attendance to a psychiatric facility by concerned parents without exclusion of possible physical causes is less likely.

Assigned task

a) Differential diagnosis on the basis of extraction

- Speech and language disorder/ Language Disorder
- Intellectual Disability

b) Information need to be gathered
- Nature and extent, severity, persistency of speech difficulties (phonological/articulation problem, pragmatic language impairment).
- Non-verbal communication intact in language disorder and explainable according to the level ID, impaired in ASD.
- Other developmental milestones- assessing physical, social, emotional and cognitive milestones to rule out global developmental delay.
- Causal assessment- pre or perinatal history.
- Family history of any neurodevelopmental disorder.
- Checking and rechecking hearing. If necessary, audiometry will be done.
- Parental understanding about the problem and expectation.
- Psychometric tools. Following validated tools will be used.
  Validated Diagnostic Interview for Social & Communication Disorders (DISCO)
  Validated Vineland Adaptive Behavior Scale

11. A 14-year-old boy attends CAMH OPD with his father. Father says that the boy cannot perform well in his study due to his "mental disability" and seeks a certificate to get possible benefit from the educational authority.
a) How will you proceed before issuing such a certificate?
b) List the areas that you need to assess.

Given information

Demography and referral
Age- 14 years
Sex- Male
Referred to- CAMH OPD
Accompanied by- Father
Reason for referral- Seeks certificate to get possible benefit from the educational authority

Chief complaints
Cannot perform well in his study due to his “mental disability”- not mentioned likely long

Extracted information

The term “mental disability” reflects the boy’s inability to achieve age-appropriate intellectual and adaptive functioning.

As this mid adolescent boy is not studying in a special school and the father has no other concern than his study, the severity of the intellectual disability can be said to be mild. Because, in mild ID the social functioning is adequate and the child can cope in mainstream schools. Their intellectual deficits remain unrecognized unless the demand of the situation exceeds their capability.

It needs to be mentioned here that in mainstream school there is provision of some listed benefits for students with intellectual disability including special supervision of teachers, getting more time in examination.

Assigned task

a) Proceeding before issuing certificate

Explaining to the parents about the boy's problem, mentioning the list of special privileges for such children from the educational authority and process of issuing such certificates and the assessment plan.

In order to get a certificate for intellectual disability, an application should be submitted in the hospital office or psychiatry department as per existing rule. After that, the following steps are to be taken.

- Particulars of the patient: Name in full, age, sex, religion, education, occupation, present and permanent address, name of the parents, legal guardian of the child. Here, a child's identity check is mandatory by necessary documents.
- Presenting complaints if possible, from parents and from school.
- Possible benefits from educational authority if found disabled.
- Forming a medical board composed of three consultant psychiatrists.
- If the boy is found disabled that would be mentioned in the certificate along with the severity level.
- After issuing the certificate, the parents will visit the civil surgeon’s office for the final approval.

b) Areas need to be assessed

History

Intellectual functioning level (reasoning, planning, problem solving, abstract thinking, judgment, academic learning and learning from experience).

Adaptive functioning level (communication, social participation, independent living across multiple environments).

Onset of the problem (in the developmental period).

Whether the poor academics is due to lack of effort or not, emotional problems or social disadvantage.

Presence of any other neurodevelopmental disorder especially ASD.

Presence of comorbid psychiatric disorder (e.g. Depression).

Family history.

Birth history, especially perinatal infection.

Physical examination

Careful physical examination, particularly for neurological signs, dysmorphic features and the skin signs of the neurocutaneous syndromes (neurofibromatosis, tuberous sclerosis).

Investigations

Psychometric tool: Wechsler Intelligence Scale for Children, fourth edition

Lab investigation: to the cause of the ID based on clinical assessment. Here, special emphasis will be given to the most common and manageable cause like hypothyroidism and chromosomal abnormalities, fragile X syndrome, and metabolic disease.

[NTK: According to "National strategic plan for Neurodevelopmental disorders 2016-2021", Neurodevelopmental disorders include ASD, Down syndrome, ID and cerebral palsy]

Education plan for person with neurodevelopmental disorder (PwNDD)

- Most children with NDDs will need some special education before eventual mainstreaming to the regular schools.
- A small percentage of children with NDDs (mostly those with very mild disabilities) may be able to go directly to mainstream schools.
- Some children with NDDs will neither be able to go to mainstream schools nor to special schools for education. This is usually because they are unable to function in classroom environments, or were forced to drop out from mainstream/special schools for any particular reason, or were never able to go because of socioeconomic reasons. For such children, there needs to be non-formal learning options that give them some qualifications needed for survival in society and sustainable employment.
- Special schools should develop their students with the primary aim of enabling them to transition to mainstream schools, colleges and universities.
- Employment specialists should plan and coordinate the career planning, exploration and vocational development of PwNDDs in special schools. They should also assist those students in mainstream schools in choosing their career paths, as well as develop vocational training programs for PwNDDs outside the school system.

- PwNDDs who graduate from mainstream education could either go directly into employment or seek vocational training.
- Those students with NDDs who were never able to become mainstream generally move towards vocational training after they complete schooling.]

12. An 18-year-old intermediate student had three short-lived episodes of hearing voices. Each episode had occurred when she did study at night to combat his academic load and had really frightened her. Before these episodes, she reported feeling faint for a few minutes and experiencing the sensation of *déjà vu*.
Based on your logical deduction and interpretation of the given information in the scenario─
a) What is the most possible diagnosis?
b) How will you treat this case?

Given information

<u>Demography and referral</u>
Age- 18 years
Sex- Female
Occupation- Student

<u>Chief complaints</u>

- Feels faint for few minutes at night in awakening, episodic- duration not mentioned likely recent
- Sensation of *déjà vu* along with- same duration

- Three episodes of hearing voices, short-lived prior fainting experience that frightened her –same duration
- Associate stressor- Academic load

Extracted information

This late adolescent girl is clear and at least three episodes short lived auditory hallucination, followed by experiencing fainting and *deja vu* for a few minutes. Clearly indicates the girl has temporal lobe epilepsy. Persistent anxiety or stress precipitates such epileptic episodes. The girl is stressed with her academic load and tries to cover it up by doing night time study, possibly depriving sleep.

Her frightening experience is due to psychological reaction to unusual events particularly auditory hallucination and likely a normal response.

De javu can be associated with persistent anxiety. Though this girl is anxious about her academic issues, this is state anxiety and other features do not support the anxiety disorder.

This girl could be a case of conversion disorder due to her inability to cope with academic load with the presentation of fit-like features and hearing voices. However, her presentation is not anomalous and inconsistent, clearly clustered and explainable by epileptic type of episode.

That could be due to sleep deprivation or normal experience of excessive load. Here it is clearly episodic typical for TLE and repetitive in nature with 3 or more times that will not happen in normal experience or else.

Assigned task

c) <u>The best possible diagnosis</u>

From the extracted information of the given information in the case scenario, the best possible diagnosis is Temporal Lobe Epilepsy/ Complex partial seizure because,

- Symptoms are short lived, episodic; precipitating aura present and the experience is frightening.
- Not associated features of conversion disorder like attention seeking behavior, la belle indifference is present and the symptoms are not anomalous.
- Good insight present.
- *Déjà vu* related with neurobiological abnormality.

d) <u>Treatment</u>

Explanation, assurance and empathic support to the girl and caregiver.
AED- with inadequate dose and duration following the general principle of prescribing AED.
Monotherapy with carbamazepine or oxcarbamazepine is the first line.
Alternative AEDs for monotherapy- levetiracetam/valproate/topiramate/lamotrigine.
Dose adjustment can be done after follow up of the patient and considering the response and adverse effect profile.

13. A 10-year-old boy appears to CAMH OPD referred by a GP who has been bed-wetting for 4 years. The boy was fidgeting, inattentive and moved around in the examination room. On questioning, the parents agree that the boy has hyperactivity since his early life and they thought it as normal. Considering dual diagnosis based on extracting points from the given information─

a) What are the areas you need to assess the child?
b) Make a comprehensive management plan.

Given information

Demography and referral
Age-10 years
Sex- Male
Referred to- CAMH OPD
Referred by-GP

Chief complaints
- Hyperactivity- since early life
- Bed-wetting- 4 years

M/S/E findings
Appearance and behavior- fidgetiness, inattentive, moved around the room

Extracted information
This boy of late childhood has been bedwetting for the last 4 years. That means the boy achieved bladder control before age of 6 years and loses it again at 6 years of age. Therefore, this is a case of secondary enuresis.

On appearance, the child found to be constantly fidgeting and moving around, indicative of over activity, along with inattentiveness. Moving around is likely an expression of impulsivity. All these features clearly indicate that the boy has ADHD. However, the parents did not complain about that issue. On query, they admit the onset of the problem in the early developmental period. It is possibly due to the lack of understanding of parents that such types of persistent and excessive features in their child are excess than normal and manifestation of a disorder. The boy's hyperactivity is severe as observed in his appearance and behavior that is further supported by GP referral.

The boy might have ASD as he was inattentive and constantly moving around that may be the part of autistic aloofness and repetitive behavior & movement. Further, ADHD is a common comorbidity of ASD. Here, in the given information no specific features of ASD is mentioned and it is unlikely that at this age social-communication problems will remain unnoticed. However, it needs exclusion.

Other comorbid neurodevelopmental disorders like speech problem, ADHD spectrum disorder, any specific learning disorder, ID may present with the boy that needs exploration.

At this age with long persistent problems can cause the development of emotional and behavioral problems that need to be enquired.

The parents seek treatment four years after the enuresis problem and ignore ADHD symptoms. It seems the parents are mainly concerned about the child's enuresis rather than hyperactivity. It is certain that undereating ADHD along with persistent enuresis has caused severe impact on this boy and burden to the family.

Considering all the factors together, it can be said that this child has dual diagnosis- ADHD, Severe along with persistent Nocturnal Enuresis.

Assigned task

a) Areas need to be assessed

Gathering information of enuresis

- Detailed history of wetting.
- Any other urological symptoms present or not.
- Distress and impact on child and family.
- Did the family do anything to manage enuresis? If so, what was that?
- Treatment history and outcome.
- Attitude of the parents toward the child.
- Predisposing factors (positive family history, stressful life events in early childhood), social disadvantage).
- Precipitating factors (stressful life events before the onset).
- Perpetuating factors (parental reinforcement).
- Are the parents motivated to participate in treatment?

Gathering information of ADHD

- Thorough assessment of hyperactivity-impulsivity and inattention symptoms.
- Pervasiveness (in home, school and other social settings).
- Chronicity of symptoms (presence of symptoms for at least 6 months).
- Age of onset of problems.
- Impact on the child and family.
- Psychometrics: validated Conners rating scales for severity and the and symptoms areas**.**

Other areas of assessment

- Any other neuro developmental problems or disorder- Speech & language Disorder, Specific learning Disorder particularly reading and writing, ID.
- Any other comorbid emotional or behavioral problems or disorder–especially any anxiety disorder, disruptive behavior disorder like ODD.
- Birth and developmental history- particularly birth asphyxia, speech delay.
- Intellectual and adaptive functioning level using psychometric tools.
- Family history of neurodevelopmental disorder specially ADHD and enuresis.
- Current social circumstances of the child (e.g. dysfunctional family, excessive reinforcement).
- Temperament of the child.
- Parental attitude and behavior.
- Combined impact and burden of both disorders on the child and family including domains of functional impairment
- Areas of strengths of child and level of family support.
- Parents' perception about the disorders and their expectations.

b) Comprehensive management plan

Common for both disorders

- Offering explanation, support and advice to the boy and the parents.
- Psychoeducation- explain the nature of the disorders, combined and cumulative effect on child, intervention and outcome.
- Treatment options and possible outcomes.

- Role of the parents and teachers.
- Parental counselling.
- Liaison work with school for school spurt and involvement in intervention.

For enuresis

- Behavioral measures-
  Emphasis on praise, attention and other rewards for dry nights rather than on criticism and punishment for wet nights.
  Making a wall chart of wet and dry nights for a month (with the child marking each dry night with a star).
- Enuresis alarm
- Bladder training- regular fluid intake and toileting during the day and voiding at a regular interval at night.
- Medication
  Desmopressin- first choice of drug
  TCA- Imipramine 25-75 mg at bedtime.

For ADHD

- Behavior modification therapy.
- Parent training program on parent's child management skill, ADHD focused group parent training program.
- Medication
  First line-Methylphenidate, initially short acting followed by long acting if response
  Switching to lisdexamphetamine if methylphenidate fail after 6 weeks trial
  Second line- atomoxetine
  Other options- Clonidine, atypical APD (Risperidone, Aripiprazole).
- Other components- Deep brain stimulation in treatment refractory condition (depends on availability and affordability).

14. An 11-year-old boy is referred to CAMH OPD from Neurology OPD for his persistent abnormal muscular movements. During the interview with his parents, the boy barks at infrequent episodes and shouts expletives.
Based on the logical deduction of the given information─
a) What is the most likely diagnosis?
b) Make an assessment plan.

Given information

Demography and referral
Age- 11 years
Sex- Male
Referred to- CAMH OPD
Referred from- Neurology OPD
Accompanied by- Parents

Chief complaints
Abnormal muscular movements persistent in nature-duration not mentioned

M/S/E finding
Appearance and behavior- barked at infrequent episodes and shouted expletives

Extracted information

This early adolescent boy has persistent abnormal muscular movements for whom he got psychiatric referral from neurology OPD. It is most likely not due to any gross neurological problems rather psychiatric problems and need such intervention.

The persistent abnormal macular movements commonly fall into neurodevelopmental motor disorders.

The child's unusual muscular movements associated with observed infrequent episodes of barking and expletive shouts are the clear evidence both motor tics and vocal tics and the boy has tic disorder. The child showed two and shouted explicates. These are indicative that the boy certainly has multiple motor tics as mentioned in the chief complaints.

Persistency of both types of tics at the same time at this age is very much indicative of Tourette Disorder. Here, confirming the exclusion of any other medical cause of tics are required.

It could be Persistent Motor or Vocal Tic Disorder and cross-sectional observation of both tics at this time may be incidental or transient. However, it is less likely because of patterned presentation multiple tics along with persistency.

Assigned task

a) Most likely diagnosis

From the above extraction, the most likely diagnosis is Tourette Disorder.

b) Assessment plan

- Details of the types, frequency, persistency, perversity and severity of both motor and vocal tics. Checking for common as well as rare forms like coprolalia, copropraxia, echolalia, echopraxia, palilalia as expletives are already present.
- Age of onset of the problems and duration as the disorder typically begins at prepubertal period and at least one-year duration is required to confirm the disorder.
- Overall course of the tics.
- Associate other features- like obsessive –compulsive symptoms, ADHD symptoms, and impulsive-aggressive behavior.
- Comorbid any externalizing (commonly anxiety), internalizing (commonly disruptive behavior- ODD, CD) disorders or problems, neurodevelopmental disorder (commonly ID, SLD), and substance misuse.
- Medical assessment for confirming the exclusion or presence of any organic causes of tics. - Neurological, GMC.
- Developmental history, educational status, past psychiatric and relevant medical history
- Temperament and parental attitude.
- Degree of impact over the boy including level of functional impact and burden of the family
- Stress assessment- particularly stressors related to school, peers and social relations with special emphasis on bullying.

- Risk assessment- suicide and self-harm.
- Strengths of the child- special abilities and skills, extracurricular activities and level of family support.
- Psychometric assessment-validated Yale Global Tic Severity Scale (YGTSS) for assessing severity, frequency and impact of the tics.

15. A 18-year-old boy who has ASD recently shows repetitive violent behavior for which he has been hospitalized.
a) List the areas you need to assess to manage this case.
b) Outline your treatment plan.

Given information

Demography and referral
Age- 18 years
Sex- Male
Referred to- Psychiatry inpatient department

Chief complaint
Repetitive violent behavior

Psychiatric diagnosis
Autism Spectrum Disorder

Extracted information

This patient has ASD with challenging behavior for which he has been hospitalized. It clearly indicates that this behavior is severe enough at this late adolescent age and likely unmanageable in outdoor settings and at home and certainly a risk for him and family members.

Self-injury is likely associated with the current violent behavior from wide ranges that needs to be addressed.

ASD is such a pattern of neurodevelopmental disorder in which the core problem is social communication impairment and restricted repetitive behavior. Apart from these associated features like self-injurious behavior (e.g. head banging, wrist biting) and disruptive or challenging behaviors are commonly present.

Following reasons may lead to violent aggressive and challenging behavior for this patient:
- Persistent disruption of set lifestyle for any reason.
- Persistent desire for reinforced attention or other reward.
- Effect of enduring or recent stress in family and immediate environment-abuse and bullying.
- Part of the ASD mainly due to persistent communication difficulties-unclear communication, insufficient vocabulary.
- Prolong adverse impact of the disorder over the patient- learning failure, absence of peer relationship or peer rejection, restricted recreation, under stimulating or overstimulating home life.
- Longstanding frustration that usually leads to aggression.
- Changing pattern of negative attitude and behavior of parents and family members as part of their increased burden and intolerance due to patient's disease-mainly hostile and rejecting.

- Presence of comorbid psychiatric disorder- ADHD, ID, Disruptive, Impulse-Control and Conduct Disorder, Anxiety Disorder, Depressive Disorder, Bipolar disorder, Psychosis.
- Combined effect of co-occurring Physical Disorder like epilepsy, TBI or any physical problem that causes pain, discomfort.
- Adverse or withdrawal effect of medication- sedative-hypnotics, phenobarbital.

