

DON BOSCO COLLEGE, KOTTIYAM

(Affiliated to the University of Kerala)



DEPARTMENT OF PSYCHOLOGY INTERNSHIP RECORD

SUBMITTED BY

MEGHA. S

BSC. PSYCHOLOGY (S4)

DON BOSCO COLLEGE , KOTTIYAM

CASE NO: I

Date: 21/04/2026

HISTORY

Socio-Demographic Details

- Name: R. M
- Sex: Female
- Date of Birth: February 1995
- Age: 29
- Education: B.Sc Nursing Graduate
- Occupation: Homemaker (formerly Staff Nurse)
- Marital Status: Married
- Address Local: Edappally, Ernakulam
- Address Permanent: Edappally, Ernakulam
- Domicile: Urban
- Socio-economic Status: Middle
- Religion: Christian
- Mother Tongue: Malayalam
- Languages Spoken: Malayalam, English
- Source of Referral: Husband
- Purpose of Referral: Psychiatric intervention

Informant:

- *Informant's Name:* Mr. A. M
- *Informant's Relationship with Client:* Husband
- Information was adequate and reliable.

Presenting Complaints:

- Persistent low mood and tearfulness
- Difficulty bonding with newborn
- Severe sleep disturbance (beyond normal newborn disruption)
- Loss of appetite and significant weight loss
- Excessive guilt and feelings of being an inadequate mother
- Withdrawal from husband and family
- Recurrent intrusive thoughts of harm coming to the baby

Onset of Illness: Abrupt, within 4 weeks postpartum

Course of Illness: Continuous

Progress of Illness: Deteriorating

Predisposing Factors:

- Biological Factor: Personal history of premenstrual dysphoric disorder (PMDD); hormonal vulnerability
- Psychological Factor: Perfectionist personality traits; high self-expectations regarding motherhood

- Social Factor: Relocated away from family of origin following marriage; limited social support network

Precipitating Factors:

- Psychological: Emergency caesarean section (unplanned); guilt over inability to breastfeed adequately
- Social: Strained relationship with mother-in-law residing in the same household; husband's long working hours

Perpetuating Factors:

- Sleep deprivation due to infant care demands
- Continued conflict with mother-in-law
- Absence of confidential emotional support

History of Present Illness:

R. M delivered her first child, a son, via emergency cesarean section on 10/02/2026 following complications during labour. According to her husband, R. M was initially cheerful in the days immediately following delivery but began showing signs of significant emotional distress approximately two to three weeks postpartum. He reported that she would cry without any identifiable reason, often in the middle of the night, and became increasingly reluctant to hold or feed the baby, expressing fear that she would inadvertently hurt him.

R. M herself reported feeling "like a failure as a mother" and expressed profound guilt over the unplanned caesarean and her difficulties with breastfeeding, which she attributed to personal inadequacy. She stopped eating regular meals and lost approximately 4 kg in three weeks. Her husband noted that she had withdrawn from all social interaction, including with her own parents, whom she had previously spoken to daily over the phone.

Notably, R. M disclosed recurrent intrusive thoughts in which she imagined the baby falling or being harmed, which caused her significant distress and she found ego-dystonic in nature. She denied any intention to act upon these thoughts. The conflict with her mother-in-law, who was critical of R. M's parenting and frequently dismissed her concerns, was identified as a significant source of daily stress. The husband, concerned by her rapid deterioration, brought her to the attention of their family physician who referred her for psychiatric evaluation.

Negative History:

- No h/o of psychotic symptoms, hallucinations, or thought disorder
- No h/o of manic episodes, grandiosity, or elevated mood
- No h/o of suicidal ideation or intent (intrusive thoughts are ego-dystonic)
- No h/o of substance use
- No h/o of head injury or seizures
- No h/o of thyroid dysfunction, diabetes, or hypertension
- No h/o of repetitive or compulsive behaviours

Past Psychiatric History:

No previous formal psychiatric history. Patient self-managed premenstrual mood symptoms in the past without professional consultation.

Medical History:

Emergency lower segment caesarean section (LSCS) on 10/02/2026. No other significant medical history. Currently on postnatal vitamins and iron supplementation.

Family History and Family Genogram:

- *Consanguinity*: No
- *Type of Family*: Joint (living with husband and paternal in-laws)
- *Interaction Patterns in Family*: Strained relationship with mother-in-law; warm and supportive relationship with husband; limited contact with own parents due to geographic distance
- *Family History of Mental Illness*: Maternal aunt reportedly experienced a depressive episode; details unavailable

Birth and Development History:

- *Mother experienced no significant stress or illness during pregnancy*: N/A (this is the patient)
- *Patient's own birth history*: Full-term, normal vaginal delivery, no complications reported
- *Developmental milestones*: Achieved within normal limits
- *Self-help skills*: Independent across all domains

Childhood and Adolescent History:

R. M described a stable and warm childhood environment. She was an academically high-achieving student with close family relationships. She reported being a conscientious and responsible child who often took on care giving roles for younger siblings. No significant adverse childhood experiences were reported.

