NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI - 629 153

DEPARTMENT OF SOCIAL WORK

2021-2022

CONCURRENT FIELD WORK REPORT

FOURTH SEMESTER

Submitted to

Manonmaniam sundaranar University

Thirunelveli in partial fulfillment of the

requirement for MASTER OF SOCIAL WORK Degree

Submitted by,

Name: MALAVIKA A L

Reg. No: 20203102108222

Signature of Guide

Signature of the Examiner

Signature of HOD

Head
Department of Social Work
Nanjil Catholic College of Arts & S...
Kaliyakkavilai - 629 153, Tamil ...

NANJIL CATHOLIC COLLEGE OF ARTS & SCIENCE
KALIYAKKAVILAI 629 153 K.K. DISTRICT TAMILNADU INDIA

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE
KALIYAKKAVILAI – 629 153
DEPARTMENT OF SOCIAL WORK

CASE STUDY

CASE STUDY I

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

A case of Lipoma Right shoulder excision

Socio Demographic Data

Name	:	X
Age	:	29
Sex	:	Female
Education	:	BDS
Occupation	:	Dentist
Religion	:	Hindu
Marital status	:	Married
Socio Economic Status	:	Middle Socio Economic Status
Family Type	:	Nuclear
Language known	:	Malayalam

Brief Clinical History

Patient was brought to NIMS Medicity Neyyattinkara by her husband. Pre morbidly she was described as opinionated person. There is past history of lipoma that is fat deposit or epidermal cyst since 7 years. She had taken treatment under Ayurveda and Homeopathy since 6 months. Now she is conscious. The doctor suggested her for surgery. There is no

FIELD WORK – RECORD SHEET

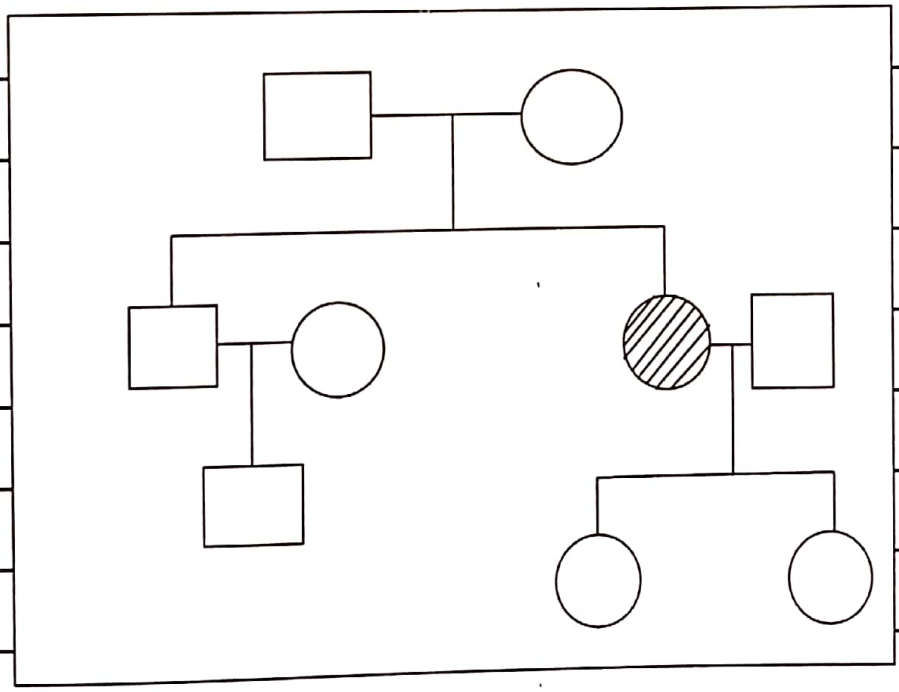
history suggestive of cancer or tumour.

Family history

Socio demographic data of the family

The family belongs to a Hindu nuclear family of middle socio economic status from the rural background of Irumbil, Thiruvananthapuram. Patient is staying with her husband and two children. The patient has one brother, she is the second child for her parents.

Family Tree



FIELD WORK – RECORD SHEET

Father

59 years old, male, business man, educated. He was very much attached to his children and family and was reported to be very caring and sociable in natures.

Mother

56 years old, female, housewife, educated. She is reported to be a bold woman. She supports her husband, children and family members in all means.

First Sibling

35 years old, male, doctor, educated, got married and living with his wife and son. He is leading a nuclear family.

Second sibling (Patient)

Patient has good relationship with her sibling, she is educated. She is very close to her children and husband.

Personal History

College

Patient has studied up to BDS at government Dental College Thrissur.

Occupation

Started at the age of 23 years old, she was a dentist working in a

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

Dental clinic at Thiruvananthapuram.

Psycho social intervention

Goals of intervention:

Patient:

- ❖ To educate the nature of illness and the need for medication in improving his quality of life.
- ❖ To bring change in the quality of life.
- ❖ To bring insight orientation.
- ❖ To educate the importance of medication in improving her qualify of life.
- ❖ To enhance the coping skills.

Family level:

- ❖ To create good rapport with family members.
- ❖ To counsel the husband the need of family support to cope up with the stress.
- ❖ To conduct family counseling.

