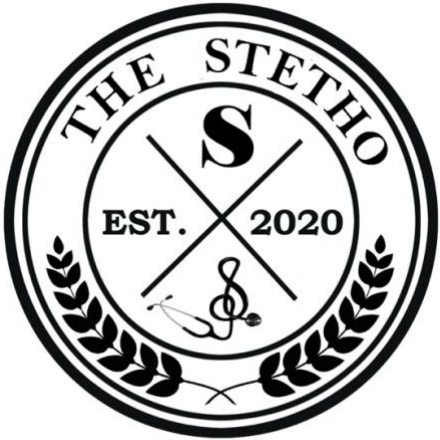
ILLUSTRATIVE CASES IN PSYCHIATRY



ILLUSTRATIVE CASES IN PSYCHIATRY

For Medical Students & House Officers

BY

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Introduction to the Book

Psychiatry, the medical discipline focused on diagnosing, treating, and preventing mental, emotional, and behavioral disorders, occupies a unique space within the practice of medicine. Unlike other medical specialties, psychiatric diagnoses are not made through imaging or lab tests but through listening, observation, and the structured assessment of thoughts, emotions, and behaviors. This makes psychiatry deeply humanistic and nuanced.

Through this book, we aim to provide an in-depth, practical resource that bridges the gap between theoretical knowledge and real-world clinical practice. Each chapter focuses on specific clinical cases that reflect common and challenging scenarios seen in psychiatry.

Why Case-Based Learning?

Case-based learning provides context and meaning to psychiatric knowledge. Rather than

listing abstract criteria, cases tell stories—of pain, resilience, confusion, and healing. They help us connect clinical signs with real people. Stories engage the clinician's curiosity and emotional intelligence, promoting a deeper understanding of psychiatric illness.

In psychiatry, every diagnosis is multifactorial. Biological predispositions interact with psychological vulnerabilities and social circumstances. Thus, the case-based format enables learners to consider these dimensions holistically.

This book presents illustrative cases that reflect common and complex psychiatric conditions. Each chapter includes the following sections:

- **Case Vignette**: A narrative of the patient's presentation.
- **Diagnostic Reasoning**: A structured exploration of the diagnosis, including differential diagnoses and relevant criteria.

- **Clinical Discussion**: A deeper dive into contributing factors, psychosocial context, and the nuances of presentation.
- **Management**: Evidence-based therapeutic interventions, including pharmacologic and psychotherapeutic options.
- **Key Takeaways**: Summary points designed to reinforce essential clinical knowledge.

Who Is This Book For?

This book is written for:

- Medical students beginning their psychiatry rotations.
- Psychiatry residents refining diagnostic and therapeutic strategies.
- Primary care physicians encountering mental health conditions.
- Mental health professionals seeking case-based clinical insight.

- Any clinician who believes in the healing power of understanding.

A Note on Empathy and Stigma

Patients with psychiatric conditions frequently experience social stigma and internalized shame. A thoughtful, nonjudgmental approach can be therapeutic in itself. Clinicians must not only apply medical knowledge but also embody empathy and hope.

Mental health disorders are not moral failings or personality flaws. They are complex conditions requiring the same rigorous medical attention as physical illnesses. Every chapter in this book reminds us of this reality.

As we move through each case, let us listen to the stories not just with our minds, but with our hearts. Let this book be a guide not only to mastering psychiatric knowledge but also to becoming a compassionate and thoughtful healer.

Chapter 1: Major Depressive Disorder "The Weight of Silence"

Case Vignette

Sara, a 29-year-old elementary school teacher, visits the clinic with complaints of extreme fatigue, sadness, and loss of interest in daily activities. Over the past eight weeks, she has experienced poor concentration, disrupted sleep, and feelings of worthlessness. She has stopped engaging in hobbies and socializing. Recently, she admitted to passive thoughts of dying, although she denies any current suicidal plan.

Diagnostic Reasoning:

Sara's symptoms meet the DSM-5 criteria for Major Depressive Disorder (MDD):

- Duration of symptoms > 2 weeks
- Depressed mood
- Anhedonia
- Sleep disturbance

- Fatigue
- Poor concentration
- Significant weight loss
- Feelings of worthlessness

At least five symptoms are present, including one of the core criteria (depressed mood or anhedonia). Organic causes (e.g., hypothyroidism) and substance-induced depression were ruled out through history and lab work.

