The case of YKF

Name: Madam YKF

Age: 62 years old

Gender: Female

Race: Chinese

Religion: Taoism

Marital status: Married

Occupation: Housewife

CHIEF COMPLAINTS:

Low mood, lethargy and reduced concentration

for the past 2 months.

HISTORY OF PRESENTING ILLNESS:

Patient was diagnosed to have Major Depressive Disorder in 1995 by a private psychiatrist, due to financial constraint, she had decided to be treated in Hospital Universiti Kebangsaan Malaysia (HUKM) since April 2000.

She had been complaining of low mood for the past 2 months, on most days and most time of the day. There was no diurnal variation in her mood. Sometimes, she would feel sad and cry for no apparent reason. Patient said she would feel sad and worry about her eldest son who was still

a bachelor. She kept nagging him to get married so that he had someone to look after him if she died. Her son would just ignore her but never scolded her in return. She also wanted her son to get married because she wished for a daughter-in-law to stay at home in order to accompany her and talk to her. Patient admitted to feeling lonely at home as the other members of the family would go to work in the daytime. Furthermore, she felt being neglected as they were too tired at night to talk to her.

During this period of illness, patient noticed reduction in her interests. She did not enjoy watching television and video anymore. She did not like to listen to the radio unlike before. She also felt lazy to visit her neighbours and disinterested to go shopping with them.

Patient complained of feeling lethargy. She described herself as weak and lazy. She would prefer to lie on bed after waking up, feeling difficult to get out of bed. She had to force herself to do house chores before succumbing to tiredness.

She also felt she took a longer time to complete her house chores. Even her family members remarked to her that she was slow in doing her work.

Patient also complained of poor concentration and attention. She found it difficult to follow the show on television. She could not concentrate while

reading newspaper and would just glance at the pictures rather than reading the words.

She found it difficult to fall asleep. Normally she would sleep at 10 p.m. but lately she only fell asleep after midnight. She had many unpleasant dreams which she could not remember. She did not have nightmares. Although she did not wake up in the middle of the night, she said she woke up much earlier than usual. At times, she would wake up at 3 or 4 Am. and found it difficult to continue sleeping. This made her very tired the whole day, moreover she could not sleep in the daytime.

Her appetite had reduced over the weeks. The food seemed tasteless and she had to force herself to finish the same amount that she normally ate.
There was no apparent loss of body weight.

She had many negative thoughts like failing to recover from her illness and becoming a burden to her family. She felt guilty of incurring heavy financial constraint on her family. At time like these, she thought of herself as being worthless. As an example, she had to rely on her son to prepare and to administer her insulin injections twice a day. She thought she was useless having to depend on others.

There were times when patient felt hopeless. She thought her condition was

not improving as the depression kept recurring. Furthermore, she felt hopeless as she had to continue living with daily injection of insulin. Sometimes she thought life was too difficult to live, that she would be better off dead and relieve her family from taking care of her. She had suicidal plan like injecting herself with more insulin. She knew it could kill her because she had asked her personal doctor before. Even though she did harbour suicidal thought, she denied any suicidal attempt.

Ever since she was diagnosed as suffering from depression, she had have anxiety and worries, which she realised were excessive and difficult to control at times. She would worry when her children came home late although she knew they might be busy with their work and independent enough to take care of themselves. She would also worry over trifle things. These made her restless, fatigued and difficult to concentrate in her activities. She felt her whole body tensed up and difficult to fall asleep. On the other hand, she claimed these feelings were not constant, but agreed that they might have been present for more days than not.

Patient denied ruminating thoughts, obsessive thoughts or compulsive kind of behaviour.

She also denied ever experiencing psychotic features like hallucination, neither persecutory delusion nor any symptoms to suggest mania.

PAST PSYCHIATRIC HISTORY:

Patient was apparently alright until 1995 when she first developed symptoms of depression. It was concurrent with the change in her diabetic management from oral hypoglycemic medication to daily injection of insulin. Patient herself thought that her diabetic condition was getting worse, hence the need for insulin injection. She started to feel insecure about her future and thought she might die any time.

It was then that she started to feel sad with thought of worthlessness and hopelessness. Moreover, her depressed mood was exacerbated by her fear of injecting insulin herself and needed to rely on her son to administer the injection. This made her think of herself as being a burden to her family.

She was brought to many general practitioners to treat her depressed mood. She did not know the type of medications given to her but said they were mainly to make her sleep (presumably sedative-hypnotic) and to relax her (presumably anxiolytic).