Intervention carried out

- ❖ Supportive therapy.
- ❖ Family counseling.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

utcomes of the intervention

- Rapport established with the patient and patient ventilated his feelings and stress factors.
- Family members understood her illness and agreed to take good care of her and assessed to give medicines and follow her medication.
- Coping strategies helped the patient to look things more positively and optimistically.

uture plan

- To ensure regular medication and follow ups.
- Setting goals for the family and to work with them.
- To counsel the patients to act more effectively when there is a crisis or issues.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE
KALIYAKKAVILAI – 629 153
DEPARTMENT OF SOCIAL WORK

CASE STUDY II

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

A case of hypertension and Diabetics

Socio Demographic Data

Name	:	Y
Age	:	67
Sex	:	Male
Education	:	Higher Secondary
Occupation	:	Business
Religion	:	Hindu
Marital status	:	Married
Socio Economic Status	:	Middle Socio Economic Status
Family Type	:	Nuclear
Language known	:	Malayalam

Brief Clinical History

Patient was brought to NIMS Medicity Neyyattinkara by his neighbours. He was unconscious while admitting in the hospital. There was a variation in ECG and low oxygen level at the primary stage of admission in the hospital. He was admitted in the ICU for one day. His locomotor activities are normal. He had a past history of kidney selected

FIELD WORK – RECORD SHEET

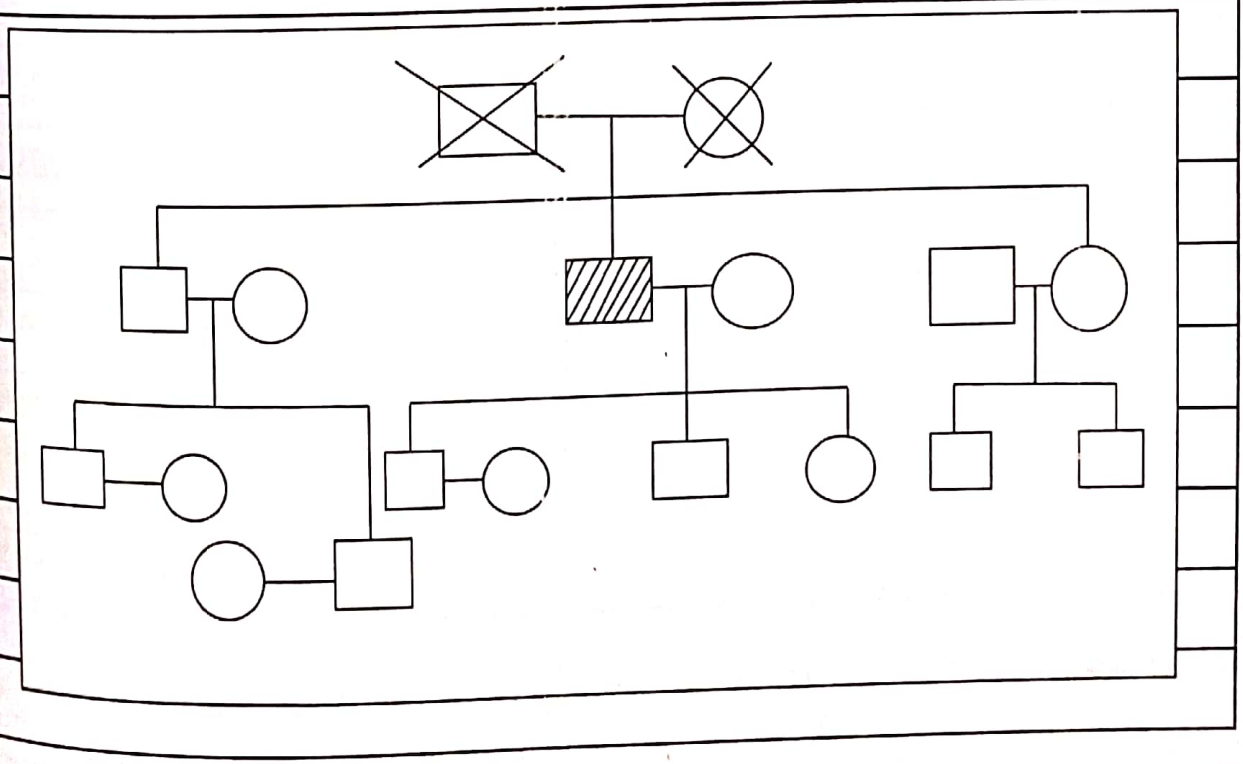
surgery. Presently he is suffering from fever. He was anxious about his health status and has low knowledge related to his disease condition.

Family history

Socio demographic data of the family

The Family belongs to a Hindu nuclear family of middle socio economic status from the rural background of Mangalathukonam. Patient is staying with his wife. He has two sons and one daughter. Patient has one brother and one sister, he is the second child for his parents.

Family Tree



NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

Father

87 years old, male, farmer, uneducated. He was very much attached to his daughter than his sons and was reported to be very caring and sociable in nature. He was died 10 years back.

Mother

85 years old, female, illiterate and she was reported to be introvert and won't interact much with the outsides, after her husband's death. She started avoiding any functions and family gatherings. She died five years back.

First Sibling

70 years old male, educated, got married and living as a nuclear family.

Second sibling (Patient)

Patient has a good relationship with his siblings. He is educated. He is a business man. He is very close to his family.

Third sibling

She is 63 years old, female, educated, home maker, She is extrovert, she helps the patient.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

Personal History

School

Patient has studied up to 12th standard at government school.

Occupation

Started at the age of 20 years old, he is a business man.

Psycho social intervention

Goals of intervention:

Patient:

- To educate the nature of illness and the need for medication in improving his quality of life.
- To bring change in the quality of life.
- To bring change in his negative attitude.
- To bring insight orientation.
- To educate the importance of medication in improving her qualify of life.
- To enhance the coping skills.

Family level:

- To psycho educate patients.
- To create good rapport with family members.

FIELD WORK – RECORD SHEET

- To counsel spouse the need for family support.

Intervention carried out

- Psycho education.
- Supportive therapy.
- Family counseling.

Outcomes of the intervention

- Rapport established with the patient and patient ventilated his feelings and stress factors.
- Family members understood his illness and agreed to take good care of him and assured to give medicines and follow his medication continuously.
- Coping strategies helped patient to look things more positively and optimistically.