Assigned task

a) Areas need to be assessed

Violent behavior

- Types, frequency, persistency and perversity of the violent behavior including self-injurious behavior.
- Checking for any injury, bruises or laceration.
- Assessing risk of harm of the patient and for others.
- Full assessment of ASD, its treatment and outcome, present status.
- The possible reasons for the violent behavior as stated in the above extraction, with particular emphasis on any externalizing or internalizing problems and psychotic features.
- Any sign of physical illness.
- Features of sensory deprivation.
- Stressors- abuse or loss, bullying, relocation, any exit and entry events.
- Daily lifestyle including any change of routine.
- Recent intake of any new medication and possible adverse effects.
- ABC analysis of his behavior with special emphasis on attention seeking behavior- nature and degree of reinforcement.
- Details of the efforts already taken by the family including receiving treatment to manage the violent behavior and its outcome.
- Lab investigation- Routine investigations, CT scan for any head trauma, EEG for possible seizures or existing epileptic status, and others relevant investigations indicated from clinical assessment.

Assessing developmental status

- Any other comorbid neurodevelopmental disorder.
- Physically challenged features-deficit or deformity, degree of physical underachievement and disability, if any.
- Extent of language and vocabulary impairment.
- Any other developmental backwardness including intelligence.
- Applying developmental assessment tools as appropriate.

Family assessment

- Family environment- Over stimulating or under stimulating, environment, any recent change.
- Attitude and behavior of the parents and family members-overprotecting, harsh, hostile and rejecting.
- Psychiatric and physical illness of parents and any family member.
- Any downgrading of SES of the family.

Impact and burden

- Areas of impairment at home, schoolwork (if any), peer relation/social interaction and leisure activities.
- Areas, extent and degree of burden to the family for the violent behavior and overall burden.

b) Management plan

General
- Explanation, support and advice to the patient and caregivers.
- Treating physical injury, if any.
- Maintaining nutrition and monitoring vitals.
- Continuous vigilance by direct observation and video monitoring.
- Maintaining ADL as per applicability.

Specific
- *Biological*
- Applying rapid tranquilization protocol.
- Risperidone/Aripiprazole (USFDA approved for treating behavioral disturbance in autism).
- Clozapine/Haloperidol/Valproate/Lithium- if non-responding.
- ECT- in treatment refractory condition.

Psychosocial
- Applying behavior modification therapy on the basis of functional behavioral analysis.
- Reinforcement strategies- Differential reinforcement to other than violent behaviors.
- Functional communication training (e.g. touching a picture of mother rather than hitting her in order to get attention).
- Managing stressors.
- Parent education and positive parenting.

16. A 13-year-old boy is referred by GP for psychiatric consultation who episodically cries, fears, rapidly breaths, chews, walks about, searches things and talks incoherently in sleep for two years for 5-15 minutes duration. The boy cannot recall the events when he is asked about. EEG finding for the boy was found normal. Parents are worried for the boy as the problem persists and increases gradually. Subsequently, the boy defies, demands things, is reluctant in study, and engages more with mobile gaming and watching TV.
Doing logical extraction and interpretation of the given information─
a) What is the best possible diagnosis to explain the boy's condition?
b) Outline treatment plan.

Given information

Demography and referral
Age- 13 years
Sex- Male
Referred by- GP
Refried to-Psychiatric facility
Reason for referral- Parents worry about persistency and increase of problems

Chief complaints

- Crying, fear, rapid breathing, chewing, walking about, searching things and incoherent talks during sleep, episodic with 5-15 minutes for each, persistently increased-2 years
- Cannot recall the events when asked-same duration
- Increasingly defiant, demanding behavior, reluctant in study, and engages more with mobile gaming and watching TV- subsequent onset

Investigation

EEG- Normal

Extracted information

Repeated awakening with described behaviors is a parasomnia feature. Inability to recall the events is the event amnesia and strongly indicative that these behaviors happen in NREM clearly indicates features of sleep terror disorder. (Fear arousal, crying, screaming, rapid breathing autonomic arousal-Sleep terrors).

Walking with complex behavior is likely due to sleepwalking.

No evidence of the features of seizure attack along with normal EEG, GP referral for psychiatric evaluation in general are the exclusion of epilepsy as well as evidence of prior non-psychiatric consultation.

Absence of any features of phobia, panic excludes these diagnoses.

The boy's disruptive features are most likely due to reinforcement from parents and previous intervention and channeling of his distress and not typical presentation of ODD/CD. However, there is a possibility of development of emotional and behavioral disorder.

Parental worries are rational and reinforced by past interventional failure.

Assigned task

a) The most likely diagnosis

From the logical deduction of the given information, the most likely diagnosis is Sleep terror (Night Terrors), Sleepwalking (Somnambulism) /NREM Sleep Arousal Disorders, both Sleepwalking and Sleep Terror type.

b) Management plan

- Explanation, support, reassurance and advice to the family.
- Applying ADL-restoring premorbid life.
- Safety measures.
- Getting extra 30-40 minutes sleep at night.
- Measures for managing disruptive behavior.
- Drugs- low dose BDZ, Low dose TCA.
- Periodic follow up.

17. A 17-year-old girl attends CAMH OPD with her mother who is over concerned about her weight. Mother says that she is losing weight and quarrels with parents if they talk about and try to prevent her efforts of losing weight. The girl looked irritable.
a) What is the single best possible diagnosis based on your logical deduction of given information?
b) Outline the treatment plan to manage this case.

Given information

Demography and referral
Age-17 years
Sex-Female

Chief complaints
- Loss of weight- duration not mentioned, likely long
- Over concern about weight-same duration
- Quarrels with parents if they talk about her weight loss and weight losing behavior- subsequent duration

M/S/E Findings
Appearance- irritable

Extracted information

This late adolescent girl has weight loss and weight-losing behavior as reported by parents. This weight loss seems to be significant as evident by the parental concern and seeking helps for the CAMHS. The weight loss efforts of the girl clearly indicate having compensatory measures to reduce weight further. That confirms that this girl has distorted thinking about her increased weight despite of losing weight. All these features go in favor of the diagnosis of anorexia nervosa. Here, the loss of weight is significant for this diagnosis needs confirmation.

The girl's irritability expressed through querulous behavior could be psychological reaction of her unwillingness for treatment and discussing her problems, consequences of her problem behavior or part of her syndromal depression that usually present. However, syndromal depression is not unusual with the case at this age.

There is no such specific indication of any features of other emotional or behavioral disorders or problems. However, this weight loss can be expressed as part of psychiatric disorders, mainly major depression and other eating disorders- Bulimia nervosa, Avoidant/restrictive food intake disorder. Comorbidity of other psychiatric disorders is also common with anorexia nervosa at this age. Detailed psychiatric assessment is required to exclude other disorders and explore any possible comorbidity.

A good number of general medical conditions can cause weight loss. Thorough physical assessment is required to exclude such causes.

Assigned task

a) The best possible diagnosis

Based on the above logical deduction from the given information in the scenario the single best possible diagnosis is Anorexia Nervosa.

b) Treatment plan

The specific and feasible treatment plan can only be made after assessment as indicated in the extraction usually as outpatient or inpatient when necessary. The basic outline is as follows:

General

- Explanation, support and advice.
- Psychoeducation about the disease, effect and diet.
- Restoration of expected weight: this is the immediate and sustained component of the treatment. Usually it is gradual and steady. That can be achieved by eating modest meals more often e.g. 4-6 times in a day.

Biological

- SSRI- for weight gain and if depression is present.
- Antipsychotic-olanzapine may help in weight gain.
- Drugs for the treatment of any comorbid psychiatric disorder.

Psychosocial

- Family-based therapy (FBT)-with the aim to involve the family as a resource of practical resolution of the disorder, particularly, to facilitate the desired weight gain keeping the girl towards the way of recovery.
- Family therapy- with the aim of restructuring the family that will enhance the whole recovery process.
- Behavior modification therapy- using reinforcement for diet adherence and targeted weight gain.
- CBT- at this age it is very effective. Particularly cognitive restructuring can change her deliberate weight losing behavior and gaining inside.
- Group therapy- effective in both patients group and affected family group.
- Social skill training.
- Problem solving training.

[NTK:
WHO categories of thinness in adults based on BMI are given here. For children and adolescents, corresponding BMI percentiles should be used.
Mild: ≥17 kg/m^2; Moderate: 16-16.99 kg/m^2; Severe: ≥15–15.99 kg/m^2; Extreme: <15 kg/m^2]

Chapter 3: Transcultural Child and Adolescent Psychiatry

1. A 12-year-old girl appeared in psychiatry OPD with intense headache followed by repetitive fit 3 days back. Nothing abnormal was found in neurological assessment and investigations.
Based on your logical deduction and interpretation of the given information─
a) What is the most likely diagnosis?
b) Make a checklist of content of assessment of this case.
b) Outline the treatment plan.

Given information

Demography and referral
Age-12 years
Sex- Female

Chief complaints
Intense headache followed by repetitive fit-3 days

Treatment and outcome
Neurological assessment and investigation done and no abnormality found

Extracted information

This early adolescent girl is presented with the complaints of headache followed by repetitive fit, for that no abnormality found in neurological assessment. The diagnosis goes more in favor of functional neurological disorder (Conversion Disorder).

Acute onset of the problems is suggestive of a stressful event prior to the attacks that needs exploration.

Associated features for conversion disorder are attention seeking behaviors, primary gain and secondary gain. Here, possible presence of those features at least reinforcement from parental help seeking behavior, and their concern and support for the diagnosis.

This girl may be a case of Somatoform pain disorder/Somatic Symptom Disorder as she has specific somatic symptoms-headache, unexplained by organic etiology. However, onset of this disorder is usually gradual and persists for a long duration (at least 6 months) associated with persistent and irrational thoughts, worries and related behavior.

This headache and engagement with help seeking activities expectedly disrupt the girl's daily functioning.

Assigned task

a) The most likely diagnosis

Based on above extraction for the given information the most likely diagnosis is Dissociative neurological symptom disorder/Conversion Disorder or Functional Neurological Symptom Disorder, as the patient has features that are suggestive of neurological disorder but neurological examinations and investigations revealed no abnormality.

Checklist of the content of assessment

- Etiological assessment
  Presence of any precipitating stressful event.
  Perpetuating factor- Primary and secondary gain.
  Predisposing factor- Temperament of the girl.
- School factor- history of bullying, academic stress or others.
- Family assessment
  Family history of psychiatric disorder.
  Parental attitude and behavior toward the symptoms.
  Relationship with parents.
  Family structure whether organized or disorganized.
- Treatment history details of the assessment and intervention including visit to traditional healers.
- Impact of the symptom on the girl and degree of burden to family and the parents.
- Strengths of the girl.
- Investigation- EEG, CT or MRI of brain if indicative.

b) Treatment plan

General

- Explanation, support and advice to the patient and caregivers.
- Explain the nature of disease, cause, psychopathology, treatment and outcome in their understandable way.
- Hospitalization, if patient warrants crisis intervention, or needs extensive assessment
- Maintenance of adequate food, nutrition and monitoring of vitals.
- If insomnia – give sleep hygiene and hypnotics for short duration if necessary.
- If anxiety and distress - relaxation and anxiolytics.
- Maintenance of an active daily living program.
- Initially minimum with gradual increase of activities. Set it with discussing patients on “as much as you can” basis.
- Reducing secondary gain or reinforcement.

Specific

- Minimizing symptoms by feasible suggestions.
- Resolution of stressor or conflict either removal, modification or acceptance.

If necessary, apply problem solving strategies, counselling, supportive psychotherapy, cognitive therapy, and insight-oriented psychotherapy, family counselling to make them clear about the pros and cons of all the options so that patients can adopt any of the above options.

Preventive Measures

This will be aimed from initiation of treatment and should be the main focus during follow-up.

Working with patient

Any vulnerable component of a patient's personality traits like anxiety prone mood, poor stress coping ability, dependent, avoidant, uncontrolled emotion, misperception of social cues, tendency to see and deal with the environment only through their own perspectives.

For this stress coping, assertion training, social skill training, CBT can be used.
Remedial education and other measures of rehabilitation with the aim of regaining premorbid functional status.

Establishing or rebuilding a patient's social network, if necessary.

Working with family
Managing dysfunctional family, unhealthy parental behavior, family conflicts including marital discords by positive parenting, family therapy and couple therapy where appropriate.

Developing supporting measures in the family partly by sharing and communication.

[NTK
In South-East Asian countries like Bangladesh, it is a very common pattern of expressing distress. In the face of fear of being stigmatized, some people do not share their mental problems. It is common in female gender, adolescent and young age group and rural and illiterate people. Their cry for help thus channelized in a maladaptive way like conversion]

2. An 11-year-old girl appears with hyperventilation and fit that occurred several times. She has been diagnosed as a conversion disorder in CAMH OPD but no definite psychological stressor has yet been identified. Two months back she had a similar episode that lasted for two weeks.
Considering the diagnosis, that best explains her symptoms─
a) Outline the steps of your management plan.
b) What information do you need to gather for preventive measures?

Given information

Demography and referral
Age- 11 years
Sex- Female
Referred to-CAMH OPD
Accompanied by-Parents

Chief complaints
- Hyperventilation and fit like the one attack several times lasted for two weeks –2 months back
- Same episode- Recent onset

Psychiatric diagnosis
Conversion Disorder, without psychological stressor

Extracted Information

This early adolescent girl is a diagnosed case of conversion disorder for which no stressor is yet identified. Her problems first appeared 2 months back several times for 2 weeks. As per rule and convention at least symptom free period of 2 months or more is necessary to consider it as past history.

Here, the initial onset of the symptoms is just 2 months back with 2-week duration. Further, nature of onset, course and reappearing symptoms are clearly indicative of the continuum of the same disorder

Certainly, this girl has a temporal psychological stressor that is not yet identified and unresolved that becomes enduring and may be added with sequential further stressors.

The diagnosis has been assigned by CAMH services in an outpatient setting, where identification of deep traumatic stress is difficult. It is also the convention, to recheck the diagnosis particularly important for any diagnosed case of conversion disorder to exclude any possible organic etiology.

Assigned task

a) Management plan

Key assessment for planning

- Reassessing the diagnosis of conversion disorder along with checking for associated features with details of her fit and hyperventilation. Here checking video recording of her problems is very helpful.
- Checking for any associated emotional problems like panic disorder, GAD or depression and disruptive behavioral features.
- Checking all records and doing general, systemic and neurological examinations.
- Lab Investigation: Here the principle will be minimum and necessary for the diagnosis and treatment plan.
- Serum electrolyte- to check the pathophysiological effect of hyperventilation as it may cause alkalosis. Serum Na HCO3 level, Serum Ca (for tetany-like feature for hyperventilation), ECG, Echocardiography, NCS [if not done before].

General management

- Explanation and reassurance to the patient and the caregivers.
- Hospitalization- if crisis intervention is needed or if the persisting symptoms are severe enough.
- Ensuring hydration, nutrition and bowel bladder care.
- Relaxation- Breath holding or PMR, simple yoga
  - Drugs- BDZ for anxiety and muscular tension
    SSRI for comorbid depression
- ADLP-Encouraging to maintain normal functioning

Specific management

Patient focus

- Encouraging Symptom reduction by suggestion. Breathing in bag- supervised breathing in bag (usually transparent polythene bag) in the state of relaxation. It usually works instantly in the majority of the cases. Cautionary measures are necessary for full safety.
- Explorative psychotherapy: Identification of stressors and removal/ modification/ acceptance of them. If required, aided exploratory technique needs to apply.
- Improving stress coping ability.
- Insight oriented psychotherapy to understand the dynamic principles and conflict behind the symptoms.

Parents focus

- Parental counseling-to support the family, showing desired attitude behavior to the girl, establishing sharing and communication.
- Encouraging the girl's desired behavior and discouraging undesired behavior by using reinforcement.
- Family therapy-if indicated.

b) Information needed for preventive measures:
- Patient's stress coping ability.
- Personal factors- child's premorbid temperament, social condition, academic condition, financial condition.
- Family factors- parenting style (overprotective/authoritative/hostile/rejecting).
- Environmental factor- school factors, social networking, occupational factors, sexual/physical abuse.

[NTK:
Repetitive Conversion disorder/ Persistent Conversion disorder in childhood
If stressor is assumed but not rightly identified, it can be suspected that there is strong possibility of having toxic stress like sexual abuse, serious parental discord, witnessing domestic violence, extramarital sexual act of parents.]

3. An 18-year-old girl attends CAMH services with her family member who has marked restlessness, irrelevant talks, emotional lability for 11 days and failure to recall the events in and around those days. She is untidy and has multiple bruises, and mutters loudly.
Considering differentials by doing logical extraction and interpretation of the given information─
a) What is the best possible differential diagnosis to explain the girl's condition?
b) Prepare a checklist of assessment for confirming the diagnosis and making a treatment plan.

Given information

Demography and referral
Age- 18 years
Sex- Female
Referred to- CAMH service
Accompanied by-Family members

Chief complaints
- Restlessness- for 11 days
- Irrelevant talks- same duration
- Emotional lability- same duration
- Loss of memory of the events in and around of those days -same duration

M/S/E finding
Appearance- untidy, loud muttering, multiple visible bruises

Extracted information

Failure to recall the events in and around the onset of all symptoms that appear more or less for the last 11 days and likely with sudden onset. It is likely that it starts after a recent traumatic event or

situation that she fails to cope with and traumatic stress has a temporal relationship with the onset of all the features. These features along with emotional changes like mood lability, restlessness-expression of inner negative feelings indicate this early adolescent girl is a case of dissociative disorder.

Considering the types of dissociative disorder, loss of memory of the events in and around those days is very much indicative of localized amnesia. The circumscribed failure to recall with acute and recent onset along with inner distress indicate this early adolescent girl is a case of dissociative amnesia.

If this amnesia is related with disruption of identity only, either one name and identity or presence of two or more distinct identities then the girl's diagnosis will be dissociative identity disorder. Alternatively, both dissociative amnesia and identity disorder will be diagnosed on the basis of sufficient evidence in favor.

Other features like loud muttering, irrelevant talks can be considered as associated features of dissociative state explainable in the cultural context of possession state or variant features of dissociative disorder. Common shared beliefs in this context are Jinn possession, ghost possession, evil spirit or identification with a bereaved person. Her loud talks could be an expression of distress or talking with some explainable entity. In this view, the girl may be a case of possession trance disorder.