Her symptoms gradually disappeared over few months and she felt normal again.

Unfortunately she had another episode of depression following a stroke in 1999. She was admitted to a private hospital, Tung Shin, for her stroke and was diagnosed to suffer from Major Depression by a private psychiatrist for

the first time. She was compliant with her medications that were Amitriptyline (25mg bd.) and Alpraxolam (0.25mg bd.).
Although she felt better and able to perform her house chores, she was worried if she would get another relapse.

Therefore, she went to HUKM Clinic for further check up and was advised to get admitted to HUKM for a thorough investigation for her illness.
Patient was admitted from 12.4.2000 – 29.4.2000 as a case of Major Depressive Disorder and improved with tablet Sertraline 50mg o.n, tablet Alpraxolam 0.25mg b.d and tablet Midazolam 7.5mg p.r.n basis.

PAST MEDICAL AND SURGICAL HISTORY:

Patient was diagnosed to have Diabetes Mellitus 20 years ago by a general practitioner who started her on oral hypoglycemic agent. Due to poor control of her blood sugar level, she was put on injection insulin twice a day which was administered by her eldest son every time. Her insulin was started 5 years ago, following which she claimed to feel depressed.
Her present insulin dosage is 24 units and 12 units of mixtard insulin in the morning and evening respectively.
She underwent a right cataract operation in early 1999 which was successful, but lately she complained of blurring of vision in her left eye.

She had a right-sided cerebral infarct with left hemiparesis in late 1999.

She was depressed with this incapacitation and was admitted to a private hospital for a week.

She gradually improved and had now achieved full recovery with normal powers in all limbs.

While admitted in the private hospital, she was discovered to have high blood pressure. The doctor diagnosed her as suffering from hypertension and she was prescribed T.Captopril 25mg twice a day.

FAMILY HISTORY:

Patient is the eldest of 9 siblings. Both her parents had died many years ago. There was no known psychiatric illness in her family.

Father:

Patient's father died in his 70s more than 20 years ago. She did not know the exact cause of his death but attributed it to his chronic cough from smoking.

She described her father as the 'typical Chinese man' who worked very hard for the family and did not spend much time with the children.

He was not emotionally expressive, rather emotionally distant and did not talk much to his children. He was more like a provider to the family working hard in planting and selling vegetables. She was not particularly

close to him and remembered him as being strict, but fair to all his children. She did not experience prolonged grief when he died.

Mother:

Patient's mother also died in her 70s about 5 years after the demise of her father. She died following a long period of hospitalisation. Patient was not able to tell the cause of her mother's death.

She described her mother as more loving, caring and warm compared to her father.

Her mother was a hardworking housewife who took care of all her children.

Patient was able to communicate and confide in her.

She denied pathological grief following her mother's death.

Siblings:

1) Patient: aged 62.
2) Brother: aged 61. He is married with 3 children. He worked as an odd-job labourer before retiring a few years ago. Patient was close to him in their younger years but has not been in close contact since their respective marriage.
3) Brother: aged 50. He is married with children. Patient was unable to recall the number of children he has. She does not know the nature of his work and is not close to him.

Patient has doubt if this brother and the rest of her younger siblings are born from her same biological parents. She had never clarified her doubt with her parents when they were alive.

She is not close to any one of them and has long lost contact with them. Similarly, she does not have much information regarding the following siblings:

4) Brother: aged 48. Married with children.
5) Brother: aged 47. Married with children.
6) Brother: aged 43. Married with children.
7) Brother: aged 42. Marital status unknown.
8) Sister: aged 40. Married with children.
9) Sister: aged 39. Marital status unknown.

PERSONAL HISTORY:

Childhood history:

Patient was born full term by normal delivery without complication.

She had normal milestone and uneventful childhood. There was no history of childhood neurosis like separation anxiety.

Academic history:

She did not attend formal education in school.

Occupational history:

She was not gainfully employed prior to marriage.

She only worked as a part time baby-sitter for 2 years prior to onset of her depressive illness.