Future plan

- To ensure regular medication and follow ups.
- Setting goals for the family and to work them.
- To counsel the patient to act more effectively when there is a crisis or issues.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

CASE STUDY III

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE
KALIYAKKAVILAI – 629 153
DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

A case of Cardiac Arrhythmia

Socio Demographic Data

Name	:	Z
Age	:	74
Sex	:	Male
Education	:	Higher Secondary
Occupation	:	Business
Religion	:	Hindu
Marital status	:	Married
Socio Economic Status	:	Middle Socio Economic Status
Family Type	:	Nuclear
Language known	:	Malayalam

Brief Clinical History

Patient was brought to NIMS Medicity Neyyattinkara by his wife. He had a past history of stroke, cardiac arrhythmia and Hypothyroidism. The patient came to emergency department with the complaints of cough on and off since one month and also decreased food intake since 2 days. His present symptoms are Trauma to head, chest and

FIELD WORK – RECORD SHEET

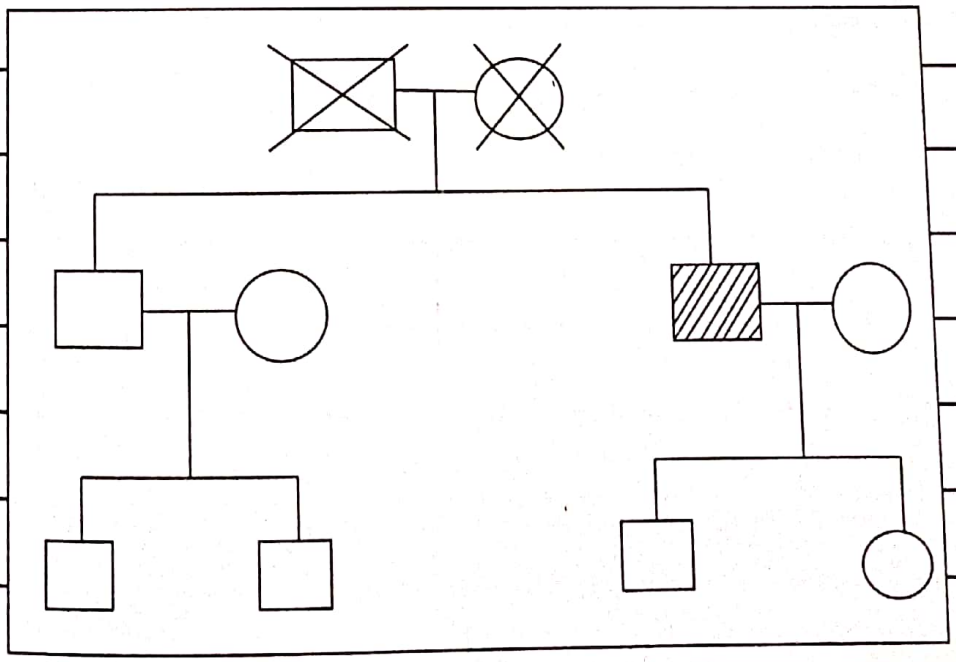
pelvis, seizure, vomiting etc. At present he was under physio therapy Treatment.

Family history

Socio demographic data of the family

The family belongs to a Hindu nuclear family of middle socio economic status from the rural background of Kottaykal Thiruvananthapuram. The patient is staying with his wife and children. The patient has one sibling; he is the second child of their parents.

Family Tree



FIELD WORK -- RECORD SHEET

Father

92 year old, male, tailor, uneducated. He was very much attached to his children and family and was reported to be very caring and sociable in nature. He died 10 years back.

Mother

89 years old, female, housewife, illiterate. She was reported to be a bold woman. She supported her family in all means.

First Sibling

72 year old, male, business man, educated, got married and living with his wife and two children. He is leading a nuclear family.

Second sibling (Patient)

The patient has a good relationship with his siblings and family members. He is educated and a good business man. He is very close to his wife and children.

Personal History

School

Patient has studied up to higher secondary education at government school.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

Occupation

Started at the age of 25 years old, he is a business man.

Psycho social intervention

Goals of intervention:

Patient:

- ❖ To educate the nature of illness and the need for medication in improving his quality of life.
- ❖ To enhance the coping skills.
- ❖ To bring insight orientation.
- ❖ To give stress management interventions.

Family level:

- ❖ To create good rapport with family members.
- ❖ To counsel the wife and children the need of family support to cope up with the stress.
- ❖ To conduct family and structured counseling.
- ❖ To give the family members the importance of care - coordination.

Intervention carried out

- ❖ Supportive therapy.
- ❖ Family counseling.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK -- RECORD SHEET

Outcomes of the intervention

- Rapport established with the patient and patient ventilated his feelings and stress factors.
- Family members understood his physical condition and agreed to take good care of him and assured to give medicines and follow his medication and therapy sessions.
- Coping strategies helped the patient to look things more positively and optimistically.

Future plan

- To ensure regular medication and follow ups.
- Setting goals for the family and to work with them.

CASE STUDY IV

FIELD WORK – RECORD SHEET

A case of Irreducible Hernia

Socio Demographic Data

Name	:	A
Age	:	48
Sex	:	Female
Education	:	Degree
Occupation	:	Housewife
Religion	:	Hindu
Marital status	:	Widow
Socio Economic Status	:	Middle Socio Economic Status
Family Type	:	Nuclear
Language known	:	Malayalam

Brief Clinical History

Patient was brought to NIMS Medicity Neyyattinkara by her sister. She came with complaints of pain and swelling abdomen. She had history of Hernia repair on 2017. Diagnosed as incisional hernia and admitted for incisional hernia repair. The patient was conscious and oriented. Her vitals are stable and there are no features of obstruction.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