The irrelevant talks, loud self-muttering untidy appearance are indicative of psychotic disorder with acute onset. However, there is no mentioned cardinal future like delusions, hallucinations, disorganized behavior and irrelevant talks may be present in many psychiatric conditions and not the same as incoherence or disorganized speech. Further, mood lability, memory loss is unusual with this diagnosis. Rather, these can better be explained by the variant presentation of dissociative disorder- Unspecified Dissociative disorder.

Reason for bruises may be result of restraining (as these are visible and likely marks only in hands and feet), domestic violence, physical or sexual abuse or sign of maltreatment by traditional healer possibly due to cultural belief of evil possession.

It is possible that the girl is a case of acute stress disorder as there is a strong possibility of traumatic stress as mentioned above. Impaired recall of traumatic events may present with this disorder, duration is 11 days, and has features of distress. However, there is no mentioned avoidance, over arousal, re-experiencing symptoms of this disorder. Rather, mood lability does not go with this disorder. As there is an anomalous relation between psychotic, emotional, mood and motor symptoms, it is unlikely to be a psychotic mood disorder.

This girl may be a case of mood disorder. Her restlessness, loud muttering may be an expression of irritable mood, agitation from her inner distress indicative of depressive disorder. Alternatively, these features along with labile mood may be the expression of irritable, euphoric or expansive mood, over activity and suggestive of manic episodes of bipolar disorder. Again, memory loss along with overall inconsistent features do not support this diagnosis

The girl's problems may be due to TBI or SOL or other cuss in the brain as amnesia is an extreme lability found in such conditions. In TBI it is usually retrograde and anterograde amnesia. Here, the amnesia is localized, patterns of bruises do not support it. For other conditions, the onset is insidious with gradual progression.

Assigned task

a) <u>The best possible differential diagnosis to explain the girl's condition</u>

From above mentioned discussion and confirming details based on extraction of the given information in the scenario, the best possible differential diagnosis is as follows:

- Dissociative disorder- Dissociative amnesia, Dissociative identity disorder, Possession trans disorder, Unspecified dissociative disorder
- Acute stress disorder
- Acute and transient psychotic disorder/ Brief Psychotic disorder
- TBI

b) Checklist of the assessment for confirming the diagnosis and making treatment plan

- Checking the type, extent of amnesia and its relation with any event and other features- to confirm the diagnosis of dissociative disorder and existence of one or more types.
- Confirming the expected traumatic event- types, time of onset, persistency, severity, girl witnessed or victim, coping strategy and state of coping failure.
- Evidence of any head trauma, nature, extent and related features, any psychiatric manifestation.
- Enquiry about the bruises including any other injury, cuts and gathering information of the reasons- maltreatment, restraining effort or physical and sexual abuse.
- Relevant information and evidence for addressing medico legal issues particularly for maltreatment and abuse

- Examining her irrelevant talks, loud muttering whether these are expressions of incoherence, delusions or hallucination and for other features of psychosis to exclude it.
- Searching for any features of acute stress disorders, predictors of PTSD, depressive disorders, bipolar disorder for explain her mood lability, restlessness and loud muttering.
- Risk- examining the risk of self-harm and suicide.
- Extent and level of the girl's distress and impairment over her, degree of burden to the family
- Socio cultural context- belief, attitude and behavior related with the girl's problems- causal and interventional belief particularly evil spirit, jinn possession, if the girl maltreated for that belief.
- Family assessment- parental attitude and behavior, any dysfunction, relationship between parents, parental illness, family stressors.
- Efforts taken by the family to address the problems including details of all interventions and checking relevant records.
- Strengths of the girl and support of the family.
- The girl and parent's perception about the problems and expectations from the facility.
- General health assessment and medical, neurological assessment for excluding any condition that cause the problems.
- If present and necessary relevant investigations including neuroimaging.

[NTK
Psychotic Dissociation- Typically, dissociative disorder presents with amnesia, fugue, disruption of identity and conversion disorder presents in the form functional neurological symptoms commonly motor or sensory or mixed in nature. However, there are variations of presentation of this disorder through bearing the heritage of hysteria. Psychotic presentation of dissociative disorder though not common but significantly seen in clinical practice, particularly in the South Asian region (also infrequently reported around the globe) and can be mistaken with primary psychosis. This condition is traditionally known as

psychotic hysteria, later psychotic dissociation. At this point, there is no specific room in the both ICD and DSM classification though it is certainly diagnosable within the types of Dissociative disorder in ICD 11 (e.g. Possession trance disorder, Other specified or unspecified dissociative disorder) and Dissociative Disorder (Other Specified Dissociative Disorder, Unspecified Dissociative Disorder) of DSM-5 for majority of the cases. Furthermore, these psychotic features are usually present along with the main features of dissociative/conversion disorder and straightforward assigning of this diagnosis is likable. Considering its clinical importance in Bangladesh, its main distinguishing features from psychosis are given here. Nevertheless, sometimes it is really difficult to differentiate and direct observation or video monitoring is necessary to confirm the diagnosis.

Distinguishing features of psychotic hysteria and primary psychosis

Feature	Psychotic Dissociation	Primary Psychosis
Age and gender	More among children and adolescents and female.	Mostly at adulthood of either sex.
Onset	Almost always acute.	Usually insidious also acute.
Duration	Short- few days.	Usually longer, sometimes brief.
Core symptoms	One or more psychotic symptoms are usually transient, inconsistent, anomalous with typical features of psychosis.	Typical cluster of psychotic features persistent, consistent and not anomalous with the expected features of psychosis.
Hallucination	Predominantly visual, also auditory content related to shared belief. Visual- vision of spirit, fairy or ghost scenic- enjoyable or terrified or mixed. Auditory- usually second person, advice or command in content frequently explainable by her unaware wishes, intention or distress.	Mainly auditory- content typically, third person, or first person (echoing of thought) comment, command, usually derogatory.
Odd belief	Conviction of possession and action of evil spirit (Jinn possession) or black magic, usually paranoid or control in content explainable by shared belief, overvalued idea or any other sociocultural context.	Conviction is truly delusional, ranging from bizarre to non-bizarre, unexplained by shared belief, overvalued ideas or sociocultural context.
Odd Speech	Irrelevant, self-talking, lulling explainable by her belief, infantilization, attention seeking and/or sociocultural context.	Expectedly incoherence in any form unexplainable and/or irrelevant talks explainable by other features like delusional or hallucinatory contents.
Mood/Affect	*la belle indifference*, lability or anxious-distressed in varied degree of persistency explainable by relief of distress form insoluble and intolerable events or situations or very rational external factors.	Usually apprehensive in acute state, incongruous and restricted or depressed mood/affect in residual state explainable by psychopathology of psychosis.
Odd behavior	Diverse ranged from overfamiliarity, untidiness, peculiar gait, manipulating behavior, self-harm, impulsive-aggressiveness to lack of self-care and mutism	Cardinally disorganized unexplainable to external cues or any other psychopathology and/or

	explainable by external cues, attention seeking or presence of reinforcement and sociocultural issues.	oddity explainable to other psychopathology.
Associated features	Usually one or more features of dissociation-like amnesia, identity loss, &/or features of conversion in the form of any functional neurological symptoms are common presentations unexplainable by organic pathology and can be the mainline features. Other associated features are attention seeking, suggestibility, temporal relationship with stressors and conflict usually explainable by external or sociocultural factors.	No such type of associated features, definitive causal stressor or conflict, and explainable organic pathology may be present. (The associated features are if present are totally different, wide, diverse, may have associated sequential stressors).

4. An 11-year-old boy presents in CAMH OPD with episodic convulsion and fit that extends from a few minutes to hours. History revealed that symptoms have started after being slapped by his father in face of repetitive demand for a by cycle. An EEG was done by the GP that showed suggestive generalized seizures.
Based on your logical deduction of the given information─
a) What is the best possible diagnosis?
b) Make a checklist of information you need to offer to the parents.

Given information

Demography and referral
Age- 11 years
Sex- Male
Referred by-GP
Referred to- CAMH OPD
Reason of referral- assessment and management

Chief complaints
Persisting episodic convulsion and fit extends from minutes to hours–duration not mentioned, expectedly recent

Precipitating factor
Slapped by father in face of his repetitive demand of bicycle

Investigation done
EEG- suggestive of GTCS

Extracted information

This early adolescent boy has persistent episodic convulsion and fit extends from minutes to hours. The symptom presentation is inconsistent with the typical features of epileptic seizure attack, which

starts immediately after slapping by father in face of his repetitive demand of bicycle. This feature clearly indicates this boy is a case of dissociative disorder/conversion disorder with fit attack father strengthened by GP referral for psychiatric consultation.

However, his EEG finding suggestive of GTCS, he has no mentioned history or presenting expected epileptic fit. EEG plays a central role in diagnosis of epilepsy; it has relatively low sensitivity in epilepsy, ranging between 25–56% and specificity, ranging at 78–98%. Therefore, EEG may be positive in normal cases, alternatively may be negative in true epilepsy and diagnosis of epileptic seizure is primarily based on clinical judgment. Here, presentation is pseudo seizure in nature with presence of definitive precipitating psychological event and absence of feature of true seizure is clinically judgmental for assigning the diagnosis of conversion disorder.

At this point, no investigation is needed as further investigations may reinforce the condition.

The boy's repetitive demand of the cycle is likely his desire and usually present at this age and parents usually do not give because of fear of accident. However, it could be a part of the boy's disruptive behavior that needs exploration.

This condition is acute and likely because of significant impairment of the boy's functioning. The parents' support is indicative of adequate and likely worries.

Assigned task

a) <u>The best possible diagnosis</u>

From the logical extraction of the given information, the best possible diagnosis is Dissociative neurological symptom disorder/ Conversion Disorder with attack of seizure.

b) <u>Checklist of information you need to offer to the parents</u>

- Informing the diagnosis and primary cause of the disorder.
- Explaining the psychopathology of the disorder in their understandable way.
- Informing about the possible reasons of persistency of the symptoms- role of reinforcement.
- Explaining the reason why it is not epilepsy with emphasizing key deferential points.
- Explaining to them that further medical assessment and investigation are not necessary and possible reinforcing effects.
- Informing the treatment plan giving emphasis on nonpharmacological measures of intervention and role of parents in the intervention.
- Emphasizing on the desired parental behavior to support the boy as well as to prevent the unnecessary reinforcement.
- Expressing the features of the good functioning family along with the importance of sharing and communication among the family members.
- Emphasizing the importance of mainlining feasible daily life activities of the boy in the intervention.
- Informing the way of achieving premorbid functioning.
- Emphasizing the importance of school support with emphasis on combined efforts of the boy, parents, teachers, and CAMHS.
- Informing the importance and content of wellness treatment- play, peer relations, free time activities, exercise.

- Informing the temperamental factors in causation and working plan for desired temperamental abilities.
- Assuring the parents and explaining the kinds of family support that can be offered from the facilities.
- Informing about the possible preventive strategies.
- Answering any quarries.
- Informing about the follow-up issues.

5. A 10-year-old girl presented to the child psychiatry outpatients department who is defiant and aggressive towards her father who recently came back home after 5 years of continuous staying abroad for a job. The girl gradually becomes aggressive to her mother and her sleep is not well. Father disappointedly says her daughter does not talk to him and does not call him "Dad." The girl appears annoyed and irritable.
Considering the most likely diagnosis─
a) Make a list of information that you need to assess this case.
b) What could be possible psychopathology of this case?

Given information

Demography and referral
Age- 10 years
Sex- Female
Referred to- CAMH OPD

Chief complaints
- Defiant and aggressive to father - recent onset
- Did not talk to her father and not addressing him as dad- subsequent duration
- Gradual aggressive behavior towards mother- subsequent development
- Poor sleep

Onset
Sudden

Precipitating life event
Father returns home from abroad after 5 years

M/S/E finding
Appearance- Annoyed and irritable

Extracted information

This girl in late childhood has defiance and aggressive behavior with recent onset. This disruptive behavior is clearly developed immediately after father's return from abroad. Clearly, the child fails to cope with a new and changing family environment that is likely different from her accustomed environment during the period of long absence of the father. Though the father has returned apparently looking happy, for the girl it becomes stressful. These indicate the girl has adjustment disorder.

The disruptive behaviors can be the features of oppositional/ conduct disorder. However, these behavioral problems start particularly with her father and followed by mother confined at home, clearly

has a temporal relationship with father's return, recent onset and the features are not enough for such diagnosis and explainable as features of adjustment disorder.

Separation anxiety disorder is another possibility as the mother and the daughter live together for a long period with closed association. Nature of the father staying abroad for a job continually for 5 years is representative of lower job and low SES family status. However, there is no information on child separation anxiety and related behavior.

Child annoyed and irritable mood represents child distress and anxiety or a depressed mood. In absence of features of such disorder in considerably short duration with acute onset, these are also explainable as emotional features of adjustment disorder.

Parents are really in trouble, particularly the situation is shocking for the father as expressed in his disappointing statement who returns for reunion with the family after a long hurdle abroad only for job and money.

Assigned task

a) List of information for the assessment

- The girl's perception about the father's return confirms the event as a causal stressor.
- Any other circumstantial and consequential stressful events.
- Reasons of such disruptive behavior to father followed by mother and if there are other features of disruptive behavior.
- Any features of separation anxiety, other anxiety, or depressive disorder.
- Temperament- anxiety prone, poor stress coping abilities or any other vulnerability in her traits.
- Family factors- previous actual separation, previous absence record of father, parental attitude and behavior, any vulnerability of parents, possible parental discord.
- Level of understanding of the child and parents about the problem.
- Any history of psychiatric disorder of the girl- like separation anxiety disorder, social phobia, oppositional defiant disorder.
- Strengths of the girl and level of family support.

b) Possible psychopathology

- Prolonged absence of father causes development of strong attachment with mother.
- Father's return apparently seems to be a positive event, possibly negative event for the girl because of her changed status in home environment like loss of intense attachment with mother along with mother's attention. Considering the expected home environment, there is a strong possibility that the girl slept with mother in the same room during father's absence and now it has changed, and she has to sleep alone.
- The girl may perceive that the father occupies her mother that creates jealousy, rivalry and rebuff.
- The girl failed to cope with the new situation that made her distressed. This distress are channelized through externalization and internalization.
- This aggression extended to the mother possibly due to the mother's new role and lack of the mother's understanding of the real problem and as mother does not do anything to eliminate her stress or conflict.

- Over caring and attention of parents and possible inconsistency in parental behavior are reforming her troublesome behavior.
- Unresolved problems cause the persistency of the problems.

6. A 15-year-old-girl attends a child and adolescent consultation center who has had a persistent headache for 1 year that starts prior to her marriage and gradually becomes intense along with recent fit attacks for which no explainable cause is found. Subsequently, it appears that the girl does not sleep, loses weight, and shows no interest in daily activities. She dropped out from school, becomes hopeless and blames her parents for her misfortune.
Based on the logical deduction of the given information─
a) What is the most appropriate dual diagnosis to explain her condition?
b) Prepare a checklist of your assessment for the intervention.

Given information

Demography and referral
Age- 15 years
Sex- Female
Marital status- Married
Referred to- Child and adolescent consolation center

Chief complaints
- Persistent headache gradually increased in intense form - 1 year
- Lack of sleep, weight loss- subsequent duration
- No interest in daily activities- same duration
- Headache now added with fit attack- recent onset
- Hopelessness and blames parents for her misfortune- subsequent development

Onset
Gradual

Related life events
Marriage, dropped out form study

Extracted information

This mid adolescent girl has had a headache for 1 year, persists and gradually becomes worsen and now intense and added with fit attack. No explainable organic cause was found for both the problems. However, there are explainable psychological factors behind these. Her headache started prior to her marriage that was expectedly stressful at this age and caused anxiety and distress. The headache persists due to possible consequence stressors, of which one is dropping out from study. Therefore, his headache was either somatic symptom disorder or a feature of initial anxiety disorder and persists as somatoform pain disorder/somatic symptom disorder predominant.

Addition of her organically unexplained fit attack with her nonorganic headache is again indicative of her persisting distressful state results from stressful events or situations that she fails to cope with. This is likely dissociative neurological symptom disorder/conversion disorder or broadly part of somatoform disorder. As this symptom is likely explainable by her persistent distress that disfavor this diagnosis.

The girl's gradual development of global insomnia, weight loss, pervasive anhedonia for a substantial period along with hopelessness, blaming parents for her misfortune are clearly the features of major depression and likely severe in nature. There is no clear mention of depressed or irritable mood; the circumstantial evidence along with her anhedonia is indicative of its existence. Increased severity of her headache is at least in part explainable by her depression.

The girl is clearly in severe distress and evidence indicates has global functional impairment.

Parents are really in trouble, as they are blamed by their daughter for her misfortune, possibly this is due to giving her marriage at this age and its consequences that she cannot resolve or accept.

There is a definite existence of a series of stressors for the girl before and after marriage needs exploration. Whether marriage itself is perceived as a key stressor is the key issue in this regard.

Assigned task

a) <u>The most appropriate dual diagnosis to explain her condition</u>

Based on the above logical deduction, the most possible dual diagnosis is MDD, Somatic Symptom Disorder.

b) <u>Checklist of the assessment for the intervention</u>

- The details of her headache- onset, type, frequency, severity, course, association with stress anxiety, girl's perception about the headache, help seeking behavior, intervention and outcome.
- Details of fit, single or more episodes, pseudo seizure or consequence of intense headache, inconsistency, anomaly, different mood, temporal relationship with stressor(s), link with headache, and presence of distress or concern are important for inclusion or exclusion of conversion disorder.
- Full assessment of depression with its all features with inquiry about her mood, biological and cognitive features of depression- negative cognition about self, present and future, any mood congruent psychotic features, psychomotor retardation along with confirming severity of the disorder.
- Inquiry about anxiety and any stress related disorder-present and past.
- Checking for general health status and excluding the other organic cause of loss of weight and secondary cause of her depression, particularly hypothyroidism.
- Marriage- reason for giving marriage at this age. The girl's perception of it as a stressor or not.
- Any other circumstantial and consequential stressful events or situations like the reason for her dropping out from school, trouble with in-law's house, dowry, discord between her own and in-law's family, stressors related to sexual act, motherhood.
- Assessing any adverse childhood experience- maltreatment and abuse.
- Temperament- anxiety prone, poor stress coping abilities or any other vulnerability in her traits.
- Family factors- parental attitude and behavior, possible parental discord, dysfunctional family.
- Level of understanding of the girl and parents about the problem.
- Level of impact of the problems on the girl, burden to family due to things.
- Risk assessment- risk of suicide, self-harm.
- Strengths of the girl in the form of abilities and skills.
- Perception of the girl and parents about the problems and their expectation for the facilities.

