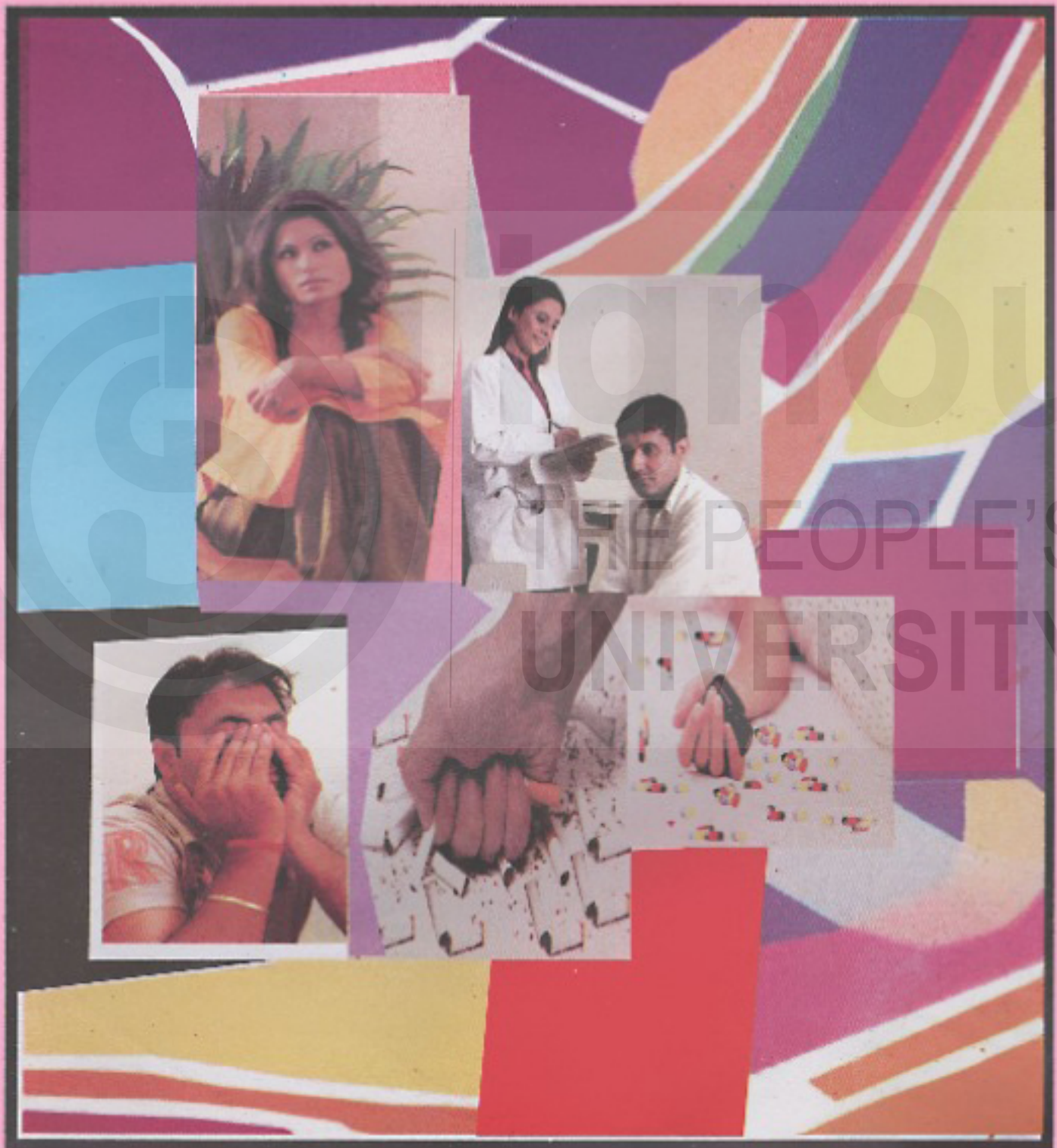




Indira Gandhi National Open University
School of Continuing Education

MCFTL-002

Mental Health and Disorders – Supervised Practicum



MANUAL FOR SUPERVISED PRACTICUM

MANUAL FOR SUPERVISED PRACTICUM

Oriental Practical	13
---------------------------	-----------

PART - I :

Foundational Aspects of Case History Taking and Mental Status Examination	19
----------------------------------------------------------------------------------	-----------

PART - II :

Practicals 1 to 12 and the Tools to be Used	23
----------------------------------------------------	-----------

Practical 1	Case History Taking and Mental Status Examination of a Young Adult - Male
Practical 2	Case History Taking and Mental Status Examination of a Young Adult - Female
Practical 3	Case History Taking and Mental Status Examination of an Individual in Middle Adulthood - Male
Practical 4	Case History Taking and Mental Status Examination of an Individual in Middle Adulthood - Female
Practical 5	Case History Taking and Mental Status Examination of an Old Person - Male
Practical 6	Case History Taking and Mental Status Examination of an Old Person - Female
Practical 7	Case History Taking and Mental Status Examination of a Preschool Child - Male
Practical 8	Case History Taking and Mental Status Examination of a Preschool Child - Female
Practical 9	Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years - Male
Practical 10	Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years - Female
Practical 11	Case History Taking and Mental Status Examination of an Adolescent - Male
Practical 12	Case History Taking and Mental Status Examination of an Adolescent - Female

Tools for Case History Taking and Mental Status Examination

Tool 1 : Case History Taking for Adult	29
Tool 2 : Mental Status Examination Inventory for Adult	34
Tool 3 : Case History Taking for Child/Adolescent	43
Tool 4 : Mental Status Examination Inventory for Child/Adolescent	52

PART - III :

Illustrations of Written Reports of the Practicals

Illustration 1 : Understanding Case History Taking and Mental Status Examination of an Individual in Middle Adulthood	63
Illustration 2 : Understanding Case History Taking and Mental Status Examination of a Young Adult	77
Illustration 3 : Understanding Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years	81
Illustration 4 : Understanding Case History Taking and Mental Status Examination of an Adolescent	94

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Dear Learner,

This course “Mental Health and Disorders – Supervised Practicum” (MCFTL-002) is the practical counterpart of the theory course, “Mental Health and Disorders” (MCFT-002). This Supervised Practicum is of 2 credits. This Supervised Practicum (MCFTL-002) helps you to understand better the theoretical concepts which have been explained in the four theory Blocks of MCFT-002.

As these practicals emerge out of the theory syllabus, it would be better to do them when you read the theory course. The practical activities will help you to get hands-on experience of working with individuals and families in different settings.

Here, we would like you to understand that in Supervised Practicum, you have to work under the overall guidance and supervision of the Academic Counsellor, generally called Counsellor in this Block. But, before starting the practical activities, it is very important for you to read this Manual for Supervised Practicum carefully. Go through the essential concepts, procedure, tools, and illustrations provided in this Manual in order to understand what has to be done.

Remember that you have to do all the twelve practicals stated in this Manual. However, you need to submit, for internal and external evaluation, written reports of only THREE practicals in the file.

Of the three written reports that you are required to submit for evaluation:

- **Report one must be that of Practical 1 or Practical 2 or Practical 3 or Practical 4;**
- **Report two must be that of Practical 5 or Practical 6 or Practical 7 or Practical 8; and**
- **Report three must be that of Practical 9 or Practical 10 or Practical 11 or Practical 12.**

Note: YOU MUST ENCLOSE IN YOUR PRACTICAL FILE FOR EVALUATION, THE ROUGH DATA COLLECTION SHEETS/CD/AUDIO RECORDING that had been used for discussion and interactions with your Academic Counsellor, WITH RESPECT TO ALL 12 PRACTICALS.

Thus, you need to submit only three practicals for evaluation. Doing the remaining nine practicals would be for practice, that would enhance your understanding, sensitivity and skill set. Assessment of these would only be through the interactions, for discussing each practical, which you would have with your Academic Counsellor based on the audio recording/CD/rough data collection sheets used for recording or noting the participants’ responses in the course of doing the practical activities in the field.

With best wishes,

**Programme Coordinators
IGNOU**

INTRODUCTION

The focus of this Supervised Practicum (MCFTL-002) is on case history taking and mental status examination. As a counsellor and family therapist, you would be trying to help individuals in different stages of the human life span — right from young children through old age. Case history taking and mental status examination of the person forms the very basis of the counselling and family therapy interventions. Thus in this Supervised Practicum, you are being provided with indepth exposure and opportunities with individuals (both males and females) at different stages in life, so that you develop the requisite skills in this critical aspect.

You have to complete the Supervised Practicum (MCFTL-002) in 15 working sessions. This Supervised Practicum, worth 2 credits, is divided into 12 practicals. The orientational practical exercise involves an exposure to analysis of situations from the perspective of mental health issues and problems. The subsequent 12 practicals listed in this Manual are more intense in nature, providing you with the indepth experience of case history taking and mental status examination. The practicals to be performed have been denoted in this Manual as Practical 1, Practical 2 and so on. For each practical, you should discuss the activities involved with the Academic Counsellor at the Programme Study Centre/ Study Centre. Carry out the practical activities; for example, taking observations, conducting interviews etc., as stipulated in this Manual. You are required to write detailed reports of three of the practicals.

Suggested Schedule

It is advised that you should start the Supervised Practicum as soon as you go through the theory component of this course. Before starting the practical activities, therefore, it is important that you read and understand the related Units in the four Blocks of the Course — “Mental Health and Disorders (MCFT-002)”.

Participating in the academic counselling sessions for practicals is essential. You are required to carry out the Supervised Practicum activities under the guidance and supervision of the Academic Counsellor for the Supervised Practicum course at your Programme Study Centre (PSC)/ Study Centre (SC). The Academic Counsellor would guide, supervise, and evaluate your practical work. Please stay in touch with your PSC/SC to find out the schedule of academic counselling sessions for the Supervised Practicum course.

As you have to complete Eleven Courses (5 Theory Courses and 6 Supervised Practicum Courses) of the programme of study Master of Science in Counselling and Family Therapy (MSCCFT) in the first year, or the Post Graduate Diploma in Counselling and Family Therapy (PGDCFT), hence, it is advisable to complete the practical activities as per the scheduled time.

Please follow the sequence of the practical activities given in the Manual, as these are sequenced according to understanding and difficulty levels.

Duration of Supervised Practicum MCFTL-002

The Supervised Practicum comprises 12 practicals, the details of which are given in this Manual. You should be able complete these practicum in a total of 15 working days; working on the practicals for about 4 hours a day. This includes the time required for participating in interaction/discussion sessions with the Academic Counsellor; finalising the tools for the practical activities; conducting the activities; engaging in post-practical activity analysis; and writing detailed report

of three of the practicals. During interaction with the Counsellor, you should discuss the tool that you would use in the practical you are about to do, as well as gain tips for the field level activity (e.g., how to form a rapport with the respondent). You should also analytically discuss your previous practical activity (e.g., what went off well; what did not; what you should have done in that instance) and gain advice and useful insights from the Counsellor. You have to carry out field work pertaining to the 12 practicals, as well as write the report of 3 practicals, prescribed in this Manual.

If the Supervised Practicum takes more time than this scheduled duration, then you can rearrange your work accordingly, but only after discussing it with the Supervisor/Academic Counsellor you are attached with at the Programme Study Centre/Study Centre.

Content Layout in the Practicum Manual

This Manual for Supervised Practicum (MCFTL-002) consists of 12 practicals which you are required to carry out.

The Orientational Practical is given in the beginning. In this Practical, Part-1 prepares the base, Part-2 comprises the case vignettes that you need to analyse, and Part-3 gives an illustration of how this analysis may be done. This practical is for self assessment.

After this orientational activity, we come to the mainstay of the practical work for this course, that is, case history taking and mental status examination with respect to a diverse range of individuals. For this, the Manual itself has been divided into three parts:

Part-I: Part I of the Manual details the theoretical aspects and background information needed to do the practicals. This section of the Manual describes the related basic concepts of the practical work of this course. It also explains how to conduct the practicum work. There are some guidelines which would help you in the completion of the practicals.

Part-II: This section of the Manual gives details regarding the individuals with whom you are required to conduct history taking and mental status examination, as well as the tools that may be used for the purpose. These may consist of check lists, interview schedules, observation schedules and other instructions to help you conduct the prescribed practicum.

Part-III: This section of the Manual illustrates the conduct/analysis/writing the report of the practicals with the help of illustrations. Four illustrations of written reports of history taking and mental status examination of diverse individuals have been given.

Please note that if you copy the given illustration in your file, you will be failed and you would have to repeat the entire practicals again. In any case, in the 'Illustration' given in each practical, some aspects and sections may have been handled very superficially. Your written report of the practical would need to be comprehensive, in depth, and analytical.

You have to do all the 12 practicals and write the report of 3 practicals for submitting the Practicum File. Please do not copy the illustrated examples as you will be asked to resubmit the Practicum File and this will lead to delay in award of the Degree/Diploma. *Also, do not copy from your peers/friends any other source, as you would be failed in that case.*

Role of the Counsellor in Supervised Practicum

- The Counsellor is a qualified professional in the field, allotted by the Programme Study Centre/Study Centre to which you are attached. The

Counsellor will supervise and guide for the Practicum Activities, during the academic year.

- Your Supervisor/Academic Counsellor will guide you on the method in which the Practicum Activity has to be performed, as well as the analysis of the same. Besides this, you can seek the help of the Counsellor at any time during the sessions.
- The Counsellor may or may not be associated with the individuals or families you identify for the practicum activity, but she or he can help you in identifying the same.
- To conduct practicum activities, you have to discuss with the Counsellor first, the practical you are going to conduct as well as the tool (e.g., the Mental Status Examination Inventory) that you are going to use for the purpose, take her or his advice and then visit your respondents [a person who is being tested, interviewed or observed by you]. Here, in this programme of study, respondent is also called 'participant' and at times 'subject' or 'patient'. It is advisable to report to your Academic Counsellor after you complete each practicum, and discuss what had transpired in the course of conducting the practical.
- **The academic counselling sessions, for the Supervised Practicum course, are the forum where you would interact with your Academic Counsellor and discuss the practicum activities. These may be scheduled face-to-face, or with use of some digital technology/online mode for interaction. Keep in touch with your study centre to find out about the same.**
- You need to submit written reports of 3 practicals. You need to write each and every detail in your report. The guidelines regarding report writing are given in Part-II of this Manual. The 'Illustration of Written Report', given as a sample practical, given in Part-III of the Manual will also give you an idea about presenting the written report. If you have any problem or query regarding report writing, then contact your Counsellor for the same.
- Apart from guiding and supervising, the Academic Counsellor will also evaluate your work. This is 'internal evaluation', which carries 50% weightage in the final score. The evaluation mark sheet to be used is given at the end of this Manual.

This evaluation would consist of:

- i) Evaluation of written reports of 3 practicals submitted by you, and
- ii) Interaction-based assessment, based on your discussions with the counsellor with respect to all 12 practicals.

Both the above components are essentially based on audio recording/CD/sheets of paper on which notes were taken by you during data collection in each practical.

Important Guidelines for Working with Individuals and Families in Different Settings

- Identify the family/individual for each practical carefully, as per the instructions given for each practical.
- Inform the Counsellor about the selected individual/family.
- Seek the consent from the family/participant before conducting the practicum activity. For each practical, separate consent needs to be taken. The consent form is enclosed at the end of this Manual.

- The time schedule for conducting the practicum activity should be planned according to the convenience of the family or the individual with whom the practical activity is to be carried out. To carry out the practical activity, you may fix an appointment on telephone too. It need not be face-to-face.
- **You may conduct the activity with the selected individual or family through face-to-face interaction, or, given the changing times, do so through use of a digital technology/online mode or telephonic conversation. Likewise, if required, you may observe a child/family setting through use of technology.**
- Be punctual for your appointment; and if there is any change in time or day inform the concerned family or individual. For practicum activity, keep your appointment with your respondent even if the interview etc. is to take place through digital technology mode.
- Try to fix the time and day, when other significant members of the family are also present, so that you can get information from other members in addition to your respondent.
- Before conducting any practicum, you should have thorough knowledge of its theoretical component and complete understanding of the procedure of performing the practicum activity.
- Before starting any practical, spend some time with the respondent(s) to establish rapport and create an environment comfortable for conversation or activity; this is generally termed as rapport building.
- Respect the views of respondents and do not interrupt or show your own attitude, opinion or prejudice regarding what they are saying or doing. The process should not be biased by your view points. Keep the information confidential, and do not discuss it with any other person including your friend, spouse, parents and other family members.
- In case the family or the individual does not cooperate with you, or you feel that you are not getting the desired information, try to improve the rapport building and make your questions clearer. If it does not work, stop the activity politely and take their leave. And, report this in your file. Also, find another respondent to carry out your practical.

Important Points for Writing a Report

1. Basic Information

Please mention all relevant details of your student status (enrolment number, study centre etc.) clearly on each Practicum Report, as well as on the cover of the Supervised Practicum File. The File should be presentable and legibly written. Attach all other materials in the File (audio tapes, CDs, sheets of paper on which you had taken notes during the interview etc.) and list each one of them as '*enclosures*' in the File along with the number of such items.