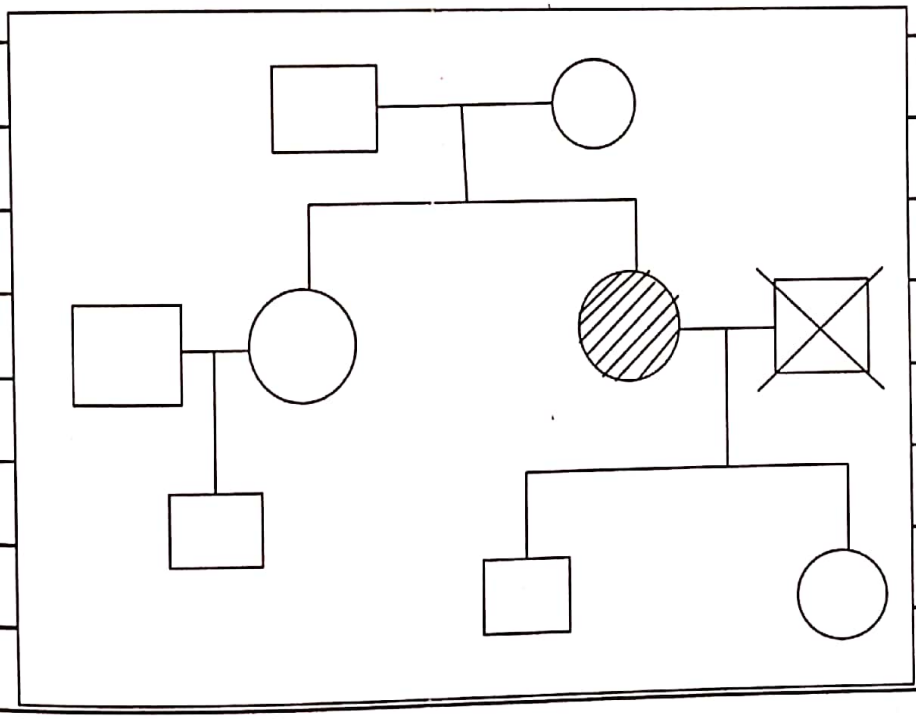
FIELD WORK – RECORD SHEET

Family history

Socio demographic data of the family

The family belongs to a Hindu nuclear family of middle socio economic status from the rural background of Pappanancode Thiruvananthapuram. Patient is living with her children and her husband had died 7 months before. The patient has one sister, she is the second child for her parents.

Family Tree



FIELD WORK – RECORD SHEET

Father

65 year old, male, shopkeeper, educated. He was very much attached to his children and family and was reported to be very caring and sociable in nature.

Mother

60 years old, female, housewife, educated. She was reported to be a bold and sociable. She supported her family in all means.

First Sibling

50 year old, female, housewife, educated, got married and living with her husband and child. She is leading a nuclear family.

Second sibling (Patient)

The patient has a good relationship with her siblings and family members. She is educated. She is very close to her children.

Personal History

College

Patient has studied up to degree at government college Thiruvananthapuram.

Occupation

She is a not working.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

Psycho social intervention

Goals of intervention:

Patient:

- ❖ To educate the nature of illness and the need for medication in improving his quality of life.
- ❖ To give awareness about the severity of the disease and the need of surgery.
- ❖ To bring insight orientation.
- ❖ To enhance the coping skills.

Family level:

- ❖ To create good rapport with family members.
- ❖ To counsel the children the need of family support to cope up with the stress.
- ❖ To give the family members the importance of care - coordination.

Intervention carried out

- ❖ Supportive therapy.
- ❖ Family counseling.

Outcomes of the intervention

- ❖ Rapport established with the patient and patient ventilated her

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

feelings and stress factors.

- Family members understood her physical condition and agreed to take good care of her and assured to give medicines and follow her medication regularly.
- Coping strategies helped the patient to look things more positively and optimistically.

Future plan

- To ensure regular medication and follow ups.
- To ensure post surgery care.
- Setting goals for the family and to work with them.

CASE STUDY V

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

A case of DSH Poisoning

Socio Demographic Data

Name	:	B
Age	:	79
Sex	:	Male
Education	:	Primary school
Occupation	:	Farmer
Religion	:	Hindu
Marital status	:	Married
Socio Economic Status	:	Middle Socio Economic Status
Family Type	:	Nuclear
Language known	:	Malayalam

Brief Clinical History

Patient was brought to NIMS Medicity Neyyattinkara by his wife. While the patient was brought to the hospital he was conscious, oriented, had headache. There was a blush colored frothy from the mouth. All the four limbs were in normal condition. He had a past history of cancer before 22 years ago. As a result he had to remove his

FIELD WORK – RECORD SHEET

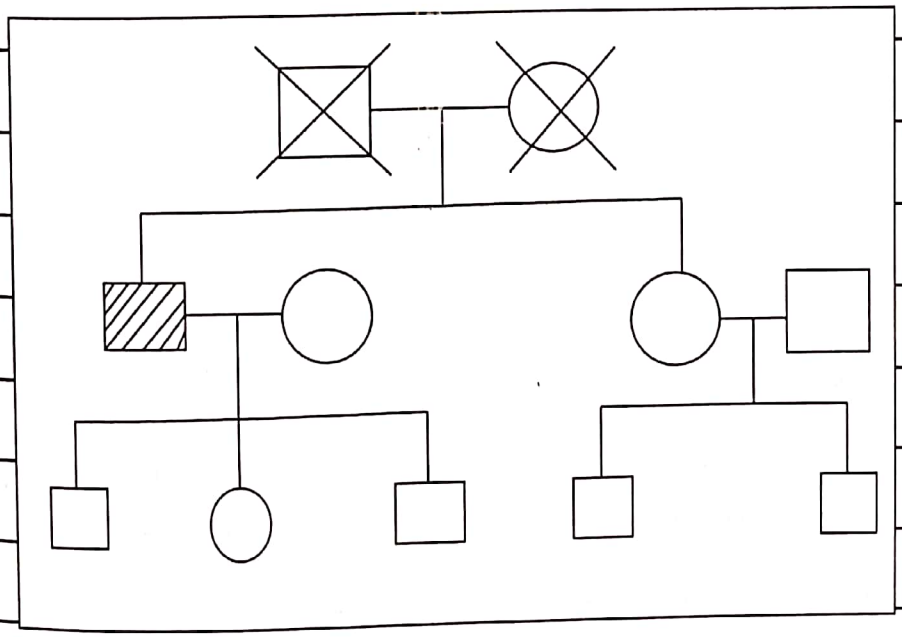
tongue. Now his present condition is; he is under ventilator support and only liquid food is provided through tube.

