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Comparative Psychodiagnostics analysis of mood and neurotic disorders: Case series of Four Patients

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Abstract
Mood and neurotic disorders represent two major categories of internalizing psychopathology that often overlap in symptom expression but differ in course, chronicity, and underlying personality organization. This case series presents a comparative psychodiagnostics analysis of four patients—two diagnosed with Bipolar Affective Disorder (BPAD) representing depressive and manic episodes respectively, and two with neurotic disorders (Generalized Anxiety Disorder and Obsessive-Compulsive Disorder). Each patient underwent comprehensive evaluation using cognitive, personality, and projective measures including PGI Memory Scale, MCMI-III, Rorschach Inkblot Test, Thematic Apperception Test (TAT), and Sentence Completion techniques.
The results revealed distinctive yet interrelated psychological profiles. Bipolar cases demonstrated episodic dysregulation of affect and impulse, with contrasting intrapsychic dynamics between depression (internalization, dependency, rationalization) and mania (externalization, grandiosity, and acting out). Neurotic disorders showed persistent cognitive overcontrol, perfectionism, and anxiety-laden dependency conflicts, with obsessive-compulsive pathology reflecting over-intellectualized defenses and constricted affectivity.
Across all cases, common transdiagnostic vulnerabilities such as dependency-autonomy conflicts, emotional constriction, and maladaptive coping were evident, underscoring the need for multimodal psychodiagnostic formulations. Findings suggest that integrated cognitive-personality-projective profiling enhances diagnostic clarity, illuminates underlying mechanisms of chronicity or episodicity, and informs individualized, course-sensitive treatment planning.

Keywords: Bipolar disorder, generalized anxiety disorder, obsessive-compulsive disorder, psychodiagnostic assessment, personality evaluation, projective techniques

Introduction
Research consistently highlights that both mood disorders and neurotic (anxiety-related) disorders are associated not only with symptomatic distress, but also with underlying cognitive, personality, and projective test abnormalities (Snyder, 2013; Widiger & Trull, 2007) [6, 7]. In bipolar disorder, meta-analyses demonstrate persistent cognitive deficits—especially in attention, memory, and executive functioning—even during euthymic phases (Alloy *et al*., 2012) [1]. Studies of personality in bipolar disorder also document higher neuroticism and lower emotional stability compared to controls. In the anxiety/obsessive-compulsive spectrum, research shows significant associations between obsessive-compulsive symptoms and higher neuroticism, lower extraversion, specific personality disorder features, and affective constriction. The goal is to deepen our understanding of intrapsychic dynamics

Case Report
Case 1
Mr. S, a 40-year-old married Hindu male businessman from Dausa, presented with low mood, reduced social interaction, anhedonia, sleep and appetite disturbances, and occupational disengagement. He had discontinued his medication in December 2024, precipitating the current episode. Past psychiatric history included two manic episodes triggered by psychosocial stressors (father's death, property dispute). Family history: maternal recurrent depression. Premorbid: cheerful, perfectionistic, socially adequate.

Assessment

- **Mental Status Examination (MSE):** Dysthymic affect, psychomotor retardation, soft and slow speech, impaired attention and recent memory, intact orientation, Grade 3 insight.
- **PGI Memory Scale:** Impaired attention and recent memory; intact immediate recall & visual retention.
- **MCMI-III:** Elevated Depressive (BR = 75), Dependent (BR = 83), Narcissistic (BR = 77), Borderline (BR = 76), Paranoid (BR = 80)
- **Hamilton Depression Rating Scale:** Score = 28.
- **TAT:** Narratives of preoccupation with failure and familial rejection; rationalization & sublimation as primary defenses.
- **Rorschach:** 25 responses, $\lambda = 3.16$; high internal stress, limited affective modulation, rigid cognitive style, guarded interpersonal representations.

Diagnosis: BPAD, current episode moderate depression (F31.30).

Case 2

Mr. A, a 27-year-old married male lawyer from Jaipur, presented with elevated mood, grandiosity, decreased need for sleep, over-talkativeness, irritability, impulsivity for 15 days. Collateral history from parents was reliable. This was his third manic episode (previous in 2020 & 2023, linked to stress & non-adherence). Childhood: familial conflict (neglectful father, supportive mother). Premorbid: cheerful, socially cordial, ambitious, self-motivated.

Assessment

1. **MSE:** Well-groomed appearance, elated affect, coherent but overproductive speech, preserved cognition, goal-directed thought with grandiose content, partially impaired judgment, Grade 2 insight.
2. **MMSE:** 28/30.
3. **MCMI-III:** Elevated Disclosure = 137.6, Paranoid Personality = 91, Delusional Disorder = 91, Alcohol Dependence = 76, Anxiety Clinical Syndrome = 75.
4. **TAT:** Emotional instability, dependency-autonomy conflicts, achievement drive vs fear of failure, acting out dominant defense.
5. **Rorschach:** Poor stress tolerance (Adj D = -2), limited coping resources (EA = 2), introversive cognitive style ($\lambda = 0.8$), emotional suppression, moderate mediational dysfunction.
6. **SSCT:** Ambivalent attitudes toward family, authority, women; self-concept ambition tempered by recognition of past mistakes.
7. **YMRS:** Score = 23.

Diagnosis: BPAD, current episode mania with psychotic features.

Case 3

Mr. D, a 25-year-old unmarried Hindu male postgraduate student from Jaipur, reported low mood, restlessness, reduced interest in work, overthinking, and low self-esteem for 1.5 years following a breakup. Learning of ex-partner's engagement intensified symptoms; appetite loss, insomnia, diminished motivation followed. Family supportive; no psychiatric history. Premorbid: reserved, emotionally reactive, self-reflective; avoidant coping.