Differential Diagnoses:

- Persistent Depressive Disorder (dysthymia)
- Adjustment disorder with depressed mood
- Hypothyroidism
- Bipolar disorder (evaluate history of hypomania/mania)

Clinical Discussion:

Sara's depression was likely triggered by a recent romantic breakup and increasing work stress. However, the persistence and severity of symptoms point to a clinical depressive disorder rather than a transient emotional reaction. She reports a family history of depression in her mother, suggesting a potential genetic predisposition.

Culturally, Sara's upbringing in a conservative community may have discouraged open emotional expression and contributed to her sense of isolation. Additionally, her internalized shame around feeling "weak" for seeking help was addressed early in therapy to foster treatment engagement.

Management:

1. **Pharmacotherapy**:

Started sertraline 50 mg once daily

Educated on potential side effects (GI upset, sleep disturbance)

Planned follow-up in 2 weeks for dose adjustment

2. **Psychotherapy**:

Referred for weekly Cognitive Behavioral Therapy (CBT)

Focused on cognitive restructuring, behavioral activation, and journaling

3. **Psychoeducation and Lifestyle**:

Discussed importance of sleep hygiene and regular exercise

Safety plan developed collaboratively due to passive suicidal ideation

Encouraged social connection through family involvement and community activities

Monitoring:

- Regular PHQ-9 screening to assess symptom changes
- Family contact (with consent) to support adherence and monitor for safety

Outcome:

At the 8-week follow-up, Sara reported improved mood, better sleep, and renewed interest in teaching. Her PHQ-9 score decreased from 20 to 7. She expressed appreciation for having her symptoms validated and learning coping skills through CBT. With continued pharmacologic and psychotherapeutic support, Sara is expected to fully remit within the next few months.

Key Takeaways:

- Depression is multifactorial; treatment should be comprehensive and personalized.

- Always assess suicide risk, even in patients without explicit ideation.
- Early pharmacological and psychotherapeutic intervention improves prognosis.
- Cultural context influences presentation and engagement with care.

Chapter 2: Schizophrenia - "Voices in the Mirror"

Case Vignette

John, a 21-year-old college student, is brought in by his parents after they notice a marked change in his behavior. Over the past six months, John has become socially withdrawn, suspicious, and increasingly incoherent. He has stopped attending classes, lost interest in friends and hobbies, and believes that his professors are spying on him through hidden cameras. He also reports hearing a male voice commenting on his actions.

Diagnostic Reasoning:

John's presentation includes hallmark features of schizophrenia:

- Positive symptoms: auditory hallucinations, persecutory delusions
- Negative symptoms: social withdrawal, flat affect, avolition

- Cognitive symptoms: poor attention and executive dysfunction

DSM-5 requires two or more core symptoms (delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, negative symptoms), lasting at least six months with at least one month of active-phase symptoms. John's symptom course and functional decline confirm the diagnosis.

Differential Diagnoses:

- Schizoaffective disorder (evaluate for mood episode criteria)
- Bipolar I disorder with psychotic features
- Drug-induced psychosis (ruled out via negative urine tox screen)
- Brief psychotic disorder (symptoms persist >1 month)

Clinical Discussion:

John was a previously high-functioning

student. He began isolating himself and expressing bizarre ideas. His hygiene deteriorated and he failed several courses. His parents noted emotional blunting and difficulty maintaining conversations. Cultural misconceptions about schizophrenia initially delayed care-seeking.

Early intervention is crucial. Research supports that shorter duration of untreated psychosis is associated with better outcomes. Family education is essential, as misunderstanding or stigmatization can lead to shame, denial, and treatment non-adherence.