Family history

Socio demographic data of the family

The family belongs to a Hindu nuclear family of middle socio economic status from the rural background of Neyyattinkara Thiruvananthapuram. The patient is staying with his wife. The patient has one sibling; he is the elder child of their parents.

Family Tree



NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

Father

He was a farmer, and uneducated, male. He was very much attached to his children and family and was reported to be very caring and sociable in nature. He died at the age of 70.

Mother

She was a housewife, illiterate, female. She was reported to be a bold woman. She supported her family in all means. After her husband's death he went in to depression and started to avoid public gatherings and functions.

First Sibling (Patient)

The patient has a good relationship with his siblings and family members. He has only basic education. He is very close to his wife and children. But after the tongue removal surgery he started to face some mental stress and because of that he started to avoid family members and functions.

Second sibling

72 year old, female, housewife, illiterate, got married and living with her husband and two children. She is leading a nuclear family.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI – 629 153

DEPARTMENT OF SOCIAL WORK

FIELD WORK -- RECORD SHEET

Personal History

School

Patient has only primary school basic education from a government school.

Occupation

Started at the age of 15 years old, he is a farmer.

Psycho social intervention

Goals of intervention:

Patient:

- To educate the nature of his physical condition and the need for medication in improving his quality of life.
- To enhance the coping skills.
- To give stress management interventions.

Family level:

- To create good rapport with family members.
- To conduct family counseling.
- To give the family members the importance of care - coordination.
- To counsel the wife and children the need of family support to cope up with the stress.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE
KALIYAKKAVILAI – 629 153
DEPARTMENT OF SOCIAL WORK

FIELD WORK – RECORD SHEET

Intervention carried out

- Supportive therapy.
- Family counseling.

Outcomes of the intervention

- Rapport established with the patient and patient ventilated his feelings and stress factors.
- Coping strategies helped the patient to look things more positively and optimistically.
- Family members understood his physical condition and agreed to take good care of him and assured to give medicines and follow his medication.

Future plan

- To ensure regular medication and follow ups.
- Setting goals for the family and to work with them.

NANJIL CATHOLIC COLLEGE OF ARTS AND SCIENCE

KALIYAKKAVILAI - 629 153

DEPARTMENT OF SOCIAL WORK

2021-2022

CONCURRENT FIELD WORK REPORT

FOURTH SEMESTER

Submitted to

Manonmaniam sundaranar University

Thirunelveli in partial fulfillment of the

requirement for MASTER OF SOCIAL WORK Degree

Submitted by,

Name: NANDU S. DAS

Reg. No: 20203102108223

Signature of Guide

J. Nagaraj 10/6/22

Signature of the Examiner

S. Mary Pelet

Signature of HOD

Head
Department of Social Work
Nanjil Catholic College of Arts & Science
Kaliyakkavilai - 629 153, Tamil Nadu.

CASE STUDY I

CASE STUDY

SCHIZOPHRENIA

DEMOGRAPHIC DETAILS

Name: Ms. V

Age: 55y

Occupation : house maid

Marital status: separated

Socio economic status: Low

Religion : Hindu

Place: pullimavilkam

Bystander: Mrs. N

Relationship with patient: daughter of patient

Length of stay with the patient: 1 year

Degree of concern regarding the patient: primary

PRESENTING CHIEF COMPLAINT :

- Self talk (10years)
- Sleep very low
- Night time auditory hallucinations both voice and sound for last one month.

Onset of present symptom: 1month

Duration of present symptom: during night time

Precipitating factor: problem on the work house

History of present illness:

Patient has self talking for the past 10 years, and did not take any psychiatric treatment because of family unawareness. Patient was working in a house to look after a old woman as a house maid. Past month of 23 she contacted her daughter and explain about a hearing voice

of that old woman when she is not around. After that during night time, she hear about sound like temple *chendamelam and other* musical instruments. From the husband of daughter, they aware that its a psychiatric issue and seek for treatment.

Past psychiatric and medical history:

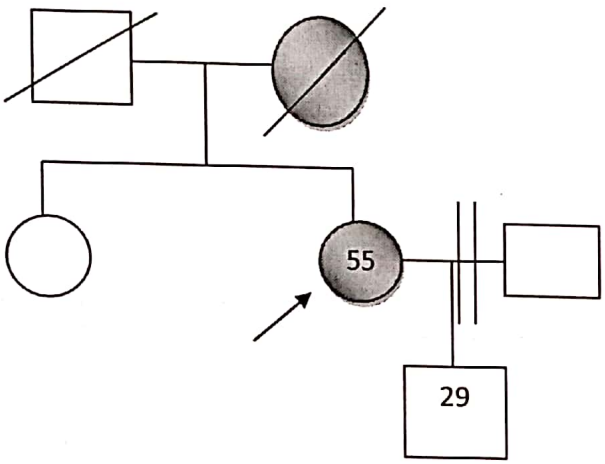
- No past psychiatric and medical history

Treatment history:

- Patient takes medicine from a CHC and forward to medical camp

FAMILY HISTORY :

Family structure :



- No psychiatric illness, medical illness, alcohol or drug dependences and suicide history.
- Current leader of the family: son in law

Personal and social history :

Perinatal history : not available

Childhood history: patient was grown with his sister. Parents were died due to medical problem. Details of the medical Problem was not available. Both daughters grown up in cousins and relatives house.

Education history : not available

Play history : not available

Menarche: at 13 year's old

Age at which Appearance of secondary sexual characteristics : 14 year old

Menstrual and obstetrics history :

- Number of children born: one girl child
- Last menstrual cycle : five years ago
- Termination of pregnancy : Nil

Occupational history :

- The age at starting work: 20 year

Patient was first work in hotels for helping in cleaning and in kitchen work. After the daughter marriage she looked for job with stay, so she choose house maid job.