Educational History:

- *Syllabus*: Kerala State
- *Medium of Instruction*: Malayalam and English
- *Academic Performance*: Above average; completed B.Sc Nursing with distinction
- No repetition of classes or breaks in schooling
- Active participation in extracurricular activities including college NCC unit

Occupational History:

- Worked as a Staff Nurse in a private hospital from age 23 to 28
- Voluntarily resigned six months prior to delivery to prepare for childbirth
- Reported high work satisfaction and professional pride in her nursing career
- Future ambitions: Plans to return to nursing once child is older, though currently doubtful of capability

Sexual and Obstetric History:

- *Menarche*: 13 years
- *Cycle*: Regular, 28-day cycle prior to pregnancy
- *History of PMDD*: Self-reported premenstrual irritability, tearfulness, and low energy for approximately 5 days before each cycle
- *Obstetric History*: G1P1, LSCS on 10/02/2026
- No history of miscarriages or previous pregnancies
- No sexual dysfunction reported prior to current episode

Marital History:

- *Married:* 2026 (arranged marriage)
- *Duration of Marriage:* 2 years
- *Relationship with Spouse:* Described as warm and supportive prior to current illness; husband reports feeling helpless and strained in navigating her current condition and his mother's interference

History of Psychoactive Substance Usage:

No history of psychoactive substance use.

Premorbid Personality:

- *Attitude to Others:* Warm, empathic, and nurturing; drew professional satisfaction from patient care
- *Attitude to Self:* High standards; prone to self-criticism when perceived as underperforming
- *Moral and Religious Attitudes:* Devout Christian; attends church regularly; faith is described as an important coping resource
- *Social Relations:* Warm and sociable, with a close circle of friends from nursing college
- *Predominant Mood:* Generally euthymic with cyclical premenstrual dips
- *Leisure Activities:* Reading, cooking, church choir
- *Reaction to Stress:* Internalising; tends to suppress distress and project competence

Impression: Premorbid personality was conscientious, warm, and achievement-oriented with a tendency toward internalisation of distress.

EXAMINATION OF HIGHER MENTAL FUNCTIONS

Date and Day: 21/04/2026, Tuesday

Time: 11:00 AM

Attention and Concentration:

- **Serial Test:** Completed first series with minor errors; second series completed successfully
- **Weekdays and Months Backwards:** Correct
- **Digit Span:** Correct up to 6th series forward and 5th series backwards

Impression: Mildly impaired, likely secondary to sleep deprivation and preoccupation

Orientation: Oriented to place, time, date, day, and person.

Memory:

- **Immediate:** Adequate
- **Recent:** Mildly impaired (difficulty recalling details of past week)
- **Remote:** Adequate
- **General Knowledge:** Adequate

Abstractibility:

- **Proverbs:** Correct
- **Similarities:** Mildly impaired
- **Differences:** Adequate

Impression: Largely functional with mild impairment likely attributable to low mood and fatigue

Judgement:

- **Personal Judgement:** Adequate; patient acknowledges need for treatment
- **Social Judgement:** Adequate
- **Test Judgement:** Adequate

MENTAL STATUS EXAMINATION

Date and Day: 22/04/2026, Wednesday

Time: 02:30 PM

General Appearance and Behaviour:

- *Consciousness:* Alert and awake
- *Eye Contact:* Intermittent, avoidant when discussing baby
- *Rapport:* Established with moderate difficulty; patient tearful during interview
- *General Appearance:* Visibly fatigued; slightly unkempt in appearance compared to apparent baseline
- *Hair:* Tied back, unwashed
- *Fingernails:* Bitten; poorly maintained
- *Grooming:* Slightly neglected
- *Dressing:* Appropriate but minimal effort apparent
- *Comprehension:* Intact
- *Gait and Posture:* Slightly stooped; movements slow and effortful
- *Attitude Towards Examiner:* Cooperative but guarded; intermittent tearfulness throughout

Motor Activity: Psychomotor retardation evident; reduced spontaneous movement

Speech:

- *Intensity:* Soft
- *Pitch:* Monotonous
- *Reaction Time:* Slightly delayed
- *Speed:* Slow
- *Ease of Speech:* Speaks when prompted; occasional long pauses
- *Relevance:* Relevant
- *Coherence:* Coherent
- *Goal Direction:* Goal-directed
- *Manner:* Sad, apologetic in tone
- *Productivity:* Reduced

Form of Thought:

- *Speed of Thought:* Slowed
- *Flow and Coherence:* Normal
- *Loose Associations:* No
- *Circumstantial Thoughts:* No
- *Tangential Thoughts:* No
- *Derailment/Substitution/Omission:* No

Stream of Thought:

- *Flight of Ideas*: No
- *Thought Blocking*: No
- *Perseveration*: No
- *Neologisms*: No

Content of Thought:

- *Delusions*: No
- *Obsessions*: Recurrent ego-dystonic intrusive thoughts of harm coming to infant (no compulsive behaviour in response)
- *Compulsions*: No
- *Overvalued Ideas*: Overvalued belief of personal inadequacy as a mother
- *Homicidal/Violent Thoughts*: Denied

Possession of Thought:

- *Thought Insertion*: No
- *Thought Withdrawal*: No
- *Thought Broadcasting*: No

Perceptual Abnormalities:

- *Hallucinations*: No
- *Pseudo-Hallucinations*: No
- *Illusions*: No
- *De-personalisation*: No
- *De-realisation*: No

Mood: Depressed, anxious, guilt-ridden

Affect: Dysthymic; constricted; reactive to content (tearful when discussing baby and her perceived failures)

Insight: Level III – Awareness of being sick but attributing the cause to her own personal failure and inadequacy rather than illness

Formulation:

R. M, a 29-year-old female, presented for psychiatric evaluation four weeks following the birth of her first child via emergency LSCS. A premorbid personality characterised by perfectionism and a strong professional identity in nursing created a vulnerability to the perceived failures surrounding delivery and infant care. The precipitating factors of an unplanned surgical delivery, inability to breastfeed, and an unsupportive home environment converged with biological hormonal changes to trigger a significant depressive episode in the postpartum period. Perpetuating factors include ongoing sleep deprivation, interpersonal conflict with the mother-in-law, and geographic isolation from her family of origin. The presentation is complicated by the presence of ego-dystonic intrusive thoughts regarding infant safety, which are distressing to the patient and require close monitoring.