- Level of family support.

[NTK
Underage girl marriage and mental health problem
Early marriage, otherwise known as child marriage, is the marriage of a young person (typically a girl) before the onset of adulthood as defined by the 1989 Convention on the Rights of the Child. The vast majority of married adolescent girls do not choose their husbands, their parents did. Most are informed of the marriage at the last moment, some not until the day of the event.

Child marriage is significant and burning problems throughout the globe. In developing countries, about 80.2 million girls marry at the age between 10-17 years. The highest rate of child marriage is in Bangladesh (2 out of every 3 girls marry before the age 18) followed by India, Nepal and Afghanistan. About 33% of girls got married before the age of 15 years and that was increased to 74% before 18 years. Rural-urban distribution of this child marriage is 48.4 and 65.4%. The incidence is likely more real than reported. Girls who marry as adolescents attain lower schooling levels, have lower social status in their husband's families, report less reproductive control, and suffer higher rates of maternal mortality and domestic violence. About 55% of these girls dropped out from school after their marriage due to engaging with physical labour in household work in the husband's house and the opportunity of social communication is decreased for them. About 27% of married women between the age group of 15-19 years become the mother.

They suffer more from mental and physical problems including damage to their sexual life. Along with anaemia, gynaecological and obstetrical diseases other systemic diseases are equally prevalent with early onset. Most common psychiatric disorders are anxiety, conversion somatoform and depressive and stress related disorders. Other disorders are equally prevalent like this population group. The impact and burden are certainly severe enough to address these issues. There exists a significant excess of psychosocial stressors onset of the psychiatric disorder. Marriage itself played as a stressor. Beside this, marital discord, trouble with in-laws have a causal relationship with depressive and conversion disorder. It is obvious that the cumulative effect of marriage and related stressors on girls may result in the development of psychiatric disorders among them.

Social insecurity, parents' belief, increasing dowry, psychosocial adversity are the main causes of underage girl marriage and the tendency of conception and childbirth. This tendency is not decreasing despite providing free education for girls up to the secondary education and stipends for them from the government. The tendency of conception is more among married women with younger age. Despite knowing the existing law on the age of marriage, parents perceive their daughter as a burden, fear of victim of acid burn violence, sexual harassment and sometimes for family prestige were the main reason of underage girl marriage as mentioned by the parents. Therefore, it can be viewed that girl child marriage is rooted in social norms as well as in social factors. Moreover, lack of common family law is possibly one of the important reasons for underage marriage.]

Chapter 4: Addiction Child and Adolescent Psychiatry

1. A 14-year-old boy attends CAMH OPD with his parents under parental pressure. The parent says that since a-long, the boy has been involved with a bad group and recently they explored cannabis in his bag. On one-to-one interview, the boy acknowledges that he tests almost all available drugs of abuse and currently takes cannabis and amphetamine.
a) What are the areas you need to assess?
b) How will you manage this case?

Given information

Demography and referral
Age- 14 years
Sex- Male
Referred to CAMH OPD
Referred by- parents

Chief complaints
- Involved with bad group-not mentioned likely long
- Tested almost all available drugs- same duration
- Taking cannabis and amphetamine- ongoing

M/S/E findings
Appearance and behavior- Initially reluctant but rapport established in one to one interview

Extracted information

Substance abuse is a pattern of behavior, which is against social norms and values. It is also age-inappropriate for the boy. His long-standing pattern of such antisocial behavior goes in favor of conduct disorder. The adolescent boy also keeps bad company that increases the risk of the disorder.

In most of the cases with substance abuse, the first attempt is a part of novelty-seeking behavior. In course of time, individuals get habituated with the behavior depending on their vulnerability. The adolescent in this case has tested almost all available drugs possibly for having the experience. Currently he is abusing cannabis and amphetamine. There is a chance of getting dependent on one or both of them because both drugs have high potential for dependence.

Reluctance of the boy for visiting psychiatrist indicates his poor insight. Assessment of current drug use pattern, other antisocial behavior and vulnerability and protective factors are crucial for managing the case and predicting prognosis.

Assigned task

a) Assessment areas

- Onset, duration, detailed history of each drug, nature of group involvement.
- Sign symptoms of drug abuse (e.g., evidence of weight loss, injection mark, examination of nasal cavity), features of dependence, withdrawal, or intoxication.
- Assessing other symptoms of conduct disorder.
- Assessing any other externalizing or internalizing problems or disorders, particularly comorbid depressive, anxiety, adjustment disorder.
- M/S/E-Behavior, affect, any psychotic features, cognitive state.
- Level of impact on the child in terms of functional impairment in all domains and degree of burden to the family.
- Temperament of the boy- predominant mood, relationship, attitude to the social norm and values.
- Motivation behind the behavior and giving up addiction.
- Family factors- Rejecting parenting style, family dysfunction, abuse, under or over controlling parents, family stress-parental discord, separation or divorce.
- School and peer factors.
- Protective factors of the adolescent including his special skills and abilities.
- Investigation- Routine and Dope test.

b) Management of this case

Steps of detoxification-motivation- rehabilitation will be applied to a multidisciplinary team and multiagency involvement. CAMH facility will provide the following intervention and appropriate referral will be made as required.

Managing the problem of drug abuse

- If the patient is dependent on amphetamine and cannabis, abstinence is the usual goal.
- The patient should be motivated for change.
- BDZ for acute distress associated with severe withdrawal symptoms.
- Psychosocial management: CBT, Contingency management; Rehabilitation as necessary.

Managing Conduct Disorder

- Anger management training.
- Social skills training.
- Treating comorbid depression.
- Parent management training for conduct disorder.
- Encouraging the adolescent to maintain a healthy peer group.

2. A 14-year-old girl presented in psychiatry OPD who is mute and nearly immobile for one day. Parents say that their daughter engages with mobile gaming for one year and is reluctant to study. Very recently, she does not go to school, stays in her room in the dark, does religious activities, does

not take food regularly, and does not sleep at all. When parents ask about it, she replies that she gains knowledge from a game app (Tarot Reading) that helps her to think about diverse topics in very novel ways. The girl did not respond to any questions during the interview though she appears watchful.
Drawing inference through logical deduction from the given information─
a) Make an assessment plan giving differential diagnosis from extracted information and logical interpretation of the given information in the scenario.
b) What will be the treatment plan for this case?

Given information

Demography and referral
Age- 14 years
Sex- Female
Referred to- Psychiatry OPD
Accompanied by- Parents

Chief complaints
- Engaged in mobile gaming and reluctant in study-1 year
- Does not go to school and says that she gains knowledge from a game app- recent development
- Stays in room in dark, does religious activities- same duration
- Decreased food intake and does not sleep at all- subsequent development
- Mute and nearly immobile- 1 day

M/S/E findings
Appearance and behavior- Watchful appearance but rapport could not be established

Extracted information

This mid adolescent girl has had mobile gaming behavior for one year. Excessive and compulsive use, unsuccessful effort to cut down the use, tolerance and withdrawal to the behavior, mood alteration, reduction of distress and continuation of behavior despite negative consequences are common criteria for all addiction. The girl's dependence on the internet and the resultant negative consequences in her life are highly suggestive of internet addiction disorder and more specifically Gaming disorder.

Here, other forms of behavioral or substance addiction need to be assessed as this form of comorbidity is common.

Recent behavioral changes like staying in the dark room, practicing religious activities (which she was not used to doing before as parents are complaining about it now) and reduced food intake and sleep may be part of psychotic disorder, mood disorder or a reaction to threat or abuse on the internet.

Mutism and immobility are presenting features of catatonia that may occur due to mood disorder, psychotic spectrum disorder or conversion disorder. Here, any organic cause needs exclusion.

Assigned task

a) Assessment plan
Assessment of the present behavior
- Pattern of use, what types of materials are surfed

- Genre of gaming
- Previous effort to cut down
- Daily time consumption for internet
- Explanation behind the way of gaining knowledge through mobile app (normal learning or delusion of thought possession)
- Recent changes in mood
- Any hallucinatory behavior
- Suicidal idea, intent or attempt- current or past
- Any other behavioral addiction or substance misuse
- Catatonic features
- Any features of anxiety, depression, stress related disorder or disruptive behavior or primary psychosis
- Functional impairment in all domains- especially in her academic and social domain

Assessment of the associated factors with the girl
- Birth and developmental history
- Premorbid temperament
- Current social circumstances- school and peer factors, relationship with parents and siblings
- Risk assessment
- Strengths assessment in the form of special abilities and skills

Assessment of the family
- Parenting style-particularly, authoritarian, permissive, rejecting
- Family structure and system- possible existence of disorganized family
- Any enduring or acute stress-parental discord, parental physical or mental illness

Medical assessment
- General health status
- Systemic assessment for any possible organic causes of catatonia or nay coo occurring physical disorder along with necessary lab investigation including dope test

b) <u>Treatment</u>

General
- Explanation advice and support to the family about the girl's condition
- Hospitalization for proper assessment and management

Treatment of catatonia
Tab Lorazepam 1-2 mg and following up after 24-48 hours

Treatment if evidence of psychosis
Antipsychotic in low dosage

Treatment if evidence of mood disorder
SSRI- preferably sertraline

Psychological treatment options for behavioral addiction

- CBT
- Motivational interviewing
- Acceptance and commitment therapy
- Family therapy

3. A 17-year-old boy is brought to emergency by his father because his son is found "abnormal and non-communicative". Father suspects the boy is an addict. Preliminary examination shows the boy to be drowsy, with slurred speech, pupillary constriction, lethargy, and generally positive effect.
Considering the most likely diagnosis based on your logical extraction of the given information─
a) How will you proceed for diagnostic confirmation?
b) What is your immediate management plan for this boy?

Given information

Demography and referral
Age- 17 years
Sex- Male
Referred to- Emergency department
Accompanied by- Father

Chief complaints
- Father suspects the boy is addict- duration not mentioned possibly long duration
- Father found the son 'abnormal and non- communicative'- not mentioned likely recent

Examination findings
Appearance- Drowsy, lethargic
Speech- Slurred
Pupil- Constricted

Extracted information

Presenting features of this late adolescent boy indicative of substance intoxication. Pupillary constriction and lethargy- signs of opiate intoxication. There is no information of other causes of confusion and the condition can be better explained by other substance intoxication. Considering all these factors, the best possible diagnosis is Opiate intoxication.

There may be associated other substance dependence and intoxication as usual expectations that need exploration.

Father's suspicion of addiction strongly goes in favor of substance misuse for a substantial long period. It is likely to have poly substance misuse and therefore needs elaborative information in this area.

The common comorbidity like conduct disorder, depression needs exploration along with possibility of any other behavioral air emotional disorder and early onset psychosis.

Assigned task

a) Assessment for diagnostic confirmation

- Collateral information related to addiction and intoxication.
- Checking for other features of intoxication- other sign symptoms-confusion, behavioral change, psychotic features.
- Toxicological screening- Urine for opiate, cannabinoid, amphetamine.

b) Immediate management plan

- Hospitalization.
- Measuring confessional state and features of delirium.
- Maintenance of nutrition, hydration, and electrolytes.
- Checking and monitoring vital signs.
- Details history, clinical exam, and lab investigations for diagnostic and therapeutic purposes.
- Detoxification.

4. A 18-year-old boy referred to CAMH OPD from First Episode Psychosis Service for his persistent paranoia and hearing derogatory voice. He has had cannabis intoxication. His recent dope tests are normal. The boy looked perplexed and partially withdrawn.
a) What will be the best possible diagnosis based on logical interpretation of the given information?
b) Mention the specific areas of your assessment to confirm the diagnosis and make a treatment plan.

Given information

Demography and referral
Age- 18 years
Sex- Male
Referred from- First Episode Psychosis Service
Referred to- CAMH OPD

Chief complaints
- Persistent paranoia- duration not mentioned likely long
- Persistent hearing of derogatory voice- same duration

M/S/E finding
Appearance- perplexed and partially withdrawn

Past psychiatric history
Cannabis intoxication

Extracted information

The boy has psychiatric disorder as evident in the chief complaints further strengthened by the source of referral- first episode psychosis service.

Persistent delusion and auditory hallucination in absence of any effect of substance at this point is very much indicative of schizophrenia spectrum disorder. Here. Duration of symptoms is essential for the diagnosis that is necessary for schizophrenia at least 6 months, for schizophreniform at least more than 1 month and for brief psychotic disorder at least 1 day is required. Here the overall scenario and referral pattern indicates that of longer duration of psychotic features.

Presenting features along with perplexity and partially withdrawn affect indicate the presence of active phase symptoms and there is strong possibility of having other types of delusion and hallucinations that go more in favor of schizophrenia and schizophreniform disorder.

Cannabis induced psychotic disorder is another possibility as the patient had cannabis intoxication. For such diagnosis, temporal relationship between psychotic features and intoxication is essential that must be within one month. Here no such information is present. Alternatively, cannabis can act as precipitating factors in a person who is predisposed with schizophrenia or related disorder. Attending clinic, treatment of cannabis intoxication, and possible dependence, recovery as evident by normal dope test followed by assessment and referral indicate that persistency of psychotic features is a substantial period without intoxication. Further, cannabis misuse and dependence can be present with primary psychotic disorder in any stage.

These psychotic features can happen due to general medical conditions. However, referral to the CAMHS does not support its possibility.

Assigned task

a) Best possible diagnosis

From the above extraction of the given information, best possible diagnosis is Schizophrenia or other primary psychotic disorder/Schizophrenia Spectrum Disorder (schizophrenia or schizophreniform disorder).

b) Specific areas of your assessment to confirm the diagnosis and make a treatment plan

- Types, persistency, extent, severity, distress and impact of psychotic features especially other features of schizophrenia- disorganized thought and behavior.
- Duration of onset of psychotic features and whether psychotic features start earlier or developed after intoxication.
- Details of cannabis intoxication, treatment, outcome and period between remission and psychotic features along with history of cannabis or any other substance misuse.
- Past psychiatric history.
- Past medical history, especially any other medical condition including TBI that causes psychotic features.
- Risk assessment- harm to self and others.
- Temperament including possible paranoid traits to exclude personality disorder.
- Etiological assessment- especially family history of schizophrenia, psychosocial stressors particularly recent that may act as precipitating and perpetuating factors.
- Assessment of good and bad prognostic factors.
- Assessment of the strengths of the boy in term of his special abilities and skills.

Chapter 5: Forensic Child and Adolescent Psychiatry

1. A 13-year-old boy is sent to you for psychiatric assessment from the court who has killed his friend with the help of another friend. Observation report says that the boy is indifferent, sleeps well and takes food regularly.
   How will you assess this case with the aim of sending a court report?

Assigned task

Process of assessment of this case of juvenile offender

Preliminary information
At whose request the assessment is going to be undertaken.
Source of information.
The boy's capacity to take part in assessment.

Background history
Personal history including level of intelligence; drug and alcohol history; forensic history; family history; medical and psychiatric history and assessment of temperament.
Circumstances of the alleged offence.
Progress since the alleged offence.

Current mental state
Presence of any mental disorder now or at the time of offence; relationship between the mental state and the offence. ODD and conduct features should be sought carefully.
Grounds for diminished responsibility.
Risk assessment.

2. Seven inmates of a Male Juvenile Correction Centre cut different parts of their bodies in a group grievously as a protest of enduring torture of the wardens. Two days back, an inmate cut his wrist severely for the same reason. In response to a request of support, your consultant asks you to visit the center with a mental health team.
a) Prepare a checklist for assessing self-harm.
b) Outline the immediate and ultimate plan of managing the condition.

Assigned task

a) Assessment of self-harm/ repeated wrist cutting

Assessing status of the injury

- Pattern, extent, treatment and outcome.
- Any systemic involvement.

Assessing suicidality

- Intention.
- Current intention to die.
- Was the act planned / carried out on impulse?
- Were precautions taken against?
- Did they seek help?
- Was the method thought to be dangerous?
- Was there a final act (writing suicide note?)

Current problems that caused the act

- Nature, severity, extent, and persistency of the enduring abuse- physical, sexual, emotional and neglect.
- Peer problem.
- Social isolation.

Risk-immediate risk of suicide and subsequent risk of suicide and further self-harm

- Thinks that life is no longer worth living.
- Suicidal thought or idea.
- Past suicidal attempt.
- Presence of any psychiatric disorder- with special emphasis on depression.
- Current medical problems or disability.
- Stressors-both acute and enduring-type nature, severity, and impact.
- Exposure to adverse childhood experiences (ACE).

Thorough assessment of Psychiatric assessment for any problems or disorder commonly:

- Substance Use Disorder
- Depressive Disorder
- Anxiety Disorder
- Stress related Disorder
- Personality Disorder
- Impulse control and Related Disorder
- Adjustment Disorder
- Schizophrenia

Milue of the center

- Structure of the center and way of functioning particularly living standard- food, room, daily living style including leisure and recreation.
- Way of supervision and care.

b) <u>Action plans have to be considered keeping in mind what helpful resources are available</u>

Immediate

- Explanation support and advice to the institution including explaining the role of the mental health team and other agencies.
- Support to other relevant persons-parents, siblings, friends, peers, teachers.

- Crisis intervention.
- Treatment of any existing psychiatric disorder.
- Medical referral where appropriate.
- Crisis/emergency support over telephone.