Sexual and marital history :

Duration of marriage: 5 years

- Arranged marriage by relatives
- After 5 year of marriage they separated and she didn't married after that or in a relationship.

DIAGNOSTIC CRITERIA :

- Thought eco
- Bizarre delusions
- Hallucinations present
- Delusion control
- Third person auditory hallucination present

SUGGESTION

- Discuss treatment plan with family members and obtain their support
- Explained that drugs will prevent relapse and inform patient of side effects
- Encourage patient to function at the highest reasonable level in work and other daily activities.
- Psycho education to patient and family
- Encourage patient to respect community standards and expectations

- Encourage patient to function at the highest reasonable level in work and daily activities.

TREATMENT

- Antipsychotic medication will reduce psychotic symptoms (risperidone 2 mg).
- Treatment started in a low dose. Common motor side effect includes acute dystonias or spasms. Parkinsonian symptoms managed with oral anti parkinsonian drugs.
- Acute dystonias can be managed with injection phenergan.

CASE STUDY II

CASE STUDY

(MODERATE DEPRESSION)

DEMOGRAPHIC DETAILS

Name: Mr. M

Age: 18yr

Education : ITI, +2 science pass

Place: kor***i

Religion : Hindu

Bystanders : Mr. R (Father) Mrs. S (mother)

Reliability : reliable

Information : Adequate

PRESENTING COMPLAINTS :

- Social phobia
- Like loneliness
- Not interested to do work and study
- Chest heaviness
- Sudden angry
- Negative thoughts

Onset of present illness: 1month

Mode of onset: insidious

Precipitating factor: bike accident

History of present illness

Patient feels loneliness and not interested to do daily works and loss of interest in study for the 1st week of February. Then he had an bike accident, cause some minor injuries, so he taken leave from the college, after recovery he is not interest to go class. After 3 weeks he is not going outside of home, always stay inside the room. Some time he feel negative that he is

not looking good, not having a best friend. This continuous negative thoughts leads to loss of appetite. During March 1st he feels angry towards other family members for small reasons like saying to bath or study etc.

Past psychiatric and Treatment history:

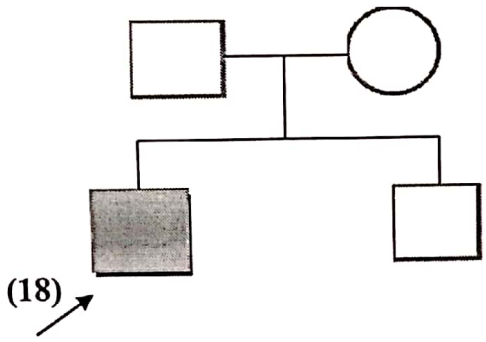
- Minor bike accident and muscle growth in the nose.
- No past psychiatric treatment history.

FAMILY HISTORY

Patient father was a auto driver for the past 4 years. 16 years ago he was a working as driver in gulf country. Mother was worked in a private *agarbathi* company just before the covid exploitation. Now she is not doing any job. Patient brother was studying in plus one standard, both of them are in good relationship. His father was strict with other family members include the patient.

- No past psychiatric history in family

Family genogram



Socioeconomic status: middle class

Leader of the family : Father

PERSONAL AND SOCIAL HISTORY :

Perinatal history:

No other complications in the first three months of gestation or any other problems. Delivery was in government hospital by natural.

Child hood history :

No problems in the child hood

Educational history :

School phobia: small level

Learning difficulties :

Present (dyscalculia and dysgraphia)

Play history : Not available

Relationship with peer:

impaired

Sexual history :

Masturbation:

intact

Sexual practices :

Normal

Gender identify disorder: Nil

Premorbid personality :

Interpersonal relationship : introverted, he feels he don't have any best friends, but mother saying he is active with friends. Inside family he shows angry towards mother, brother and sometimes to the father too.

Use of leisure time:

- **Hobbies-** youtube, phone addict (watching depression videos [2 weeks])
- **Interest :** Nil
- **Predominant mood:** pessimistic, prone to anxiety.
- **Attitude to self & others:** self confidence level is low, have self criticism, no self appraisal.
- **Religious believes :** altruism

- **Attitude to work and responsibility :** Impaired
- **Fantasy life:** intact
- **Habits :** no drugs history. No alcohol and smoking history.

Alcohol and substance history :

Phone addict for the past 3 years.

FINDINGS :

Major depressive disorder because he shows the all symptoms- work lessness, hopelessness, worthlessness.

TREATMENT :

Psychiatry treatment started with low dose by the psychiatrist. And then suggested to counsling psychology to the clinical psychologist.

SUGGESTION

- Counseling
- Psycho education
- Family therapy
- Occupational therapy
- Need motivation class

CASE STUDY III

CASE STUDY

(PSYCHOSIS WITH OR WITHOUT DEMENTIA)

DEMOGRAPHIC DETAILS

Name: Mrs. K

Age: 90y

Gender: Female

Education : 9th standard

Occupation: Retired nursing assistant; DMHP hospital

Bystander: Rani, Daughter

Place: poovar

PRESENTING COMPLAINT:

- Disorganized speech – imaginary talking
- self crying
- anxiety
- sleep problem- insomnia
- low memory

Duration: 2 months

Sleep: Low

History of present complaint: 2 months

Patient started disorganized speech from the last 2 months and self crying for the past one month. Always show anxiety for small reasons like cooking, with family members etc.