2. Content

In most of the practicals, one has to give information about the individual/family and its members. As you would realise, others (especially your evaluators!) would not have access to this information unless you provide the same in the report of the Practicum! So do remember to provide all relevant information. At the same time, be true to yourself as you are learning important concepts from the practicum activity. Do not falsify the report or modify the record of the practicum activity to make it look 'good'.

Don't worry if everything in the individual or family does not fit a given, stereotypical norm of a person, family or a relationship. The idea here is to move away from being judgemental and learn to create a view that is unbiased, encompassing and sensitive to plurality. Your evaluations pertaining to mental issues are going to be based on an objective and unbiased treatment of the same in analysis. Please use the concepts you have learnt in the Course in order to meet this end.

The content of your file will also be evaluated on how comprehensively and objectively you have dealt with the issues at hand. Your personal beliefs and preconceived notions should not hinder the understanding of the content.

3. Presentation

Your report for each practical should be comprehensive and analytical. Be organised and help the evaluator know that you have understood the concepts. Use pseudonyms rather than the actual names for the subjects and family members. But rest of the information should be truthful.

4. Length

Give all relevant details of a situation or a person. Be careful not to beat about the bush! The richness of content and organisation of your report carry more weight than how many pages it consists of or how long it is!

Supervised Practicum File

You have to prepare the Supervised Practicum File by compiling:

- written reports of **three** practicals;
- supplementary enclosures/records (audiotapes, sheets of paper on which notes were taken, CDs, etc.) **of all the 12 practicals**;
- duly filled-in, signed and stamped Annexures 'A' and 'B'.

Let's now talk about each of these components in greater detail.

You are required to submit three practicals forevaluation. Thus, you will prepare the Supervised Practicum File by compiling the written records of three practicals. And there are some stipulations in this regard. **The first written report has to be of one of the practicals out of Practical 1, Practical 2, Practical 3, and Practical 4. Thus, having done Practicals 1-4, you may write the report of whichever of the four practicals you did best and submit it to your Counsellor for internal evaluation. Likewise, the second report has to be of one of the practicals out of Practical 5, Practical 6, Practical 7, and Practical 8, and the third report has to be of one of the practicals out of Practicals 9-12.**

You must also include in the File enclosures (audio tape recording/CD/sheets of paper on which notes were taken during data collection of all the 12 practicals), that formed the basis of your interaction with your counsellor.

Marks will be given by the Academic Counsellor for the three practicals (written reports), as well as for the interaction-based assessment with respect to all 12 practicals, based on the audio recording/CD/rough data collection sheets used for noting the participants' responses in the course of doing the practical activities in the field.

The Counsellor will record the marks that you have obtained for your Practicum Work in Section 1 of the Evaluation Sheet (given at Annexure 'A' at the end of this Manual). Sections 2 & 3 of Annexure 'A' have to be left blank, as these are to be filled-in by the External Evaluator.

This Annexure 'A' with duly filled-in, signed and stamped Section 1 and blank Sections 2 & 3 must be included in the Supervised Practicum File that you submit.

In addition, the Counsellor will certify the Form given at Annexure B at the end this Supervised Practicum Manual which declares that every practicum activity was conducted by you under her or his guidance and supervision. You must also include this duly filled-in, signed and stamped Annexure 'B' in the File that you submit.

Maximum Duration of the Practicum

For this 2 credit Supervised Practicum Course, you have to carry out 12 practicals at the field level, and write detailed reports of three practicals. The maximum time you can take to complete the practicum is four months from the date of commencement of the Supervised Practicum for this Course.

Evaluation of Supervised Practicum File

The evaluation of Supervised Practicum is done at two levels. These are:

- Evaluation Level 1 : Internal Evaluation
- Evaluation Level 2 : External Evaluation

Remember that:-

- 1) **Though it is mandatory to do all the twelve practicals, written reports of only THREE practicals are required to be submitted for evaluation (and thus included in the practical file). Stipulation in this regard is as follows:**
 - **Written Report one must be that of Practical 1 or Practical 2 or Practical 3 or Practical 4;**
 - **Written Report two must be that of Practical 5 or Practical 6 or Practical 7 or Practical 8; and**
 - **Written Report three must be that of Practical 9 or Practical 10 or Practical 11 or Practical 12.**
- 2) **You must enclose in your practical file for evaluation, the rough data collection sheets/CD/audio recording used for discussion and interactions with your Academic Counsellor, with respect to all 12 practicals.**

Thus, you need to submit only three practicals for evaluation. Doing the remaining practicals would for practice, that would enhance your understanding, sensitivity and skill set. Assessment of these would be in the course of your interactions/discussions with the Academic Counsellor.

Evaluation Level 1: At the Programme Study Centre / Study Centre by the Academic Counsellor

Every practical will be evaluated by the Academic Counsellor/ Supervisor with whom you have been attached by the Programme Study Centre/Study Centre for this Supervised Practicum Course. The Academic Counsellor will evaluate the three written reports (the three practicals) which have been submitted by you for evaluation. As stated earlier, of these three written reports, the first one has to be of one of the practicals out of Practical 1-4; second has to be of one of the practicals out of Practical 5-8, and third has to be of one of the practicals out of Practical 9-12.

The Academic Counsellor will also assess your performance during interactive sessions for all the 12 practicals. These two components together comprise the Internal Evaluation.

The marking scheme is as follows:

Maximum marks (MM) for each of the three written reports/practicals = 50

Maximum marks (MM) for interaction with the Academic Counsellor (with respect to all 12 practicals) = 50

Hence, total MM for the internal evaluation component of the Supervised Practicum is 200.

Evaluation Level 2: External Evaluation (Evaluation of Practicum File at IGNOU Headquarters)

An expert from the panel, nominated by IGNOU HQs., will evaluate the Supervised Practicum File. This is called *External Evaluation*. The External Evaluator will record the marks in Sections 2 and 3 of Annexure 'A' of this Supervised Practicum Manual, that you would have enclosed in the File.

External evaluation will therefore be done on the basis of the Supervised Practicum File submitted by the learner.

The External Evaluator shall evaluate each of the three written reports out of 50 marks. 50 marks would be based on review of the enclosures included in the File (audio tape recording/CD/sheets of paper on which notes were taken during data collection) with respect to all 12 practicals, that formed basis of your interaction with your Counsellor.

Thus, the total marks for the external evaluation component shall be 200.

Weightage of the Two Levels of Evaluation

The two levels of evaluation carry equal weightage towards final marks:

- The marks given by the Supervisor at Level 1, known as '*Internal Assessment*', will be calculated as 50% weightage; and
- The marks given by the expert at Level 2, known as '*External Assessment*', will also be calculated as 50% weightage.

You have to secure 40% as pass marks in both the assessments, internal as well as external. If you are not able to secure 40% marks in either assessment, you have to repeat the complete Supervised Practicum MCFTL-002. It means you have to re-do all the Practicum Activities, make a new Practicum File and submit it.

For practical (Supervised Practicum) courses, there is no term-end exam.

Note: *The panel of experts nominated by IGNOU, who are going to evaluate your Practicum File, have the right to moderate the Internal Assessment marks awarded through the Programme Study Centre / Study Centre in any component of the Practicum.*

Submission of Supervised Practicum File

- Once the internal evaluation has been done, you must submit your duly complete practical file (including the duly filled, signed and stamped Annexures A & B) to SED, IGNOU, for external evaluation.

The duly complete Practicum File must be sent for external evaluation to the following address:

Registrar (SED)
Student Evaluation Division
Indira Gandhi National Open University
Maidan Garhi, New Delhi – 110068.

- Depending on when you submit your Supervised Practicum file to SED, your internal and external evaluation marks would be included in the June/December TEE grade card, as per University norms.
- The file submitted will not be returned to you.

Note: Before mailing the Practicum File, you must keep a photocopy of the File with yourself, so that in case of loss in transit or misplacement, you would be able to submit the copy of that file.

Essential Checklist

When submitting your Supervised Practicum File, please ensure that you have included the following:

- 1) Written record of 3 practicals as specified.
- 2) Enclosures (audiotape/CD in case of recording, or sheets of paper on which you noted the answers of the respondents/recorded the observations; etc.) with respect to all the 12 practicals;
- 3) Duly filled-in, signed and stamped Annexures 'A' and 'B'.

The cover page should clearly state the title "Supervised Practicum File for the Course MCFTL-002". Your name and enrolment number must also be mentioned on the cover page.

The first page or the face sheet must also have your name; enrolment number; full address; name, designation, and address of your Supervisor; as well as name and address of your PSC/SC. The format for the face sheet of the Practicum File is given below:

**SUPERVISED PRACTICUM FILE
MSCCFT - First Year/
PGDCFT**

MCFTL-002

Name of the Student :

Enrolment No. :

Address :

Phone No. :

Study Centre/Programme Study Centre :

Regional Centre :

Name & Address of Supervisor :

Phone No./Mobile No./

e-mail address of Supervisor :

Signature of the Student :

Date :

ORIENTATIONAL PRACTICAL

Structure

1.1 Introduction

1.2 Part-1

1.3 Part-2

Activity: Assessment of Case Vignette

1.4 Part-3

Illustration: Assessment of Case Vignette

1.1 INTRODUCTION

In this practicum, we would introduce you to assessing mental health issues. These concepts are essential components of developing clinical skills in counselling and family therapy.

Objectives:

After undertaking this Practical, you will be able to:

- Analyse when problems arise in any situation;
- Understand mental health issues; and
- Comprehend mental health problems.

1.2 PART-1

In your role as a counsellor and family therapist, you would need to use your skills in understanding any given situation or problem. Comprehension of a given situation is an art which is learnt. In this Practical, we are introducing you to understanding case vignettes. In the subsequent Practicals given in this Manual, one would go into clinical aspects of psychiatric case history taking and mental status examination.

Let us first undertake this orientational practical exercise.

1.3 PART-2

Activity: Assessment of Case Vignette

AIM:

This activity aims to inculcate comprehension skills in the learners regarding understanding of a given situation.

OBJECTIVES:

After undertaking this Practical, you will be able to:

- Analyse when problems arise in any situation;
- Understand mental health issues; and
- Comprehend mental health problems.

Case Vignette 1

Tahira Khan, a 22 year old art graduate lives in Jammu. Her marriage has been fixed to a well settled boy, 26 years old, from business family of Muzzafarpur, Uttar Pradesh. These days she looks very upset, in a world of her own, uninterested in people and things around her. At times she is rude with her mother; at other times she holds her tight and cries a lot. Her mother is worried seeing her behaviour.

1) What is happening in Tahira’s life?

.....
.....

2) Is she portraying normal behaviour of a girl whose marriage has been fixed?

.....
.....

3) What is her mother’s concern?

.....
.....

4) What could be possible reasons for such behaviour?

.....
.....

Case Vignette 2

Nisha is a five year old beautiful girl. She started going to a preschool at four years of age. She has one younger brother, three year old. Some of her classmates often complain that Nisha misbehaves with them, shouts at them, is rude, and at times throws their belongings on the floor too! The class teacher has called Nisha’s parents to school.

1) Analyse the problem areas needing intervention.

.....
.....

2) Do you think Nisha is at fault?

.....
.....

3) What could be the possible reasons for such behaviour?

.....
.....

1.4 PART-3

Illustration : Assessment of Case Vignette

AIM :

This activity aims to inculcate comprehension skills in the learners regarding understanding of a given situation.

OBJECTIVES:

After undertaking this Practical, you will be able to:

- Analyse when problems arise in any situation;
- Understand mental health issues; and
- Comprehend mental health problems.

Case Vignette 1

I am school counsellor in Rampur District of Uttar Pradesh. Ruby Thakur had been one of the bright students of her XIth class. Now, she is in class XIIth.

These days she is consistently losing weight, looks upset and distressed. She is obtaining poorer marks and low grades these days. Yesterday her class teacher told that last week she felt dizzy in their school trip to Science Museum, which was 5 kms from the school.

Now, I started thinking on the following lines. *Here, think and try to answer the following questions without seeing the response.*

- 1) Was her proper medical examination done?

.....
.....

- 2) What could be possible reason for her dizziness?

.....
.....

- 3) Anything that I could do?

.....
.....

Now compare your answers to the above questions with the following responses.

Ans 1. Proper medical examination by a qualified doctor should have been done. Her tests for anaemia, blood pressure, blood sugar etc. should be done.

Ans 2. The various possible reasons could be:-

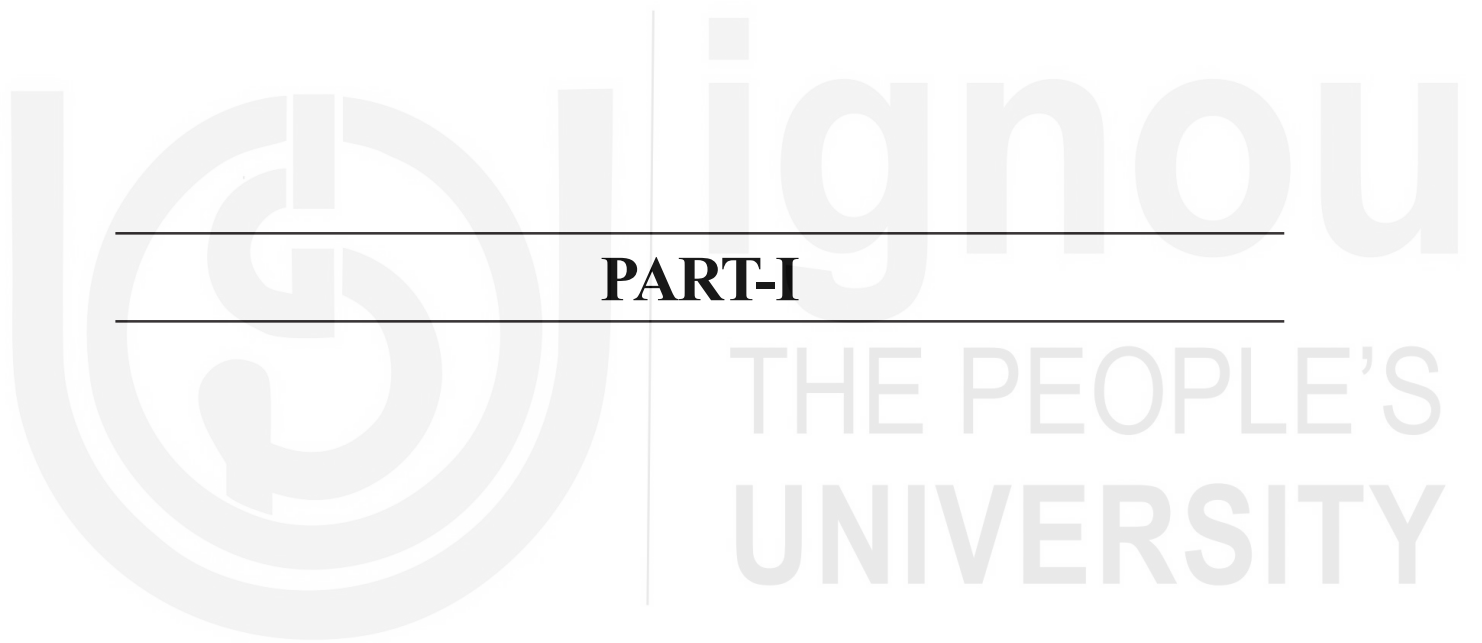
- i) Poor diet and low intake of nutritive food items.
- ii) Since she is an adolescent girl, it could be menstruation cycle is going on.

- iii) As she is in Class XIIth she could be suffering from stress due to achievement pressure in class XIIth, poor marks or low grade.
- iv) She might have been empty stomach that day.
- v) There might have been some personal family problem as her marks and health was consistently reducing.

Ans 3. Yes, I could talk to her and discuss these questions with her. Then also call her parents and discuss this problem with them. Later, I would decide what actually needs to be done.







PART-I

**THE PEOPLE'S
UNIVERSITY**

PART - I

FOUNDATIONAL ASPECTS OF CASE HISTORY TAKING AND MENTAL STATUS EXAMINATION

Structure

- 1.1 Introduction
- 1.2 Concepts
 - 1.2.1 Psychiatric Case History
 - 1.2.2 Mental Status Examination

1.1 INTRODUCTION

Case history taking is a very skilled part of clinical work which is an essential component of counselling and family therapy. Through good case history diagnosis can be formulated and further course of action can be decided. In medicine there are number of diagnostic tests and investigations to provide help in making decision about patient's illness. In a patient with psychological problem, medical diagnostic tests, X-rays or other investigations do not help much as we are studying abnormality in behaviour. Thus, a good case history facilitates understanding of person's deviant behaviour, thoughts and beliefs; and helps in decision about presence of mental illness; what type of disorder etc. The importance of case history taking of psychiatric disorders facilitates understanding the role of specific factors; physical, constitutional and psychogenic, which have contributed to its appearance.