Provisional Diagnosis: F53.0 – Mild Mental and Behavioural Disorders associated with the Puerperium, not elsewhere classified (Postpartum Depression)

Diagnostic Guidelines:**Differential Diagnosis:**

- F32.1 Depressive Episode, Moderate
- F41.2 Mixed Anxiety and Depressive Disorder
- F42 Obsessive-Compulsive Disorder (given intrusive thoughts; however, no compulsive behaviour and mood episode is primary)

Assessment Plan:

- Edinburgh Postnatal Depression Scale (EPDS) administration
- Thyroid function tests and hormonal panel to rule out organic contributors
- Risk assessment for infant safety

Therapy Plan:

- Psychotherapy – Cognitive Behavioural Therapy (CBT) targeting maladaptive cognitions regarding motherhood
- Psychoeducation for patient and husband regarding postpartum depression
- Interpersonal Therapy (IPT) addressing role transition and relationship stressors
- Pharmacotherapy review if symptoms do not improve (with consideration of breastfeeding status)

CASE NO: II

Date: 24/04/2026

HISTORY

Socio-Demographic Details

- Name: T. K
- Sex: Male
- Date of Birth: July 1980
- Age: 43
- Education: SSLC (Class X)
- Occupation: Auto-rickshaw driver (currently unemployed)
- Marital Status: Married
- Address Local: Aluva, Ernakulam
- Address Permanent: Aluva, Ernakulam
- Domicile: Semi-urban
- Socio-economic Status: Lower middle
- Religion: Hindu
- Mother Tongue: Malayalam
- Languages Spoken: Malayalam
- Source of Referral: Wife
- Purpose of Referral: De-addiction and psychiatric intervention

Informant:

- *Informant's Name:* Mrs. L. K
- *Informant's Relationship with Client:* Wife
- Information was adequate and reliable, corroborated partially by eldest son.

Presenting Complaints:

- Daily alcohol consumption from early morning
- Aggression and verbal abuse towards wife and children when intoxicated
- Inability to maintain occupation due to intoxication
- Tremors and sweating upon waking (withdrawal symptoms)
- Neglect of personal hygiene and self-care
- Depressed mood and tearfulness during sober intervals
- Expressed hopelessness and passive suicidal ideation during sober periods

Onset of Illness: Gradual, with escalation over the past 7 years

Course of Illness: Continuous with periods of partial remission

Progress of Illness: Deteriorating

Predisposing Factors:

- *Biological Factor:* Father and paternal uncle were chronic alcohol users; strong family history suggesting genetic vulnerability
- *Psychological Factor:* Low frustration tolerance; avoidant coping style; low self-esteem
- *Social Factor:* Peer group with pervasive alcohol use from adolescence; financial stressors

Precipitating Factors:

- *Psychological*: Loss of elder brother in a road traffic accident (2017); unresolved grief
- *Financial*: Business failure in 2018 following borrowing to invest in a transport vehicle that was subsequently impounded
- *Social*: Social ridicule from peers and extended family regarding financial failure

Perpetuating Factors:

- Continued access to alcohol and drinking peers
- Loss of licence and therefore livelihood, deepening financial dependence
- Marital conflict secondary to behaviour while intoxicated
- Social stigma preventing earlier help-seeking

History of Present Illness:

T. K has a prolonged history of alcohol use dating back to approximately age 18, when he began drinking socially with friends and co-workers in the transport industry. According to his wife, his drinking remained relatively controlled until the death of his elder brother in a road traffic accident in 2017, following which he began consuming alcohol daily as a means of managing his grief. His consumption escalated significantly in 2018 when a transport business venture failed after a vehicle he had purchased on loan was impounded by authorities, leaving him unable to repay the loan and effectively unemployed.

His wife described a progressive deterioration in his functioning over the following years. T. K would begin drinking immediately upon waking and would remain intoxicated for the majority of the day. He lost his auto-rickshaw driving licence following an incident in which he was found driving under the influence. He became increasingly verbally abusive towards his wife and two teenage children when intoxicated, and the family described living in a state of ongoing fear and instability. He has been brought to the attention of the local panchayat on two occasions due to public intoxication and disturbance.

During periods of relative sobriety, T. K was described by his wife as remorseful, tearful, and increasingly hopeless. He had disclosed on two separate occasions that he did not see any purpose in continuing to live, though he denied formulating any specific plan. He had also been brought to a de-addiction centre in Aluva approximately 18 months ago but discharged himself against medical advice after 3 days. His wife, accompanied by their eldest son, brought him again for psychiatric evaluation following an episode in which he became severely disoriented and fell, sustaining a minor head injury.

Negative History:

- No h/o of psychotic symptoms, hallucinations outside of withdrawal state, or thought disorder
- No h/o of manic or hypomanic episodes
- No h/o of use of other substances beyond alcohol and occasional tobacco
- No h/o of head injury prior to recent fall; no history of seizures (to be monitored in withdrawal)
- No h/o of diabetes, hypertension, or significant cardiac history (to be investigated)
- No h/o of repetitive or compulsive behaviours beyond alcohol-seeking

Past Psychiatric History:

Brief admission to de-addiction centre in Aluva approximately 18 months ago; self-discharged against medical advice after 3 days. No formal psychiatric diagnosis was established at that time. No history of prior psychiatric treatment otherwise.