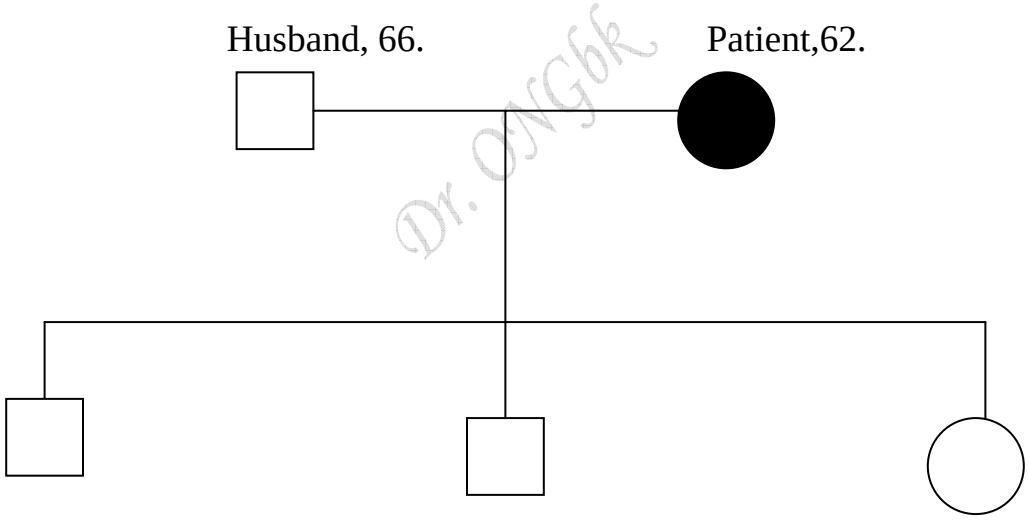
Sexual and relationship history:

She attained menarche at 12 years old and menopause at 55 years old.

She met and dated her would-be-husband for a few years before they decided to marry. It was her first and only heterosexual relationship.

She married at the age of 27 years old, it was a love marriage.

Her husband is 4 years older than her.



Husband:

Husband is 66 years old now. He is a taxi driver and is still driving on a rotation basis with his eldest son. He drives during the day and his son will drive during the night. Patient said her husband is financially supportive but

not emotionally supportive.

She cannot share her thoughts and feelings with him.

There had been a few occasions when her husband scolded her to shut up when he deemed she spoke too much.

Nevertheless, he had never beaten her or abused her physically.

He would spend more time with his group of friends than staying at home with her. Patient felt 'being left out', or in her own words, "as though I am transparent, I am not there."

Both of them had not been sleeping together for a few years. She would normally sleep earlier in the bed but her husband would only come home very late at night or in the wee hours of the morning. Patient did not know the reason why but accepted the way thing has been going. She was of the opinion that her husband must have stayed up late with his friends in coffee shops and did not want to disturb her sleep, hence he preferred the sofa which was also cooler in the hall.

1st son:

He is the eldest child, aged 34 years old.

He drives his father's taxi at night until the next morning.

Patient said he is an obedient and good son.

He would prepare and administer patient's insulin injection in the evening before going to work, and again in the morning when he returned from work.

He is still single and does not have many friends.

Patient said she was worried if he would ever get married. She would feel sad when thinking nobody will take care of him after she died. Though she described him as a good son, they did not spend enough time talking as much as she would like. She did believe she might have wanted to spend more time with him as a way of getting some attention at home.

2nd son:

He is 33 years old, married 2 years ago and has a son. He works as a sales representative for a clothing company and has been living away from patient for the last few years. Patient is less close to him compared to her eldest son. Nevertheless, she loves and cares for him equally much.

On the other hand, she did not share her problems with him.

She is happy whenever he comes home to visit her with her grandson, which is 2-3 times a month.

Daughter:

She is a single, 30 year-old, lady who is still staying at home.

She works as a sales promoter for a brand of shampoo in supermarket.

Patient said her daughter is always busy, going to work early in the morning and coming home late at night. Sometimes she hardly has the opportunity to sit down and talk to her.

Patient would worry if she comes home late. Her daughter on the other hand does not like to explain her habits and lifestyle to her. Patient worries if she is in the company of ‘bad men’.

Patient describes her daughter as the most ‘independent’ and ‘rebellious’ among her children.

Socio-cultural background:

Husband and eldest son are the main breadwinners in the family. Their total income is about Ringgit Malaysia (RM) 4000 – 5000 per month.

Her second son sometimes gives her monthly allowance of RM 300.

Her daughter does not contribute financially to the family.

Patient denied any debt except their housing loan, which they have no difficulty to pay monthly.

She denied facing financial constraint but felt herself a burden to her family in terms of medical expenses.