Mental status examination of psychiatric patient is similar to physical examination in medical problems. It provides a format of systematic observation and recording of information about patient's thinking, emotions and behaviour.

Case history taking in psychiatric patient is often more difficult and challenging due to the patient's lack of insight or inability to appraise her/his own self in an adequate way.

OBJECTIVES:

After undertaking these Practicals, you will be able to:

- Understand the importance of psychiatric case history taking and mental status examination;
- Know methods of taking psychiatric case history in children, adolescents, and adults;
- Apply skills of case history taking in understanding mental health disorders; and
- Develop skills of assessing mental status of individuals across the life span.

1.1 CONCEPTS

1.2.1 Case History

The case history should take a longitudinal view of the patient's life (biography) which helps in cross-section (comprehensive view) of patient's mental state at the time of examination, in a clear lucid manner. The best plan for history taking is to have a frame-work of a questionnaire but allow the patient to tell her/his own story. Whenever a patient is referred to mental health professional, it is important to take a comprehensive case history of the patient. With case history you can understand progression of the disorder, as well as family interaction patterns and patient's adjustment in different situations.

1.2.2 Mental Status Examination

Mental status examination of the patient is very important part of psychiatric case history, as this helps to assess the current status of illness. When you go to a doctor for any medical problem, she/he examines your pulse, BP, respiration rate etc. to understand your symptoms and to make diagnosis on the basis of the findings. Similarly, mental status examination is the process of eliciting symptoms and signs of psychiatric illness to formulate diagnosis of the patients.

Important points to keep in mind while conducting the practicals:

- 1. Be sensitive to your respondents as some need more time to think about the questions.**
- 2. You can change the order of some questions during the interview depending on how the conversation between you and the respondent progresses.**
- 3. You should record or document responses that you gathered in the interview for future references.**
- 4. Your report for the practicals should include the case history and mental status examination of the patients/respondents/clients.**



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PART-II
PRACTICALS 1 - 12
(Involving Case History Taking and Mental
Status Examination)
&
THE TOOLS TO BE USED



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PART - II

PRACTICALS 1-12 & THE TOOLS TO BE USED

INTRODUCTION

In this Part, details regarding the following practicals are given:

- | | |
|--------------|-----------------------------------------------------------------------------------------------------|
| Practical 1 | Case History Taking and Mental Status Examination of a Young Adult - Male |
| Practical 2 | Case History Taking and Mental Status Examination of a Young Adult - Female |
| Practical 3 | Case History Taking and Mental Status Examination of an Individual in Middle Adulthood - Male |
| Practical 4 | Case History Taking and Mental Status Examination of an Individual in Middle Adulthood - Female |
| Practical 5 | Case History Taking and Mental Status Examination of an Old Person - Male |
| Practical 6 | Case History Taking and Mental Status Examination of an Old Person - Female |
| Practical 7 | Case History Taking and Mental Status Examination of a Preschool Child - Male |
| Practical 8 | Case History Taking and Mental Status Examination of a Preschool Child - Female |
| Practical 9 | Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years - Male |
| Practical 10 | Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years - Female |
| Practical 11 | Case History Taking and Mental Status Examination of an Adolescent - Male |
| Practical 12 | Case History Taking and Mental Status Examination of an Adolescent - Female |

The tools to be used for history taking and mental status examination of individuals are also given, viz.

- | | |
|----------|----------------------------------------------------------|
| Tool 1: | Case History Taking for Adult |
| Tool 2 : | Mental Status Examination Inventory for Adult |
| Tool 3: | Case History Taking for Child/Adolescent |
| Tool 4: | Mental Status Examination Inventory for Child/Adolescent |

Now we would explain in detail how to go about the above mentioned practicals by following the given instructions like writing aim, objectives, method, tools, findings, analysis and discussion, provisional diagnosis, management plan/ conclusion, and current treatment and observations/ reflections. You need to, of course, do all the 12 practicals using the tools given in the Manual.

**FORMAT TO BE USED FOR DOING AND WRITING DOWN
THE REPORT OF THE PRACTICALS**

TITLE : Practical Activity ... (e.g. '1')—Case History Taking and Mental Status Examination of (e.g., 'a Young Adult - Male')

(In the Practical Title, the individual mentioned would change as per the practical number)

AIM:

Case history taking and mental status examination of (e.g., 'a Young Adult - Male')

(Under 'Aim', the individual mentioned would change as per the practical number)

OBJECTIVES:

After undertaking this Practical activity, you will be able to:

- Understand the importance of psychiatric case history taking and mental status examination;
- Know method of taking psychiatric case history in (e.g., 'a Young Adult - Male');
- Apply skills of case history taking in clinical practice;
- Know method of conducting mental status examination in (e.g., 'a Young Adult - Male'); and
- Apply skills of assessing mental status of patient.

(Under 'Objectives', the individual mentioned would change as per the practical number)

METHOD:

Materials Required:

Interview schedule for case history taking, Tool for mental health status examination, pen, paper, tape recorder.

Note: The tools for case history taking and mental status examination are given in this Section. Use the ones relevant for the individual whom you have identified for the specific Practical. Thus, for Practicals 1-6, you will use Tool 1 (meant for case history taking for Adult), and Tool 2 (Mental Status Examination Inventory for Adult). Likewise, for Practicals 7-12, you would use Tool 3 (Case History Taking for Child/Adolescent) and Tool 4 (Mental Status Examination Inventory for Child/Adolescent).

Sample - The individual identified for the Practical would be as per the title of the Practical. *Please refer to Course MCFT-001 for the age groups to be selected for each practical.*

Procedure:

Identify a patient from the desired age group. Explain the respondent about the practical activity and convince her or him, and/or the family to give you an interview. Take a detailed case history and mental status examination (MSE) by using the given tools. Remember, the schedule is only a broad guideline. If need be, you can ask more questions or probe further in order to get detailed and complete information about a topic in the interview. Remember that the patient has to be accompanied by another person who would be an informant for you and help in answering your questions. Be sensitive to your respondents. Some of them may want to take some time to think about the questions. You can also change the order of some sections in the interview, depending on how the conversation between you and the respondent progresses. On an average, the interview should take about 1½ -2 hours. You must record or document the responses you gathered in the interview, especially for discussions with your Academic Counsellor and writing report for this practical, and enclose the same in your file. You may use a tape recorder for recording purpose, after seeking permission from the respondent. Your report for this practical should include the case history and mental health status of your respondent and the CD/Tape/Written Sheets on which the interview was recorded. Refer to the instructions given later for analysis and report writing for the same.

FINDINGS:

(This would include data obtained from administering the tool of case history taking and tool for mental status examination.)

.....
.....
.....

In this section, you must enclose the written record of the interview as it look place. Thereafter, write out the following information on the basis of the interview. You must also enclose in the File the CD containing the audio recording or the audio tape if used, or the written sheets (on which you noted the answers of the respondent during the interview). In this Section, you need to state the information obtained through interview with the subject and the other informant(s) as well as that obtained through your own observations. You may use the format of the tools for the purpose.

ANALYSIS AND DISCUSSION:

.....
.....
.....

In this section you have to write down your inference and analysis of the observations you have made about the individual. Analyse the behaviour and characteristics of the individual.

CONCLUSIONS:

.....
.....
.....

In this section you have to conclude this practicum in about 500-750 words. Here you have to record the inferences that you have been able to draw on the basis of this practical activity. Broadly, you need to focus on the findings and the interpretations of the same.

REFLECTIONS:

.....
.....
.....

You may state how you went about this practicum activity, and how your respondents reacted towards you. Note down any particular behaviour of the respondent/patient which you came across like too self conscious, adjusting dress or hair constantly, etc. Write your inner self experience in this whole practicum. In a simple paragraph of about 250 words, reflect on your experience while performing this practical.



TOOLS

You can use the following formats to elicit information from the patient and accompanying informant who is generally a family member staying with the patient or some close friend/relative.

Tool 1 Case-History Taking of an Adult

A) Background Information of Patient:

Date of assessment:

Name:

Age of patient/respondent:

Date of Birth:

Sex:

Education:

Occupation:

Residence:

Family Structure: Nuclear/Joint/Other

Background Information of Informant:

Name of the informant:

Relationship with the patient:

Length of acquaintance:

Adequacy of information:

Reliability of information:

B) Specific Information

1. Presenting complaints (Chief complaints to come to the hospital or seek intervention/help)

According to patient:

According to informant:

2. Duration of illness

How long the patient has been ill?

.....Days / months / years

3. Precipitating Factors

Onset (acute or gradual):

Course of illness (time when the patient is unwell and period when he/she feels better)

There could be some events for example, marriage, and change of job which could precipitate an illness. Find out if any such things have happened in the patient's life before the illness started.

.....

.....

4. Family History

Family type: Nuclear/ Extended/ Joint

Socio-economic status: Upper/ Middle/ Lower

Family tree:

S.No	Relation with patient	Age	Education	Occupation	Health	Personality

Family interaction and communication:

.....

Family history of psychiatric illness:

.....

Personal history

Date of birth:

Place of birth:

Mother's condition during pregnancy:

Full term birth/ normal delivery/others:

Any delay in early development and milestones (for example: neck holding sitting, walking, talking etc.): Yes/ No

If yes, please mention:

Neurotic symptoms in childhood (like temper tantrums): Yes/ No

If yes, please mention:

Night terrors: Yes/ No

Behaviour problems like thumb sucking or nail biting etc.: Yes/No

If yes, please mention:

Health during childhood

If patient suffered from any childhood infections or illness? Yes/ No

If yes, please mention if there was any effect of illness on development?

.....

If patient suffered from any infantile convulsions? Yes/No

School:

Special abilities/disabilities:

Performance in academics:

Number of friends:

Relationship with peers:

Participation in co-curriculum activities like drama/sports etc.:

Hobbies and interests:

Occupation

Age of starting work:

Ambition in life:

Present jobs held:

- Designation:

- Wages:

Satisfaction in work:

Present economic conditions:

Menstrual history (for female patients)

Age of 1st period:

Regularity/duration:

Amount of pain:

Sexual inclinations and practice

Sexual information/how acquired:

Masturbation/sexual fantasies:

Homosexuality/hetero sexuality:

Marital history

Spouse's age:

Occupation:

Personality:

Compatibility:

Pre-morbid Personality

Ask from patient and informant to describe her or his personality before the illness started. Like:

- i) Social relations with
 - Family:
 - Friends:
 - Relatives:
 - Societies:
 - Workmates:
- ii) Intellectual activities like:
 - Hobbies:.....
 - Interests:.....
 - Memory:
 - Observation:
 - Judgement:
- iii) Mood of patient:
 - Bright/cheerful:.....
 - Despondent:
 - Optimistic :.....
 - Pessimistic:
 - Self depreciative:
 - Satisfied:.....
 - Stable:
 - Unstable:
- iv) Character
 - Attitude to work or responsibility:.....
 - Interpersonal relationships:.....
 - Standards in religious/social/health matters:.....
- v) Fantasy life
 - Frequency and content of day dreaming:
- vi) Habits
 - Eating/alcohol consumption:
 - Self medication:
 - Tobacco consumption:.....

Mode and frequency of sexual intercourse: **Case History Taking and Mental Status Examination**

Sexual satisfaction:

Contraceptive measures:

Children

Chronological list of children and miscarriages:

.....

S.No.	Year of birth	Name	Sex	Personality

Medical history

Has the patient undergone any:

- illness
- operation
- accidents
- surgical problem

If yes, Please mention:

Past psychiatric history

Information of patient's past psychiatry record:

- Dates:
- Duration:
- Symptoms:
- Diagnosis:
- Treatment:

Tool 2
Mental Status Examination Inventory for Adults

This is systematic observation on a standard format. Use the following format to observe the patient and ask the following questions.

D) General Appearance of Behaviour

(This comprises of a brief description regarding the patient's appearance, behaviour and manner of relating to the examiner. This helps to elicit any abnormalities that might be evident in the way the person appears and relates to the examiner, for example, a patient suffering from a psychotic episode may not be able to establish base on support with the examiner. He/she may look overdressed or untidy and may not cooperate with the examiner.)

i) General appearance

Record the following observations:

- Physique of body build:

Approximate height:

Weight:

Appearance:

- Looks: Comfortable/Uncomfortable
- Physical health:

Grooming:

Hygiene:

Self care:

Dressing: appropriate/adequate/any peculiarities

- Non verbal expression :
- Mood:
- Effeminate/masculine:

ii) Attitude towards the examiner/counsellor

Is the patient

- Cooperative
- Guarded
- Evasive
- Hostile
- Attentive
- Interested/disinterested/apathetic
- Any odd behaviour

iii) Comprehension

Can patient understand your questions?

- Intact/impaired (Partially/fully)

iv) Gait and posture

Posture	Normal	Abnormal
Way of sitting		
Standing		
Walking		

v) Motor Activity

This is observed while interacting with the patient.

- Increased/Decreased
- Excitement/Stupor
- Abnormal involuntary movements : Tics, Tremors
- Restlessness
- Catatonic signs:
 - Mannerisms (habitual involuntary movement)
 - Stereotypes (repetitions of physical activities)
 - Posturing (strange, fixed and bizarre bodily positions)
 - Waxy flexibility (condition in which person maintains the body position in which he or she is placed)
 - Negativism (verbal or non-verbal opposition to suggestion)
 - Ambitendency (making series of movements that don't reach the goal)
 - Stupor (state of decreased activity and less awareness of surroundings)
 - Echolalia (repetitions of words or phrases)
- Social withdrawal/autism
- Compulsive Acts:
- Rituals:
- Habits:

vi) Social manner with non verbal behaviour

- Increased
- Decreased
- Inappropriate

Eye contact: Gaze aversion
 Staring vacantly
 Hesitant eye contact
 Normal eye contact

vii) Rapport

Whether a working empathetic relationship can be established with the patient?

Yes/ No

viii) Hallucinatory behaviour

Ask the patient if she or he hears some voices in absence of any external stimuli or whether the family members notice the following kinds of behaviors in the patient:

- Smiling or crying without any reason
- Muttering/ talking to self (non social speech)
- Odd gesturing in response to auditory/visual/factory stimuli
- Tactile hallucinations

II) SPEECH

During the interview observe the rate of speech, new words being coined, stammering and articulation problem. The content of speech is also important to make diagnosis e.g. a manic patient will be over talkative and depressed patient will talk after lots of persuasion. You may record the rate of speech e.g. fast or slow, volume and tone of speech.

i) Rate with quantity of speech

Observe the patient during the interview for the following:

- Speech: Present/Absent
- Spontaneous speech: Yes/No
- Productivity: Increased/Decreased
- Rate: Increased/Decreased/Appropriate
- Pressure or poverty of speech:

ii) Volume with tone of speech

On the basis of your interaction with the patient notice whether the speech is:

- Increased/decreased (its appropriateness)
- Low/high/normal pitch

iii) Flow with rhythm of speech

Observe the patient's speech, whether it is:

- Smooth/hesitant

- Sudden blocking (disruption of thought or break in flow)
- Derailment (breakdown in logical connections between ideas)
- Stuttering/stammering
- Circumstantialities (including irrelevant details and returning to the point)
- Tangentiality (responding to the topic being discussed but not answering the question posed)
- Word salad (incoherent mixture of words)
- Verbal stereotypy (repeating similar words again and again)
- Flight of ideas (shifting from one idea to the next)
- Clang association (thoughts associated with sounds rather than words e.g., bang, lang, tang)

III) Mood with affect

Inquire from the patient how her or his mood is usually. This helps to elicit the emotions felt by the person cross-sectionally and over a period of time. Example, a patient suffering from a depressive episode may describe his predominant feelings as that of sadness and appear as feeling depressed.

Mood (Pervasive feeling tone, which is sustained, total experience of a person)

Observe and inquire the patient about the following:

i) Quality of mood

Subjectively: How do you feel?