Medical History:

Minor laceration to scalp following recent fall while intoxicated; treated at casualty. No other formal medical diagnoses. Patient has not attended routine medical check-ups in several years. Nutritional deficiency suspected clinically given dietary neglect.

Family History and Family Genogram:

- *Consanguinity*: No
- *Type of Family*: Nuclear (wife and two sons, aged 17 and 14)
- *Interaction Patterns in Family*: Severely strained; wife has considered separation on multiple occasions but has remained due to financial dependence and concern for children; children exhibit signs of emotional distress and social withdrawal attributable to home environment
- *Family History of Mental Illness or Substance Use*: Father and paternal uncle were chronic alcohol users; father died of liver cirrhosis at age 52

Birth and Development History:

- *Patient's birth history*: Full term, hospital delivery, no known complications
- *Developmental milestones*: Reportedly within normal limits
- *Self-help skills*: Historically independent; currently compromised by chronic intoxication

Childhood and Adolescent History:

T. K. described a difficult childhood characterised by domestic instability due to his father's chronic alcoholism. He reported witnessing frequent verbal and occasional physical altercations between his parents. Despite this, he described a close bond with his elder brother, whose subsequent death in 2017 he identified as the most significant loss of his life. He left school after completing Class X (SSLC) and began working in the transport sector. He described his adolescent peer group as one in which alcohol use was normalised and widespread.

Educational History:

- *Syllabus*: Kerala State
- *Medium*: Malayalam
- Completed up to SSLC (Class X); did not pursue further studies
- *Academic performance*: Average; no repetition of classes
- Limited participation in extracurricular activities

Occupational History:

- Worked as an auto-rickshaw driver and transport worker from age 18
- Lost driving licence following drink-driving incident approximately 3 years ago
- Currently unemployed; family subsisting on wife's income from domestic work
- Reports significant shame and loss of identity related to inability to provide for family
- Future ambitions: Expressed desire to regain licence and resume work if he achieves sobriety

Sexual and Marital History:

- *Married*: 2004 (arranged marriage)
- *Duration of Marriage*: 22 years
- Wife reports progressive deterioration in marital relationship over the past 7 years commensurate with escalation of alcohol use
- Patient reports reduced libido; wife confirms absence of sexual relationship for approximately 2

years

- No history of extramarital relationships reported

Menstrual and Obstetric History:

Not applicable.

History of Psychoactive Substance Usage:

- **Alcohol:** Daily use for approximately 10 years; use from morning for the past 5 years; estimates daily consumption at 500–750ml of brandy; previously consumed toddy in earlier years
- **Tobacco:** Smokes 8–10 cigarettes daily; has smoked since age 20
- No history of illicit drug use

Premorbid Personality:

- *Attitude to Others:* Described as sociable and good-natured prior to escalation of drinking; now perceived by family as unpredictable and threatening when intoxicated
- *Attitude to Self:* Declining self-esteem; currently describes self as "useless" and "a burden"
- *Moral and Religious Attitudes:* Nominally Hindu; discontinued temple attendance following shame related to his condition
- *Social Relations:* Progressive social isolation; former friends have distanced themselves
- *Predominant Mood:* Dysphoric when sober; disinhibited and irritable when intoxicated
- *Leisure Activities:* Previously enjoyed watching cricket and playing cards with neighbours; no longer engages in these activities
- *Reaction to Stress:* Avoidant; consistently turns to alcohol as primary coping mechanism

Impression: Premorbid personality was sociable and functional; current presentation represents significant departure from baseline, primarily driven by chronic alcohol dependence.

EXAMINATION OF HIGHER MENTAL FUNCTIONS

Date and Day: 24/04/2026, Friday

Time: 09:30 AM

Attention and Concentration:

- **Serial Test:** Unable to complete first series; required repeated prompting; completed partial second series
- **Weekdays and Months Backwards:** Errors noted; required two attempts
- **Digit Span:** Correct up to 5th series forward; 4th series backwards

Impression: Significantly impaired; likely reflecting combined effects of withdrawal, nutritional deficiency, and chronic alcohol-related cognitive decline

Orientation: Oriented to place and person; mild disorientation to time and date noted.

Memory:

- **Immediate:** Impaired (unable to recall 3-item list after 5 minutes)
- **Recent:** Impaired (patchy recall of events in preceding days)
- **Remote:** Relatively preserved
- **General Knowledge:** Adequate for educational level

Abstractibility:

- **Proverbs:** Partially correct with prompting
- **Similarities:** Impaired
- **Differences:** Partially adequate

Impression: Moderately impaired; consistent with alcohol-related cognitive effects

Judgement:

- **Personal Judgement:** Partially adequate; patient acknowledges alcohol problem but minimises severity and impact on family
- **Social Judgement:** Impaired
- **Test Judgement:** Partially adequate

MENTAL STATUS EXAMINATION

Date and Day: 24/04/2026, Friday

Time: 04:00 PM

General Appearance and Behaviour:

- *Consciousness:* Alert, though mildly drowsy and distractible
- *Eye Contact:* Poor; intermittent; avoidant
- *Rapport:* Established with significant difficulty; patient initially reluctant and dismissive
- *General Appearance:* Unkempt; odour of stale alcohol; visibly malnourished
- *Hair:* Dishevelled, unwashed
- *Fingernails:* Dirty; poorly maintained
- *Grooming:* Significantly neglected
- *Dressing:* Worn, soiled clothing; inappropriate to setting
- *Comprehension:* Impaired
- *Gait and Posture:* Unsteady; tremor observed in both hands at rest
- *Attitude Towards Examiner:* Initially hostile and guarded; became more cooperative as interview progressed