Patient does not have many friends, she only talks to a few neighbours and hardly go out with them.

Although she is a Taoist by religion, she seldom goes to the temple to pray or participate in religious functions. She is not a devout follower.

Patient does not smoke, drink alcohol or consume illicit drugs.

PREMORBID PERSONALITY:

Patient was fairly sociable and used to have a few close friends before her marriage. She had not kept in touch with her friends after her marriage. She preferred to stay at home and look after her household.

She did not have obsessive traits.

Although she admitted to being a ‘worrier’ since young, she was not markedly disturbed by it.

MENTAL STATE EXAMINATION. (On admission)

General appearance:

Patient was an elderly Chinese lady of medium built.

She was neat in hospital attire, without make-up and her shoulder-length hair was combed. She appeared a little apprehensive at first with a down cast gaze but able to maintain fair eye contact towards the end of interview.

Speech:

She had a monotonous voice.

Her speech was coherent and relevant though not very forthcoming.

There was some poverty of speech as she would answer in a few words only.

The content of her speech was mainly about ‘sad theme’.

She even sighed on a few occasions.

Mood:

She appeared sad with down cast gaze, rather oblivious to other patients walking about.

She was not tearful.

Her mood was depressed and congruent with her thoughts.

There was no mood lability.

She admitted to having suicidal thought and suicidal plan before. She would think about them for a few seconds before shifting her thoughts to something more pleasant as she knew these thoughts were 'bad'.

She said these thoughts were less now compared to her first admission.

Moreover, she denied suicidal intent now.

Thought and perception:

She did not have hallucination, persecutory delusion or other Schneiderian first rank symptoms.

Although she worries over trifle events, she denied having obsessive thoughts or phobias.

Orientation:

Patient was orientated to time, place and person.

Memory:

Her immediate, recent and remote memories were good.

She was able to do the 5-minute memory test.

Attention and concentration:

Her attention and concentration were poor as she was unable to perform the serial 7's test.

Judgement:

Her judgement was fairly intact.

She could be reasoned that harming herself was not the right way of solving her problems.

Insight:

She had fairly good insight.

She knew she was ill.

She attributed her symptoms to her depression.

She was willing to seek treatment from the doctors.

PHYSICAL EXAMINATION:

Pulse: 80/ min, regular, of normal volume and character.

Blood pressure: 140/80 mmHg.

Afebrile

No pallor, icterus, cervical lymphadenopathy, clubbing and pedal edema.

No thyroid enlargement or tremors.

Cardiovascular system: dual rhythm, no murmur.

Respiratory system: bilateral good air entry, no adventitious sound.

Abdominal system:	soft, non-tender, no mass palpable.
Central nervous system:	cranial nerves examination were normal.
	Fundoscopy showed right intra-ocular lens with myopic degeneration and left cataract.
	She had normal power, reflex and sensation.

SUMMARY:

Y.K.F. is a 62 year-old Chinese lady who was diagnosed as suffering from Major Depressive Disorder in 1995. Though she was compliant with treatment, she develops recurrence of depressed mood, anhedonia, lethargy, psychomotor retardation, poor concentration, insomnia and reduced appetite for 2 months prior to admission. She has thought of worthlessness, hopelessness and suicidal plan although she denies suicidal attempt. In addition, she has symptoms of anxiety. She has diabetes mellitus for 20 years, her oral medication was changed to insulin injection 5 years ago following which she developed her first episode of depression.

In 1999, she underwent a right cataract operation. She also suffered a right-sided cerebral infarct and another bout of depression.

She has no family history of psychiatric illness and her childhood was uneventful.

Her emotionally unsupportive husband, rebellious daughter and her own personality may have contributed to her depressive illness.

Mental state examination revealed an elderly Chinese lady who appeared sad with depressed mood but no suicidal intent. She was also worrying over trifle events but her cognitive functions were largely intact with fair insight.

PROVISIONAL DIAGNOSIS:

AXIS I: 296.33 Major Depressive Disorder, Recurrent, Severe without psychotic features,
with comorbid Generalised Anxiety Disorder (300.02)

AXIS II: No diagnosis.

AXIS III: Diabetes mellitus.
Right cataract operation with failing left eye sight.
Right cerebral infarct with left hemiparesis.
Hypertension.

AXIS IV: Problems with primary support group, i.e.,
emotionally unsupportive husband and
a rebellious daughter.

AXIS V: Global Assessment of Functioning = 41 - 50 (current).