Ultimate
- Group therapy and counselling.
- Psycho education to the warden and other personnel of the institution.
- Advocacy for multiagency involvement-health, social, educational and law enforcing and relevant personals particularly,
  -GP
  -Social workers
  -Voluntary agencies.
- Periodic follow-up for psychiatric disorder.
- Liaison with other health agencies, referral, and back referral.

3. A 15-year-old-girl has been sent from the court for psychiatric assessment who is a rape victim 3 weeks back.
a) Prepare a checklist of the areas you need to assess.
b) Mention the points of your opinion that you should provide in the report.

Assigned task

a) Checklist for assessment

Act assessment
- Nature, severity, degree, and danger of abuse.
- Perpetrator- information about him. If known, relationship with the victim.
- Circumstantial information.

Subsequent events
- Analyzing the stated reasons for sending the girl by the court for psychiatric assessment.
- Effect on the girl- physical, psychological and social.
- Response and reaction of the family members.
- Measures of safety and security of further victimization or any other harm.
- Measures and efforts have already been taken by the family.
- Level of multi-agency-multi professional involvement-e.g., relevant health, social and legal agencies or facilities; GP, pediatrician, gynecologist, family social worker, volunteers.
- Detailed information of psychosocial stressors and events.

Family assessment
- Types.
- Structure-organized or disorganized.
- Family dynamics-functional or dysfunctional.
- Parental attitude and behavior before and after the events.

General assessment
- Interview of all members of the household.

- Collateral information from relevant sources- police, safe house, custody and school.
- Checking reports of physical examinations done by GP, pediatrician, gynecologists along with reports of laboratory investigations and given management.
- Thorough general examination.

Psychiatric assessment

- Thorough clinical assessment- details history, general, systemic and mental status examination with special emphasis on: Adverse childhood experience- particularly maltreatment, toxic and enduring stressors.
- Types and severity of present stressors.
- Temperament.
- Past psychiatric history.
- Psychiatric Disorder-Stress Related Disorders-Acute Stress disorders, PTSD, Conversion-Dissociation, Depressive Disorder.
- Impact: as sexual abuse has significant impact on both physical and mental health effects.
- Risk: risk for suicide and self-harm.

b) <u>Points of opinion that need to provide in court</u>

- Current mental state-stating whether significant harm of mental health has occurred and whether treatment is needed.
- Further risk/impact/outcome.
- Further protection needed-whether the girl needs to be removed from family or present care.
- Clear custodial order.
- Child's age, state of development, temperament, relevance of these to case.
- Whether the child has a psychiatric disorder.
- The child's own wishes about her future (considered in relation to her age, understanding).
- Parenting skills of the care, how far they can meet the child's needs.
- The child's physical, emotional, educational needs.
- Any possible change of circumstances (removal from home).
- Any harm that the child has suffered/likely to suffer.

Chapter 6: Community Child and Adolescent Psychiatry

1. A 11-year-old boy was referred to your CAMH OPD from his school for his increased troublesome behavior in the classroom and poor academic performance. He has been diagnosed with dyslexia and advised accordingly. Hearing this diagnosis, the head teacher says the boy should be placed in a special school. Anxious parents come with his class teacher with this issue.
Based on logical deduction of information for the case scenario─
a) Prepare a checklist of the contents of your discussion with them.
b) List the provisions of support for the boy that should be implied by the school.

Given information

Demography and referral
Age- 11 years
Sex- Male
Referred to- CAMH OPD
Referred by- School
Reason of referral- Assessment and treatment followed by right placement
Accompanied by- Father and schoolteacher

Chief complaints
- Persistent troublesome behavior in classroom increasing in nature- duration not mentioned likely long
- Poor academic performance- subsequent duration

Present psychiatric diagnosis
Dyslexia

Extracted information

This early adolescent boy is a diagnosed case of Dyslexia or Reading Disorder, which is a specific learning disorder of neurodevelopmental origin.

Here, learning difficulty and impaired academic skills are due to impaired reading abilities in the form of inaccurate, slow and effortful reading and difficulties in understanding the meaning of reading, poor spelling abilities.

These difficulties occur in the presence of normal levels of intellectual functioning and therefore, not associated with intellectual disability. In this view, the opinion of the head teacher about placing the boy in a special school and that is most likely for ID is wrong.

The boy's poor academic performance is certainly due to this disorder and its impact, possibly due to lack of care and supervision from school as well as from home due to lack of understanding about the disorder and due to the stigma as a child has been assigned a psychiatric disorder.

The boy's behavioral problem is likely due to his frustration about his performance and possible abuse, neglect, and bullying.

Most likely, the boy has no other comorbid disorder as the boy is assessed by tertiary level specialized facilities.

The Father's worry is clearly rational; that comes from the threat of special school placement for ID that added with the already existing worries about the child's problems, uncertainty of treatment and outcome.

Diagnosis at this age, getting high standard management and family support is very much indicative of a favorable outcome and that will certainly be enhanced from school support.

Assigned task

a) Checklist of the contents of discussion with the father and schoolteachers

- Gathering information on reaction of the school authority after getting back referral and the diagnosis, especially to know the reason for the head teacher about placing the child in a special school.
- Understanding the belief, attitude and behavior of the school authority and father and their individual expectation from the CAMH facilities.
- Providing background information, summary of the assessment and assigned diagnosis and management plan.
- Psychoeducation: features, course, treatment and prognosis of Dyslexia with special emphasis on normal intelligence of the affected child and needs mainstream education with special support and supervision rather than placing him in specialized school.
- Informing role of family, school and multidisciplinary mental health professionals.
- Informing the provisions of privileges for the children with dyslexia in mainstream education as recognized and written in the policy act, rules and procedure.
- Asking a schoolteacher what the school can do in this aspect.
- Explaining the father about what he and the family can do in this regard for getting the expected outcome.
- Discussion with the aim of creating positive attitude and feasible role of school and mentioning further action plan (e.g., visiting school and providing talk to the teachers).

b) List of the provisions support for the boy that should be implied by the school

General

- Training teachers and other stuffs
- A clear outline of each lesson
- Clear, unambiguous language
- Information in a variety of forms
- Repetition
- Empathetic support in class work and group activities

- Extracurricular activities
- One to one supervision other than formal learning session
- Using behavioral methods of reinforcement
- Prevent bullying

Specific
- Writing in plain Bangla, English and Mathematics checking the readability.
- Use the inbuilt heading styles in word for learners to get a content overview in the navigation panel.
- Use pop up information over images to help contextualize explanations.
- Ensuring documents and presentations comply with basic accessibility practice.
- Giving progressively increasing and stimulating home tasks.
- Use creative e-learning approaches that minimize text heavy resources and activities.
- Making resources available online in digital format.

2. A 14-year-old girl has suddenly developed an episodic attack of cry, incoherence, hyperventilation, convulsion and fit during school period followed by subsequent episodes for 3 days. In this period, similar features developed among a good number of her peers. This situation creates marked worries and concerns among teachers and parents and school authority seeks help from your CAMHS. You are a member of a medical team intending to visit the school to do the needful.
Drawing inference from the given information─
a) What is the most likely diagnosis of this girl and her peers?
b) Outline the assessment plan from your part.

Given information

Demography and referral
Age- 14 years
Sex- Female

Chief complaints
- Crying, incoherence, hyperventilation, convulsion and fit episodic in nature- 3 days
- Similar features developed among good number her peers- subsequent duration

Extracted information

This mid adolescent girl's features of episodic convulsion and fit clearly functional neurological symptoms associated with crying, incoherence, and hyperventilation as other motor symptoms. These features likely have no explainable organic pathology evident by the seeking support by the school from the CAMHS. The girl is most likely a case of Dissociative disorder/Conversion Disorder with mixed symptoms.

It is likely that her other peers who have similar symptoms have the same diagnosis.

Overall, the condition of this girl and her peers with the same diagnosis clinically well known as mass hysteria. In mass hysteria, there is a primary figure who is influential, usually histrionic and may have some associated medical condition and the secondary figures are suggestible. Core psychopathology is observational learning.

This is likely that this girl has a precipitating psychological event or situation that she fails to cope with and possibly similarly stressful to other students. The school or the workplace where the situation usually arises is generally highly organized, with more regimental rules, overburdened work for better performance and achievement. It is expected that the stressor of this and other girls are related to academic, or situation related in school and very uncommonly with home or environment.

Assigned task

a) The most likely diagnosis of this girl and her peers

On the basis of above logical extraction and interpretation of the given information, the most likely diagnosis of this girl and her peers is Dissociative disorder/Conversion Disorder with mixed symptoms.

b) Outline of the assessment plan

- Clinical assessment is related to confirming the diagnosis along with identifying stressful events and related issues for an intervention plan.
- Thorough assessment of the primary figure including the precipitating event, the premorbid personality and other predisposing factors.
- The common factors between the primary and secondary figures.
- Associated factors among the sufferers and potential sufferers.
- School factors
  - Structure- Teacher-student ratio and relationship, pattern and level of supervision
  - Rules for the students including disciplinary measures
  - Level of academic load among the students
  - Level of pressure given by the school authority and caregivers
  - Status of competitiveness
  - Opportunity of play and other extracurricular activities
  - Pattern of communication of school and caregivers
  - Perception of teachers about the situation.
- Home factors
  - Parental attitude and behavior
  - Parental expectation for the girl(s)
  - Perception of parents or caregivers about their daughter's problem.
- Environmental factors
  - Neighborhood status- safe, secured or not
  - Possibility of harassment in any form during school, or way to and from school
  - Role of media.

b) Plan of intervention

General
Explanation and reassurance

Specific
Group counselling for parents and teachers and managing if conflict is present.
Primary figure- Individual therapy as per Conversion Disorder protocol.

Secondary figure- group therapy.

3. A 12-year-old girl with high functioning autism reads in a reputed mainstream school. She performs less and is frustrated with her performance. The school principal sent this girl to your CAMHS and wants to know whether they can do some more for her better school performance.
a) What will be your task plan to address the issue?
b) What are the recognized ways that the school can support this girl?

Given information

Demography and referral
Age- 12 years
Sex- Female
Occupation-Student
Referred to- CAMH Service
Referred by- Principal of her school
Reason of referral: to improve her academic performance

Chief complaints
Frustration- not mentioned and likely long
Poor performance at school- subsequent duration

Present psychiatric diagnosis
ASD- High Functioning

Extracted information

High-functioning autism (HFA) is an autism where the patient exhibits no intellectual disability, but may exhibit deficits in communication, emotion recognition and expression, and social interaction. The classification according to level of functioning: high or low, is very useful mainly in deciding educational placement and assessing learning needs of a child with autism.

Children with HFA usually have a better verbal reasoning ability, visual/spatial skills, (higher performance IQ), emotional sensitivity, curiosity and interest for many different things less deviating locomotion (e.g. clumsiness). However, they usually have devotion to routines, dislike of change, focus on self and linguistic oddities despite better communication skills and often have problems functioning independently.

This early adolescent pupil is a case HFA and it is likely that she has sufficient abilities to perform mainstream academic programs further strengthened by her enrollment in a reputed school.

The school authority is quite supportive, as she has been referred by the head of the institution with a positive notion to work for her better academic achievement. It is also evident that they have already given their efforts and now want to give more therefore clearly, they are well motivated.

Girl's frustration comes from her comparatively lower school performance and that can be explained by the expected psychological reaction. However, thorough psychiatric assessment is necessary to exclude any psychiatric disorder or problem possibly not a part of syndrome presentation.

Therefore, a good number of supportive tasks can be applied by the school as per provision of such children with autism with the aim of considerable improvement of her academic performance.

Assigned task

a) Task plan to address the issue

- Girl's explanation about her performance.
- Details of present academic performance and expected, plus past performance level.
- Full psychiatric assessment including features, extent, and severity of HFA.
- Level of functioning in other domains-home, peer relation, leisure activities.
- Strengths of the child from the perspective of HFA.
- Details of efforts already given by school and parents.
- Need and expectation level of school and parents from the CAMH.
- Details of the provisions for learning disability students in the schools.
- Discussion to define the feasible task for the school.

b) The ways the school can support this girl

It depends upon the outcome of the above task plan. Here are the recognized supportive measures for ASD in mainstream school.

Adjustments in school setting include:

- Clear unambiguous instructions.
- Limited amounts of text.
- Graphics including photos and diagrams.
- Use of videos.
- Graphical planning tools such as mind maps.
- Text-to-speech.
- Consistency of approach, message, and organization.
- Content available in a range of media.

What school authority can do

- The institution should have support strategies in place before any disabled learner enrolls.
- Autistic learners may be sensitive to sensory stimulation and struggle to cope with noisy environments. Teaching needs to be in parts of the building with little passing 'traffic' such as away from the canteen or common room.
- Some autistic learners may not cope with changes in timetables or rooms. If possible, advance notification of any changes should be sent directly to the learner if appropriate.
- Staff must have an understanding of autistic learners' needs. Support staff need to be aware of the services available to learners and how to access them.
- Teachers must provide a creative and productive learning environment and should be aware of the issues that learners may experience. Our recommendations below should provide a useful starting point.

What teachers can do

- Clear outline of each lesson.
- Clear unambiguous language.
- Information in a variety of forms.
- Signpost changes to routines, class/group work, new/additional content and new language/concepts.

[NTK: Regulation for students with ASD
People with ASD will get an extra 20 minutes in academic examination and a 2% quota is reserved for disabled children including children with autism according to their merit in mainstream secondary, junior and conjoint primary schools.
For further reading: https://www.dghs.gov.bd/index.php/bd/2015-08-02-10-10-44]

4. A school authority in the catchment area of your CAMHS requests to educate teachers of the school as part of an anti-bullying campaign. Your team leader has been assigned to perform the task. Answer the following through systematic approach.
a) What information will you provide to the teachers to detect possible bully victims?
b) List the major steps that need to be taken by school.

Given information

Task
To provide learning activities to educate teachers at a school as part of anti-bullying campaign

Task requested by
School authority

Requested to
CAMHS

Task given by
CAMH team leader

Extracted information

From the above information, it is clear that an anti-bullying campaign in school is going on and the components of the education related to CAMHS are required.

Any team member of the CAMHS is capable of doing so. More specifically, requirements related to a child and adolescent psychiatrist are necessary evident for assigning the task.

Bullying in school is common and one of the cardinal causes that has immediate and distant effects on the mental and physical health of the bully victims. It is also one of the risk factors for developing psychiatric disorders and acts as predisposing, precipitating and perpetuating factors of psychiatric disorders.

Bullies are also the sufferers. Bullying to others can be the expression related to family like maltreatments, violence, unhealthy parental attitude, part of any existing externalizing or internalizing disorder, particularly, DBD or temperamental problems that may lead to PD, delinquency, addiction among them.

It has a worse impact on child development and achievement, particularly academic under achieving and failure.

Prevention of bullying is the responsibility of the school. Main responsibility of this task goes on teachers to implement the anti-bullying strategy. It seems that the school authority is well concerned about the bullying and takes organized initiatives evident from the nature of their request.

Role of child and adolescent psychiatrists in this issue is crucial and he has to cover all aspect of bullying including necessary for school teachers including assessment and screening and preventive measures.

Assigned task

a)Detecting possible bully victim

- Any physical deformity.
- Physical weakness.
- Physical impediments, especially speech impediments.
- Height and weight outside normal range, physical pattern.
- Different clothing patterns.
- Child/adolescent with short temper.
- Academic status.
- Warning signs of victims of bullying- typically are physically smaller, more sensitive, unhappy, cautious, anxious, quiet, and withdrawn. They are often described as passive or submissive.
- Physical and psychological signs.
- Unexplainable injuries, symptoms of anxiety and post-traumatic stress, lost or destroyed clothing, changes in eating habits, declining grades, continual school absences, self-harm, suicidal ideations, and becoming overly apologetic.

b)Steps to be taken by school

Preventive strategies

- Education of the students, parents and teachers about harmful consequences of bullying both on the bully and the victim.
- Developing a plan of action about how and when to intervene in bullying.
- All the teaching and supporting staff should be made aware of.
- Restrictions on recording devices to prevent cyberbullying.
- Security technologies like video cameras can be set in the school premises.
- Internal guards or watchmen can be employed.

Reactive strategies

- Avoiding rigid confrontation with the bully (e.g., corporal punishment).
- Ensuring anonymity of the witness.
- Informing parents of both the bully and the victim.
- Provision for suspension and expulsion.
- Psychosocial support-new group of friends, engaging in new extracurricular activities.

5. The Principal of a special school for autism requests to your CAMH Services to train the teachers about ASD. Your consultant assigned you to perform the task.
a) What necessary information do you need to provide about autism?
b) Outline the learning contents of adjustment, role of school and teachers.

Given information

Task
Providing learning activities to teachers on ASD of a special school

Task requested by
Principal of a school for autism

Requested to
CAMHS

Task given by
Consultant of CAMHS

Extracted information

From above information, it is clear that most of the ASD children are Low Functioning Autism to whom special school is required. Some of the children may have a moderate level of functioning.

Children and adults with autism who show the most severe symptoms of ASD are considered as Low Functioning Autism (LFA). The exhibits lack of social skills, extremely impaired communication, repetitive behavior, self-harm, severe intellectual disability. Comorbid other neurodevelopmental disorders specially ADHD usually present that make the condition worse. They are usually unable to live independently and require persistent support from caregivers, specialized schools and related community facilities.

Those at moderate level can get significant benefit from such schools and some of them are able to achieve mainstream education.

It is expected that the teachers at this school already have baseline knowledge, skills and attitude necessary to perform their task.

The school authority is motivated in achieving their goal evident in seeking further education for the teachers from the CAMHS.

Any team member of the CAMHS is capable of doing so. More specifically, requirements related to a child and adolescent psychiatrist are necessary for them that appear in assigning the task.

Here, a child and adolescent psychiatrist has to give the input on ASD with special emphasis on low and moderate functioning autism necessary for the teachers of such special schools.

Assigned task

a) Necessary information you need to provide about autism

- Brief reviewing of their knowledge on autism providing necessary input.
- Multidisciplinary and multiagency approach of management- particularly coordinative role of educational, health and social agencies.
- Working with family- family education and participatory role in their children's well-being.
- Educational category of autism-high and low functioning and their importance.
- Features of ASD children who can benefit from special school.
- Comorbid psychiatric and co-occurring physical disorder-point and lifelong prevalence.