Motor Activity: Visible resting tremor bilaterally; occasional picking at fingers; restless

Speech:

- *Intensity:* Variable; raised at points of defensiveness
- *Pitch:* Low, monotonous during sober-state interview
- *Reaction Time:* Delayed
- *Speed:* Slow
- *Ease of Speech:* Effortful; patient required frequent pauses
- *Relevance:* Largely relevant with occasional tangentiality
- *Coherence:* Generally coherent
- *Goal Direction:* Goal-directed with prompting
- *Manner:* Guarded, occasionally irritable, tearful at discussion of family impact
- *Productivity:* Reduced

Form of Thought:

- *Speed of Thought:* Slowed
- *Flow and Coherence:* Generally maintained
- *Loose Associations:* No
- *Circumstantial Thoughts:* Mild circumstantiality noted
- *Tangential Thoughts:* Occasional
- *Derailment/Substitution/Omission:* No

Stream of Thought:

- *Flight of Ideas*: No
- *Thought Blocking*: No
- *Perseveration*: Mild perseveration noted around themes of failure and financial loss
- *Neologisms*: No

Content of Thought:

- *Delusions*: No (history of past jealous ideation regarding wife reported by wife during heavy drinking periods; not present at interview)
- *Obsessions*: No
- *Compulsions*: No
- *Overvalued Ideas*: Strong overvalued belief that he is irredeemably worthless and has destroyed his family
- *Homicidal/Violent Thoughts*: Denied

Possession of Thought:

- *Thought Insertion*: No
- *Thought Withdrawal*: No
- *Thought Broadcasting*: No

Perceptual Abnormalities:

- *Hallucinations*: No frank hallucinations at time of interview; wife reports patient has, on prior occasions during severe withdrawal, expressed fear of "seeing things" – requires monitoring
- *Pseudo-Hallucinations*: No
- *Illusions*: No
- *De-personalisation*: No
- *De-realisation*: No

Mood: Dysphoric; hopeless; ashamed

Affect: Constricted; labile – tearful when discussing family; irritable when challenged on alcohol use

Insight: Level II – Partial awareness of illness; acknowledges drinking is a problem but significantly minimises consequences and externalises responsibility

Formulation:

T. K, a 43-year-old male, presented for psychiatric evaluation with a long-standing history of alcohol dependence that has progressively worsened over the past seven years. A family history of paternal alcohol use represents a significant biological predisposing factor. Early exposure to domestic instability and a peer environment that normalised alcohol use from adolescence constituted social predisposing factors. The death of his elder brother in 2017, with whom he had his closest interpersonal bond, and a subsequent financial collapse in 2018 served as the primary precipitating factors that transformed heavy drinking into frank dependence. Chronic unemployment, marital conflict, social isolation, and continued access to alcohol have perpetuated the cycle. Current presentation includes physical withdrawal features, significant cognitive impairment, depressed mood in the sober state with passive suicidal ideation, and marked deterioration in all domains of functioning. Risk assessment for suicide and alcohol withdrawal complications is a clinical priority.

Provisional Diagnosis: F10.2 – Mental and Behavioural Disorders due to use of Alcohol: Dependence Syndrome

Diagnostic Guidelines:**Differential Diagnosis:**

- F10.3 Alcohol Withdrawal State
- F32.1 Depressive Episode, Moderate (superimposed on alcohol dependence)
- F10.6 Amnesic Syndrome due to use of Alcohol (Korsakoff's; to be assessed following detoxification)

Assessment Plan:

- AUDIT (Alcohol Use Disorders Identification Test) and SADQ (Severity of Alcohol Dependence Questionnaire)
- Clinical Institute Withdrawal Assessment (CIWA-Ar) for monitoring withdrawal severity
- Liver function tests, complete blood count, thiamine levels, B12, folate
- Neurological assessment and cognitive screen post-detoxification
- Risk assessment for suicidal ideation with safety planning

Therapy Plan:

- Medically supervised detoxification protocol with CIWA-Ar guided benzodiazepine tapering
- Thiamine (Vitamin B1) supplementation to prevent Wernicke's encephalopathy
- Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT) targeting relapse prevention
- Family therapy and psycho education for wife and children
- Referral to Alcoholics Anonymous (AA) or equivalent peer support group post-discharge
- Occupational rehabilitation planning for long-term recovery support.

CASE NO: III

Date: 23/04/2026

HISTORY

Socio-Demographic Details

- Name: V. S
- Sex: Male
- Date of Birth: August 1993
- Age: 33
- Education: B. Com Graduate
- Occupation: Accountant at a private enterprise
- Marital Status: Unmarried
- Address Local: Thrippunithura, Ernakulam
- Address Permanent: Thrippunithura, Ernakulam
- Domicile: Rural
- Socio-Economic Status: Middle
- Religion: Hindu
- Mother Tongue: Malayalam
- Languages Spoken: Malayalam
- Source of Referral: Mother
- Purpose of Referral: Psychiatric intervention

Informant:

- *Informant's Name:* Mrs. S. V
- *Informant's Relationship with Client:* Mother
- Information was adequate and reliable.