TREATMENT HISTORY:

- BP, breathing difficulty

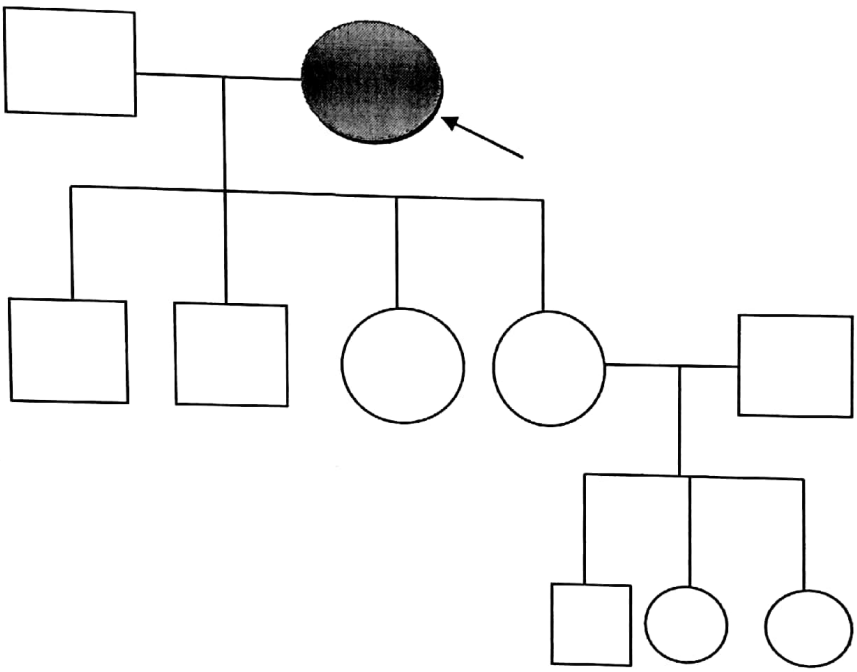
Family History:

Patient is a retired government staff from peroorkada hospital, his husband is a bedridden and she has two daughters and two sons. Patient is staying with his son.

Personal history:

She has hearing complaint, so, social work trainees didn't get accurate data to confirm illness.

Family genogram:



MENTAL STATUS EXAMINATION

Absence of any facial expression, looking calm and quiet.

Attitude towards the examiner :

Patient was cooperative, but not attentive towards the examiner.

Comprehension :

Intact

Gait and posture :

Normal

Rapport:

Established

Psycho – motor activity:

Normal

Orientation:

Impaired , talking previous working place

Thought:

Impaired

Memory:

Impaired

Mood:

Dysphoria

Hallucinatory behaviour:

Not present

Perception: Nil

Insight:

Patient has insight

Judgement:

Good

SUGGESTION AND FINDINGS

Patient need have hearing problem so, can't identity the dementia problem, so she need hearing aid support, trainees suggests to get a treatment from ENT doctor.

- Suggested to clinical psychology

TREATMENT

- Psychiatrist started treatment for psychosis
- Give counselling

CASE STUDY IV

CASE STUDY

(Major depressive disorder with OCD symptoms)

DEMOGRAPHIC DETAILS

Name: Mr.S.k

Age: 40 year

Gender: male

Occupation: Auto driver

DOB: **/**/1980

Religion: Muslim

Education: SSLC (F)

Place: Puliyoorkonam

Type of Family: Nuclear

Socio-economic status: Middle

Bystander: Mrs. A (wife)

Reliability: Reliable

Adequacy Of information: Adequate

PRESENTING COMPLAINTS

- Fear
- Negative thoughts
- Head Numbness
- Anxious feel
- Suicide thought
- Loss of appetite
- Memory problem

HISTORY OF PRESENT ILLNESS

Onset of symptom: 3 year

Mode of onset: insidious

Course of symptoms : continuous

Intensity : increasing

Precipitating factor: Financial problem

The patient was a driver in gulf country for 18 years, and just before covid pandemic at 2018, returned to native place to do business like own shop in puliyarkonam. Unfortunately due to covid pandemic, his business plan stopped and cause financial problems. After this financial problem arises he feels negative thought that his life is going down, not getting any financial success in his life. This continues feel of negative (financial problem) turns into head numbness (thalaperuppu) during 2019 April-may, In October 2019, he goes into neighbours funeral function, and feels Fear, that if he is dead or what happens if he died also. in this period of time, he repetitively thinking about his financial life, family's future that turns into continues Fear about death, financial crisis so, he didn't get enough sleep after this. During same period of time, he forgets some things to do, or basic jobs at home like purchasing or buying grocery items.

Later he is not interest in job and family functioning, and then sometimes he feel suicide thoughts too. So, he get treatment from private psychiatric hospital, and started medication. He takes medicine for few months and he rejoined his driver job in gulf country. He take medicine while at the driver job, but he can't able to focus on driving, he thinks that he may hit someone or what happens his life in jail after the hit & drive. Due to this continues Fear, he can't focus on driver job. So he returned to native place, and consulted another psychiatrist, in private clinic and taken medicine at higher dose. Now the patient gets sleep while taking medicine and when this fear arises he don't want food and cause loss of appetite. Finally, from his neighbours he learned about DMHP and consulted in kesavapuram CHC.

PAST PSYCHIATRIC & MEDICAL HISTORY

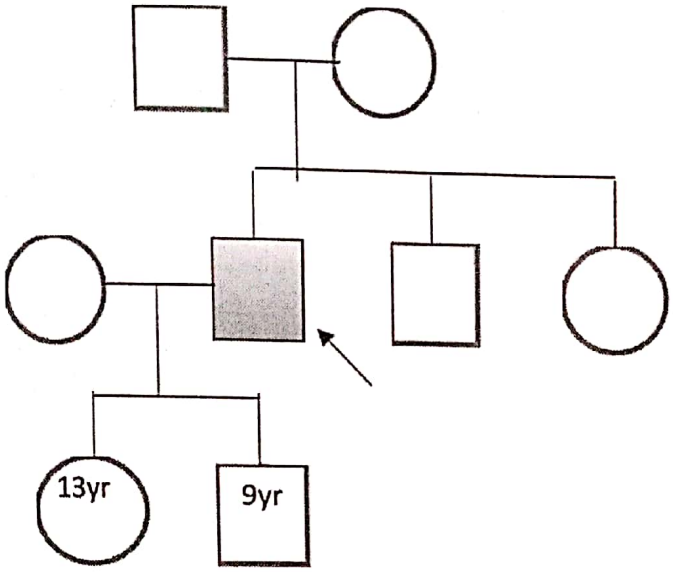
No past psychiatric history. Patient has Thyroid and cholesterol issue so, he taking medicines for the past one and half year.