Management:

1. **Pharmacotherapy**:
    - Initiated risperidone 2 mg/day, titrated to 4 mg
    - Considered aripiprazole for metabolic concerns

    - Long-acting injectable discussed due to potential adherence issues
2. **Psychosocial Interventions**:
    - Psychoeducation for family to reduce expressed emotion
    - Social skills training
    - Supported education through disability services at university
3. **Therapeutic Alliance**:
    - Validated patient's fears without reinforcing delusions
    - Engaged in collaborative goal-setting (e.g., attending one class weekly)

Monitoring:

- Monitored for extrapyramidal symptoms (EPS) and metabolic side effects
- Tracked progress using PANSS (Positive and Negative Syndrome Scale)

- Coordinated care with university mental health services

Outcome:

After three months of treatment, John showed partial remission of positive symptoms and improved personal hygiene. He reconnected with a classmate and resumed a reduced academic load. Although negative symptoms persisted, he demonstrated insight into his illness and agreed to a monthly injectable formulation to improve adherence.

Key Takeaways:

- Schizophrenia requires early diagnosis and sustained multidisciplinary care
- Long-acting injectables can improve outcomes in patients with poor adherence
- Family psychoeducation improves prognosis by reducing relapse risk

- Social reintegration is possible with supportive, recovery-oriented interventions

Chapter 3: Bipolar Disorder - "The Pendulum Swings"

Case Vignette

Maria, a 35-year-old graphic designer, is brought to the emergency department by her partner following a week of increasingly erratic behavior. She has been sleeping only 2–3 hours per night, spending large amounts of money, and engaging in risky sexual behavior. She expresses grandiosity, stating she is launching an international fashion label within the week. Her speech is pressured, and she rapidly jumps between topics.

Diagnostic Reasoning:

Maria's symptoms fulfill DSM-5 criteria for a manic episode:

- Abnormally elevated and expansive mood
- Inflated self-esteem (grandiosity)
- Decreased need for sleep

- Pressured speech and flight of ideas
- Distractibility
- Risky behaviors (spending, sex)

A diagnosis of **Bipolar I Disorder** is made based on the presence of at least one manic episode, with or without a history of depressive episodes. Differential diagnoses such as substance-induced mood disorder are ruled out with a negative tox screen.

Differential Diagnoses:

- Bipolar II disorder (no full manic episodes)
- Borderline personality disorder (if affective instability is reactive)
- Schizoaffective disorder (rule out concurrent psychotic symptoms outside mood episodes)
- Substance-induced mood disorder (tox screen negative)

Clinical Discussion:

Maria's partner reports that her behavior was initially interpreted as productivity and creativity but quickly escalated to dysfunction. She has a prior history of depressive episodes, but this is her first known manic episode. There is a family history of mood disorders on her maternal side. She also reports previous episodes of "high energy" that were less severe.

Culturally, Maria views mental illness as a "weakness" and is reluctant to accept psychiatric medication. Her background in the fashion industry, where eccentricity is often accepted, delayed the recognition of her behavior as pathological.

Management:

1. **Acute Stabilization:**
    - Initiated lithium 300 mg BID
    - Monitored renal function and thyroid levels before initiation

- Short-term use of olanzapine 5 mg for agitation

2. **Psychoeducation:**
   - Explained the chronic nature of bipolar disorder
   - Discussed the importance of medication adherence and sleep hygiene
3. **Psychotherapy:**
   - Referred for Interpersonal and Social Rhythm Therapy (IPSRT)
   - Emphasis on routine, mood tracking, and early warning sign identification
4. **Family Involvement:**
   - Engaged partner in supportive education
   - Discussed relapse prevention and crisis plan

Monitoring:

- Serum lithium levels monitored weekly during titration
- Assessed for side effects: tremor, polydipsia, gastrointestinal upset
- Mood charting initiated

Outcome:

Within two weeks, Maria's manic symptoms began to stabilize. Over the next six weeks, she achieved full remission with good insight. She returned to work on a flexible schedule. Long-term treatment planning included lithium maintenance and routine outpatient psychiatry follow-up. A safety and relapse plan was developed collaboratively.

Key Takeaways:

- Bipolar disorder often begins with subtle symptoms misattributed to personality or lifestyle

- Mania requires urgent stabilization to prevent self-harm or legal/financial consequences
- Lithium remains a gold standard for maintenance, but adherence and monitoring are critical
- Family and occupational support significantly influence long-term outcomes

Chapter 4: Generalized Anxiety Disorder – "The Constant What If"

Case Vignette

Adeel, a 43-year-old accountant, presents with persistent and excessive worry that spans across various aspects of his life—finances, work performance, family safety, and health. He describes his mind as constantly racing with "what ifs." His symptoms include muscle tension, fatigue, restlessness, difficulty concentrating, and trouble sleeping. These issues have persisted for over a year and are significantly impairing his quality of life.