Presenting Complaints:

- Aggression / irritability
- Suicide attempt
- Anxious / worried
- Withdrawn / detached from workplace
- Falsely believes co-workers are talking about him
- Depressed mood
- Shyness

Onset of Illness: Abrupt

Course of Illness: Continuous

Progress of Illness: Static

Predisposing Factors:

- *Biological Factor:* Alcohol abuse disorder in the father
- *Social Factor:* Absence of father figure in the life of the individual

Precipitating Factors:

- *Psychological:* Stress intolerance, introverted nature
- *Social:* Stress at workplace

Perpetuating Factors:

- Not present

History of Present Illness:

The patient has an introverted character and was socially withdrawn, but was efficient and productive at his workplace. According to accounts provided by V. S's mother, he was working hard and earning before the pandemic of 2019–2022. After the pandemic, the patient started to have issues with a female colleague at his workplace, falsely believing that she had spread rumours about him, resulting in his colleagues gradually isolating him. The patient also developed a false belief that everybody at his workplace was constantly complaining and gossiping about him behind his back. This led to stress and frustration at his then workplace.

The stress and frustration slowly transitioned into increased social withdrawal and inactivity with family members. The patient also developed problems relating to appetite and sleep due to his situation of isolation.

The patient, at a very young age, had a history of anger outbursts at home wherein he would engage in verbal abuse towards family members. He also had problems with his uncle (mother's brother), with whom he was living, who ridiculed him constantly for his condition. These factors culminated in a suicide attempt two months ago. He was saved due to timely intervention by members of his RSS Sakha, who were alerted by a message he left in their WhatsApp group. Following this, the patient was admitted to a hospital in Thrissur and subsequently referred to Nair's Hospital for further psychiatric intervention.

Negative History:

- No h/o of crying spells
- No h/o of increased talk, tall claims, overspending, over familiarity, or increased sexual energy
- No h/o of multiple, variable physical symptoms referred to a specific organ or system
- No h/o of thought insertion, withdrawal, thought broadcasting, voices being heard, or wandering tendency
- No h/o of head injury, seizures, or substance abuse
- No h/o of repetitive behaviours (hand washing, mirror checking, counting)
- No h/o of thyroid disorder, hypertension, or diabetes

Past Psychiatric History:

The patient has no past psychiatric history.

Medical History:

The patient has no previous medical history.

Family History and Family Genogram:

- *Consanguinity:* No
- *Type of Family:* Nuclear
- *Interaction Patterns in Family:* Close with family members; problematic relationship with maternal uncle who ridiculed him for his condition and nature
- *Family History of Mental Illness:* None; however, the father had an alcohol abuse disorder and died from related complications

Birth and Development History:

- *Maternal stress during pregnancy or delivery:* No
- *Maternal illness during pregnancy:* No
- *Place of delivery:* Hospital
- *Maturity:* Full term
- *Type of delivery:* Natural
- *Birth cry:* Normal
- *Incubated:* No
- *Birth weight:* Slightly reduced
- *Other complications:* No
- *Motor and language milestones:* Within normal limits

Self-Help Skills:

- *Brushing, Eating, Bathing, Toilet Training, Grooming, Dressing:* All independent

Toilet Control:

- *Bowel and Bladder Control:* Full control
- *Any other problem:* No

Childhood and Adolescent History:

The patient had a childhood characterised by neglect from his father due to alcohol abuse. As a result, the patient developed an introverted and socially withdrawn nature, engaging with others only when spoken to. A healthy bond with family members was maintained until he was ridiculed and teased by his maternal uncle for his condition.

Educational History:

- *Syllabus:* Kerala State
- *Medium:* Malayalam
- *Age of starting school:* 3–5 years
- *Problem in starting school:* No
- *Any break or change in schooling:* No; continued to complete a college degree (B. Com)
- *Repeated any class:* Yes

- *Academic performance:* Average
- *Friends in school / college:* Yes, but limited
- *Participation in extracurricular activities:* No

Occupational History:

- *Age of starting work:* 26
- *Jobs held:* Accountant; office staff
- *Work satisfaction:* Unsatisfied
- *Relationship with superiors and colleagues:* Adequate with superior; isolated and withdrawn with colleagues
- *Future ambitions:* None described

Sexual History:

- *Age of attaining sexual knowledge:* During college years
- *Mode of knowledge:* Peers
- *Masturbatory practices:* None described
- *Anxiety or guilt related to sexual fantasies:* No
- *Homosexual or heterosexual inclinations / experiences:* No
- *History of extra-marital relationship:* Not applicable
- *History of unsafe practices or STD/AIDS risk:* Not applicable
- *Sexual problems:* Not applicable

Menstrual and Obstetric History:

Not applicable.

Marital History:

Not applicable.

History of Psychoactive Substance Usage:

No history of psychoactive substance use.

Premorbid Personality:

- *Attitude to Others:* Limited positive attitude towards others; fairly negative attitude towards those he dislikes
- *Attitude to Self:* Feels unwanted and burdened
- *Moral and Religious Attitudes:* Religious; blind faith; follower of horoscopes and astrology
- *Social Relations:* Restricted
- *Predominant Mood:* Sad, anxious
- *Leisure Activities and Interests:* Watching TV
- *Reaction Patterns to Stress:* None described
- *Biological Functions and Habits:* Functional; visits temple often

Impression: Premorbid personality was restrictive and isolating yet approachable.

EXAMINATION OF HIGHER MENTAL FUNCTIONS

Date and Day: 23/04/2026, Thursday

Time: 10:45 AM

Attention and Concentration:

- **Serial Test:** Difficulty completing the first series; second series completed without problems
- **Weekdays and Months Backwards:** Correct
- **Digit Span:** Correct up to 7th series forward and 6th series backwards

Impression: Easily aroused but not sustained

Orientation:

Oriented to place (hospital location), time (10:50 AM), date (8th December), day (Saturday), and person (name of intern).