Objectively: By examination

ii) Stability of mood: Over a period of time

iii) Reactivity of mood: Variation in mood with stimuli

iv) Persistence of mood: Length of time the mood lasts

Affect (Outward expression of the immediate experience of emotion at a given time)

Based on your readings regarding the characteristics of the descriptors below, observe whether the patient's demeanor reflects the following:

i) Quality of affect

ii) Range of affect (of emotional changes displayed over time)

iii) Depth or intensity of affect: Normal/increased/blunted

iv) Appropriateness of affect: In relation to thought and surrounding environment

- vi) **Anxiety:** Anxious, restless
- vii) **Depression:** anxious, restless, sad, irritable, angry, anhedonia
- viii) **Schizophrenia:** Shallow, blunted, indifferent, restricted, inappropriate, labile, anhedonia

IV) Thought

It helps to elicit the patient's thoughts and ideas, as well as communicates their attitude towards various aspects of their life. E.g., a patient suffering from psychosis may express that other persons are plotting against him or that the newspaper and T.V sets are broadcasting his thoughts.

i) Stream and form of thought

Based on the way the person verbally interacts with the examiner, the following observations regarding the thought can be made:

- Spontaneity: Present/Absent
- Productivity: Present/Absent
- Flight of ideas (shifting from one idea to the next) : Present/Absent
- Proximity/ordered flight of ideas: Present/Absent
- Poverty of content of speech: Present/Absent
- Thought blocking (sudden disruption in flow of thoughts): Present/Absent
- Continuity of thought: Present/Absent
- Relevant to questions asked: Yes/ No

Observe the following behaviour in patient:

- Any loosening of associations: Present/ Absent
- Tangential circumstantialities: Present/Absent
- Illogical thinking: Present/Absent
- Preservation: Present/ Absent
- Variegation: Present/Absent

ii) Content of thought

- Obsessions: Present/ Absent
- Contents of phobia: Present/ Absent
- Delusion: Present/Absent
- Over valued ideas: Present/ Absent

Observe the following contents in thoughts of the patient:

- Ideas of persecution :

- Grandeur :
- Love :
- Jealousy :
- Guilt :
- Nihilism:
- Poverty :
- Somatic symptoms :
- Hopelessness :
- Haplessness :
- Worthlessness :
- Suicidal ideation :

V) Perception

This helps to understand how the patient makes sense of her or his environment and processes information. For example, a person suffering from paranoia may perceive that her or his family members are plotting against her or him or wanting to poison her or him.

i) Hallucinations

- Auditory/visual/olfactory/gustatory/tactile (whether the patient hears voices discussing something about him/her, smells any unusual odours, feels certain sensations in the absence of any external stimuli): Yes/No
- Elementary (sounds) or complex (voices) (hears certain sounds like the dripping of a tap or a sound which is repetitious in nature): Yes/No
- What is heard/how many voices, when, male or female, 2nd or 3rd person?
.....
- During wakefulness / hypnagogic (while going to sleep) or hypnopompic (while getting up from sleep) for example, sees a human figure while falling asleep or waking up? Yes/ No

ii) Ask the patient regarding whether she or he reports to have experienced any of the following:

- Illusions/misinterpretations (misperception of certain stimuli like mistaking a rope for a snake): Yes/No
- Depersonalization/de-realization (feelings of unreality regarding self or the environment): Yes/No
- Somatic passivity phenomenon (feeling that any external agency is controlling one's actions like making one do certain acts): Yes/No

VI. Cognitive Assessment

This helps to assess the patient's higher mental functions. For example, a person suffering from delirium may have confusion in thought.

i) Consciousness

Check for whether person is in a wakeful state by observing her or him as well as through the way she or he responds verbally and non-verbally towards the examiner.

- Conscious
- Confusion
- Somnolence
- Clouding
- Delirium
- Stupor
- Coma

ii) Orientation

- Time: Ask Time:.....
Date:
Day:
Month:
Year:
Reason:
Time spent in hospital (if applicable) :.....
- Place: Ask present Location:.....
Building:
City:
- Person: Ask Name:
Her or his role in the setting:
People around him/her:

iii) Attention

- Easily aroused/sustained
- Can repeat digit

iv) Concentration

- 100 – 7 test
- 40 – 3 test (keep on subtracting 3 from 40 until he/she reaches 0 like 40, 37, 34)
- Count backward from 20

v) **Memory**

- Immediate memory

Digit span test (ask the patient to repeat the digits spoken by the examiner forwards or backwards)

- Recent memory

Ask how did the patient come to the room? :

What foods did he/she have for breakfast? :

What foods did he/she have the previous night? :

- Remote memory

Birth date:

Date/place of marriage:

Any relevant questions from past:

vi) **Intelligence**

- General information

E.g. Current Prime Minister, capital of India or any state etc.

- Simple tests of calculations (e.g., 4 + 5?)

vii) **Abstract thinking**

- Proverb testing: Atleast 3 simple proverbs, for example, the examiner should ask the patient what does it means. - ‘every cloud has a silver lining’, ‘people who live in glass houses should not throw stones’, ‘Sour grapes’.

- Similarities with analogies: For example, ask “what is similar between banana and orange, dog and cat, table and chair?”.

VII. Insight

This describes the acceptance of whether a patient feels she or he is suffering from an illness as well as whether she or he is able to understand the factors which may have caused the illness. Example, a person suffering from obsessions and compulsions may communicate that she or he is having repeated thoughts which compel her or him to wash hands repeatedly and that these thoughts are irrational. On the other hand, a patient who is having hallucinations or delusions says that he/she doesn't have a problem and says that she/he is normal is said to have an insight rating of 1, that is, she or he has no insight about her/his illness.

Insight is rated on 6 points scale given below:

1. Complete denial of illness. Yes/No
2. Slight awareness of being sick and needing help, but denying it at the same time. Yes/ No

3. Awareness of being sick, but it is attributed to external or physical factors. Yes/No
4. Awareness of being sick, due to something unknown in self. Yes/No
5. Intellectual insight : Awareness of being ill, and that the symptoms/ failures in social adjustment are due to over particular irrational feelings/ thought; yet does not apply this knowledge to the current/future experiences. Yes/No
6. True emotional insight: Awareness of being ill leads to significant basic changes in the future behaviors and personality. Yes/No

VIII) JUDGEMENT

This section involves whether a patient is able to communicate personal goals and respond to social situations in an appropriate manner. Example, the patient suffering from manic episode may sing and dance in the waiting area or during the interview and communicate that her or his goal is to be the president of India though it is not in accordance to her or his ability and education.

- i) Observed during interview, the ability to assess a situation currently and act appropriately in that situation like social judgement e.g., evaluation of personal judgement
- ii) Test judgement by asking what patient would do in particular situations:
 1. He is walking on the road, finds a sealed envelope with address and stamp lying on the street. What will he do?
.....
 2. He has gone to watch movie in a theatre, suddenly the theatre catches fire, what will he do?
.....
 3. If you find an injured child on the road, what would you do?
.....
 4. If it is raining outside, what should you do?
.....

Tool 3
Case History Taking for Child and Adolescent

The proforma for taking history in children and adolescents is given below. In this more emphasis is placed on early development and adjustment in school. In this proforma, use only what is relevant with your respondent and for other items, you may write 'not relevant' or 'not applicable'.

Date of assessment:

Name:

Age of patient/respondent:

Date of Birth:

Sex:

Education:

Occupation:

Residence:

Family Structure: Nuclear/Joint/Other

Background Information of Informant:

Name of the informant:

Relationship with the patient:

Length of acquaintance:

Adequacy of information:

Reliability of information:

B) Specific Information

1. Presenting complaints (Chief complaints to seek intervention/help)

According to patient:

According to informant:

2. Duration of illness

How long the patient has been ill?

..... Days / months / years

3. Precipitating Factors

Onset (acute or gradual):

Course of illness (time when the patient is unwell and period when she/he feels better)

There could be some events for example, birth of a sibling or change of school, which could precipitate an illness. Find out if any such things have happened in the patient's life before the illness started.

.....
.....
.....

4. Family History

Family type: Nuclear/ Extended/ Joint

Socio-economic status: Upper/ Middle/ Lower

Family tree:

S.No.	Relation with patient	Age	Education	Occupation	Health	Personality

Family interaction and communication:
.....

Family history of psychiatric illness:
.....

1. PERSONAL AND DEVELOPMENTAL HISTORY

History of Early Development

1. Parental attitude towards pregnancy: wanted/unwanted
2. Mother's health during pregnancy
 - (i) Any illness
 - (ii) X-ray exposure
 - (iii) Prolonged drug administration
 - (iv) Attempted abortion
 - (v) Any other
3. Nature of birth:
 - (i) Full term normal delivery
 - (ii) Premature birth
 - (iii) Instrumental or operation
 - (iv) Complicated delivery.....
 - (v) Head injury

(vi) Jaundice, cyanosis

(vii) Delayed cry after birth

4. Feeding habits in early childhood :

(i) Breast

(ii) Bottle

5. Age of :

(i) Neck holding

(ii) Tooth eruption.

(iii) Sitting

(iv) Standing (unsupported)

(v) Walking

(vi) First word

(vii) Three-word sentence

(viii) Bowel control

(ix) Bladder control.....

Developmental problems (if any) of speech, language, motor function.

.....
.....
.....

Any delay in early development and milestones (for example: neck holding, sitting, walking, talking etc.): Yes/ No

If yes, please mention:

Neurotic symptoms in childhood (like temper tantrums): Yes/ No

If yes, please mention

Night terrors: Yes/ No

Behaviour problems like thumb sucking or nail biting etc.: Yes/ No

If yes, please mention:

Health during childhood

If patient suffered from any childhood infections or illness? Yes/ No

If yes, please mention if there was any effect of illness on development?

.....

If patient suffered from any infantile convulsions? Yes/ No

Special abilities/disabilities:

Performance in academics:

Number of friends:

Relationship with peers:

Participation in co-curriculum activities like drama/sports etc.:

Hobbies and interests:

Occupation

Age of starting work:

Ambition in life:

Present jobs held: - Designation:

- Wages:

Satisfaction in work:

Present economic conditions:

Menstrual history (for female patients)

Age of 1st period:

Regularity/duration:

Amount of pain:

Sexual inclinations and practice

Sexual information/how acquired:

Masturbation/sexual fantasies:

Homosexuality/heterosexuality:

Marital history (if early marriage)

Spouse's age:

Occupation:

Personality:

Compatibility:

Mode and frequency of sexual intercourse:

Sexual satisfaction:

Contraceptive measures:

Chronological list of children and miscarriages:

S.No.	Year of birth	Name	Sex	Personality

SOCIAL AND PERSONAL HISTORY

- 1. Habits
 - (a) Sleep:
 - (i) Normal
 - (ii) Over-eating
 - (b) Feeding
 - (i) Fussy
 - (ii) Over-eating
 - (iii) Others.....
 - (c) Personal care:
 - (i) Adequate
 - (ii) Unkempt
- 2. Neurotic traits
 - (i) Nail biting
 - (ii) Thumb sucking
 - (iii) Morbid fears of persons, animals, darkness
 - (iv) Nightmares
 - (v) Night terrors
 - (vi) Obstinance

- (vii) Temper tantrums
- (viii) Enuresis, Encopresis beyond 3 years

3. Behaviour problems

- Stealing
- Lying
- Truancy
- Disobedience
- Others

4. Play:

- individual/group
- companies: a few/many
- older/younger/same age
- good/bad/both/others

5. Sexual history – masturbation, preoccupation

Normal/Malpractices

Medical history

Has the patient undergone any:

- Illness
- Operation
- Accident
- Surgical problem

If yes, please mention:

Past psychiatric history

Information of patient's past psychiatry record:

- Dates:
- Duration:
- Symptoms:
- Diagnosis:
- Treatment:

Pre-morbid Personality

Ask from patient and informant to describe her or his personality before the illness started. Like:

- i) Social relations with

- Family:
 - Friends:
 - Relatives:
 - Societies:
 - School mates:
 - ii) Intellectual activities like
 - Hobbies:
 - Interests:
 - Memory:
 - Observation:
 - Judgement:
 - iii) Mood of patient
 - Bright/cheerful:
 - Despondent:
 - Optimistic :
 - Pessimistic:
 - Self depreciative:
 - Satisfied:
 - Stable:
 - Unstable:
 - iv) Character
 - Attitude to work or responsibility:
 - Interpersonal relationships:
 - Standards in religious/social/health matters:
 - v) Fantasy life
 - Frequency and content of day dreaming:
 - vi) Habits
 - Eating/alcohol consumption:
 - Self medication:
 - Tobacco consumption:
- III. EDUCATIONAL HISTORY**
1. Qualified upto

2. Educated at
 - (i) home
 - (ii) school
 - (iii) hostel
3. Started reading at..... years
4. Educational problems (if any)
 - (i) poor progress
 - (ii) repeated absences
 - (iii) poor peer relationships
 - (iv) problem with teachers,
 - (v) scholastic skills development
 - (vi) any others.

(also make a global assessment of functioning at school here)
5. Failures if any
Class no. of failures
6. Problem in attention, concentration, difficulty with any particular subject.

TEMPERAMENTAL CHARACTERISTICS

- Activity
- Rhythmicity
- Approach-Withdrawal
- Adaptability
- Mood
- Intensity of Reaction
- Threshold of Responsiveness
- Attention-Span
- Persistence
- Distractibility in infancy and later stages

FAMILY HISTORY

1. Family Tree [with age, sex, personality descriptions and any history of (h/o) mental illness in the family]
.....
.....

2. Family functioning (any discord between family members, lack of interaction or communication, any problems with the family as a whole, e.g. isolated family).

.....
.....
.....

3. Parent-child interaction (lack of warmth, hostility towards/scapegoating of child, abuse)

.....
.....
.....

F) PATTERNS OF PARENTAL FUNCTIONING:

Permissiveness/rigidity.....

Consistency/inconsistency

Strictness of discipline/liberal (any inappropriate supervision)

Approval of interests/disapproval

Protectiveness/non-protectiveness (any overprotection)

Toleration of deviance/non-toleration

Expectations from the child (any pressures, deprivation)

Reactions towards the illness

SOCIAL AND ENVIRONMENTAL CONDITIONS

(Mention any aspect of living conditions which you might consider stressful for the child)

Type of dwelling

Degree of crowding

Type and amount of help in the care of child

Affluence of the family/degree of financial stress

SPECIAL ENVIRONMENTAL CIRCUMSTANCES

(like birth, death, illness, accident, divorce, hospitalization, etc, in the family. If present, mention the effect of the life event on the child, e.g. on self-esteem.)

.....
.....
.....
.....
.....

Tool 4

Mental Status Examination of Child/Adolescent

This is systematic observation on a standard format. Using the following format, you have to observe the patient and ask the following questions.

I) General Appearance of Behaviour

(This comprises of a brief description regarding the patient's appearance, behaviour and manner of relating to the examiner. This helps to elicit any abnormalities that might be evident in the way the person appears and relates to the examiner, for example, a patient suffering from a psychotic episode may not be able to establish base on support with the examiner. She/he may look overdressed or untidy and may not cooperate with the examiner.)

i) General appearance

Record the following observations:

- Physique of body build:

Approximate height:

Weight:

Appearance:

- Looks: Comfortable/Uncomfortable

- Physical health:

Grooming:

Hygiene:

Self care:

Dressing: appropriate/adequate/any peculiarities

- Non verbal expression :

- Mood:

- Effeminate/masculine:

ii) Attitude towards the examiner/counsellor

Is the patient

- Cooperative
- Guarded
- Evasive
- Hostile
- Attentive
- Interested/disinterested/apathetic

iii) Comprehension

Can patient understand your questions?

- Intact/impaired (Partially/fully)

iv) Gait and posture

Posture	Normal	Abnormal
Way of sitting		
Standing		
Walking		

v) Motor Activity

This is observed by the student while interacting with the patient.

- Increased/Decreased
- Excitement/Stupor
- Abnormal involuntary movements : Tics, Tremors
- Restlessness
- Catatonic signs:
 - Mannerisms (habitual involuntary movement)
 - Stereotypes (repetitions of physical activities)
 - Posturing (strange, fixed and bizarre bodily positions)
 - Waxy flexibility (condition in which person maintains the body position in which he or she is placed)
 - Negativism(verbal or non-verbal opposition to suggestion)
 - Ambitendency (making series of movements that don't reach the goal)
 - Stupor (state of decreased activity and less awareness of surroundings)
 - Echolalia (repetitions of words or phrases)
 - Social withdrawal/autism
 - Compulsive Acts:
 - Rituals:
 - Habits:

vi) Social manner with non verbal behaviour

- Increased
- Decreased
- In appropriate

Eye contact: Gaze aversion

Staring vacantly

Hesitant eye contact

Normal eye contact

vii) Rapport

Whether a working empathetic relationship can be established with the patient?
Yes/ No

viii) Hallucinatory behaviour

Ask the patient if she or he hears some voices in absence of any external stimuli or whether the family members notice the following kinds of behaviours in the patient:

- Smiling or crying without any reason
- Muttering/talking to self (non social speech)
- Odd gesturing in response to auditory / visually/olfactory stimuli
- Tactile hallucinations

II) SPEECH

During the interview observe the rate of speech, new words being coined, stammering and articulation problem. The content of speech is also important to make diagnosis e.g. a manic patient will be over talkative and depressed patient will talk after lots of persuasion. You may record the rate of speech e.g. fast or slow, volume and tone of speech.

i) Rate with quantity of speech

Observe the patient during the interview for the following:

- Speech: Present/Absent
- Spontaneous speech: Yes/ No
- Productivity: Increased/Decreased
- Rate: Increased/Decreased/Appropriate
- Pressure or poverty of speech:

ii) Volume with tone of speech

On the basis of your interaction with the patient notice whether the speech is:

- Increased/decreased (its appropriateness)
- Low/high/normal pitch

iii) Flow with rhythm of speech

Observe the patient's speech, whether it is:

- Smooth/hesitant

- Derailment (breakdown in logical connections between ideas)
- Stuttering/stammering
- Circumstantialities (including irrelevant details and returning to the point)
- Tangentiality (responding to the topic being discussed but not answering the question posed)
- Word salad (incoherent mixture of words)
- Verbal stereotypy (repeating similar words again and again)
- Flight of ideas (shifting from one idea to the next)
- Clang association (thoughts associated with sounds rather than words; eg., bang, lang, tang)

III) Mood with affect

Inquire from the patient how her or his mood is usually. This helps to elicit the emotions felt by the person cross-sectionally and over a period of time. Example, a patient suffering from a depressive episode may describe her/his predominant feelings as that of sadness and appear as feeling depressed.