- Emergencies may raise among ASD children- self-injuries, harm to others, seizure attack, and immediate way of interventions.
- Needs for periodic psychiatric consultation and review along with medical consultation.
- Screening of child and adolescent mental health problems along with use of screening tool- e.g. SDQ with the aim of identifying the problem and referral.
- Purpose, organizational setup, and way of functioning of such a special school emphasizing on the importance of grouping of students based on their ASD, functional level and degree of teacher's supervision and caregivers' participation.
- Information of available mental health and other liaison health services for ASD children and their caregivers

b) Outline of the learning contents of adjustment, role of school and teachers

Adjustments to support autistic learners include:

- Clear unambiguous instructions
- Limited amounts of text
- Graphics including photos and diagrams
- Use of videos
- Graphical planning tools such as mind maps
- Text-to-speech
- Consistency of approach, message and organization
- Content available in a range of media.

Role of School

- Organizations should have support strategies in place before any disabled learner enrolls.
- Autistic learners may be sensitive to sensory stimulation and struggle to cope with noisy environments. Teaching needs to be in parts of the building with little passing 'traffic' such as away from the canteen or common room.
- Some autistic learners may not cope with changes in timetables or rooms. If possible, advance notification of any changes should be sent directly to the learner if appropriate.
- Staff must have an understanding of autistic learners' needs. Support staff need to be aware of the services available to learners and how to access them.
- Teachers must provide a creative and productive learning environment and should be aware of the issues that learners may experience. Our recommendations below should provide a useful starting point.

Role of teachers

- Clear outline of each lesson
- Clear unambiguous language
- Information in a variety of forms
- Signpost changes to routines, class/group work, new/additional content, and new language/concepts.

6. A 11-year-old boy who has mild intellectual disability. He goes to a mainstream school and performs poorly. Teachers are annoyed with the boy. Anxious father comes along with the boy to CAMHS for advice with the aim of improving the child's class performance.
Answer the following with evidence-based deduction from the given information.

a) What will be your content of advice to the father?
b) What are the things the school can do?

Given information

Demography and referral
Age- 11 years
Sex- Male
Occupation-Student of mainstream school
Referred to- CAMH Service
Referred and accompanied by- Father
Reason of referral- To improve the class performance of the boy

Chief complaints
Poor performance at school for which the teachers are annoyed and father is anxious- duration not mentioned, expectedly long

Present psychiatric diagnosis
ID, Mild

Extracted information

This early adolescent boy has an ID at a mild level that clearly indicates that the boy has some abilities to perform mainstream academic program. His main school enrolment supports both the diagnosis of mild level severity and ability of the boy.

Individuals with mild ID are slower in conceptual and social domains and more in practical domain. These individuals can learn practical life skills, which allows them to function in ordinary life with minimal levels of support. They can achieve limited education but are quietly trainable. Vocational training helps them to maintain a sizable occupation.

The poor academic performance of this boy is expected as the boy with mild ID cannot perform like others in mainstream school. Special support both from the school and parents are necessary to perform the boy at minimum qualifying level to achieve at least some level of education.

The teachers' annoyance possibly due to their increased burden for this boy with this disability, and they are not accustomed to carrying this burden.

The father's anxiety is certainly due to his poor school performance as well as teachers' annoyance and possibly, father's expectation is high from both the boy and school.

Therefore, a good number of supportive tasks can be applied by the school as per provision of such children with ID with the aim of considerable improvement of his academic performance.

Assigned task

a) Content of advice to the father

- Accepting that his son has restricted ability of academic performance in comparison to others in the school, and he will not be able to go far along the path of school grades without required support and engorgement both from home and school.
- Informing that child may develop any emotional and behavioral problems if he is pressured to improve his performance and that will damage the existing performance level.
- Explaining the role of parents in this state including their behavior to the boy.
- Protecting the boy from possible maltreatment and bullying.
- Requesting the school to provide more support for the boy and providing assurance that CAMHS is ready to help the school if they asked for.
- Attending CAMHS for periodic review of the boy and parent training and collaborative tasks with school, home and CAMHS.

b) <u>The things the school can do</u>

It depends upon the capability, interest and feasibility of the school. Here is the list of recognized support that the school can offer considering the boy's educational needs.

General

- A clear outline of each lesson
- Clear, unambiguous language
- Information in a variety of forms
- Repetition
- Signpost changes to:
  - Routines
  - Class or group work
  - New or additional content
  - New language or concepts

Specific

- The provision of recorded lectures or a note taker.
- Access to peer lecture notes.
- Access to Assistive Technology, such as screen reader and word prediction software.
- Part-time practical with carefully negotiated goals and steps required.
- Examination timetable with exams spread over non-consecutive days.
- Access to Assistive Technology or scribe in examinations.

Supporting contents for teachers

- Making learning participative.
- Encouraging peer learning.
- Breaking tasks down into smaller steps that will incrementally build into the task objective.
- Using learners' own words, language, materials, and personal context - be clear about activity purpose and how it relates to the skills needs of the learner.
- Making both written and spoken information clear, use unambiguous terms and follow plain English guidelines.
- Aware of their own attitudes and views and how they can unintentionally influence learners.
- Observing what works for a particular learner and what does not.
- Working through any emotional issues that create a barrier before learning can take place.

- Avoiding being too directive – some people with learning disabilities may say what they think you want to hear.
- Aware of the language the teacher uses and of that used by other members of the group including nonverbal communication; doing change if the teacher thinks it is appropriate.
- Encouraging learners to ask for help - showing that this is acceptable and is not a sign of failure.
- Listening closely to what learners say, always responding to the content of what someone is saying and do not be misled by the style of delivery.

Chapter 7: Rehabilitation Child and Adolescent Psychiatry

1. An 18-year-old boy with ASD who has comorbid ADHD and ID. He also has severe behavioral problems that poorly respond with treatment. His parents are totally sick and tired of their son. Your consultant plans for adopting a rehabilitation program for this boy assigned to you for the task.
a) Outline rehabilitation assessment for this boy.
b) Prepare the contents of this rehabilitation program.

Given information

Demography and referral
Age- 18 years
Sex- Male
Reason for referral- Rehabilitation program

Chief complaints
Severe behavioral problems-duration not mentioned, expectedly long

Psychiatric diagnosis
ASD, ADHD, and ID

Treatment response
Poor

Impact
Parents become sick and tired

Extracted information

Autism spectrum disorder is a neurodevelopmental disorder having high rates of co morbid psychiatric disorders. Intellectual disability has been present in almost 70% cases of ASD. ASD children have language deficits, so it is difficult to measure intellectual functioning level by verbal IQ tests. Non-verbal IQ tests and adaptive functioning level scores are higher than verbal IQ tests.

ADHD, another neurodevelopmental disorder, also present here as a comorbidity. In ASD, symptoms of ADHD are present as over activity and poor concentration.

Behavioral problems poorly responsive to treatment may be suggestive of biological treatment failure. However, parents' exhaustion indicates that the parents put a lot of effort behind the boy but nothing helps that much.

Assigned task

a) Assessment for rehabilitation

- Reassessment of existing disorder with special attention with the followings: Is it ASD high or low functioning? ID-types and severity in all domains (occupational, social, practical); ADHD- its types (Combined, Inattentive, Hyperactive/Impulsive), and severity.
- Problem behaviors-what type (s)? How long? Precipitating and perpetuating factors?
- Any other externalizing or internalizing problems with special enquiry of the following.
  - Are there significant sleep issues?
  - Special sensitivities?
  - Individual and combined impact and burden of all disorders and problems
- Extent and degree of disability as whole and each domain. Clinical as well was using disability scale- WHO-DAS.
- Strengths of the boy-What is the area(s) of special interest and skill?
- Thoughts of career direction?
- What training might be useful for his career direction?
- What kind of employment experiences has he had, if any?
- What did he like the best?
- What accommodations or assistance makes work go well?
- What does the boy find rewarding?
- What helps the boy to cope or release tension?
- What is the boy's level of independence—with daily hygiene, schedules and time, safety, following directions, handling money, and engagement in the community.
- What is the family's expectation?

b) Contents of rehabilitation program

- Life skill training
- Education and training
- Employment
- Living arrangements
- Recreational/leisure opportunities
- Physical capacities
- Spiritual health
- Nutritional balance
- Medical healthcare
- Behavioral healthcare

2. A 16-year-old boy diagnosed with a conduct disorder under psychiatric consultation. He is increasingly impulsive, aggressive and destructive. He is expelled from the school due to repeated bullying and stealing. They boy has a gang involved and recently, gets trouble with police due to charges of snatching. Parents are very hopeless and extremely worried for the child's future.

a) Outline your assessment of the disability of this boy.
b) Prepare a feasible rehabilitation program for him.

Given information

Demography and referral
Age- 16 years
Sex- Male
Referred to- Psychiatry OPD
Accompanied by- Parents
Reason for referral- Parents are hopeless and worried about the child's future

Chief complaints
- Gradual increase of impulsive, aggressive, and destructive behavior- duration not mentioned, expectedly long
- Repeated bullying and stealing in school- subsequent development
- Expelled from school- same duration
- Involvement in gang-subsequent duration
- Gets trouble with police due to charge of snatching- recent onset

Present psychiatric diagnosis
Conduct Disorder

Forensic history
Trouble with police due to charge of snatching

Extracted information

This late adolescent boy is a case of conduct disorder. He has features of conduct disorders under domains of aggression to people and animals, deceitfulness and theft and serious violation of rules. Gradual increase of such disruptive behaviors is a strong indicator of poorer prognosis.

Conduct disorder has been linked to the externalizing spectrum of antisocial personality disorder. There are also high chances of substance abuse and involvement in more serious crimes. The most common reasons behind development and maintenance of such disorders are dysfunctional family, marital discord, parental criminality, hostile parenting and history of abuse. These factors interact with genetic factors and other factors in a wider social environment.

Earlier intervention and appropriate rehabilitation programs, directed toward the boy and the family may halt the progression of conduct problems and prognosis may be expected to be better.

Assigned task

a) Disability assessment

Factors associated with poor outcome
- Onset- Early age of onset (Before 8 years old)
- Phenomenology- Severe, varied and frequent antisocial acts
- Comorbidity- Hyperactivity and attention problems
- Intelligence- Lower IQ

- Family history- Parental criminality, parental drug abuse or alcoholism
- Parenting- Harsh, inconsistent parenting with high criticism, low warmth, low involvement and low supervision
- Wider environment- Low-income family in poor neighborhood with ineffective school
  - Impact on the boy
  - Burden to the family
  - Risk assessment including substance abuse, harm to self and harm to others

b) Rehabilitation program

Rehabilitation of the adolescent with conduct disorder should include:

- Cognitive behavioral approaches as individual or group therapy.
  Three stages:
  - First- psychoeducation (to help the boy to understand more about his own thought, behavior and mood and the links between these).
  - Second- identification with the young person of the areas to work on.
  - Third- a program of learning and practicing those new patterns and seeing what effect they have
- Anger coping or management training
- Problem solving training
- Education and training with special emphasis on employment
- Recreational/leisure opportunities
- Family focused interventions

Chapter 8: Infant Psychiatry

1. A 1-year-old boy presented in CAMH OPD who is malnourished. Her mother is schizophrenic and has been getting treatment for 5 years. The mother always keeps the child with her and does not allow anyone to take care of her child. She does not take care of the child and seemed to be not concerned at all. The family members are increasingly worried about the child's growth and asked whether the child should be taken away from her.
Analyzing the given information in the scenario─
a) Mention the areas of assessment for your plan of action.
b) Mention the points that you need to communicate with the family.

Given information

Demography and referral
Age- 1 year
Sex- Male
Referred to-CAMH OPD
Accompanied by- Family members

Chief complaints
Malnourishment-duration not mentioned, likely long

Family history
Mother schizophrenic, under treatment for 5 years
She neither takes care of the child, nor allow anyone else for the job
Other family members want to take the child away from mother

Extracted information

The malnourishment of this infant is a sign of child maltreatment due to neglect as evident.

The mother of the child is schizophrenic and receiving treatment for the last 5 years. Therefore, the duration of the disorder is more than at least 5 years or more. If there is a long duration of untreated psychosis, that will lead to poor prognosis.

Again, from the vignette it is apparent that the mother is under treatment for 5 years, but symptoms are probably persisting. Reason behind not taking care of the child may be the negative symptoms of schizophrenia and not allowing others to do the job may be due to paranoid symptomatology.

Therefore, the course of the disorder is most likely to be multiple episodes with inter-episodic residual features.

As the other family members are concerned about the child, it is a strength of the family that can be work with.

Assigned task

a) Areas of assessment

For the mother

- Total duration of schizophrenia (long duration of untreated psychosis indicates poor prognosis).
- Course of the disorder (the most common course is multiple episodes with inter-episodic residual features).
- Current symptom profile (paranoid symptomatology, does not allow anyone to take care of the child, command hallucination poses greater risk).
- Presence of negative symptoms as the patient does not take care of the child, presence of depressive symptoms.
- Treatment response and adherence (whether patient is taking regular medication and whether she responded to it or not, whether treatment refractory, adverse effect profile of drugs).

For the child

- Birth history- delivered by NVD or C/S, perinatal events, any complication of the mother, H/O perinatal asphyxia.
- Assessing the developmental milestones- motor, sensory, speech, cognitive, social, and emotional.
- Measuring the height and weight of the child and plotting in the growth chart.
- Feeding and sleeping pattern of the child.

Risk assessment for both the child and mother

b) Points to be communicated with the family

- The course and prognosis of schizophrenia keeping in mind the duration, family history, symptomatology, substance abuse history and treatment response and adherence.
- The treatment of the mother should be ensured not only with drugs but also with psychosocial management. Here, involvement of psychiatric social workers is essential along with relevant social agency.
- The child can be kept to the mother only when the mother can take the responsibility. Until then other family members will take care of the child. If the baby is still breast-fed, the feeding time should be adjusted according to the psychotropic drug (the rule of thumb is feeding or expressing milk just before and 2 hours after taking the drug).
- Consulting a pediatrician for restoring the weight of the malnourished baby.

2. A 17-month-old toddler presents poorly responsive to caregivers, withdrawn and fearful for five months, after the sudden death of her mother.

a) What is the best possible diagnosis based on logical interpretation of the given information?
b) Outline your assessment plan.

Given information

Demography and referral
Age- 17 months
Sex- Female

Chief complaints
- Poor responsiveness to caregivers-5 months
- Withdrawn- same duration
- Fearful- same duration

Temporal stressor
Sudden death of her mother – 5 months or more

Extracted information

This toddler exhibits negative emotional responses like fear and withdrawal. Lack of social and emotional responses, absence of attachment behaviors even in times of stress and marked problems in emotional regulation are the core features of reactive attachment disorder.

Reactive attachment disorder is usually associated with either neglect or deprivation or repeated changes of primary caregiver any of which can be possible for the child as she lost her mother 5 months ago.

The disturbance is evident before the age of 5 years, which is one of the diagnostic criteria for reactive attachment disorder.

As the onset of the problems are evident after the sudden death of mother, autism spectrum disorder can be ruled out.

Assigned task

a) The best possible diagnosis

The best possible diagnosis based on above extraction from given information is Reactive Attachment Disorder (write in details from extraction).

b) Assessment plan

- Severity of the problem
  - The girl's pattern of interaction when distressed (seeking or responding to comfort or not).
  - irritability, sadness, and fearfulness- whether present even during nonthreatening interactions with adult caregivers.
  - Pervasiveness

- Whether the attachment problem is evident across a number of caregivers.

- Distress or disability
- Exclusion of autism spectrum disorder
  Absence of restricted, repetitive behavior and communication difficulties especially non-verbal communication rule out ASD.
- Mental age assessment
  To diagnose RAD, the mental age of the child should be above 9 months.
- Pathogenic care.
- Thorough history of caregiving after mother's death.

3. A 2-year-old boy referred to CAMH OPD from an orphan's home where he lives appears markedly over familiar with strangers and shows disinhibited social behavior. During observation, he expresses intimate behaviors with others in the room.
Analyzing and interpretation of the given information─
a) Write your most likely diagnosis.
b) Mention your main points of assessment and intervention.

Given information

Demography and referral
Age- 2 years
Sex- Male
Referred to- CAMH OPD
Referred from- Orphan's home

Chief complaints
- Overfamiliarity with strangers- not mentioned
- Disinhibited social behavior- same

On observation
Intimate behavior with others in the room

Extracted information

The 2-year-old toddler has been referred for his overfamiliar behavior which is not age appropriate and culturally sanctioned.

He shows socially disinhibited behavior which cannot be better explained by ADHD, because in ADHD, the core features are hyperactivity-impulsivity and attention deficit.

The toddler lives in an orphan's home that may limit opportunities to form stable attachments. Maybe the type of care he has received is responsible for the disturbed behavior.

Assigned task

a)The most likely diagnosis

On the basis of above extraction and logical interpretation of given information, the most likely diagnosis is Disinhibited Social Engagement Disorder.

b)The main points assessment and intervention

Assessment

Assessment of the child

- Careful history from multiple informants
- Observing the child in several settings
- Aspects of attachment- secure base, disinhibited exploring of new situation, promiscuous affection
- Severity
- Pervasiveness
- Developmental milestones of all dimensions
- Mental age

Assessment of the care received

- Pre and perinatal care
- Number of changes of caregivers
- Quality of the care receiving now (warmth, emotional availability, neglect, hostility or abuse)
- Direct observation of the interaction of the child and the current caregiver.

Intervention

In this case, multiprofessional and multiagency involvement is required.

- Improving the child's caregiving environment by providing necessary advice.
- Stepping for alternative care, if necessary.
- Long-term good quality parental type care (foster care) with sensitive responding to the child's need is the ultimate goal.

