Advanced International Journal for Research (AIJFR)
E-ISSN: 3048-7641 ● Website: www.aijfr.com ● Email: editor@aijfr.com

Developing Understanding over Case History and Mental Status Examination: A Single Case Study

Dr. Priyam Sharma

Assistant Professor
Department of educational psychology and foundation of education
National Council of Educational Research and Training

Abstract

The aim of the study is to conduct Case History and MSE on a client under the guided supervision of a psychologist. Case History that is also known as patient history is defined as a record of information relating to a person's psychological or medical condition, according to the American Psychological Association. It is used as an aid to diagnosis and treatment; a
case history usually contains test results, interviews, professional evaluations, and sociological, occupational, and educational data. Mental Status Examination on the other hand, according to APA is defined as a comprehensive workup of a patient, based on interviews, tests, and other sources of information and including details of mental status, personality characteristics, diagnosis, prognosis, and treatment options. These methods are important so as to gain the deepest of insights about the individual: their psyche, their dispositions, diagnosis, etc. which will be of the utmost importance while designing a treatment plan, be it medication or psychotherapy.

Keywords- Case History, Mental Status Examination

1. Introduction

According to APA – "Case History is a record of information relating to a person's psychological or medical condition. Used as an aid to diagnosis and treatment, a case history usually contains test results, interviews, professional evaluations, and sociological, occupational, and educational data."

The importance of taking a case history lies in the fact that it reduces the chances of misdiagnosis, the problem may be tackled at the grassroots, there will be a better treatment plan and the practitioner is better able to understand the symptoms and the possible causes for them.

A case history typically includes:

- Demographic Details: It encompasses all the basic information pertaining to an individual be it his/her age, sex, religion, socio-economic status, etc.
- Current Symptoms: The perceived signs of the issue or problem experienced that brought one to a clinical practitioner.
- History of the Problem: A record is taken if these symptoms are recurring or if this is the first experience with such symptoms.
- Family History: A record of whether any family member has had a similar experience or any psychiatric or psychological incident or disorder.
- Psychological/Psychiatric History: It is noted whether the client has had any clinical diagnosis of a psychiatric or psychological issue prior to this.
- Current Risk and Safety Concerns: The perceived risks like harming oneself or others or concern for safety which are particularly debilitating for the client.
- Impairments in Life Functioning: The impact on the client's daily functioning of said symptoms be it any domain of one's life.

A case history can be a useful tool for the purpose of gaining a deeper insight into the client's experiences, perceived impairments etc., which can be utilised to develop client
specific treatment methods. The case history method is applied such that the practitioner has everything required for better understanding the client and the problems faced by them.

According to APA – "Mental Status Examination is a comprehensive workup of a patient, based on interviews, tests, and other sources of information and including details of mental status, personality characteristics, diagnosis, prognosis, and treatment options."

It was given by Adolf Meyer (1918) and the purpose is to evaluate, quantitatively and qualitatively, a range of mental functions and behaviours at a specific point in time. The MSE provides important information for diagnosis and for assessment of the disorder's course and response to treatment. Observations noted throughout the interview become part of the MSE, which begins when the clinician first meets the patient.

The major drawback of a Mental Status Examination is the fact that it is fairly subjective. It solely lies on the experience and interpretation of the practitioner. A statement made by the client may be misinterpreted by some thus leading to a misdiagnosis. Therefore, it is of the utmost importance that one is careful and considerate while conducting such an examination.

A proper mental status examination usually considers multiple facets such as the judgement of the client, be it pertaining to society or oneself. There are questions directed to gauge the attention and concentration, thought process, mood, orientation of time, place and oneself. The memory of an individual is also checked in the present, recent and remote sense. Their behaviour during the examination is also of note to the psychologist. Things such as eye-contact, cooperativeness, motor behaviour, speech pattern are noted.

The purpose of the MSE is to obtain a comprehensive cross-sectional description of the patient's mental

state, which when combined with the biographical and historical information of the psychiatric history, allows the clinician to make an accurate diagnosis and formulation, which are required for coherent treatment planning.