Mood (Pervasive feeling tone, which is sustained, total experience of a person)

Observe and inquire the patient about the following:

- Quality of mood**
Subjectively: How do you feel?
Objectively: By examination
- Stability of mood:** Over a period of time
- Reactivity of mood:** Variation in mood with stimuli
- Persistence of mood:** Length of time the mood lasts

Affect (Outward expression of the immediate experience of emotion at a given time)

Based on your readings regarding the characteristics of the descriptors below, observe whether the patient's demeanor reflects the following:

- Quality of affect**
- Range of affect** (of emotional changes displayed over time)
- Depth or intensity of affect:** Normal/increased/Blunted
- Appropriateness of affect:** In relation to thought and surrounding environment
- Mania:** Euphoria, elation, exaltation, ecstasy.
- Anxiety:** Anxious, restless

- vii) **Depression:** anxious, restless, sad irritable, angry, anhedonia
- viii) **Schizophrenia:** Shallow, blunted, indifferent, restricted, inappropriate, labile, anhedonia

IV) Thought

It helps to elicit the patient's thoughts and ideas as well as communicate their attitude towards various aspects of their life. E.g., a patient suffering from psychosis may express that everyone is plotting against him or that the newspaper and T.V sets are broadcasting his thoughts.

i) Stream and form of thought

Based on the way the person verbally interacts with the examiner, the following observations regarding the thought can be made:

- Spontaneity: Present/Absent
- Productivity: Present/Absent
- Flight of ideas (shifting from one idea to the next) : Present/Absent
- Prolivity/ordered flight of ideas: Present/Absent
- Poverty of content of speech: Present/ Absent
- Thought blocking (sudden disruption in flow of thoughts): Present/ Absent
- Continuity of thought: Present/Absent
- Relevant to questions asked: Yes/ No

Observe the following behaviour in patient:

- Any loosening of associations: Present/Absent
- Tangential circumstantialities: Present/Absent
- Illogical thinking: Present/Absent
- Preservation: Present/Absent
- Variegation: Present/Absent

ii) Content of thought

- Obsessions: Present/ Absent
- Contents of phobia: Present/ Absent
- Delusion: Present/Absent
- Over valued ideas: Present/ Absent

Observe the following contents in thoughts of the patient:

- Ideas of persecution :
- Reference :.....
- Grandeur :.....

- Love :
- Jealously :
- Guilt :
- Nihilism:
- Poverty :
- Somatic symptoms :
- Hopelessness :
- Haplessness :
- Worthlessness :
- Suicidal ideation :

V) Perception

This helps to understand how the patient makes sense of her or his environment and processes information. For example, a person suffering from paranoia may perceive that her or his family members are plotting against him or wanting to poison him.

.....

i) Hallucinations

- Auditory/visual/olfactory/gustatory/tactile (whether the patient hears voices discussing something about him/her, smells any unusual odors, feels certain sensations in the absence of any external stimuli). Yes/ No
- Elementary (sounds) or complex (voices) (hears certain sounds like the dripping of a tap or a sound which is repetitious in nature). Yes/ No
- What is heard/how many voices, when, male or female, 2nd or 3rd person?
.....
- During wakefulness/hypnagogic (while going to sleep) or hypnopompic (while getting up from sleep) for example, sees a human figure while falling asleep or waking up? Yes/ No

ii) Ask the patient regarding whether she or he reports to have experienced any of the following:

- Illusions/misinterpretations (misperception of certain stimuli like mistaking a rope for a snake). Yes/ No
- Depersonalization/de-realization (feelings of unreality regarding self or the environment). Yes/ No
- Somatic passivity phenomenon (feeling that any external agency is controlling one's actions like making one do certain acts). Yes/ No

VI. Cognitive Assessment

This helps to assess the patient's higher mental functions. For example, a person suffering from delirium may have confusion in thought.

i) Consciousness

Check for whether person is in a wakeful state by observing her or him as well as through the way she or he responds verbally and non-verbally towards the examiner.

- Conscious
- Confusion
- Somnolence
- Clouding
- Delirium
- Stupor
- Coma

ii) Orientation

- Time: Ask Time:.....
Date:
Day:
Month:
Year:
Reason:
Time spent in hospital:.....
- Place: Ask present Location:.....
Building
City:
- Person: Ask Name:
Her or his role in the setting:
People around him/her:

iii) Attention

- Easily aroused/sustained
- Can repeat digit

iv) Concentration

- 100 – 7 test
- 40 – 3 test (keep on subtracting 3 from 40 until he/she reaches 0 like 40, 37, 34)
- count backward from 20
- Names of months/days of week in reverse order

v) **Memory**

- Immediate memory

Digit span test (ask the patient to repeat the digits spoken by the examiner forwards or backwards)

- Recent memory

Ask how did the patient come to the room? :

What foods did he have for breakfast? :

What foods did he have the previous night? :

- Remote memory

Birth date:

Any relevant questions from past:

vi) **Intelligence**

- General information

E.g. Current Prime Minister, capital of India etc.

- Simple tests of calculations (e.g., 4 + 5?)

vii) **Abstract thinking**

- Proverb testing: At least 3 simple proverbs, for example, the examiner should ask the patient what does it mean—‘every dark cloud has a silver lining’, ‘people who live in glass houses should not throw stones’, ‘Sour grapes’.
- Similarities with analogies: For example, ‘ask what is similarity between banana and orange, dog and cat, table and chair’?

VII. Insight

This describes the acceptance of whether a patient feels she or he is suffering from an illness as well as whether she or he is able to understand the factors which may have caused the illness. Example, a person suffering from obsessions and compulsions may communicate that she or he is having repeated thoughts which compel her or him to wash hands repeatedly and that these thoughts are irrational.

For example, the patient who is having hallucinations or delusions says that he/she doesn't have a problem and says that he/she is normal is said to have an insight rating of 1, that is, he or she has no insight about his/her illness.

Insight is rated on 6 points scale given below:

1. Complete denial of illness. Yes/ No
2. Slight awareness of being sick and needing help, but denying it at the same time. Yes/ No
3. Awareness of being sick, but it is attributed to external or physical factors. Yes/ No

4. Awareness of being sick, due to something unknown in self. Yes/ No
5. Intellectual insight : Awareness of being ill, and that the symptoms/failures in social adjustment are due to over particular irrational feelings/thought; yet does not apply this knowledge to the current/future experiences. Yes/ No
6. True emotional insight. Awareness of being ill leads to significant basic changes in the future behaviours and personality. Yes/ No

VIII) JUDGEMENT

This section involves whether a patient is able to communicate personal goals and respond to social situations in an appropriate manner. Example, the patient suffering from manic episode may sing and dance in the waiting area or during the interview and communicate that her or his goal is to be the president of India though it is not in accordance to her or his ability and education.

- i) Observed during interview, the ability to assess a situation currently and act appropriately in that situation like social judgement e.g., evaluation of personal judgement
- ii) Test judgement by asking what patient would do in particular situations:
 1. You are walking on the road, and find a sealed envelope with address and stamp lying on the street. What will you do?
.....
 2. You have gone to watch movie in a theatre. Suddenly the theatre catches fire.What will you do?
.....
 3. If you find an injured child on the road, what would you do?
.....
 4. If it is raining outside, what should you do?
.....

PART-III

**ILLUSTRATIONS OF WRITTEN REPORTS
OF THE PRACTICALS**



PART 3

ILLUSTRATIONS OF WRITTEN REPORTS OF THE PRATICALS

- Illustration 1 : Understanding Case History Taking and Mental Status Examination of an Individual in Middle Adulthood
- Illustration 2 : Understanding Case History Taking and Mental Status Examination of a Young Adult
- Illustration 3 : Understanding Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years
- Illustration 4 : Understanding Case History Taking and Mental Status Examination of an Adolescent

Illustration 1 : Understanding Case History Taking and Mental Status Examination of an Individual in Middle Adulthood

AIM:

To understand the importance of case history taking and mental status examination of an adult in middle adulthood years - Male.

OBJECTIVES:

After undertaking this Practical activity, you will be able to:

- Understand the importance of psychiatric case history taking and mental status examination;
- Know method of taking psychiatric case history in adults;
- Apply skills of case history taking in clinical practice;
- Know method of conducting mental status examination in adult patients; and
- Apply skills of assessing mental status of patient.

METHOD:

Materials Required:

Interview schedule for case history taking, tool for mental health status examination, pen, paper, tape recorder.

Sample: 1) 47 year old man

Procedure:

I contacted Mr. QRS, who is 47 years of age, through a common contact to fulfill the aim of this practical. I had decided to take interview of Mr. QRS. I contacted Mrs. XYZ also who is his mother, 65 years old and his sister, 28 years old as informant. He lived in a nuclear family with his parents, and siblings. I approached the subject and his mother and explained the purpose of practicum activity to him with guidance of my supervisor (Counsellor). I sought their consent to conduct practicum activity. After asking some questions related to the programme M.Sc. (CFT) they agreed to provide desired information to conduct practicum activity. After some brief discussion, I started asking questions from given interview schedule. It took one hour to complete the interview schedule. I also noted the additional information in note pad which would help in report.

Tool 1: Proforma for Case-History Taking

FINDINGS:

I. History Taking:

A) Background Information of Patient:

Name:	QRS	Age/Sex:	47 / Male
Address:	16 street, 9 lane, Santa Cruz Mumbai		
Education:	Post Graduate		
Family Structure:	Nuclear		
Informant:	Mother and Younger Sister		
SES:	Upper middle Class Date of assessment: 19th Jan. 2020		
Occupation:	Unemployed		
Sibling: -	Younger Sister and younger brother		
Mother: -	Name: XYZ		
	Age: 65		
	Occupation: Housewife		
Father -	Name: LLS		
	Age: 68		
	Occupation: Business		
Sister: -	Name: SBB		
	Age: 28 years		
	Education: M.A Economics		
	Occupation: Service		
Younger Brother: -	Name: BHG		
	Age: 24		
	Education: B.A		
	Occupation: Sales job		

Background Information of Informant:

INFORMANT: Patient and his mother and younger sister

RELIABILITY: Reliable

ADEQUACY: Adequate

Presenting Complaints (According to informants):

- Is very suspicious of the family
- Distorted cognition — thinks that there is an agent who wants to harm his family and mix poison in his food.
- Has violent outbursts
- Complains of seeing old friends, teachers, bosses etc.
- Feels like somebody is trying to insert few words in his ears.
- Erratic (sleep before and after losing his job)
- Low appetite

Duration: Since May 2019

Precipitating Factors: Loss of job

Onset (acute or gradual): gradual

Course of illness- deteriorating/ worsening

History of Present Illness:

According to informant:

Started behaving violently and complained of seeing old teachers, friends, bosses etc. Said that there is an agent trying to harm his family and somebody is trying to insert few words in his ears.

March 2019- lost his well placed job in a reputed company due to recession

Family Medical/Psychological History:

Family type: Nuclear

Socio-economic status: Middle

Family tree:

S. No.	Relation with patient	Age	Education	Occupation	Health	Personality
1.	Father	68	BA	Business-man	Poor	Aggressive and Strict
2.	Mother	65	XIIth	Housewife	Poor	Submissive
3.	Younger Sister	28	M.A	Service	Healthy	Leadership
4.	Younger Brother	24	BA	Sale's job	Healthy	Introvert

Family interaction:

Strained interaction pattern among the family members. Also expectations from the patient being eldest son are high.

Family history of psychiatric illness:

Father is alcoholic and mother suffering from undiagnosed depression. First uncle (maternal) has psychiatric problem, currently unknown.

Personal History:

Date of birth: **15th August, 1973**

Place of birth: **Delhi**

Mother's condition during pregnancy: **Normal**

Birth and early developmental history:

- Pregnancy/Labor/Delivery: **The child was born of normal delivery.**
- Developmental milestones: **Had normal milestones.**
- Caretakers' Attitude: **Since he was first child therefore was pampered a lot by both parents.**
- Temperamental Style: **He was an aggressive and stubborn child.**

Any delay in early development and milestones (for example: neck holding, sitting, walking, talking etc.): **No**

Neurotic symptoms in childhood (like temper tantrums): **Yes**

If yes, please mention: **Used to cry out loud when his wish was not fulfilled**

Night terrors: **No**

Behaviour problems like thumb sucking or nail biting etc.: **Yes**

If yes, please mention: **Nail-biting**

Health during childhood

If patient suffered from any childhood infections or illness? **No**

If yes, please mention if there was any effect of illness on development? **No**

If patient suffered from any infantile convulsions? **No**

School

Special abilities/disabilities: **Good in academics**

Performance in academics: **Above average**

Number of friends: **Many**

Relationship with peers: **Friendly**

Participation in co-curriculum activities like drama/sports etc.: **Yes, active in extra-curricular activities**

Hobbies and interests: **Cricket and reading fiction novels, collecting stamps**

Occupation

Age of starting work: **24 years**

Ambition in life: **To be rich and successful**

Present jobs held: -Designation: **Manager**

- Wages: Rs. **30,000**

Satisfaction in work: **Was absent and wanted to work hard**

Present economic conditions: **Poor**

Sexual inclinations and practice

Sexual information/how acquired: **Inadequate and acquired through friends**

Masturbation/sexual fantasies: **Present**

Homosexuality/heterosexuality: **No**

Marital history - **Single**

Concurrent Medical History/ Past Medical History

Medical history

Has patient undergone any: **No**

- Illness
- Operation
- Accidents
- Surgical problem

Past Psychiatric History: Was treated for clinical depression in 2015.

Information of patient's past psychiatry record:

- Dates: **January, 2015**
- Duration: **1 year**
- Symptoms: **Pessimistic and negative thinking, low appetite, sadness, wanted to remain alone, disturbed sleep, suicidal thoughts etc.**
- Diagnosis: **Clinical Depression**
- Treatment: **Medication and individual counselling**

Pre-morbid personality:

- **Introvert**
- **Very caring and understanding**
- **Family oriented**
- **Very ambitious in life**
- **Hard working and dedicated**

- vi) Social relations with
 - Family: **Cordial but high expectations from the family members were persistent**
 - Friends: **Cordial**
 - Relatives: **Cordial**
 - Societies: **Cordial**
 - Workmates: **Cordial and friendly**
- vii) Intellectual activities like:
 - Hobbies: **Collecting stamps**
 - Interests: **Cricket**
 - Memory: **Adequate**
 - Observation: **Adequate**
 - Judgement: **Adequate**
- viii) Mood of patient:
 - **Cheerful, Despondent at sometime and Unstable**
- ix) Character
 - Attitude to work or responsibility: **Hard-working**
 - Interpersonal relationships: **cordial**
 - Standards in religious/social/health matters: **very religious**
- x) Fantasy life
 - Frequency and content of day dreaming: **to be rich and successful, very often**
- xi) Habits
 - Eating/alcohol consumption: **NO**
 - Self medication: **NO**
 - Tobacco consumption: **NO**

II. Mental Status Examination

D) **General Appearance of Behaviour**

- Physique of body build

Approximate height: **170 cm**

Weight: **82 kg**

Appearance: **untidy**

- Looks: **dirty**

- Physical health
 - Grooming: **neglected**
 - Hygiene: **neglected**
 - Self care: **neglected**
 - Dressing: **untidy**
- Non verbal expression : **straight look on the face**
- Mood: **irritable**
- Effeminate/masculine: **appropriate**
- ii) Attitude towards the examiner
 - The patient – **is guarded, evasive, and hostile and disinterested**
- iii) **Comprehension**
 - Can patient understand your questions?
 - **Intact (fully)**
- iv) **Gait and posture- Abnormal gait**
 - Way of sitting- **on the edge and guarded**
 - Standing – **excessive movements**
 - Walking- **normal**
- v) **Motor Activity**
 - This is observed by the student while interacting with the patient.
 - **QUANTITY: Increased**
 - **QUALITY:**
 - Abnormal involuntary movements : Tics, Tremors: **nil**
 - Restlessness: **present**
 - Catatonic signs:
 - Mannerisms (habitual involuntary movement): **present (rubbing hands firmly)**
 - Stereotypes (repetitions of physical activities): **verbal repetitions**
 - Posturing (strange, fixed and bizarre bodily positions): **absent**
 - Waxy flexibility (condition in which person maintains the body position in which he or she is placed.): **absent**
 - Negativism (verbal or non-verbal opposition to suggestion): **absent**
 - Ambitendency (making series of movements that don't reach the goal.): **absent**
 - Stupor (state of decreased activity and less awareness of surroundings): **absent**