Diagnostic Reasoning:

Adeel meets DSM-5 criteria for Generalized Anxiety Disorder (GAD):

- Excessive anxiety and worry occurring more days than not for at least 6 months
- Difficulty controlling the worry

- Presence of associated symptoms (e.g., muscle tension, sleep disturbance, restlessness)
- Clinically significant distress and impairment

Differential Diagnoses:

- Major depressive disorder (evaluate for anhedonia and low mood)
- Panic disorder (no episodic panic attacks)
- Obsessive-compulsive disorder (worries are not intrusive obsessions)
- Hyperthyroidism (ruled out via TSH testing)

Clinical Discussion:

Adeel has high-functioning anxiety, often masked by professionalism and productivity. His cultural background places high value on duty and success, making it harder for him to admit psychological distress. He describes his

anxiety as “being on edge since childhood,” which was normalized by his family. His insight into the chronic nature of his condition motivated him to seek help.

Cognitive distortions-catastrophizing, all-or-nothing thinking, and hypervigilance—were identified during assessment. His symptoms have worsened due to workplace restructuring and family financial stressors.

Management:

1. **Pharmacotherapy:**
    - Initiated escitalopram 10 mg daily, titrated to 20 mg over 3 weeks
    - Offered hydroxyzine as-needed for acute anxiety episodes
2. **Psychotherapy:**
    - Weekly CBT focused on worry exposure, cognitive restructuring, and relaxation training

    - Implemented worry journaling and mindfulness exercises
3. **Lifestyle Modifications:**
    - Sleep hygiene education
    - Limiting caffeine and screen time
    - Encouraged moderate exercise (e.g., 30-minute walks daily)

Monitoring:

- Monitored using GAD-7 scale biweekly
- Reviewed side effects and medication adherence
- Scheduled monthly follow-up for ongoing support and dose adjustment

Outcome:

By week 6, Adeel reported significant improvement in sleep and a 50% reduction in worry intensity. By week 10, he resumed hobbies like playing chess and reading fiction.

He reported increased confidence in managing stress and continued therapy with enthusiasm. His GAD-7 score dropped from 17 to 6.

Key Takeaways:

- GAD is often underdiagnosed in high-functioning individuals
- CBT and SSRIs remain first-line treatments
- Long-term outcomes improve with psychoeducation and skill-based therapy
- Cultural sensitivity is key in engagement and stigma reduction

Chapter 5: Obsessive-Compulsive Disorder – "The Locked Door"

Case Vignette:

Neha, a 25-year-old graduate student, presents with intense anxiety centered around contamination. She reports washing her hands over 50 times a day, often until they bleed. She also checks the stove, door locks, and her school bag repeatedly before leaving home. These rituals consume over three hours of her day and have led to academic and social decline.

Diagnostic Reasoning:

Neha meets DSM-5 criteria for Obsessive-Compulsive Disorder (OCD):

- Presence of obsessions (fear of contamination, doubts about safety)
- Presence of compulsions (repetitive washing, checking)
- Behaviors are time-consuming and cause significant distress

Her symptoms are not better explained by another mental disorder or substance use. A Yale-Brown Obsessive Compulsive Scale (Y-BOCS) score of 29 indicates severe OCD.

Differential Diagnoses:

- GAD (worry is not accompanied by compulsive rituals)
- Body dysmorphic disorder (no concerns about appearance)
- Autism spectrum disorder (repetitive behavior not linked to intrusive thoughts)
- Psychotic disorders (insight preserved in OCD)

Clinical Discussion:

Neha's rituals began in adolescence and worsened during the COVID-19 pandemic. She is highly distressed by her behavior but feels unable to stop. She describes a strong internal urge to "neutralize" her thoughts through repetitive actions. Family members

have unknowingly reinforced her compulsions by participating in rituals.