Assessment

- **PGI Memory Scale:** Intact cognitive abilities; reduced mental balance due to emotional interference.
- **MCMI:** High Depressive, Avoidant, Self-defeating scales; syndromes: Major Depression, Anxiety, PTSD.
- **Beck Inventories:** BAI = 41; BDI = 29.
- **SSCT:** Familial attachment present, mistrust in romantic relations, unresolved grief, low self-worth.
- **TAT:** Themes of loss and helplessness; defenses of denial and intellectualization; dependency conflicts prominent.
- **Rorschach:** $\lambda = 2$, high intellectualization index = 7, MOR = 2, dependency conflicts (PHR > GHR), guarded ambivalent thinking.

Diagnosis: GAD with secondary depressive features.

Case 4

An 18-year-old male student living with grandparents; father has unspecified psychiatric illness. Three-year history of intrusive, ego-dystonic thoughts (initially checking behaviours) evolving into mental rituals neutralizing anxiety over imagined harm to relatives. Insight preserved. Family context: emotionally close to grandparents especially grandfather. Quiet, socially withdrawn since childhood.

Assessment

- **MMSE:** 27/30.
- **PDE:** Schizoid and anankastic traits confirmed; emotional detachment and preference for solitude.
- **TAT:** Themes of guilt, duty, conflict between autonomy and dependency; rationalization & intellectualization dominant.
- **Rorschach:** R = 20; $\lambda = 1.85$; affective constriction, cognitive overcontrol, low emotional resonance—indicative of schizoid organization.

Diagnosis: OCD - predominantly obsessional type.

Discussion

The psychodiagnostic profiles across cases illuminate both shared vulnerabilities and disorder-specific expression. Dependency-autonomy conflicts, perfectionistic tendencies, and emotional constriction emerged as transdiagnostic vulnerabilities, predisposing individuals to maladaptive coping. The mode of manifestation, however, differentiated the groups.

In BPAD, depressive episodes showed internalized affective regulation, reflected in overcontrolled cognition and reliance on sublimation and rationalization, whereas mania demonstrated externalized emotional and cognitive patterns, with grandiosity, impulsivity, and relational ambivalence. Neurotic disorders, including GAD and OCD, exhibited chronic internalization, characterized by emotional suppression, cognitive overcontrol, and intellectualization. The OCD case further illustrated schizoid organization, emphasizing cognitive defense against perceived dependency.

Despite these differences, common underlying mechanisms were observed. Dependency-autonomy conflicts were expressed episodically in mood disorders but chronically in neurotic disorders. Perfectionistic and mistrustful traits manifested as rumination or withdrawal in depression and GAD, and as impulsivity and relational ambivalence in

mania. Projective measures elucidated subtle intrapsychic dynamics: TAT narratives highlighted conflict resolution strategies, Rorschach indices differentiated cognitive-affective rigidity from flexibility, and SSCT revealed relational ambivalence not captured by self-report.

Clinically, these insights emphasize the necessity of multi-modal psychodiagnostics assessment to inform individualized formulation. Understanding transdiagnostic vulnerabilities alongside disorder-specific expression patterns allows clinicians to tailor interventions, target latent personality risks, and anticipate functional or relational difficulties. Recognition of internalized versus externalized coping provides a framework for prioritizing cognitive-behavioral, interpersonal, or relational strategies across both episodic and chronic presentations.

Clinical Implications

The comparative psychodiagnostics evaluation of these four cases highlights the value of integrating cognitive, personality, and projective measures alongside symptom rating scales for refining case formulation beyond categorical diagnosis. In the bipolar cases, contrasting intrapsychic patterns—overcontrolled affect and perfectionistic rigidity in depression versus outward emotional and behavioral dysregulation in mania—helped clarify whether interventions should emphasize emotional activation, impulse regulation, or structured behavioral containment. Such nuanced differentiation supports evidence that psychodiagnostics profiling can enhance treatment matching within bipolar spectrum presentations, beyond what is possible through DSM-5 criteria alone (Alloy *et al*., 2012; Miklowitz, 2014) [1, 4].

The neurotic disorder cases (GAD and OCD) revealed persistent cognitive vigilance and defensive overcontrol, but with divergent relational consequences. The OCD patient displayed social withdrawal and schizoid tendencies, whereas the GAD patient exhibited reassurance-seeking and attachment-related insecurity. Recognizing these differences informs intervention prioritization: exposure-based strategies for ritualized anxiety in OCD versus interpersonal and rumination-focused therapy for GAD (Snyder, 2013; Widiger & Trull, 2007) [6, 7]. This approach helps prevent the common clinical error of applying uniform cognitive-behavioral strategies to all internalizing disorders.

Personality-informed assessment also offers practical guidance for anticipating therapy engagement and adherence. For instance, the self-defeating expectancy patterns in the GAD case could predict dropout if not addressed early, while the manic patient's ambivalence toward authority indicated the need for early alliance-building and collaborative decision-making (Peters *et al*., 2011) [5]. Such patterns are often subtle and may not emerge in standard clinical interviews.

Finally, comparing mood versus neurotic disorder cases provided insight into course and stability, allowing clinicians to plan care according to temporal needs. Bipolar disorder presentations required episodic relapse prevention and mood stabilization strategies, whereas chronic neurotic conditions demanded sustained emotion-regulation skill-building and coping strategies (Mihura *et al*., 2013) [3]. Overall, this case series demonstrates that multi-method psychodiagnostic assessment can shift clinical care from solely symptom-targeted interventions to course-sensitive, personality-attuned, and functionally prioritized treatment, enhancing both patient outcomes and family understanding.

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