- Echolalia (repetitions of words or phrases.): **absent**
- Social withdrawal: **present**
- Compulsive Acts: **absent**
- Rituals: **absent**
- Habits: **absent**

vi) Social manner with non verbal behavior: Inappropriate
Eye contact: **Avoid Gaze**

vii) Rapport

Whether a working empathetic relationship can be established with the patient? **No**

viii) Hallucinatory behaviour

Asked the patient if he hears some voices in absence of any external stimuli or whether the family members notice the following kinds of behaviours in the patient:

- Smiling or crying without any reason: **absent**
- Muttering/ talking to self (non social speech): **whispering**
- Odd gesturing in response to auditory/visual/olfactory : **present (visual)**
- Tactile hallucinations: **absent**

II) SPEECH

i) Rate with quantity of speech

Observe the patient during the interview for the following:

- Speech: **Present**
- Spontaneous speech: **No**
- Productivity: **Decreased**
- Rate: **Decreased**
- Pressure or poverty of speech: **Speech had delayed reaction time with lack in spontaneity, unpleasant tone with whispering and hesitant rate**

ii) Volume with tone of speech

On the basis of your interaction with the patient notice whether the speech is:

- **Decreased** (its appropriateness)
- **Low pitch**

iii) Flow with rhythm of speech

Observe the patient's speech, whether it is:

- Smooth/hesitant : **hesitant**

- Sudden blocking (disruption of thought or break in flow) : **present**
- Derailment (breakdown in logical connections between ideas): **absent**
- Stuttering/stammering: **absent**
- Circumstantialities (including irrelevant details and returning to the point.): **absent**
- Tangentiality (responding to the topic being discussed but not answering the question posed): **absent**
- Word salad (incoherent mixture of words): **present (neologism)**
- Verbal stereotypy (repeating similar words again and again): **Absent**
- Flight of ideas (shifting from one idea to the next): **absent**
- Clang association (thoughts associated with sounds rather than words. For eg., bang, lang, tang): **absent**

III) Mood with affect

Observed and inquired the patient about the following:

- i) Quality of mood
Subjectively: How do you feel?: **ok**
Objectively: By examination: **guarded and suspicious**
- ii) Stability of mood: **unstable**
- iii) Reactivity of mood: **unstable**
- iv) Persistence of mood: **one day**

Affect

- i) Quality of affect: **inappropriate**
- ii) Range of affect: **flat, blunted**
- iii) Depth or intensity of affect: **Blunted**
- iv) Appropriateness of affect: **inappropriate**
- v) Type: **Schizophrenia- present - Shallow, blunted, indifferent, restricted, inappropriate.**

IV) Thought

ii) **Stream and form of thought**

Based on the way the person verbally interacts with the examiner, the following observations regarding the thought are made:

- Spontaneity: **Absent**
- Productivity: **Absent**
- Flight of ideas (shifting from one idea to the next) : **Absent**

- Prolivity/ordered flight of ideas: **Absent**
- Poverty of content of speech: **Absent**
- Thought blocking (sudden disruption in flow of thoughts): **absent**
- Continuity of thought:**Absent**
- Relevant to questions asked: **Yes**

Observed the following behaviour in patient:

- Any loosening of associations: **Absent**
- Tangential circumstantialities: **Absent**
- Illogical thinking: **Absent**
- Preservation: **Absent**
- Variiegation: **Absent**

ii) Possession of thought:

- Obsessions and verbal compulsions: **absent**

Thought Alienation: present – (in terms of someone putting thoughts in his mind- thought insertion)

iii) Content of thought

- Obsessions: **Absent**
- Contents of phobia: **Absent**
- Delusion: **Present (false belief that he is an agent and other people are going to harm him)**
- Overvalued ideas: **Absent**

Observed the following contents in thoughts of the patient:

- Ideas of persecution : **Present**
- Reference : **Absent**
- Grandeur : **Absent**
- Love : **Absent**
- Jealously : **Absent**
- Guilt : **Absent**
- Nihilism : **Absent**
- Poverty : **Absent**
- Somatic symptoms : **Absent**
- Hopelessness : **Absent**

- Worthlessness : **Absent**
- Suicidal ideation : **Absent**

V) Perception

i) Hallucinations- Visual hallucinations are present — seeing his old teachers, boss etc. thus significant people who held higher or elder positions in his life.

- Auditory/visual/olfactory/gustatory/tactile (whether the patient hears voices discussing something about him/her, smells any unusual odors, feels certain sensations in the absence of any external stimuli). **Yes-visual**
- Elementary (sounds) or complex (voices) (hears certain sounds like the dripping of a tap or a sound which is repetitious in nature). **No**
- During wakefulness/hypnagogic (while going to sleep) or hypnopompic (while getting up from sleep) for example, sees a human figure while falling asleep or waking up? **No**

ii) Asked the patient regarding whether she/he reports to have experienced any of the following:

- Illusions/misinterpretations (misperception of certain stimuli like mistaking a rope for a snake): **No**
- Depersonalization/de-realization (feelings of unreality regarding self or the environment): **No**
- Somatic passivity phenomenon (feeling that any external agency is controlling one's actions like making one do certain acts): **No**

VI. Cognitive Assessment

i) Consciousness: Present

ii) Orientation

- Time : Asked- Time: **not sure**
- Date: **not sure**
- Day: **not sure**
- Month: **not sure**
- Year: **2020- present**
- Reason: **not sure**
- Time spent in hospital: **not sure**
- Place: Asked present Location:**could answer**
- Building:..... **not known**
- City: **not known**
- Person: Asked Name: **appropriate**

Her or his role in the setting: **not known**

People around him/her: **not sure**.....

iii) Attention: Easily aroused and difficult to sustain

- Can repeat digit - **yes**

iv) Concentration: absent

- 100 – 7 test
- 40 – 3 test (keep on subtracting 3 from 40 until he/she reaches 0 like 40, 37, 34)
- count backward from 20
- Names of months/days of week in reverse order

v) Memory: Appropriate

- Immediate memory

Digit span test (asked the patient to repeat the digits spoken by the examiner forwards or backwards) - **done accurately**

- Recent memory

Ask how did the patient come to the room? : **with sister and mother- Appropriate**

What foods did he have for breakfast? : **milk and bread** _____
Appropriate _____

What foods did he have the previous night? : **roti with sabji** _____
Appropriate _____

- Remote memory

Birth date: _____ **Appropriate** _____

vi) Intelligence

- General information- **not known properly**

E.g. Current Prime Minister, capital of India or any state etc.

- Simple tests of calculations (e.g., 4 + 5?)- **Appropriate**

vii) Abstract thinking

- Proverb testing: **not known properly**
- Similarities with analogies: **not known properly**

VII. Insight

Level-I, Complete denial of illness

VIII) JUDGEMENT- Inappropriate social, test and personal judgment according to his age

- You are walking on the road, and finds a sealed envelope with address and stamp lying on the street. What will you do?

_____ **not know** _____

- 2. You have gone to watch movie in a theatre. Suddenly the theatre catches fire. What will you do?
..... **not know**
- 3. If you find an injured child on the road, what would you do?
..... **not know**
- 4. If it is raining outside, what should you do?
..... **not know**

III. Analysis and Discussion

QRS, is a 47 year old, male, unmarried, educated up to post-graduation and living with parents and siblings in a nuclear family, hailing from middle socioeconomic strata. His mother and sister informed that his main complaints were suspicious thinking pattern, distorted cognition in terms of imagining oneself as agent and others harming him along with violent outbursts. He imagines seeing some significant old people, complains of someone inserting words in his mouth, erratic sleep and low appetite. Onset of symptoms was 1 year back with loss of his job; which are deteriorating further with disturbance in family, social and occupational functioning. His mother reported past psychiatric history of him being treated for clinical depression. Family psychiatric history revealed his father being an alcoholic, mother suffering from depression and his maternal uncle being treated for unknown disorder. MSE findings revealed hazy consciousness, untidy general appearance and neglected physical health. Also the attitude towards the examiner was guarded with avoided eye contact; gait was abnormal due to mannerism. Motor behaviour involves stereotypes in terms of such as rubbing hands firmly. Speech had delayed reaction time with lack in spontaneity, unpleasant tone with whispering with hesitant rate and neologism. Mood was unstable with flat blunted thoughts involving insertion and delusions of persecution. Perception included visual hallucinations and cognition involved lack of orientation, concentration, attention and abstract thinking. Also judgment was poor with insight of Level-I, complete denial of illness.

Behavioural observation: The patient looked untidy, with oily hair, and a stooped posture. He would sit only after being instructed to, and sat with his face bent downwards. He spoke softly, slowly, and the productivity was decreased. His affect was apathetic, was reactive at times, and during conversation would seem as if he was lost somewhere, and had a vacant look in his eyes.

IV. Provisional diagnosis/Conclusion

Undifferentiated Schizophrenia - According to ICD-10
Undifferentiated type Schizophrenia - According to DSM-IV-TR Criteria
General Criteria (According to ICD-10) - following the exclusion criteria by referring to the general criteria by ICD-10 given below.

General criteria for Schizophrenia:

G1. Either at least one of the syndromes, symptoms and signs listed below under (1), or at least two of the symptoms and signs listed under (2), should be present for most of the time during an episode of psychotic illness lasting for at least one month (or at some time during most of the days).

- (1) At least one of the following:
 - a) Thought echo, thought insertion or withdrawal, or thought broadcasting.
 - b) Delusions of control, influence or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception.
 - c) Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing him between themselves, or other types of hallucinatory voices coming from some part of the body.
 - d) Persistent delusions of other kinds that is culturally inappropriate and completely impossible (e.g. being able to control the weather, or being in communication with aliens from another world).
- (2) or at least two of the following:
 - e) Persistent hallucinations in any modality, when occurring every day for at least one month, when accompanied by delusions (which may be fleeting or half-formed) without clear affective content, or when accompanied by persistent overvalued ideas.
 - f) Neologisms, breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech.
 - g) Catatonic behaviour, such as excitement, posturing or waxy flexibility, negativism, mutism and stupor.
 - h) "Negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses (it must be clear that these are not due to depression or to neuroleptic medication).
- G2. Most commonly used exclusion criteria: If the patient also meets criteria for manic episode or depressive episode, the criteria listed under G1.1 and G1.2 above must have been met before the disturbance of mood developed.
- G3. The disorder is not attributable to organic brain disease, or to alcohol - or drug-related intoxication, dependence or withdrawal.

Comments: In evaluating the presence of the abnormal subjective experiences and behaviour, special care should be taken to avoid false-positive assessments, especially where culturally or sub-culturally influenced modes of expression and behaviour, or a subnormal level of intelligence, are involved.

Criteria for Undifferentiated schizophrenia

- A. The general criteria for Schizophrenia (F20.0 - F20.3) above must be met.
- B. Either (1) or (2):
 - (1) There are insufficient symptoms to meet the criteria of any of the sub-types of schizophrenia;
 - (2) There are so many symptoms that the criteria for more than one of the subtypes listed in B (1) above are met.

Illustration 2: Case History Taking and Mental Status Examination of a Young Adult

AIM :

To understand the importance of case history taking and mental status examination of a young adult (male).

OBJECTIVES:

After undertaking this Practical activity, you will be able to:

- Understand the importance of psychiatric case history and mental status examination;
- Know method of taking psychiatric case history in adults;
- Apply skills of case history taking in clinical practice;
- Know method of conducting mental status examination in adults patients; and
- Apply skills of assessing mental status of patient.

METHOD:

Material Required:

Interview schedule for case history taking, tool for mental health status examination, pen, paper, tape recorder.

Tool 1: Proforma for Case-History Taking of an Adult

Name: XYZ
Age/Sex 28 years Male
Education 12th
Occupation Business
Religion Hindu
Marital status Married
Address Delhi
Informant: Self and Mother

Chief Complaints

Patient	Informant	
Giddiness	Trembling	- Mother Mrs. R staying with patient
Trembling	Forgetting	information reliable
Forgetting		
Tension		

Duration of illness

Total duration : 8 years , currently for the last 10 months.

Precipitating factors : Not clear

Onset : gradual

Course – Improving

History of present illness (HOPI)

(Chronological record of illness)

The patient was maintaining well till one year back. He was anxious regarding marriage to a person he used to love and the parents did not like the girl. In November 2018, patient started to experience tremors. Sensation in both the lower limbs. It was precipitated after standing for more than 10 minutes, while previously, he was able to stand for a longer duration i.e. 1 hour. He would feel discomfort and would need to rest thereafter. Not associated with weakness/tingling/ loss of sensation/pains. It would last for 15-20 minutes and subsequently increased in duration but not severity. It would not occur at night during sleep. It was also associated subsequently with tremor of hand. The severity of such tremors was varied over course of the day, more in evenings.

The patient left his job due to this as he was not able to discharge the duties for more than 15 days. At this time he would also experience some strange sensations that things are looking alternately bigger and smaller. This would occur when he was not busy and was lost in his thoughts. He would just be a passive observer and the objects included living and non living things. He vividly described inanimate objects gaining life. He would be anxious due to this. He would be oriented and consider this not imposed by external source.

He would also be lost in his thoughts and be concerned for his marriage which took place in April, 2019. As he was not doing any job, occasionally he would feel sad for days thinking whether he had taken right decision of marriage and how he would manage in the future. He would have self doubt and gloomy views of the future and demeaning thoughts about self. He even considered his existence useless and contemplated suicide but did not muster courage for the same. He would eat less than what he had earlier and would not be able to sleep properly and felt fatigued all day. He thought of doing a business but could not plan properly. He would also forget things easily.

During spells of low mood he would also hear sounds of whistles which were not heard by others. He heard these sounds with both ears as if coming from outside usually in the evenings, against his will and he would be perplexed due to this. He had experienced this only 3 times in the last one month.

His self care though maintained, he would groom less than usual and did not take interest. Neither did he take interest in meeting anyone else, or watching TV or any other thing. He would also complain of mild headache in frontal area. No blurry vision / vomiting. He would experience things which seemed odd to him.

No history of seizures/head trauma/head injury

No history of elevated mood with increased activity.

No history of visual hallucinations, has fears of being alone in dark, sleeps with both lights on.

Treatment history - he was getting medication.

Medical history – no major medical or surgical problem.

Past psychiatric history – History of dizziness, low feeling, thinking disturbed when he was seeing objects bigger and smaller as compared to their actual size. Decreased concentration, impairment in memory, low mood, anxiety . Started treatment in 2011, continued till 2014. There was improvement for one year. During this period self care had improved.

Family type – Middle Socio-Economic Status, Hindu joint family

Family tree

Father

Mother

61 retired from government job

58 Homemaker

(Hypertensive)

diabetic

Sibling 37 Male, 35 Male, 32 Female, 30 Male, **28 Patient**

All the siblings were educated till 12th std. They were employed and married. Had children.

There were no major stresses or conflicts in the family. Patient and his wife stay in the same house, with the parents and one brother and his family.

Spouse– age 27 years, education – B.A., works as stenographer in a private firm

Family History of psychiatric illness – None significant.

Personal History

Birth and early childhood – not available

Academic history – X – XII – Diploma 2014 -15 (Pvt.)

Sexual history – He had satisfactory sexual relations with wife. Did not report any other sexual relation.

Occupation history – Started working in a private organization from Jan. 2006. Was earning about Rs.5,500 p.m., well adjusted in work place, respected

Marital history - Married in April, 2019

Love marriage, courtship 2 years

Adjusted in family

Drug history Cigarette /2017/ daily – dep/ Bundle

Alcohol/4 yrs. Occ use/ once/ week – last 4 months

Premorbid personality

Patient has few close friends since early age as he feared being judged and criticized. Would meet the relatives but did not talk much. Interest in TV.

Mood would be normal neither too happy or sad but became anxious easily. He would like things done his own way. Not easily angered.

General physical examination : Average built appears healthy on observation.

4.4.1 Example of Mental Status Examination

Attention should be paid to any abnormalities seen in the behavior. For example, over dressing, over talkativeness and looking around in doubt. One should remember the socio-cultural background of patient. The observations are as follows:

Mental status examination – Told about problems

General appearance and behaviour – A young adult male came into interview room and sat comfortably. He was appropriately kempt and dressed. He sat on the edge of chair.

Orientation – oriented to time, place and person

Psychomotor activity – normal (inferred as normal because the patient was sitting in the chair normally and conversing with the examiner.)

Attention concentration – aroused but not sustained (inferred from the digit span test as the patient could repeat 4 digits correctly forwards and 3 digits backwards correctly)

Eye to eye contact – made but not sustained (as observed by the examiner)

Speech – spontaneous, coherent, reactive and goal directed.

Mood – a) Subjective – “tension hai”

b) Objective – anxious

Thought – no abnormality

Perception : Presently no sensory distortion/deception

Memory (recent, remote and immediate) – intact

Judgment (personal, social and test) – intact

Intelligence - Average

Insight – 4/5 (as based on the rating described above)

Diagnostic formulation – A 28 year old married male belonging to middle SES Hindu joint family with no family history of psychiatric illness, presented with complaints of giddiness and tremors and forgetting trivial information. His mental status examination revealed poor attention and concentration and anxious affect.