Memory:

- **Immediate:** Slightly impaired; difficulty recollecting the name in the address
- **Recent:** Adequate
- **Remote:** Adequate
- **General Knowledge:** Adequate

Abstractibility:

- **Proverb:** Correct
- **Similarities:** Difficulty noted
- **Differences:** Difficulty noted

Impression: Functional

Judgement:

- **Personal Judgement:** Adequate — patient acknowledges the necessity of treatment
- **Social Judgement:** Adequate
- **Test Judgement:** Adequate

MENTAL STATUS EXAMINATION

Date and Day: 24/03/2026, Thursday

Time: 3:45 PM

General Appearance and Behaviour:

- *Consciousness:* Alert and awake
- *Eye Contact:* Poor to none
- *Rapport:* Established with difficulty
- *General Appearance:* Sickly
- *Hair:* Well groomed
- *Fingernails:* Well maintained
- *Grooming:* Well groomed
- *Dressing:* Appropriate
- *Comprehension:* Partially impaired

- *Gait and Posture*: Abnormal; difficulty holding himself upright; walked sluggishly
- *Attitude Towards Examiner*: Disinterested and defensive

Motor Activity: Preoccupied; stereotyped

Speech:

- *Intensity*: Abnormally soft
- *Pitch*: Monotonous
- *Reaction Time*: Adequate
- *Speed*: Slow
- *Ease of Speech*: Speaks only when questioned
- *Relevance*: Relevant
- *Coherence*: Coherent
- *Goal Direction*: Goal directed
- *Manner*: Tensed and disinterested
- *Productivity*: Scant
- *Deviation*: Not applicable — patient rarely spoke beyond the point and gave only short, sufficient replies

Form of Thought:

- *Speed of Thought*: Normal
- *Flow and Coherence*: Normal
- *Loose Associations*: No
- *Circumstantial Thoughts*: No
- *Tangential Thoughts*: No
- *Derailment / Substitution / Omission*: No

Stream of Thought:

- *Flight of Ideas*: No
- *Thought Blocking*: No
- *Perseveration*: No
- *Neologisms*: No

Content of Thought:

- *Delusions*: No
- *Obsessions*: No
- *Compulsions*: No
- *Overvalued Ideas*: No
- *Homicidal / Violent Thoughts*: No

Possession of Thought:

- *Thought Insertion*: No
- *Thought Withdrawal*: No
- *Thought Broadcasting*: No

Perceptual Abnormalities:

- *Hallucinations*: No
- *Pseudo-Hallucinations*: No
- *Illusions*: No
- *De-personalisation*: No
- *De-realisation*: No

Mood: Anxious and sad

Affect: Fixed affect

Insight: Level III — Awareness of being sick but attributing the cause to others or external/organic factors

Formulation

V. S was admitted to the institution following referral from a hospital in Thrissur where he was treated after a failed attempt to take his own life. The patient presented with anger, lack of sleep and appetite, and persistent depressed mood. He exhibited significant social withdrawal and refrained from meaningful interaction at his workplace. A predisposing social factor was an alcohol-abusive father who died at a young age, leaving no father figure in the family. The perpetuating factors include workplace difficulties arising from his introverted nature and anger issues that were present from a young age.

Provisional Diagnosis: F32.8 — Other Depressive Episodes

Diagnostic Guidelines:**Differential Diagnosis:**

- F31.3 — Bipolar Affective Disorder, current episode mild or moderate depression
- F38.0 — Other single mood (affective) disorders
- F38.00 — Mixed Affective Episode

Assessment Plan**1. Risk Assessment**

- **Columbia Suicide Severity Rating Scale (C-SSRS):** To assess current suicidal ideation, intent, plan, and lethality given prior attempt.
- **Overt Aggression Scale (OAS):** Baseline measure of verbal aggression episodes toward family members.
- **Means restriction counselling:** Assess and limit access to potential means; involve mother in safety planning.
- **Hamilton Depression Rating Scale (HAM-D):** Clinician-rated severity measure; preferred over self-report given V.S.'s limited verbal productivity.
- **Beck Depression Inventory-II (BDI-II):** Self-report measure of depressive cognitions; tracks negative cognitive triad.
- **Brief Psychiatric Rating Scale (BPRS):** To clarify whether workplace paranoid ideation represents mood-congruent cognition or subsyndromal psychotic features.
- **Hamilton Anxiety Rating Scale (HAM-A) and Liebowitz Social Anxiety Scale (LSAS):** Given presenting anxiety, worry, and lifelong shyness predating the current episode.

- **MMSE / MoCA:** Cognitive baseline; attention found impaired at examination.
- **MMPI-2:** Comprehensive personality assessment to characterise premorbid traits and screen for personality disorder features

4. Social and Functional Assessment

- **Global Assessment of Functioning (GAF):** Baseline psychosocial functioning across occupational, interpersonal, and self-care domains.
- **WHODAS 2.0:** Disability assessment across cognition, self-care, getting along, life activities, and participation.
- **Social support mapping:** Identify available supports beyond mother — RSS Sakha network, community contacts.

Therapy Plan

1. Pharmacotherapy

- **SSRI — Escitalopram 10mg OD (morning):** First-line antidepressant; titrate to 20mg at 4 weeks based on response and tolerability. Minimum duration 6–9 months post-remission.
- **Sleep adjunct if required:** Low-dose Mirtazapine 7.5mg nocte or Melatonin 3mg nocte.
- **Monitoring:** Review at weeks 2, 4, and 8 — assess side-effects and tolerability; monitor for emergence of suicidal ideation in early weeks.
- **If psychotic features confirmed:** Augmentation with low-dose atypical antipsychotic (e.g., Risperidone 0.5–1mg) in consultation with treating psychiatrist.