2. Method

Demographic Details Name: ABC
Age: 30 years

Sex: Female

Date of Conduction: 7th September, 2022

Time of Conduction: 11:30AM

Place of Conduction: UDAI Special School

Materials Required

- Hard copy of the MSE and Case History Sheet
- Pencil

Tools

- Case History
- MSE

3. Procedure

For the conduction to commence, the material should be arranged first. The administrator must ensure they have all the materials that they require in hand. In this particular setting, a case history and MSE format are required along with something to note down the information. The rapport is built with the participant by enquiring about their interests, hobbies and activities they engage in on the daily. The demographic details are obtained during the same time. The precautions kept in mind should be a soft tone, patience, good intent and a fairly peaceful environment. The environment and the practitioner's

behaviour should relay that the client can feel comfortable and answer questions in their truest form The client is instructed to answer questions to the best of their abilities while making them feel comfortable enough so that there is least amount of hindrance on the client's part.

The administration is commenced and questions such as their impairment in daily life, history of the problem are posed. A detailed report is obtained wherein the individual's behaviour, cognition, thought process, age appropriateness of behaviour and thought are gauged. The introspective report given by the client - "It was nice and I had fun." The client behaved normally and answered all questions with remarkable kindness and zeal. They were willing to participate as actively as possible. It was nothing out of the ordinary and they remained cordial and cooperative throughout.

4. Results and Discussion

Name: ABC **Age:** 30 years **Date:** 7th September, 2022

Sex: Male/ Female/ Other Reason for referral (if any):
Occupation: Unemployed

Highest level of education: School/ Graduation/ Post-graduation/ other

Current symptoms and behavior	**History of the problem**
• Problems in studying, learning, calculations. • Difficulty understanding social relationships. • Intellectual disability • Mild mental retardation. • Cerebral Palsy • Severe headaches • Back and neck pain	• Cerebral palsy was diagnosed right after birth and intellectual disability was recognised later when she entered school • Moderate intellectual disability since birth and has persisted. • Has been in special schools since a very young age.

5. Impairments in life functioning

The client has a seemingly loving relationship with the parents and everyone cares for her in her household. They are loving and nurturing towards her. The school scenario was drastically different; she was constantly subjected to teasing and was often bullied because of her lack of abilities. She had difficulty understanding the course being taught in school and often had difficulty forming friendships. There was also a difficulty perceiving social relationships; even though a girl bullied her and called her names, she considered them to be best friends.

Because of the massive impairment in mental functioning, she is unemployed and doesn't have much scope when it comes to future prospects of holding a job or having her
own household or children of her own away from her parents because of the dependence of the individual and the constant care that is required pertaining to her well-being.

Psychological/psychiatric history

She has moved from one special needs school to another seeking treatment wherein

there are routine checkups and progress is noted. There are activities such as singing, arts and craft and computer - painting and typing. The client has had multiple visits to the hospital for their check ups of cerebral palsy and medication for the same but has never been hospitalized.

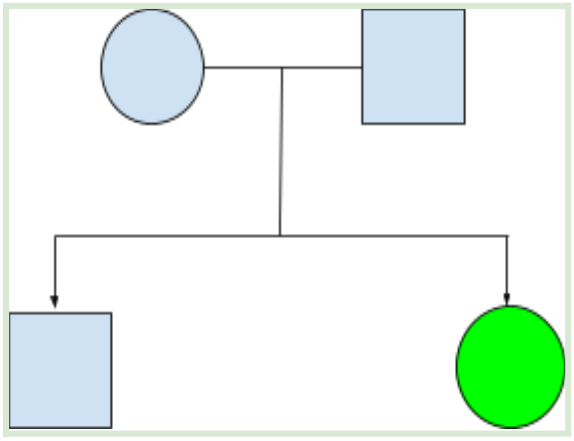
Current risk and safety concerns

The client sometimes gets agitated and is likely to harm others in a fit of rage. There have been episodes of such behaviour where she has engaged in behaviours harmful for others when things didn't go according to her.

A history of outbursts has been acknowledged by the teachers present.

Family History

a. Family Type: (Nuclear/ joint/ broken family/ any other)



b. Psychiatric illness/ mental illness/legal cases/

History of psychoactive substance in family

Mother has a history of migraine.

c. **Family dynamics and structure:**

1. **Financial stressor/ inadequacy/debt Yes/No**
2. **Client's relation with parents/guardian**

Cordial

3. **Current socioeconomic status (upper class/ upper middle class/ lower middle class/ lower class)**

Mental Status Examination
Identification: Tattoo on wrist/ fingers/ arms/ neck/other Clean/ unclean/ shabby/ hygienic/ unhygienic/ any other
Cut scars: Yes/No ● Self-inflicted/ inflicted by others ● Fresh injury/ bruises/ any other
Height: Average/Tall/Below Average/ Dwarfism
Physical Built: Masculine/ Fragile/Malnourished/Average/Healthy/Obesity
Attitude towards counsellor: Cooperative/ Coerciveness (forced) / Non-Cooperative/ Hostile/ Guarded
Eye Contact: Maintained eye contact/ avoided eye contact/ maintained eye contact at times