Chapter 9: Child and Adolescent Psychotherapy

1. A 10-year-old boy was diagnosed with oppositional defiant disorder for the first time during OPD attendance. Your consultant asked you to provide behavior modification therapy as part of the comprehensive treatment package.
a) How will you proceed to map the therapy?
b) Mention the steps of applying and monitoring the therapy.

Given information

Demography and referral
Age-10 years
Sex- Male
Referred to- Psychiatry OPD

Present psychiatric diagnosis
Oppositional Defiant Disorder

Treatment plan
Applying behavior modification therapy as part of comprehensive treatment package

Extracted information

This late childhood aged boy with ODD for which child-focused, family-focused and school-focused treatment are required. It is likely that all these components are present on a comprehensive treatment plan.

Behavior modification therapy is one of the first line treatment options, easily applicable and very effective in modifying defiant behavior and this positive outcome will be strengthened and sustained, if other components of treatment are applied and work.

This handful task is easily applicable in OPD settings, and any members of the team can offer. The consultant assigned to advanced CA Psychiatry trainee indicates psychiatrist or CA psychiatrist in existing settings should offer this task.

Assigned task

a) Mapping the behavior modification therapy

Assessment
[Mnemonic- SIRSE]
Symptoms in the child- what are the problem areas, in which setting the child shows the behavior, what are the antecedent of the behavior, what behaviors are shown, what are the consequences; developmental delay; attention and activity span; speech and language; play; motor skills; bowel and bladder control; scholastic attainment.

Impact of the behavior- how much distress or impairment does it cause for the child and for others? Impact in social life (family/classroom/friendship/leisure activities).

Risk assessment- what are the predisposing and perpetuating factors

Strengths- what assets are there to work with?

Explanatory model- what beliefs and expectations do the family bring with them?

Negotiating the goals with the parents and the child
- Specifying the target behaviors
- Assessing the impact of the behaviors
- Agreeing the desired outcome in behavioral terms
- Formulating the positive behaviors desired
- Explaining in a way that can be understood by everyone in the family.

b) <u>Steps of applying behavior modification therapy</u>

Functional analysis of behavior
Antecedent events- experiences for the child just prior to behavior; people present; place; time of the day; situations.
Behavior- nature; onset; frequency; severity; duration of episodes.
Consequences- changes of demands and expectations of the child by others; changes in attention and social set up; attainment of child's immediate goals and wants; impact on sibling and parents.

To increase desired behaviors
- Positive reinforcement- reward desired behavior.
- Negative reinforcement- remove aversive stimulus after desired behavior has occurred.
- Explaining underlying theory to parents and the child.
- Training skills with rehearsal, and role-play.

To reduce undesired behaviors
- Stimulus change- remove or change controlling antecedent stimuli.
- Extinction- this should follow removal of previous reward identified with reinforcement of the behavior.
- Differential reinforcement of incompatible behavior.
- Punishment
- Time out

[NTK: Behavior modification refers to the assessment, evaluation and alteration of behavior according to behavioral principles, and is conducted within a broad range of social, educational and therapeutic settings. Positive reinforcement is given &/or negative reinforcement is removed in response to desired behavior. Alternatively, withdrawing positive reinforcement and applying negative reinforcement for undesired behavior.]

2. A 15-year-old girl is a case of Depressive Disorder. Due to her existing many negative cognitions your consultant has decided to provide her cognitive restructuring of the cognitive distortion.
a) Mention the main points you need to assess before applying cognitive restructuring.
b) Write down the steps of the therapy that you need to apply in this case.

Given information

Demography and referral
Age-15 years
Sex- Female

Psychiatric diagnosis
Depressive disorder

Main reason for psychotherapy
Has many negative cognition

Treatment plan
Cognitive restructuring

Extracted information

This adolescent girl has depressive disorder for which cognitive restructuring has been planned. Psychotherapy is usually offered when severity of depression is mild to moderate or as an adjunct to antidepressant.

In pediatric depressive disorder, psychotherapeutic measures are applied initially as well as combination with antidepressants. This girl has many cognitive distortions for which CBT is required. Here, the consultant assigned to do cognitive restructuring which is the main component of CBT with the aim of restoring positive thought instead of distorted thought.

Antidepressant treatment responded partially and still he has marked anxiety and negative thoughts that he avoids, as he feels uncomfortable, and it is likely that he is in distress.

Adding CBT with this state will likely enhance the positive outcome. Assessment of the problem area and patient's need is necessary before starting CBT.

Assigned task

a) The main points of the assessment before applying cognitive restructuring

- Full assessment of depression- onset, duration, contents, severity, persistency, prior treatment and outcome, distress and impact with present functional levels in all domains. If an adequate record is kept-going through this and gathering information for better clarification.
- Etiological assessment including - especially ACE, enduring and acute stressors,
- Assessing negative thoughts.
- Listing the negative thoughts on its effects on her behavior and emotion.

- Understanding the psychopathology of negative thoughts-overgeneralization, selective abstraction, arbitrary inference, magnification/minimization, disqualifying positive thought overgeneralization.
- Assessing extent of support of the patients, particularly from family.
- Level of understanding of the patient and caregivers about the disorder along with their expectation from the facilities.

b) Steps of Cognitive restructuring

Explaining therapy in the context of her problems

- Types of therapy-psychological or talk therapy.
- Basic Principles-it focuses on his present problems and its adverse effect, recognizing that negative thoughts can affect mood negatively.
- Encouraging looking at different ways of thinking.
- Structure of Therapy-Usually on a one-to-one basis, typically occurs once-a-week for a few months (8-12 sessions), problem-solving strategy is used, he has to do feasible homework.
- Expected outcome-Good for aspects of depression, better when combined with medication, can help to prevent relapse.
- Other-Usual treatment including medication often requires continuing, the therapist undergoes supervision, ethical issues including ensuring confidentiality.

Applying Cognitive restructuring process

- Working on one negative thought in the initial session followed by others (one or more) in subsequent sessions.
- Applying suitable methods of reasoning. For example:
  - Stating her particular negative thoughts and inference.
  - Asking for an example of an event for which she is thinking in this way.
  - Asking whether it is logical.
  - Asking for events in the last weeks/months happened with her that she considered well.
  - Asking whether these positive incidences are signs of positive things in contrast to her negative thinking.
- Explaining the cognitive distortion causes this faulty inference that she drew.
- Advice to practice this positive thinking in her day-to-day interaction with others and to keep an activity diary and thought diary.

3. A 17-year-old girl with borderline personality disorder comes with her parents in psychiatry OPD who recently has been discharged from an emergency unit after severe overdosing. Your consultant asked you to provide dialectical behavior therapy as part of the treatment plan. Answer the following through a systematic approach.
a) What information will you gather before applying the therapy?
b) Outline the stepwise session plans of the therapy.

Given information

Demography and referral
Age-17 years
Sex- Female

Referred to- Psychiatry OPD
Referred and accompanied by -Parents

Present psychiatric diagnosis
Borderline PD under treatment

Recent past psychiatric history
Overdosing, attended and discharged from emergency service

Extracted information

This late adolescent girl certainly has remarkable features and a strong predictive factor of BPD for which she has the diagnosis before the expected age as per provision.

Impulsivity is one of the cardinal features of BPD and her harm behavior is explainable by this. Considering her diagnosis at this age, it is likely that the girl has had past one or more self-harm behavior. Further, it may be blended with possible depression.

Dialectic behavioral therapy (DBT) is one of the key tools in the treatment package of DBT particularly with suicidal adolescents. It helps patients with what needs to be changed, while accepting what is a valid response to circumstances.

Before applying the elements of DBT, assessment of the problem areas and the girl's needs is necessary.

Assigned task

a) Information needs to be gathered for dialectic behavioral therapy (DBT)

- Rapport and empathy.
- Patient and parents' recent concerns.
- Why did the patient overdose herself?
- Patient's perception about lethality of the method.
- How she was prepared for the act- suicide note/informing someone/precaution against discovery.
- What was her feeling after recovery? Any further plans?
- Any previous self-harm episodes?
- Current social circumstances of the girl.
- Co morbid psychiatric disorder, or substance misuse
- Future risk assessment.
- Strengths of the girl in the form of her special abilities and skills, creativity.
- Summary of all mental status examinations.
- Patient and family's commitment to the therapy.

b) Stepwise session plan for DBT

The session wise session plan is based on sequential contents of the main steps of DBT. These are:

- Orientation & Goal Setting

- Dialectical Thinking
- Core Mindfulness Skills
- Distress Tolerance Skills
  - Distracting with ACCEPTS (**A**ctivities, **C**ontribute, **C**omparison, **E**motions, **P**ush away, **T**houghts, **S**ensation).
  - IMPROVE the moment (**I**magery, **M**eaning, **P**rayer, **R**elaxation, **O**ne thing at a moment, **V**acation, **E**ncouragement).
  - Self-soothing.
  - Pros and cons.
- Emotion Regulation Skills
  PLEASE-skills (treat **P**hysical i**L**lness, balanced **E**ating, **A**void mood altering drugs, **S**leep, **E**xercise)
- Interpersonal Effectiveness Skills
  - DEARMAN-getting something (**D**escribe one's situation, **E**xpress why this is an issue and how you feel, **A**ssert yourself by asking for what you want, **R**einforce your position by offering positive consequences, **M**indful of the situation by focusing on what you want and ignoring distractions, **A**ppear confident even when you don't feel it, **N**egotiate with hesitant people and come to a comfortable compromise).
  - GIVE-giving something (**G**entle, **I**nterested manner, **V**alidate, **E**asy manner).
  - FAST for self-respect (**F**air, **A**pologize, **S**tick to your values, **T**ruthful).

4. A 14-year-old-girl with major depressive disorder is getting CAMH OPD based treatment. She has a gross problem with interpersonal relationships. After initial treatment with an adequate dose of sertraline, interpersonal psychotherapy has been planned for her.
a) State the assessment area with the aim of providing this therapy.
b) Outline the ways of setting goals to provide this therapy.

Given information

<u>Demography and referral</u>
Age-14 years
Sex- Female

<u>Present psychiatric diagnosis</u>
Major Depressive Disorder

<u>Treatment receiving</u>
Getting Sertraline in adequate dose

<u>Additional treatment plan</u>
Interpersonal psychotherapy

Extracted information

This mid adolescent girl is diagnosed with MDD, and getting sertraline in adequate doses. Though the outcome of the drug is not given, it is likely that the girl's symptoms have been remitted at such a level where interpersonal psychotherapy is applicable and necessary at this stage for better outcome.

Interpersonal psychotherapy (IPT) is one of the effective treatments for treating depression, especially when depression occurs in the context of interpersonal relationships. It is a time-oriented, brief form of psychotherapy.

Combined treatment of drugs and IPT gives better and sustainable outcomes.

Before applying the phases of IPT, assessment of the problem area and the girl's need is necessary.

Assigned task

a) Assessment areas for providing interpersonal psychotherapy (IPT)

Present symptoms of depression
- Mood (predominance, persistency, pervasiveness, mood reactivity)
- Biological features (sleep, appetite, bowel habit, menstrual history)
- Lack of enjoyment or interest
- Poor concentration
- Poor self-esteem
- Feeling of inappropriate guilt
- Suicidal thoughts

Impact and burden
- Level of functioning in all domains- especially family life, academic performance (before/now), social interaction.
- Degree of burden to parents and family.

Parental attitude & behavior towards the girl
Overprotective, authoritative, neglecting

Temperament of the child
Difficult, internalizing, poorly expressive, social relations and leisure

Etiological formulation
Predisposing, precipitating and perpetuating factor for the disorder

Specific assessment areas for IPT
- Interpersonal role disputes
- Interpersonal deficits
- Role transitions
- Any unresolved grief issues

b) Ways of setting goal to provide the therapy

Ultimate goal of the therapy is to solve the problems in her focal interpersonal problem areas. To achieve the ultimate goal there are phase wise goals.

Phase wise goals
- Initial phase- Engagement
  - Depression as a clinical disorder will be explained.

- The girl will be encouraged to think of herself as in treatment and at the same time do her daily chores as normally as possible.
- Parents will be encouraged to be supportive.
- If possible, the school will be approached and the effect of depression on school performance and behavior explained.

- Middle phase- Addressing the problems

  Focus will be on the interpersonal problems. This can be addressed by helping the young person
  - to identify the interpersonal role dispute.
  - to make choices about negotiations.
  - to reassess expectations for the relationships.
  - to modify communication patterns.
  - to improve social skills.
  - to identify problematic interpersonal situations and exploring new communication skills (e.g., by role play).
- Termination phase- Reviewing

  Progress will be reviewed, often with other family members present

Chapter 10: Exercise for self-practice

1. A-9-year-old boy with bronchial asthma was referred from pediatric OPD to CAMH OPD for his fear, worries, abdominal pain, tempered and argumentative behavior. The boy is marked inattentive and irregular at school attendance.

   Based on your logical deduction of the given information in the scenario—

   a) What are the most likely psychiatric diagnoses?

   b) What information do you require to confirm the diagnoses and make a treatment plan?

2. A 14-year-old girl appears in psychiatry OPD of a tertiary hospital with sudden convulsion and fit for that no physical cause was found. The girl talks incoherently.

   Considering the most likely diagnosis on the basis of your analysis of the given information—

   a) Make a checklist of content of assessment of this case.

   b) Outline the treatment plan.

3. A 6-year-old boy starts refusing to go to school after summer vacation and only agrees to go if his mother sits beside him in the classroom. On forceful effort, the child resists entering school, cries and at times vomits. This happens in every subsequent failure effort.
   Considering the best possible diagnosis from the given information—
   a) What else is required to confirm the diagnosis?
   b) Outline the management plan.

4. A 4-year-old-girl recently appears to be marked fearful, touchy, restless, easily annoyed, has poor food intake and sleep disturbance. Her mother recently returns after a two-month hospital stay due to her COVID-19 infection and is also terrified, disengaged and irritable.
   Based on logical analysis i of the of the given information —
   a) What is the possible diagnosis that explains best the child's condition?
   b) What information do you need to gather for an effective treatment plan?

5. A 15-year-old boy appears to a psychiatrist by his parents. They complain that the boy does not go to the school that they explore recently. He is ridiculously disobedient and shows no interest in study. The boy is increasingly demanding and very resentful if that is not fulfilled. Recently, he is involved with groups and stays out of home in the evening despite telling him not to do so.
   a) What is the best possible diagnosis based on systemic deduction of given information?
   b) Outline the components of the treatment plan.

6. A 12-year-old boy has been brought to CAMH OPD by his caregiver for challenging behaviors who is not willing to consult.
   a) What are the points you have to consider establishing a working relationship with this boy?
   b) Outline your assessment plan.

7. A 10-year-old boy appears in a child and adolescent psychiatry consultation center who has epilepsy for 5 years and is under AED. Overconcerned parents say the boy increasingly shows unpredictable aggressive behavior, marked inattentiveness, poorly engages with peers, does not sleep well, easily annoyed and has marked academic deficit. The boy looks irritable.
   On the basis of your logical interpretation of the given information—
   a) What could be the best possible diagnoses?
   b) Prepare a checklist of information necessary to assess this case for confirming the diagnosis and making a treatment plan.

8. A 7-year-old girl is brought up with complaints of having abdominal pain, unwilling to go to school-every day, and insisting on spending time with parents back home. Detailed examination reveals no other positive findings.
   a) What are the areas you need to assess?
   b) Make a list of information that you need to explain a child's condition to his parents.

9. A 11-year-old boy presents with marked defiance, reluctant in study and unwilling to go school. In conversation, he appears to be clever. Considering his poor academic performance, parents did

an intelligence test for him, and the score was indicative of mild to moderate intellectual impairment.

a) Mention your assessment process to reach diagnosis.
b) Outline your treatment plan.

10. A 16-year-old girl who has schizophrenia for three years. After trial of three antipsychotics with poor response, she is under clozapine therapy for one month. Though she has suspiciousness and thought broadcasting, overall, her symptoms are remitted in terms of frequency and intensity. She does not go to school since her illness, increasingly demanding, tempered, and aggressive. She behaves childishly, does not do her usual activities, keeps herself confined in own room and spends most of the time with mobile and internet mostly by listening to songs and playing virtual games. Her daily life including sleep schedule is completely disrupted. Parents become sick and tired of her management and upset about her future.
    a) Specify the area of further assessment.
    b) What could be a revised treatment plan?

11. A 14-year-old boy is brought by his parents to CAMH OPD. The parents say that the boy is very aggressive to them and fights with others. He often lies, steals and stays out of home at night without their permission. He does not study and spends time with bad boys. They have been struggling with the boy since his early childhood and the boy is now totally out of their control. Recently, he has been suspended from the school for the charge of theft. The boy was fidgeting and inattentive.
    Considering the best possible dual diagnosis ─
    a) Make a checklist of information you need to assess this case.
    b) Summarize your treatment plan.

12. A 14-year-old girl presented with repetitive convulsion and fit after a period of prolonged screaming, incoherence, and outgoing tendency for the last 2 months. The symptoms started in school followed by any time. She is the first girl in the class. Initially, she was irregular in school attendance due to her problem and recently she is not going to school. A series of consultations was made. EEG was suggestive of seizure disorder and normal in 2 occasions for each. AED was given. No improvement of her symptoms was observed, rather increasing particularly, in face of demand fulfilment. Parents are anxious and puzzled with the situation.
    On the basis of methodical extraction and logical interpretation of the given information─
    a) What could be the most possible diagnosis?
    b) Provide the management plan.

13. A 10-year-old boy attends with his mother because of his recent dysphoric mood and sleep disturbances that started after witnessing devastating violence between parents 3 weeks ago. The boy says that he hears voices of quarrelling parents from the ceiling fan only when the fan moves. His father is schizophrenic predominantly with paranoid and jealous features and hearing of conversations like voices for 4 years who adheres little with the treatment.
    Considering the differentials based on your deduction of the given information─
    a) List the points of your assessment for the single most possible diagnosis.
    b) Make an outline of a treatment plan for this case.