Despite high insight, Neha is ashamed and has delayed seeking help due to stigma around mental illness in her family. Her perfectionist personality traits and high academic pressure contribute to the chronicity of symptoms.

Management:

1. **Pharmacotherapy:**
    - Initiated fluoxetine 20 mg/day, increased to 60 mg over 6 weeks
    - Discussed delayed therapeutic onset (6–10 weeks for OCD response)
2. **Psychotherapy:**
    - Weekly Exposure and Response Prevention (ERP) sessions

    - Built hierarchy of feared stimuli and reduced safety behaviors
3. **Psychoeducation:**
    - Educated Neha and her parents on OCD mechanism and treatment rationale
    - Discouraged family participation in rituals

Monitoring:

- Weekly Y-BOCS tracking
- Monitored for SSRI side effects and suicidality
- Assessed adherence and avoidance patterns

Outcome:

At 10 weeks, Neha showed a significant reduction in compulsive behavior and anxiety. Y-BOCS dropped to 17. She resumed classes and began socializing more confidently. While

mild residual symptoms remained, she expressed hope and motivation to continue therapy.

Key Takeaways:

- ERP is the gold standard for OCD treatment
- High-dose SSRIs may be necessary and require patience
- Insight varies; treatment must validate distress without reinforcing rituals
- Family involvement should support recovery, not rituals

Chapter 6: Post-Traumatic Stress Disorder - "Trapped in the Past"

Case Vignette

Michael, a 33-year-old former combat veteran, presents with complaints of nightmares, emotional numbing, hypervigilance, and flashbacks of a traumatic incident during his military service. He avoids crowded places, startles easily at loud sounds, and has begun drinking heavily in the evenings. His partner reports that he often wakes up in a panic and is emotionally distant.

Diagnostic Reasoning:

Michael fulfills the DSM-5 criteria for Post-Traumatic Stress Disorder (PTSD):

- Exposure to actual or threatened death (combat trauma)
- Intrusion symptoms (nightmares, flashbacks)

- Avoidance behaviors (avoiding crowds, reminders of trauma)
- Negative alterations in cognition/mood (emotional numbness, guilt)
- Alterations in arousal and reactivity (hypervigilance, exaggerated startle response)

Symptoms have persisted for more than one month and cause significant distress and impairment.

Differential Diagnoses:

- Acute Stress Disorder (symptoms >1 month)
- Major depressive disorder with anxiety (no trauma link)
- Generalized Anxiety Disorder (lack of re-experiencing)
- Substance use disorder (secondary to PTSD but not primary)

Clinical Discussion:

Michael's symptoms began shortly after returning from deployment but were minimized due to stigma and fear of career consequences. Over time, avoidance behaviors and emotional detachment worsened his isolation. The increase in alcohol use is a maladaptive coping strategy. He has survivor's guilt and intrusive thoughts about comrades lost in combat.

Cultural factors include the military ethos of resilience, which can delay help-seeking. Michael's partner plays a key role in encouraging him to seek professional care.

Management:

1. **Pharmacotherapy:**
    - Initiated sertraline 50 mg, titrated to 100 mg over 4 weeks
    - Prazosin 2 mg at bedtime to reduce trauma-related nightmares

2. **Psychotherapy:**
    - Weekly trauma-focused CBT with exposure exercises
    - Explored maladaptive beliefs (e.g., guilt, responsibility)
3. **Lifestyle and Support:**
    - Referred to veterans' support group for shared experience and peer support
    - Encouraged routine, exercise, and structured daily goals

Monitoring:

- Used PCL-5 (PTSD Checklist) to track symptom reduction
- Monitored for suicidal ideation and alcohol misuse
- Evaluated sleep quality and adherence at each visit

Outcome:

By the third month of treatment, Michael reported fewer nightmares and flashbacks. He began discussing his experiences in group therapy and reduced his alcohol intake significantly. His PCL-5 score improved from 62 to 33. Emotional connection with his partner improved, and he committed to continued therapy.