Provisional diagnosis – Anxiety disorder NOS

Management plan: The management plan devised for the patient is described below under the following heads:

Pharmacological - Person may not be taking medicine. Here, in this case, SSRI low dose (as prescribed by the consultant psychiatrist) **Case History Taking and Mental Status Examination**

FINDINGS:

Write here as explained.

ANALYSIS AND DISCUSSION

Write here as explained.

CONCLUSIONS:

Write here as explained.

REFLECTIONS:

Write here as explained.



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Illustration 3: Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years

AIM:

To understand the importance of case history taking and mental status examination of a child in the middle childhood years.

OBJECTIVES:

After undertaking this Practical activity, you will be able to:

- Understand the importance of psychiatric case history taking and mental status examination;
- Know method of taking psychiatric case history in children;
- Apply skills of case history taking in clinical practice;
- Know method of conducting mental status examination in child patients; and
- Apply skills of assessing mental status of patient.

METHOD:

Materials Required:

Interview schedule for case history taking, tool for mental health status examination, pen, paper, tape recorder.

Sample : 10 year old boy.

Procedure:

State the procedure you followed.

Tool 1: Proforma for Case-History Taking for Child/Adolescent

FINDINGS:

I. History Taking:

Name: **XYZ** Age/Sex: **10/Male**

Address: **2 street, 5 Cross lane, Shadipur, Delhi**

Education/Class: **4th Standard**

Family Structure: **Nuclear**

Informant: **Mother – Reliable**

SES: **Middle Class**

Date of assessment: **12 February 2020**

SCHOOL: **Public school**

Background Information of Patient and Informant:

INFORMANT: Patient and his mother

RELIABILITY: Reliable

ADEQUACY: Adequate

Presenting Complaints:

- Restless
- Aggressive
- Disturbing other students in class, Fighting with them
- Does not want to study
- Low concentration
- Poor retention
- Disturbed sleep

History of Present Illness:

Child's current functioning: Since July, 2019 - Mother noticed that he used to be restless during nights, having disturbed sleep.

- House: Currently he does not sit in one place, is constantly breaking items, demanding food, interrupting parents, demanding attention.
- School: He was reported to be disruptive in school, not participating in tasks and demanding constant attention. His performance in school dropped to below average. Parents were called to meet the teachers many times over the last few months. The teachers complained about his indiscipline at school. He had started being a little aggressive with the other students.
- Family relationships: Attached to the mother, wants her to be with him all the time. Has a lot of fights with his younger sister

Onset: **Symptoms started appearing around 7 to 8 months back.**

Precipitating Factors: **No specific factors**

Past Psychiatric History: **NA**

Concurrent Medical History/ Past Medical History: **No major illnesses in the past.**

Family History

Family type: **Nuclear**

Socio-economic status: **Middle**

Family tree:

S. No.	Relation with patient	Age	Education	Occupation	Health	Personality
1.	Father	44	M.A	Business	Heart problem	Strict, authoritative
2.	Mother	42	B.A	Housewife	Blood pressure problem	Calm and caring
3.	Sister	4	Pre-school	Student	NIL	Cranky

Family interaction: Authoritative and strained communication patterns with frequent fights between the parents as well as siblings.

Family history of psychiatric illness: Nil

I. PERSONAL HISTORY:

Date of birth: 3rd January 2010

Place of birth: Kangra, Himachal Pradesh

Mother's condition during pregnancy: Anaemic

Birth and early developmental history:

- **Pregnancy/Labour/Delivery:** The child was born of normal delivery.
- **Developmental milestones:** Had normal milestones.
- Since the age of 8 months over activity was noted. He would not lie still in bed rolling constantly from side to side. Often as a baby he would fall off the bed.
- **Temperamental Style:** He would also actively attack and break toys that were given to him. This has been increasing gradually.

Neurotic symptoms in childhood (like temper tantrums): Yes

If yes, please mention: **Shouting and lying down on the floor to fulfill his wishes**

Night terrors: Yes

Behavior problems like thumb sucking or nail biting etc.: Yes

If yes, please mention: Thumb sucking till the age of 5 years

Health during childhood

If patient suffered from any childhood infections or illness?: No

If patient suffered from any infantile convulsions?: No

SCHOOL

Special abilities/disabilities: Can't sit at one place

Performance in academics: Poor

Number of friends: few (2)

Relationship with peers: strained (excessive fights)

Participation in co-curriculum activities like drama/sports etc.: poor

Hobbies and interests: video-game playing and cricket

i) **Pre-morbid personality:**

- Good performance In school
- Not too aggressive
- Fairly calm

ii) **Social relations with**

- Family: **stable**
- Friends: **stable**
- Relatives: **friendly**

vii) **Intellectual activities like:**

- Hobbies: **video-game**
- Interests: **cricket and cars**
- Memory: **adequate**
- Observation: **distracted easily**
- Judgment: **adequate**

viii) **Mood of patient: pessimistic, unstable, dependent**

ix) **Character**

- **Attitude to work or responsibility:** poor
- **Interpersonal relationships:** poor
- **Standards in religious/social/health matters:** adequate

x) **Fantasy life**

- **Frequency and content of day dreaming:** low

xi) **Habits**

- **Eating/alcohol consumption:** NIL
- **Self medication:** NIL
- **Tobacco consumption:** NIL

II. Mental Status Examination:

i) **General appearance**

- **Physique of body build:**
Approximate height: 143 cm
Weight: 50 kg

Appearance: **neat and tidy**

- Looks: **Comfortable**

- Physical health:

Grooming: **adequate**

Hygiene: **adequate**

Self care: **appropriate**

Dressing: **appropriate**

- Non verbal expression : **adequate**

- Mood: **irritable**

- Effeminate/masculine: **male traits**

ii) Attitude towards the examiner/counsellor: **Cooperative, Evasive**

iii) **Comprehension**

Can patient understand your questions? - **Yes**

iv) **Gait and posture: Normal**

Way of sitting: **appropriate**

Standing: **appropriate**

Walking: **appropriate**

v) **Motor Activity**

This is observed while interacting with the patient.

- Increased- **present**

- Excitement/Stupor- **present**

- Abnormal involuntary movements : **Tics, Tremors-nil**

- Restlessness- **present**

- Catatonic signs: **nil**

- Social withdrawal/autism: **nil**

- Compulsive Acts: **nil**

Rituals: **nil**

Habits: **nil**

vi) Social manner with non verbal behavior: **Increased**

Eye contact: **Normal eye contact**

vii) **Rapport**

Whether a working empathetic relationship can be established with the patient?

Yes, it was established

viii) Hallucinatory behavior: **Nil**

II) SPEECH

i) Rate with quantity of speech

Observe the patient during the interview for the following:

- Speech: **Present**
- Spontaneous speech: **Yes**
- Productivity: **Increased**
- Rate: **Increased**
- Pressure or poverty of speech: : **nil**

ii) **Volume with tone of speech**

On the basis of your interaction with the patient notice whether the speech is:

- **Increased**
- **high pitch**

iii) **Flow with rhythm of speech**

Observe the patient's speech, it is: **smooth**

III) Mood with affect

i) Quality of mood

Subjectively: **good**

Objectively: **elated**

ii) Stability of mood: **poor**

iii) Reactivity of mood: **present**

iv) Persistence of mood: **few hours**

Affect

i) Quality of affect: **appropriate**

ii) Range of affect: **irritable, angry**

iii) Depth or intensity of affect: **normal**

iv) Appropriateness of affect: **appropriate**

v) Mania: **elation**

vi) Anxiety: **restless**

vii) Depression: **nil**

viii) Schizophrenia: **nil**

IV) Thought

ii) Stream and form of thought:

Based on the way the person verbally interacts with the examiner, the following observations regarding the thought were made:

- Spontaneity: **Present**
- Productivity: **Present**
- Flight of ideas (shifting from one idea to the next) : **Absent**
- Prolivity/ordered flight of ideas: **Absent**
- Poverty of content of speech: **Absent**
- Thought blocking (sudden disruption in flow of thoughts): **Absent**
- Continuity of thought: **Absent**
- Relevant to questions asked: **Yes**

Observe the following behavior in patient:

- Any loosening of associations: **Absent**
- Tangential circumstantialities: **Absent**
- Illogical thinking: **Absent**
- Preservation: **Absent**
- Variiegation: **Absent**

ii) Content of thought

- Obsessions: **Absent**
- Contents of phobia: **Absent**
- Delusion: **Absent**
- Overvalued ideas: **Absent**

Observe the following contents in thoughts of the patient: **nil was seen**

- Ideas of persecution
- Reference
- Grandeur
- Love
- Jealously
- Guilt
- Nihilism
- Poverty
- Somatic symptoms

- Hopelessness
- Haplessness
- Worthlessness
- Suicidal ideation

V) Perception: normal

- i) Hallucinations - nil, not present
- ii) **Ask the patient regarding whether she or he reports to have experienced any of the following:**
 - Illusions/misinterpretations (misperception of certain stimuli like mistaking a rope for a snake). **No**
 - Depersonalization/de-realization (feelings of unreality regarding self or the environment). **No**
 - Somatic passivity phenomenon (feeling that any external agency is controlling one's actions like making one do certain acts). **No**

VI. Cognitive Assessment

i) **Consciousness: present/ alert**

ii) **Orientation**

Time: Ask Time: 10:20 am **Appropriate**.....

Date: **12** **Appropriate**

Day: **Tuesday**..... **Appropriate**.....

Month: **February** **Appropriate**

Year: **2020** **Appropriate**

Building: **Appropriate**.....

Place: Ask present Location: **Appropriate**.....

City: **Appropriate**.....

Person: Ask Name: **Appropriate**.....

Her or his role in the setting: **Appropriate**

People around him/her:.....**Appropriate**.....

iii) **Attention: Difficult to arouse and sustain**

iv) **Concentration: Appropriate according to his age**

- count backward from 20 - **Done properly**
- Names of months/days of week in reverse order - **Name of days and month done properly but with constant repetitive instructions to do the task**

v) **Memory: Appropriate**

- Immediate memory

Digit span test (asked the patient to repeat the digits spoken by the examiner forwards or backwards) - **done accurately**

- Recent memory

Ask how did the patient come to the room/hospital? : ____ **with parents** **Appropriate**

What foods did he have for breakfast? : ____ **milk and bread** ____ **Appropriate**

What foods did he have the previous night? : ____ **roti with dal** ____ **Appropriate**

- Remote memory

Birth date: **Appropriate**

Any relevant questions from past:

How was your last birthday celebrated? with family and friends.....Appropriate

vi) **Intelligence**

- General information - **Appropriate according to his age**
E.g. Current Prime Minister, Capital of India or name of any state etc.
- Simple tests of calculations (e.g., 4 + 5?)- **Appropriate according to his age**

vii) **Abstract thinking**

- Proverb testing: At least 3 simple proverbs, for example, the examiner should ask the patient what does it means. - 'every cloud has a silver lining', 'people who live in glass houses should not throw stones', 'sour grapes'. - **not known properly**
- Similarities with analogies: For example, 'ask what is similarity between banana and orange, dog and cat, table and chair '?- **Appropriate according to his age**

VII. **Insight -The patient has insight of Level-I, Complete denial of illness**

VIII) **JUDGEMENT-** Inappropriate social and test judgment; appropriate personal judgment according to his age

- 1) You are walking on the road, and finds a sealed envelope with address and stamp lying on the street. What will you do?

..... **not know**

- 2) You have gone to watch movie in a theatre. Suddenly the theatre catches fire. What will you do?

..... **run**

3) If you find an injured child on the road, what would you do?

..... **not know**

4) If it is raining outside, what should you do?

.....**take umbrella**

III. Analysis and Discussion

I selected XYZ, a 10 year old, male, studying in 4th standard, and living with parents in a nuclear family & hailing from middle socioeconomic strata. His mother informed that his main complaints were restlessness, indulgence in excessive aggressive behaviour, and disturbing other students in class and also engaging in peer fights. He doesn't want to study, has low concentration and poor retention in class as well suffers from disturbed sleep. Onset of symptoms was 7 months back which are deteriorating further with disturbance in academic, social as well as family functioning. Developmental milestones were reported normal. MSE findings revealed alert but not able to sustain attention and highly irritable general appearance. Also showed increase in psychomotor activity as well as frigidity in movements. Speech had increased reaction time with frequent shifts in topic according to the flow. His thought process was intact, goal oriented, and well organized. He was preoccupied with thoughts about his fight with his friend and mood was elated. No perceptual abnormalities were found, higher mental functions as well as judgement were intact and insight was level I.

IV. Provisional diagnosis/Summary

Hyperkinetic Disorder -According to ICD-10

Attention deficit hyperactivity disorder (ADHD) -According to DSM-IVTR Criteria

General Criteria (According to ICD-10) - following the exclusion criteria by referring to the general criteria by ICD-10 given below.

(Here, remember to refer to these manuals.)

G1. Inattention

Demonstrable abnormality of attention, activity and impulsivity at home, for the age and developmental level of the child, as evidenced by (1), (2) and (3):

- (1) At least three of the following attention problems:
 - (a) Short duration of spontaneous activities;
 - (b) Often leaving play activities unfinished;
 - (c) Over-frequent changes between activities;
 - (d) Undue lack of persistence at tasks set by adults;
 - (e) Unduly high distractibility during study e.g. homework or reading assignment

- (2) Plus at least three of the following activity problems:
 - (a) Very often runs about or climbs excessively in situations where it is inappropriate; seems unable to remain still;
 - (b) Markedly excessive fidgeting & wriggling during spontaneous activities;
 - (c) Markedly excessive activity in situations expecting relative stillness (e.g. mealtimes, travel, visiting, church);
 - (d) Often leaves seat in classroom or other situations when remaining seated is expected;
 - (e) Often has difficulty playing quietly.
- (3) Plus at least one of the following impulsivity problems:
 - (a) Often has difficulty waiting turns in games or group situations;
 - (b) Often interrupts or intrudes on others (e.g. butts in to others' conversations or games);
 - (c) Often blurts out answers to questions before questions have been completed.

G2. Hyperactivity

Demonstrable abnormality of attention and activity at school for the age and developmental level of the child, as evidenced by both (1) and (2):

- (1) At least two of the following attention problems:
 - (a) Undue lack of persistence at tasks;
 - (b) Unduly high distractibility, i.e. often orienting towards extrinsic stimuli;
 - (c) Over-frequent changes between activities when choice is allowed;
 - (d) Excessively short duration of play activities;
- (2) And by at least three of the following activity problems:
 - (a) Continuous (or almost continuous) and excessive motor restlessness (running, jumping, etc.) in situations allowing free activity;
 - (b) Markedly excessive fidgeting and wriggling in structured situations;
 - (c) Excessive levels of off-task activity during tasks;
 - (d) Unduly often out of seat when required to be sitting;
 - (e) Often has difficulty playing

G3. Impulsivity

Directly observed abnormality of attention or activity. This must be excessive for the child's age and developmental level. The evidence may be any of the following:

- (1) Direct observation of the criteria in G1 or G2 above, i.e. not solely the report of parent or teacher;

- (2) Observation of abnormal levels of motor activity, or off-task behaviour, or lack of persistence in activities, in a setting outside home or school (e.g. clinic or laboratory);
- (3) Significant impairment of performance on psychometric tests of attention.
 - G4. Does not meet criteria for pervasive developmental disorder (F84), mania (F30), depressive (F32) or anxiety disorder (F41).
 - G5. Onset before the age of seven years.
 - G6. Duration of at least six months.
 - G7. IQ above 50

V. Management plan/Conclusion

Attention deficit hyperactive disorder (ADHD) is caused due to developmental factors, problems in brain structure or brain function and psychosocial factors: permanent behaviour pattern that can't be corrected by medication rather can be managed for some time period. Therefore, correcting behavioural issues becomes vital which involves social skills group, training for parents regarding parenting style and behavioural intervention at school and at home are often efficacious in over all management of the child. Therefore management plan would include the following:

- **Support and advice- for parents and teachers**
- Remedial teaching
- Behaviour modification- appropriate methods can be taught to parents and teachers to prevent reinforcement of problem behaviour
- Drug treatment- under specialist supervision central nervous system stimulant drugs can be used only if recommended.

REFLECTIONS:

Write here as explained.

Illustration 4: Understanding Case History Taking and Mental Status Examination of an Adolescent - Female

AIM:

To understand case history taking and mental status examination of an adolescent girl.

OBJECTIVES:

After undertaking this Practical activity, you will be able to:

- Understand the importance of psychiatric case history and mental status examination;
- Know method of taking psychiatric case history in adolescent;
- Apply skills of case history taking in clinical practice;
- Know method of conducting mental status examination in adolescent; and
- Apply skills of assessing mental status of patient.

METHOD:

Material Required:

Interview schedule for case history taking, tool for mental health status examination, pen, paper, tape recorder.

Sample : 14 year old girl

Procedure:

I visited School counsellor and identified a girl who had some problem. Then I met the mother of that girl and took permission to conduct this practicum activity on her in the presence of the mother.