14. A 17-year-old girl appears with her mother who has not gone to college since her admission in 11 grades. The girl has a persistent fear of exams. For the last 10 years and always shows avoidance behavior, appears only by pressure, and has unexpected low academic performance all through. She has poor peer relationships and is bullied on several occasions. Gradually she became depressed and recently overdosed.
    Based on your logical deduction of the given information—
    a) What is the best possible diagnosis?
    b) Make a checklist of your assessment plan.

15. A 10-year-old girl from a district town suddenly complains of loss of vision 7 days back. Anxious parents move to Dhaka for best possible treatment. They consult an ophthalmologist followed by a neurologist and again an ophthalmologist. The child underwent several clinical examinations and investigations including CT scan and MRI of the brain and no abnormality was found. The Child's symptom remains with fluctuating course. After giving glasses with zero power, the child's vision is improved to some extent. Now, the child is asking for more glass power for better vision. Embarrassed ophthalmologist referred the girl for psychiatric consultation.
    Considering single most possible diagnosis—
    a) Outline the possible psychopathology of this condition.
    b) Specify the information areas with reason that you need to gather as part of your assessment.

16. A 13-year-old boy attends with his parents in psychiatry OPD. His parents report that since the last 7 months the boy has been irritable, tempered, keeps himself isolated at home, and gives up mixing with peers. He does not want to perform any academic activity and becomes aggressive, destructive, and self-injurious when parents ask to do so. He performs very poorly in the last exam that is totally mismatched with his previous record. The boy is non-cooperative and looks angry.
    Analyzing the given information in the scenario—
    a) What is your differential diagnosis keeping in mind the single most possible diagnosis?
    b) Outline the assessment plan.

17. An 11-year-old attends CAMH OPD with her mother with the complaints of stammering, palpitation, and occasional chest pain for 2 years that develops after dengue fever. Her mother says that since then she is inattentive, reluctant in study and going to school despite her mother's pressure and censure. She has no friends in school. She did not appear in the final examinations in this year in grade IV due to an increase in her present problems and her class promotion is uncertain. The girl said that she finds it hard to go through her class work.
    Based on your logical deduction of the given information—
    a) Write down your assessment plan considering differential diagnosis.
    b) What treatment plan will you adopt for this girl?

18. A 15-year-old girl has an intrusive thought that God is her husband. That causes her severe distress, and she frequently begs pardon to God. Subsequently she started irresistible hair pulling that caused her relieved tension.
    Considering single most likely diagnosis doing logical interpretation of the given information—
    a) Prepare a checklist of the assessment areas.

b) Outline the management plan at this point.

19. A 10-year-old boy appears distressed, irritable, isolated, and not going to school. Her mother informs that the child has had abdominal pain for the last 5 years that fluctuates but never goes out despite treatment. Mother is single.
    Considering existence of multiple diagnosis based on your logical extraction of given information-
    a) Provide a diagnosis specific assessment plan for this case.
    b) List the management options and supportive measures that you will offer.

20. A 15-year-old girl attends CAMH OPD who has marked irritability; lack of self-care shows little interest in work. She also has had menstrual dysregulation for 3 months. Recently, she stopped going to school and most of the time lies in bed, closing the door of her room.
    Based on your logical deduction and interpretation of the given information─
    a) What is the best possible diagnosis?
    b) Provide a comprehensive treatment plan.

21. An 11-year-old boy has persistent fear and avoidance of different social situations due to fear that he is observed and negatively evaluated by others. He even fears interacting in class and refuses to go school.
    This case is allocated to you for psychosocial management.
    a) How will you formulate this case for this form of management?
    b) Map your management plan.

22. A 14-year-old girl has intellectual disability at moderate level who is placed in a special school for learning and rehabilitation. Due to family relocation in a remote place, her parents are unable to continue special schooling.
    Your consultant asked you to make a home-based plan.
    a) Prepare a checklist of your assessment for home-based learning and rehabilitation.
    b) Outline the contents of this plan.

23. A 13-year-old girl who has been diagnosed with somatic symptoms disorder with recurrent abdominal pain. It runs in waxing and waning courses despite treatment. For six months, her condition has been worsening more and the girl has been brought by her anxious parents to CAMH OPD.
    Based on the most likely diagnosis on the basis of your logical interpretation of the given information─
    a) Make a checklist of your assessment.
    b) Outline your intervention plan.

24. A 12-year-old girl presents with pain in legs, recurrent vomiting and headache in CAMH OPD. All laboratory investigations found normal. The girl was admitted three times in different hospitals at district level. Recently, she became dyspneic, and her puzzled parents brought her to Dhaka for better treatment.

a) What is the best possible diagnosis based on extracted evidence from given information?
b) Write down the list of information you need for making a treatment plan.

25. A 12-year-old girl presents in Psychiatry OPD with weakness of lower limbs, hand tremor for the last 1 month. No organic cause found on repeated investigations. Three months back she failed in midterm examination. She was diagnosed with a conversion disorder by GP and treated accordingly. Three weeks after the treatment, no notable improvement was observed. Her parents are increasingly anxious for her daughter.
    Considering the diagnosis with logical explanation that explain best the girl's condition─
    a) Mention the areas of assessment in support of your diagnosis and treatment planning.
    b) What will be your treatment plan at this stage?

26. A 15-year-old boy diagnosed as bipolar disorder, current episode manic and receiving lithium carbonate with blood level of 0.9mmol/litter and quetiapine 500 mg in divided dose. Overall, his symptoms are remitted. His parents complain that he still has a buying spree, tendency of taking fast food, increasingly demanding nature and excitement. They have to fulfil his demand to make him quiet, saying that the problem still is not controlled.
    a) What are the main areas you need to assess?
    b) What could be the psychopathology of this presenting complaint?
    c) Outline the plan of further management.

27. A 9-year-old boy wets nighttime and daytime most of the days in a week and who never gains continence.
    a) Make a checklist of information to assess this case.
    b) Outline the management plan.

28. A 13-year-old boy attends CAMH OPD with his father who has developed hypersexual behavior since last six months. The behaviors include touching females in any way, fondling female clothes and masturbating that are repeatedly observed by his puzzling parents. Subsequently, he is reluctant to go to school and study. The boy says that he enjoys the acts though he tries not to do such.
    a) What are your diagnoses based on extracted evidence from given information?
    b) Prepare a checklist of your assessment to confirm diagnosis.

29. A 14-year-old girl presented by her mother who recently becomes unruly, irritable, impulsive, outgoing, inappropriate sexual behavior. Mother reports that she is a very quiet, polite and obedient girl but these changes happen in the last 3 months.
    a) Outline the assessment plan for this case mentioning the assessment areas.
    b) How will you manage this case?

30. A-12-year-old boy is increasingly involved with mobile games and becomes violent when he prevents them from doing so. He sleeps at 5 am and wakes at 2 pm. He cannot concentrate on his work and fail to attend school. His parents are tired of this boy and feel helpless.

a) How will you assess this case?
b) What will be your treatment option?

31. A 13-year-old girl presents in psychiatry OPD who suddenly forgets her name after witnessing horrific domestic violence. Subsequently, she becomes violent, and says that she frequently sees a dreadful tall man with white dress who wants to take her away. At that time, she becomes intensely fearful. Her condition is further deteriorated after maltreatment by a traditional healer. Considering the single best possible diagnosis through your logical interpretation of the scenario—
    a) What information do you need to gather to confirm the diagnosis?
    b) Provide your treatment plan for this girl.

32. A 14-year-old boy is diagnosed with major depression and has started treatment with fluoxetine 20 mg/day. After 6 days, the boy becomes highly irritable, impulsive, and agitated.
    a) How will you explain this feature?
    b) What will be your interventional steps?

33. A 15-year-old married girl presents with marked incoherence, fit, odd behavior and outgoingness that are episodic and lasts from few minutes to hours. This has happened several times in the last 3 months. She looks disheveled and distressful.
    a) What is the most likely diagnosis based on logical interpretation of given information?
    b) What information do you need to gather for a comprehensive treatment plan?

34. A 16-year-old boy presented with persistent denial of taking an adequate diet and loss of weight for 4 months followed recent food refusal and got psychiatric referral by an internist. Parents informed that the boy heard from a pious man that no one could die before finishing the allocated food by God. After that, the boy starts doing such behavior. When the boy has been asked about it, he says he is compelled to think of his long-life span. The boy looked cachectic and anxious.
    a) Extract the information from above scenarios keeping in mind the best possible differential diagnosis.
    b) Outline your assessment plan to reach the diagnosis.

35. An 18-year-old girl has been brought by her parents in a psychiatric emergency for her suicidal attempt by hanging in her room. She has had suicidal attempts on three occasions. The girl showed severe agitation.
    a) Outline the basic steps to assessment in this setup.
    b) What is your immediate and ultimate action plan to manage this case?

36. 14. A 15-year-old student presents with a lack of interest in studies since the last 6 months. He has frequent quarrels with his parents and headaches. Answer the following providing logical extraction from the given information.
    a) What is the best possible diagnosis by extracting the supportive evidence for the given information?
    b) What other things do you need to rule out?

37. A 14-year-old boy attends a psychiatrist's consultation center due to severe discomfort, feelings of senselessness and anxiety who thinks that his cheeks gradually compress inward that worries him but others cannot find such deformity. Repeated consultations do not reveal any organic etiology. He starts to unshaven his beard to cover it up. The boy says that he feels uncomfortable in social situations due to his possible ugly appearance and gradually stops going to school. On questioning, the boy says that his age could be more than said because of his thick pattern of hairs of his beard. The boy is a good student and performs his study at home.
    a) Mention most likely diagnosis providing supportive evidence from the scenario.
    b) Make a checklist of information that will be required for confirming the diagnosis and making a treatment plan.

38. A 16-year-old girl was referred to psychiatry OPD by a GP who has had a persistent headache for the last 8 months for which no organic cause was found. The girl's mother says that she cannot perform her academic activities due to headaches rather than increases during study and school. Initially, the girl responded well with 50 mg imipramine/day that has been further increased gradually up to 125 mg for waxing of the symptoms. The girl is increasingly demanding, not going to school, loses her confidence and does self-injurious behavior. Her mother expresses her persistent worries and concerns for her daughter's problems that are central to the reason for the headache.
    a) What will be your steps of assessment?
    b) Provide the contents of your treatment plan for this case.

39. An 11-year-old boy brought to CAMH OPD who appears to be a difficult learner. His parents inform that the boy has poorer intelligence than that of his age.
    a) How will you proceed to diagnose this case?
    b) Outline the assessment areas.

40. A 19-year-old boy attends to a child and adolescent psychiatrist who does not want to take food as he thinks he is overweight since the last 9 months for which his weight has been reduced from 45 kg to 33 Kg. He does vigorous exercise, reacts angrily if he is asked to take the usual quantity of food. On questioning, the boy says he starts reducing weight after passing comments of his peer as "fatty". Now he thinks he needs to reduce another 3 Kg to make him fair looking.
    a) Outline your assessment plan on the basis of your diagnosis?
    b) How will you treat this case?

41. An 8-year-old-boy appears CAMH OPD who has persistent soiling of clothes for the last 5 years along with a habit of pulling out feces from anal canal that he coats on the wall . The boy is poorly responsive, restless, impulsive, and restricted in emotion, His father says he is very tempered, cruel, irritable, inattentive in his work, frequently annoys others and is bullied both in school and playground.
    Based on the logical deduction of the of the given in information ─
    a) What is the most likely multiple diagnosis?
    b) Provide an assessment plan for a comprehensive intervention.

42. A hostel building in a school in Dhaka city collapsed at mid-night. Four students died and minor to severe casualty happened to others. Observing behavioral problems among the survivors and others, the school authority seeks mental health support from your facilities. You are assigned to lead this task.
    a) Prepare a checklist of your task plan.
    b) Outline your content intervention.

43. A 14-year-old girl has incapacitating abdominal pain with no obvious organic cause for the last 6 months. Her 12-year-old brother has no reported problems and is doing well academically. Her 10-year-old youngest brother refuses to do what his mother asks and frequently swears at her. Your consultant decided to provide family therapy as part of the treatment plan and asked to do so.
    a) Outline the therapeutic plan through family visit.
    b) How will you conduct the first therapeutic session?

44. A 6-year-old has been hurting his 6-month-old brother for five months. The problem is gradually increasing and on one occasion, he tries to kill the baby by putting a pillow on his mouth. Puzzled parents failed to manage the boy in any way.
    Considering the most likely diagnosis─
    a) Outline the assessment plan of this case.
    b) List the contents of your management plan.

45. A 6-month-old baby referred to CAMH OPD from pediatric neurology OPD who has nonorganic failure to thrive. Mother has chronic psychosis, has significant residual features despite getting treatment, and poorly concerned about child rearing. The family members are increasingly worried about the child's growth and are puzzled to handle the situation.
    a) Outline your assessment plan.
    b) List the points that you need to communicate with the family.

46. Your consultant appoints you as a team leader of child mental health team to support a care home for rape victim girls.
    a) Outline your educational contents of psycho-trauma to the career.
    b) How will you screen these girls for possible psychiatric disorders?

47. At midnight, the warden of a safe house phones you for a repeated suicidal attempt of a 14-year-old inanimate girl that she finds hard to control and feels helpless.
    As an on-call child and adolescent psychiatrist,
    a) What will be your immediate action over the phone?
    b) List the steps of your afterwards action for this woman.

48. A 16-year-old boy who is a case of treatment refractory Tourette disorder. He has given up going to school and academic work. The boy denies going out of home and does awkward and

troublesome behavior that becomes so worsened despite all efforts. Your CAMH team decides to apply for a rehabilitation program for this boy.

a) List the cardinal assessment areas necessary for preparing this rehabilitation program.
b) Outline the contents of the program.

49. A 17-year-old girl attends a psychiatrist's chamber with her mother. Worried mother says that after one and half years of COVID pandemic situation, she gradually starts religious practice that is increasing day by day. The girl says that what she is doing is the part of her religion that should be followed. Other than this, she is doing her usual daily activities including her academic work but avoids doing such activities that are conventionally against the religion. Sometimes she shows irritability and annoyance if parents advise her to give up or interrupts religious activities. On through psychiatric assessment no features of obsession-compulsion, psychosis or depression found except occasional uneasiness.
    a) Give the best explanation of this problem providing logical interpretation of information from the scenario.
    b) Outline your approach to management.

50. A-17-year-old boy with high functioning autism was referred to a child and adolescent psychiatrist by a pediatric neurologist who recently started doing odd sexual behavior. He masturbates at home and tries to get close with mother, touches her breast and other sensitive parts that makes the mother uneasy. Parents say that at school, he disturbs girls and sometimes says, "I'll touch your breasts", for the head teacher calls the parents. At times, he tried to do sexual acts with mother that makes her scared.
    Based on your logical deduction for the above information─
    a) Write the possible explanation of this behavior of the boy
    b) What treatment will you offer to manage the behavior?

51. An 18-year-old boy appears to CAMH OPD who sees many people and hears their voices and feels helpless, as he cannot control these seeing and hearing. He cannot concentrate on his work in any way that makes him worried and fearful. His mother says they could not find anything, and this may happen as an act of evil spirit.
    Drawing logical extraction from the given information─
    a) Write down your best possible explanation that you need to offer the boy and his mother.
    b) Critically map your treatment plan.

52. A 14-year-old girl attend with CAMH OPD with her parents who recently tries to commit suicide by hanging in her room. Parents say that for the last few months she is upset about frequently getting slang mobile text and comments on Facebook. Very recently, her fabricated nude photos were posted and shared on the internet. The girl looks disheveled, exhausted, and shameful.
    Answer the following drawing logical deduction for the given information.
    a) What is the single most likely diagnosis?
    b) List the information necessary to confirm the diagnosis and make treatment at the first step.

53. A-11-year-old boy appears to a child and adolescent psychiatrist who is upset and sorrowful for watching porn video with his peers 6 weeks back. He frequently begs God's pardon and asks

parents to forgive him. Parents inform that the boy does not sleep, eat, do his work and is preoccupied with this issue despite their effort to give him comfort.

Based on your logical extraction from the scenario─

a) What is the most appropriate differential diagnosis?

b) Write down your assessment plan for confirming the diagnosis and making a treatment plan.

54. A 17-year-old girl was referred to a child and adolescent psychiatrist by an endocrinologist for her excessive overweight. Worried mother says that for the last 2 years, she refuses to go school, does not do her work, keeps her isolated in her room, uses mobile phone usually, and demands fast food. The girl says she finds no confidence to manage her weight and perform her task.

    Based on analyzing the scenario─

    a) What is the most likely diagnosis?

    b) How will you manage this case with emphasizing her obesity?

55. A 16-year-old boy attends to a child and adolescent psychiatrist by his father hailing from an urban high income and religious family who has low mood, lack of concentration in his work, sleep excessively and expresses suicidal ideation for a week. It reveals that he started watching porn videos by the influence of his peers who sent him an online link and later with his own effort. Subsequently, he develops guilt feelings and stops watching such videos. However, he is increasingly preoccupied with guilt feelings and repetitively begs pardon to God as he doubts that he will not be excused in any way.

    Based on your logical deduction and interpretation from the scenario─

    a) What could be the most likely diagnosis to explain his present condition?

    b) Outline your plan of intervention.

56. Concerned parents bring their 15-year-old daughter who is nowadays spending most of the time in her room using social media. When the parents go to her room, she immediately changes the computer screen and is annoyed. Recently the mother noticed a few cuts and scratches in the daughter's hand.

    Based on your logical deduction and interpretation of the given information─

    a) What are the possible diagnoses?

    b) List the points of your assessment of this teenager for diagnostic confirmation and intervention.

57. A 10-year-old boy appears irritable, isolated and not going to school. His mother informed that the boy's problems started immediately after divorce of his parents for 6 months. She also informs that the child has had abdominal pain for the last 5 years that fluctuates but never goes out despite treatment.

    Considering differentials from extracting the information from the scenario, answer the following.

    a) How will you assess to confirm the diagnosis and make a treatment plan?

    b) List the management options and supportive measures that need to be offered.