2. Cognitive Behavioural Therapy (CBT)

- Weekly sessions × 16 weeks (45–50 minutes each).
- **Sessions 1–3 — Psychoeducation and engagement:** Introduce cognitive model; normalise diagnosis; develop written safety plan collaboratively.
- **Sessions 4–10 — Cognitive restructuring:** Thought records; identify cognitive distortions (personalisation, mind reading, selective abstraction); challenge negative cognitive triad and core beliefs of unworthiness rooted in early paternal absence and uncle's ridicule.
- **Sessions 6–14 — Behavioural activation:** Activity scheduling; graded task assignment; pleasure and mastery diary to counteract social withdrawal and inactivity.
- **Sessions 14–16 — Relapse prevention:** Personal relapse plan; identify early warning signs and coping strategies; booster sessions at 1 and 3 months post-completion.

3. Behaviour Therapy

- **Anger Management Training:** Psychoeducation on the anger cycle; Progressive Muscle Relaxation (PMR) and diaphragmatic breathing; cue recognition; problem-solving as an alternative to verbal outbursts.
- **Social Skills Training (SST):** Modelling and role-play of social initiations, eye contact, and assertive communication; graded in-vivo practice; assertiveness training distinguishing passive, aggressive, and assertive styles.
- **Sleep Hygiene:** Fixed wake time; no daytime napping; wind-down routine; stimulus control.

4. Psychoeducation

- **For V.S.:** Diagnosis, causes, treatment rationale, expected timeline, stigma reduction. Written materials in Malayalam where available.

- **For Mother (Mrs. S.V.):** Understanding depressive behaviour; reducing expressed emotion and criticism; medication adherence support; safety monitoring and crisis pathway.
- **Addressing uncle dynamic:** Family session (with consent) to address household conflict. If not yet possible, individual cognitive reappraisal and assertiveness work targeting interactions with uncle. Medium-term goal: explore feasibility of separate living arrangements.

5. Occupational and Social Rehabilitation

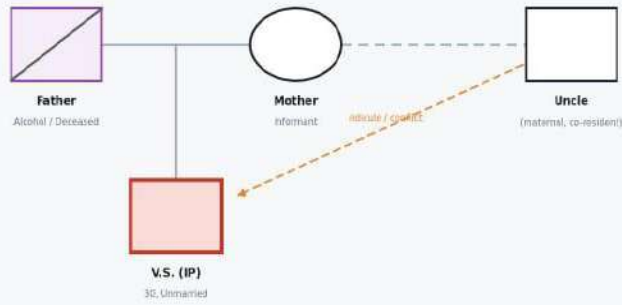
- Phased return to employment once clinically stable — initially part-time in a low-stress role.
- Gradual reintegration into community activities consistent with V.S.'s interests (temple; RSS Sakha network at own pace).
- Workplace skills: managing feedback without personalising it; communicating support needs to supervisors.

Family Genograms — Psychiatric Case Histories

Cases: V.S. (Depressive Episode) | R.M. (Postpartum Depression) | T.K. (Alcohol Dependence)

Case 1 — V.S.

Male, 30 | Depressive Episode (F32.8)



LEGEND

→ Psychosocial stressor

Male

Female

Identified Patient (IP)

Alcohol Dependence

Postpartum Depression

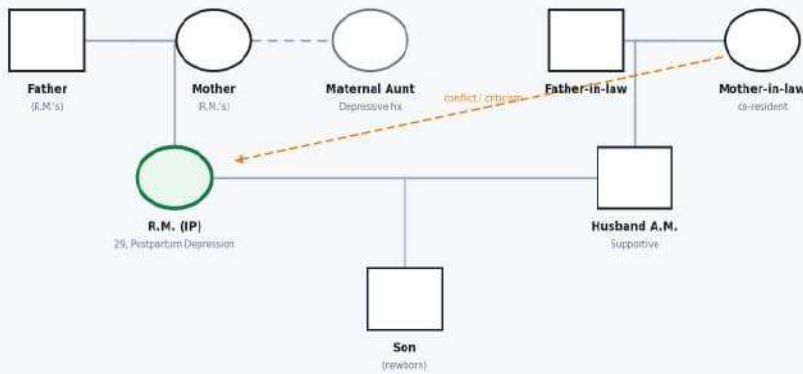
Deceased Male

Deceased Female

— Marriage line — Sibling line —> Stressor

Case 2 — R.M.

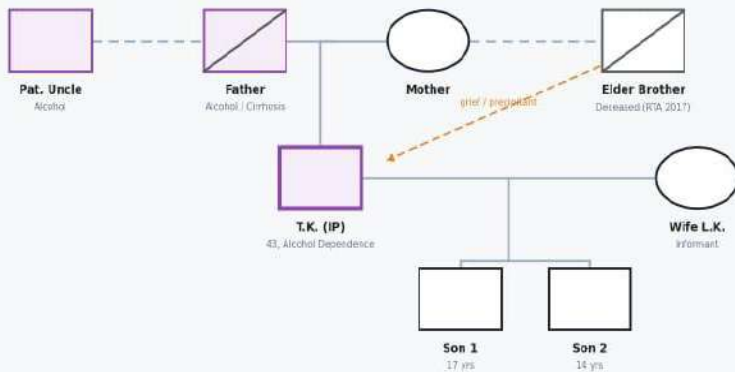
Female, 29 | Postpartum Depression (F53.0)



— Marriage line — Sibling line —> Stressor

Case 3 — T.K.

Male, 43 | Alcohol Dependence Syndrome (F10.2)



— Marriage line — Sibling line —> Deceased —> Stressor