Name-	Shilpa
Age-	14 years
Sex-	Female
Education-	Currently studying in standard VII
Address-	Shri Sangam Vihar, Madurai

MSES family (Middle Socio-economic status family)

Presenting complaints-

According to Patient

Headache ~ 20-25 days

shivering ~ 20-25 days

According to Mother

Shivering and unconsciousness × 20 days

Time Period of the start of the problem (TDI) - 2 Years

Onset: Sudden

Course: Episodic

Precipitating factor : Examination term. 2/9/19

History of Present Illness (HOPI) :

Patient was apparently symptomatic almost 20-25 days back when she was at the school and science class was going on. The patient during that day during the Tiffin hours had argument with her elder sister whom she badly abused. She was using obscene language. After the quarrel was over, while at class, the patient started having headache which was of moderate intensity, twisting in character, location at the vertex, was not accompanied by any nausea, vomiting, running nose, fever, stiffness of neck, or difficulty in vision. After a few minutes of this the patient suddenly got unresponsive and was about to fall down when her other friends caught her. The patient started shivering of hands and legs and was not responding to any call from others. The patient was unable to feel or hear what was taking place at that time. That time lasted for around one hour. During that time the teacher contacted her parents and brought back the patient to consciousness. The patient was unable to recall the events which took place during the time of unresponsiveness. The patient, thereafter started experiencing similar episodes repeatedly both inside her house as well as at her school. However, events did not happen when she was completely alone. The patient did never sustained any body trauma, have tongue bite or urinary/fecal discharge during the unresponsive spell. Usually this spell would occur whenever she would have fight with her elder sister and would remain tensed regarding her study. But after each spell the patient would become absolutely alright. Last spell happened two days back when the patient was receiving Hindi lecture class of two and half hours.

After the patient started having the symptoms, she had stopped doing the household work. Previously the patient used to clean utensils whereas her elder sister used to help her mother in cooking. The patient used to carryout these activities unwillingly and used to have argument with her elder sister on these issues in particular. The patient would feel more frustrated when the sister would use obscene language with her. The adolescent's parents contacted a physician. Her check up found nothing. Then physician asked them to consult a counsellor or family therapist to look into the case.

Past history- 2 years back 2018, similar illness lasted for one month.

Family history- Patient belongs to middle socio-economic status, Hindu nuclear family.

Father - 36 yrs, matric, shopkeeper

Mother - 33 years, matric, housewife

Siblings - 16 years	14 years	10 years	8 years
Class IX	VII	VI	IV

Past family history of psychiatric illness - absent

Family functioning: Conflict with elder sister

Birth history - Premature vaginal delivery, birth weight was 1kg 900 gm. Cried immediately after birth. No complications.

Milestones of development –

a) Motor

Neck holding – 2 months

Sitting with support – 6 months

Sitting – 8 months

Crawling – 10 months

Standing – 1 year

Walking – 1 year and 3 months

b) Speech

First word – 1 year (pa)

Two word utterance – 1.5 years (mama bye)

Full simple sentences – 2.5 years (I want ball)

c) Adaptive

Social smile – 2 months

Indicating basic needs – 3 years

Toilet training – 3.5 years

Scholastic History

She started going to school at age of 4 years. She had difficulty in adjusting to the school and initiating friendships. Required supervision to do homework. She was below average in studies till class 4 and failed in class V. According to parents, lots of hard work was done with her to complete her school tasks.

Sexual history – NA

Temperament – She was not very active in her early childhood and was slow to warm up child.

Parental functioning – Both parents were lenient in their approach. No consistent disciplining pattern was used. There were no stressful events in the family.

Mental Status Examination

General appearance and behaviour: Adolescent girl aptly dressed entered the room in normal gait and took the chair on offering.

Relationship capacity – was too much emotionally dependent on mother.

Spontaneous motility and speech – spontaneous, relevant, coherent and goal directed.

Affective behaviour : Subjective – “I’m fine”

Objective: anxious

Fantasy – she revealed her 3 wishes to be:

1. To come first
2. To have lot of friends
3. To have lot of toys

Attitude towards family, school and playmates – She was very attached to her mother and had few friends in class.

Stated interests and content of thought – She was interested in painting and drawing. She reported difficulty pertaining to academics and had high expectations from self.

Attention span and distractibility – attention was aroused but was easily distracted
Intellectual capacity – School records revealed that she scored 50% marks in most of the exams this year.

Motivation insight: Absent

FINDINGS:

Diagnostic Formulation

14 year old student of class VII with 2 years of episodic illness with current episode lasting 20-25 days of abrupt onset characterized by unresponsive spells, tremors of hands and feet, related to stressful academic situation and fight with sister, on MSE there was anxious affect with high emotional dependence on mother, poor attention span with easy distractibility, introversive tendencies and poor academic performance.

Diagnosis

Axis I (Dissociative Disorder)

Axis II (No diagnosis)

Axis III (Below average intellectual level)

Axis IV (No medical/physical condition)

Axis V (Rate 0/1/2) – 2

MANAGEMENT

Relaxation exercises, study skills training and coping skills training.

ANALYSIS AND DISCUSSION

Write here as explained.

CONCLUSIONS:

Write here as explained.

REFLECTIONS:

Write here as explained.

Global assessment of functioning (Child)

After taking history and mental status examination it is important to assess level of functioning in all areas. This information can also be used to assess degree of dysfunction due to illness and to assess improvement after treatment. The Global Assessment of Functioning for children is different from adults.

CHILDREN'S GLOBAL ASSESSMENT SCALE

For children 4-16 years of age.

(Adaptation of the Adult Global Assessment Scale)

Rate the subject's most impaired level of general functioning for the specified time period by selecting the lowest level which describes his/her functioning of a hypothetical continuum of health-illness. Use intermediary levels. (e.g. 35, 58, 62). Rate actual functioning regardless of treatment or prognosis.

100-91 Superior functioning in all areas (at home, at school and with peers), involved in a range of activities and has many interests (e.g. has hobbies or participates in extracurricular activities or belongs to an organized group such as Scouts, etc.). Likeable, confident, "everyday" worries never get out of hand. Doing well in school. No symptoms.

90-81 Good functioning in all areas. Secure in family, school, and with peers. There may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g., mild anxiety associated with an important exam, occasionally, "blow-ups" with siblings, parents or peers).

80-71 No more than slight impairment in functioning at home, at school, or with peers. Some disturbances of behavior or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sibling) but these are brief and interference with functioning is transient. Such children are only minimally disturbing to others and are not considered deviant by those who know them.

70-61 Some difficulty in a single area, but generally functioning pretty well, (e.g. sporadic or isolated antisocial acts such as occasionally playing hooky or petty theft; consistent minor difficulties with school work, mood changes of brief duration; fears and anxieties which do not lead to gross avoidance behaviour; self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

60-51 Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbances would be apparent to those who encounter the child in a dysfunctional setting or time but not those who see the child in other settings.

50-41 Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other anti-social behavior with some preservation of meaningful social relationships.

40-31 Major impairment in functioning in several areas and unable to function in one of these areas, i.e. disturbed at home, at school, with peers, or in the society at large, e.g. persistent aggression without clear instigation; markedly withdrawn and isolated behavior due to either mood or thought disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).

30-21 Unable to function in almost all areas, e.g. stays at home in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g. sometimes incoherent or inappropriate).

20-11 Needs considerable supervision to prevent hurting others or self, e.g., frequently violent, repeated suicide attempts OR to maintain personal hygiene OR gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10-1 Needs constant supervision (24 hour care) due to severely aggressive or self-destructive behavior or gross impairment in reality testing communication, cognition affect, or personal hygiene.



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EVALUATION SHEET

Remember to enclose this Annexure A (completed Section 1, and blank Sections 2 and 3) in the Supervised Practicum File when you submit it for external evaluation at IGNOU. *Keep a copy with yourself.*

SECTION I: Internal Evaluation by the Academic Counsellor at the Programme Study Centre/Study Centre

S. No.	Name of the Practical	Basis of Evaluation	Maximum Marks	Marks Obtained
1*	1. Case History Taking and Mental Status Examination of a Young Adult-Male <i>OR</i> 2. Case History Taking and Mental Status Examination of a Young Adult-Female <i>OR</i> 3. Case History Taking and Mental Status Examination of an Individual in Middle Adulthood-Male <i>OR</i> 4. Case History Taking and Mental Status Examination of an Individual in Middle Adulthood-Female	Written Report of one of the four practicals	50	
2*	5. Case History Taking and Mental Status Examination of an Old Person-Male <i>OR</i> 6. Case History Taking and Mental Status Examination of an Old Person-Female <i>OR</i> 7. Case History Taking and Mental Status Examination of a Preschool Child-Male <i>OR</i> 8. Case History Taking and Mental Status Examination of a Preschool Child-Female	Written Report of one of the four practicals	50	
3*	9. Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years - Male <i>OR</i> 10. Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years - Female <i>OR</i> 11. Case History Taking and Mental Status Examination of an Adolescent-Male <i>OR</i> 12. Case History Taking and Mental Status Examination of an Adolescent-Female	Written Report of one of the four practicals	50	
4**	1-12 All twelve practicals	Interaction with respect to all twelve practicals	50	
Grand Total			200	x

Note: * Here, the Academic Counsellor gives marks out of 50 on the basis of the report submitted for evaluation, which is to be supplemented by audio recording/CD/sheets on which notes were taken during interview/observation etc., submitted by the learner.

** Here, the Academic Counsellor gives marks based on the interaction of the learner with the Counsellor with respect to all 12 practicals, supplemented by audio recording/CD/sheets on which notes were taken during interview/observation etc., submitted by the learner, that formed the basis of interaction.

- **Weightage of marks for internal evaluation is 50%. To calculate this, use the formula given below:**

$$\frac{\text{Total marks obtained as above (x)}}{200} \times 50 = 'N'$$

Note: The pass percentage for internal evaluation is 40%. Therefore if the learner gets less than 20 marks after calculating 50% weightage (as above), then the student has to repeat the Supervised Practicum. In other words, 'N' obtained by the student should be at least 20 to pass.

The Counsellor is required to use the given formula to calculate the final marks out of 50, obtained by the learner in internal evaluation and to write this final score in figures and in words.

$$\frac{(x)}{200} \times 50 = \dots\dots\dots$$

.....
(Marks obtained out of 50 in internal evaluation to be written in both figures and words)

Academic Counsellor's/Supervisor's overall comments about the learner (use additional sheets, if needed).

.....
.....
.....
.....
.....
.....
.....
.....
.....

Date : **(Signature of the Academic Counsellor/Supervisor)**
Place :

Name & Designation of Academic Counsellor/Supervisor:
.....
Address of Academic Counsellor/Supervisor:
.....
E-mail Address of Academic Counsellor/Supervisor :
Phone/Mobile No. of Academic Counsellor/Supervisor:

Date: **(Signature and Stamp of the Programme Incharge of PSC/Coordinator of SC)**
Place :

Name of Programme Incharge of PSC/Coordinator of SC :
.....
Address of Programme Incharge/Coordinator:
.....
E-mail Address of Programme Incharge/Coordinator:
Phone/Mobile No. of Programme Incharge/Coordinator::

SECTION 2 : To be Used for External Evaluation at IGNOU

The following sheet will be used by the External Examiner identified by IGNOU headquarters to evaluate the Supervised Practicum File submitted by the Learner.

S. No.	Name of the Practical	Basis of Evaluation	Maximum Marks	Marks Obtained
1*	1. Case History Taking and Mental Status Examination of a Young Adult-Male <i>OR</i> 2. Case History Taking and Mental Status Examination of a Young Adult-Female <i>OR</i> 3. Case History Taking and Mental Status Examination of an Individual in Middle Adulthood-Male <i>OR</i> 4. Case History Taking and Mental Status Examination of an Individual in Middle Adulthood-Female	Written Report of one of the four practicals	50	
2*	5. Case History Taking and Mental Status Examination of an Old Person-Male <i>OR</i> 6. Case History Taking and Mental Status Examination of an Old Person-Female <i>OR</i> 7. Case History Taking and Mental Status Examination of a Preschool Child-Male <i>OR</i> 8. Case History Taking and Mental Status Examination of a Preschool Child-Female	Written Report of one of the four practicals	50	
3*	9. Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years - Male <i>OR</i> 10. Case History Taking and Mental Status Examination of a Child in the Middle Childhood Years - Female <i>OR</i> 11. Case History Taking and Mental Status Examination of an Adolescent-Male <i>OR</i> 12. Case History Taking and Mental Status Examination of an Adolescent-Female	Written Report of one of the four practicals	50	
4**	1-12 All twelve practicals	Review of Interaction (based on enclosures)	50	
Grand Total			200	y

Note: * Here, the external evaluator gives marks out of 50 on the basis of the report submitted for evaluation, which is to be supplemented by audio recording/CD/sheets on which notes were taken during interview/observation etc., submitted by the learner.

** Here, the external evaluator gives marks based on the review of enclosures (audio recording/ CD/sheets on which notes were taken during interview/observation etc., enclosed by the learner in the File), that formed the basis of interaction of the learner with the Counsellor with respect to all 12 practicals.

● **Weightage of marks for external evaluation is 50%. To calculate this, use the formula given below:**

$$\frac{\text{Total marks obtained as above (y)}}{200} \times 50 = 'S'$$

Note: *The pass percentage for external evaluation is 40%. Therefore if the learner gets less than 20 marks after calculating 50% weightage (as above), then the student has to repeat the Supervised Practicum. In other words, 'S' obtained by the student should be at least 20 to pass.*

The external evaluator is required to use the above formula to calculate the final marks, out of 50, obtained by the learner in external evaluation and to write this in figures and in words.

$$\frac{(y)}{200} \times 50 = \dots\dots$$

(Marks obtained out of 50 in external evaluation to be written in both figures and words)

Date :
Place :

**(Signature of the Academic Counsellor/
Supervisor)**

**SECTION 3: Grand Total of Marks for Inclusion in
the Learner's Final Marksheet**

Marks Obtained by the Learner in Sections 1 and 2, i.e. in both internal and external evaluation of Supervised Practicum File, are to be consolidated below by the External Examiner (who did the evaluation in Section 2).

Supervised Practicum (MCFTL-002)

Internal Assessment:	External Assessment:	Total marks obtained (T)
<i>(External Evaluator to write marks as stated by Supervisor as 'N' at the end of Section I of Annexure A)</i> <i>(Marks out of 50)</i>	<i>(External Evaluator to write marks here given by her/him as 'S' at the end of Section 2 of Annexure A)</i> <i>(Marks out of 50)</i>	<i>(External Evaluator to add marks 'N' and 'S' and write the total here)</i> <i>(N+S=T)</i> <i>(Marks out of 100)</i>

GRAND TOTAL OF MARKS OBTAINED BY THE LEARNER (T) :

(To be written in both figures and words)

.....

Date: **(Signature of External Examiner of IGNOU Panel)**

Place:

Name of External Examiner :

Address of External Examiner :

.....

E-mail Address of External Examiner :

Phone/Mobile No. of External Examiner :

**Certificate of Completion of Supervised Practicum
MCFTL-002**

Remember to enclose this Annexure in your Practicum File. Keep a copy with yourself.

(To be certified by the Academic Counsellor/Supervisor and the Programme Incharge of the Programme Study Centre or Study Centre Coordinator)

We certify that the student Mr. / Ms. / Dr.with enrolment number has carried out the stipulated 12 practicals of the Supervised Practicum for the course ‘Mental Health and Disorders - Supervised Practicum’ under our guidance and supervision. The Supervised Practicum File submitted herewith is the result of bonafide work done by the student for the supervised practicum MCFTL-002 from (start date) to (end date).

Date : **(Signature of the Academic Counsellor/Supervisor)**
Place :

Name & Designation of Academic Counsellor/Supervisor:

Address of Academic Counsellor/Supervisor:

E-mail Address of Academic Counsellor/Supervisor :

Phone/Mobile No. of Academic Counsellor/Supervisor:

Date : **(Signature and Stamp of the Programme Incharge of PSC/Coordinator of SC)**
Place :

Name of Programme Incharge of PSC/Coordinator of SC :

Address of Programme Incharge/Coordinator:

E-mail Address of Programme Incharge/Coordinator:

Phone/Mobile No. of Programme Incharge/Coordinator:

Sample of Permission Letter

I,(name of the student)
am pursuing M.Sc. (CFT)/PGDCFT programme from IGNOU. I am attached to
.....Regional Centre at Study Centre/
Programme Study Centre
.....
(Name, Address and PSC/SC No.). I am doing practicals of the Course ‘Mental
Health and Disorders – Supervised Practicum’ (MCFTL-002) under the guidance
of my Academic Counsellor/Supervisor.....
(name of the Academic Counsellor/Supervisor). For the completion of my course
work, I need you to grant me permission to interview /observe you and/or your
child for 2-2 ½ hours as per your convenience. Please grant me permission and
oblige.

(Student’s Signature and Name)

(Academic Counsellor’s Signature & Name)

Name & Signature of the Participant /Parent/Relative