FAMILY HISTORY:

The patient father is a fisher man and mother is a house wife. He have one Brother and a sister, both are married.

- No past history of psychiatric illness or suicide history.

FAMILY GENOGRAM



Personal and social History

Perinatal history and child history : Not available

Educational history: SSLC Failed.

Occupational history: The age of 23 he goes to gulf country as a driver in private sector(total:18 years). First he is satisfied with driver job, after 17 years, he planned for a retired life. His job is appropriate to the educational and family background.

Sexual and Marital history:

His Marriage was 13 years ago arranged by parents with consent and now he has two children, elder one is a girl 13 years old, studying on 8^{th} standard and second one is a boy 9 years old studying on 4^{th} standard.

Pre-morbid personality

- Interpersonal relationship: patient was normally a angry type, extraverted and ease to making social relationships.

Alcohol and substance history: patient takes alcohol during the driver job in gulf; he normally takes minimum level on special occasions and on some Fridays.

DIAGNOSIS

Patient may have a period of depression with

- Low or sad mood
- Loss of interest
- Disturbed sleep
- Poor concentration
- Disturbed appetite
- Suicidal thoughts
- Loss of energy

MANAGEMENT GUIDELINES

Essential information for patient and family:

- Unexplained changes in mood or behaviour are symptoms of an illness.
- Effective treatments are available. Long term treatment can prevent future episodes.
- During depression ask about risk of suicide. Close supervision by family or friends may be needed.

MEDICATION

Anti psychotic medication (olanzepine 5mg, chloropromazine 50 mg, haloperiodol 5mg)

Lithium will help relieve mania and depression and can prevent episodes from recurring. So lithium in a small dose.

CASE STUDY V

CASE STUDY

(DEMENTIA WITH BEHAVIOURAL ISSUES)

DEMOGRAPHIC DETIALS

Name: Ms. G

Age: 89 year

Gender : female

Place: ericha***or

Education : 7th standard

Type of family:

Nuclear family

Socio- economic status: middle

Bystander: Mr. S

Relationship : son

Reliability : reliable

Adequacy of information : adequate

Presenting complaints :

- Wandering
- Disorganized speech
- Scolding against mirror image
- Collecting waste items from road
- Taking food and hiding under the bed or pillow
- Drinking tea in waste bottles
- Sleep low
- Angry

History of present illness :

Onset of symptoms : 4-5 years

Course of symptoms : continuous

Intensity: increasing from the last 6 months

Precipitating factor: Nil

The patient disorganized speech and wandering started After the year of 2015. From the last months she hiding food items in her room, bed and showing memory problems. When the family members giving tea in cup, she throws cup and drink tea in a old bottle something. After the covid pandemic started she wandering around the home and collecting items from the road.

Past psychiatric & medical history

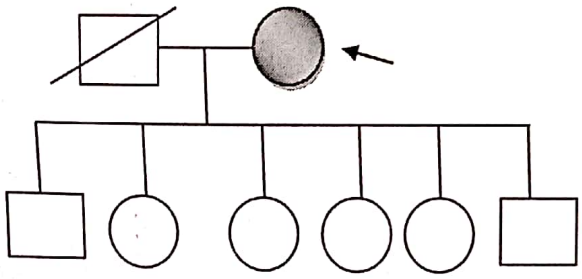
- Taking treatment for diabetics
- No past psychiatric history

FAMILY HISTORY :

Patient was living with her last son and with his family. Husband died 23 years ago.

- Son is a carpenter.
- Middle class family.
- Have Past psychiatric history – patient mother have same memory, wandering illness and get treatment from hospital.

Family genogram



MENTAL STATUS EXAMINATION

- He looked restless and lack of personal hygiene was also observed.
- Looked indifferent to people
- Restricted range of feelings.
- Absence of any facial expression.

Attitude towards examiner : Patient was cooperative, but not attentive towards the examiner

Comprehension: Intact

Gait and posture : Normal

Motor activity : Normal Social manner and non verbal behaviour Inappropriate behaviour

Eye contact : gaze aversion

Rapport: Established with difficulty

Hallucinatory behaviour : Not present

speech Rate and quantity ;

- decreased rate and quantity of speech.
- Normal volume and tone Mood and affect

Mood: shallow, blunted, indifferent

THOUGHT: Poverty of content of speech is observed.

PERCEPTION: Nil

COGNITION: The patient was oriented and had poor attention. Also had poor concentration, impaired memory and low level of intelligence

INSIGHT :Has no insight

JUDGEMENT: Good

DIAGNOSTICS FEATURES

- Decline in recent memory, thinking, judgement.
- Patients often appear apathetic or disinterested but sometime appear alert and appropriate, despite poor memory.
- Decline in everyday functioning
- Loss of emotional control
- Common in older patient

TEST OF MEMORY AND THINKING :

- Ability to recall names of three common objects immediately and again after three minutes
- Ability to name days of week in reverse order.

INVESTIGATION :

- Routine blood investigations
- Blood pressure
- CT scan head

MANAGEMENT GUIDELINES

Counselling for patients and family

- Monitor the patients ability to perform daily tasks safely
- If memory loss in mild, consider use of memory aids or reminders
- Avoid placing patients in unfamiliar places or situations
- Consider ways to reduce stress on those caring for the patients (eg: self help groups), Contact with other families caring for patients with the dementia may be helpfull.
- Whenever appropriate discuss arrangements for support in the home community or day care programme.
- Uncontrollable agitation may require admission to hospital or nursing home

MEDICATION

- Use sedatives or hypnotic medications (benzodiazepine) cautiously they may increase confusion.
- Anti psychotic medications in low doses (risperidone 1mg, olanzepine 2.5 mg) May sometimes be needed to control agitation psychotic symptoms or aggression. Beware of Drug side effects (Parkinsonian symptoms) and drug interactions.