Key Takeaways:

- PTSD often coexists with substance use; treating both is critical
- Trauma-focused CBT and SSRIs are first-line treatments
- Sleep disturbance is a common but manageable symptom
- Cultural and occupational contexts heavily influence diagnosis and engagement

Chapter 7: Borderline Personality Disorder – "Walking on a Tightrope"

Case Vignette

Lina, a 22-year-old university student, presents with intense emotional instability, impulsivity, and chronic feelings of emptiness. She reports frequent arguments with friends and family, and describes relationships that shift rapidly from idealization to devaluation. She has a history of self-injury and has made two prior suicide attempts. Lina says, “I don’t know who I am or what I want.”

Diagnostic Reasoning:

Lina meets DSM-5 criteria for Borderline Personality Disorder (BPD), which includes:

- Frantic efforts to avoid abandonment
- A pattern of unstable and intense interpersonal relationships
- Identity disturbance

- Impulsivity in at least two areas (e.g., spending, sex, self-harm)
- Recurrent suicidal behavior and affective instability

Her symptoms are persistent, began in adolescence, and cause significant interpersonal, academic, and emotional dysfunction.

Differential Diagnoses:

- Bipolar II Disorder (mood shifts not episodic)
- Complex PTSD (evaluate for trauma history)
- Histrionic Personality Disorder (less identity disturbance and self-harm)
- ADHD (distractibility lacks emotional volatility)

Clinical Discussion:

Lina describes a childhood marked by emotional neglect and inconsistent parenting. She reports feeling like a "burden" in her relationships. Her self-harm functions as a way to regulate overwhelming emotional states. She often tests the boundaries of those close to her, fearing abandonment yet pushing people away.

Her identity is fragmented—she changes her appearance, interests, and career goals frequently. While she seeks close connections, her intense fears of rejection result in sabotaging behaviors.

Management:

1. **Psychotherapy:**

Enrolled in Dialectical Behavior Therapy (DBT), the evidence-based treatment of choice

Focused on modules: emotion regulation, interpersonal effectiveness, distress tolerance, and mindfulness

2. **Pharmacotherapy:**

Low-dose SSRI (fluoxetine 10 mg) for comorbid anxiety and depressive symptoms

Avoided benzodiazepines due to risk of dependency and disinhibition

3. **Crisis Planning:**

Developed a safety plan for suicidal urges

Scheduled weekly DBT individual and group sessions

4. **Support System:**

Liaised with university mental health services for academic accommodations

Involved family in psychoeducation about BPD

Monitoring:

- Weekly mood logs and skill use diaries
- Reviewed triggers, coping mechanisms, and progress in DBT
- Monitored for medication side effects and treatment adherence

Outcome:

After three months, Lina demonstrated improved emotional regulation and reduced self-injury. She was able to maintain a stable relationship with one close friend and passed her semester with support. Although crises still arose, her ability to manage them had improved markedly. She expressed increased insight into her behavior and a growing commitment to long-term therapy.

Key Takeaways:

- BPD is a complex disorder best treated with structured, skill-based psychotherapy
- DBT has strong empirical support for reducing suicidality and improving functioning
- Pharmacotherapy targets symptoms but is not curative
- Validation, consistency, and boundaries are crucial in managing the therapeutic alliance

Chapter 8: Toward Empathy and Evidence in Psychiatric Practice

In the journey through psychiatric care, clinicians face not only diagnostic complexities but the humanity behind each diagnosis. The art of psychiatry lies in listening to what is unspoken, offering validation without enabling dysfunction, and applying science with compassion.

Each case presented in this book exemplifies a different shade of suffering—and recovery. They remind us that behind every symptom checklist is a story of pain, adaptation, trauma, resilience, or hope.

Key Reflections:

- **Diagnosis is not identity.** A diagnosis helps guide care, but it does not define the whole person. We must look beyond labels.

- **Recovery is possible.** With the right combination of therapy, medication, and support, individuals can and do reclaim agency over their lives.
- **Empathy is clinical skill.** The ability to listen, contain emotional responses, and offer judgment-free care is as critical as any tool or test.

Psychiatry is uniquely positioned to advocate for those whose struggles are often invisible. By understanding the biopsychosocial model, clinicians can provide holistic care that addresses mind, body, and environment. Let this book serve not only as a clinical guide—but also as a reminder of the privilege it is to witness the vulnerability and strength of others.

May we continue to lead with evidence and never forget to walk with empathy.

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