Speech: Rapid/Slow/Goal Directed and Relevant/ Monotonous/ Clear and Audible/Unclear/Stuttering/Coherent (Logical)/ Stammering
Orientation: ● Time - Intact/ Impaired/ Poor ● Place - Intact/ Impaired/ Poor ● Person- Intact/ Impaired/ Poor
Memory: ● Immediate - Intact/ Impaired/ Poor ● Remote - Intact/ Impaired/ Poor ● Recent - Intact/ Impaired/ Poor
Attention & Calculation: Aroused & sustained/ Aroused but not sustained/ Not attentive/ other
Abstract & Ability: Concrete/ semi abstract/ Abstract
Mood & Affect: Fluctuation of mood/ Low mood/ Anxious/ Irritable/ Guilt & Remorse/ Anhedonia (inability to experience pleasure)/ Apathy (not interested)/ Flat Affect/ Restricted/ Labile affect (repeated, rapid, and abrupt shifts)/ Euthymia/ Reactive/ Communicable/ Stable/ Angry/ Hopeless
Judgement: ● Test - Intact/ Impaired/ Poor ● Social - Intact/ Impaired/ Poor ● Personal - Intact/ Impaired/ Poor

Thought Disorder: No formal thought disorder observed/ Obsessions/ Compulsions/ Delusions/ Flight of ideas/ Suicide thoughts/ Deliberate self-harm/ thought of harm to others/any other
Perceptual Disorder: Hallucinations/ Illusions/ Somatic passivity/ No perceptual disorder observed/ Any other

6. Personal history

The participant achieved their developmental milestones a little later than the norm. She was yet to develop clear speech and her intelligence and intellectual level was that of a child which was indicated by her ability to answer questions directed at her. She took an enormous amount of time for basic mathematics which is generally perfected by the people of her age in India. The contact with parents was ample; the participant lived with them and they guided her at every step possible. She has been under their care since she was born and she has a loving and comfortable relationship with both her parents. Although, with the parents' increasing age, they are often suffering some sort of pain or illness. Medically, the issue arose with delayed developmental milestones and lack of ability to cope with the curriculum in school. She was diagnosed with cerebral palsy early in life and the intellectual shortcomings of the disorder became evident as time passed.

There was a marked difficulty adjusting to school because most of the course content was beyond her understanding after a certain age. There was a lack of academic achievement; she was almost always left behind feeling befuddled and hassled. Peer relationships were also impaired because she was also subjected to a lot of teasing and ridicule in school. There was also a lack of clarity and misperception of relationships on her part. She believed her bully to be her best friend which was debilitating for her. She has always been interested in singing and Hindi was her favourite subject.

The participant did not have any uncharacteristic reaction to the bodily changes of puberty but the cognitive changes that one undergoes during adolescence were majorly absent. Therefore, there was no dating or sexual attraction on her part because she was occupied with changing schools so that they best suit her needs.

She is still dependent on her family for financial and emotional needs because of a lack of a career or occupation. There is a certain satisfaction with her life goals because she has the mind of a child and is unaware of the hassles of adulthood. She has great familial relationships but that seems to be the end of her social circle except a friend in the current school.

7. Miscellaneous

She seems to possess a general liking towards herself and the happiest memory that she can recall is her last birthday when she celebrated it with her friends and family.

8. Summary and clinical impression

The participant has been diagnosed with cerebral palsy from a very young age and seems perfectly content with her life while possessing deep love for her family. She has had multiple school changes and never had a decent functioning peer group. She has been subjected to bullying and teasing but still seems unclear as to which people are friendly and which are not. She has difficulty in understanding intellectually tough matters and is often oblivious of social cues as well.

She seems to have intellectual disability which can be a consequence of the biological disorder cerebral palsy that she suffers from.

9. Possible Suggestive Recommendations

Since intellectual disability and cerebral palsy are disorders where the clinicians can work only on reducing the impacts and symptoms. The suggestions are as follows:

- Medication for cerebral palsy
- Occupational therapy for intellectual disability
- Therapy or counselling for the participant and their family for better coping with the problems of care-giving etcetera.

10. Discussion

The aim of the current study was to conduct a case history and mental status examination of an individual. Case history helps us understand an individual on a deeper level than is visible to the eye and a mental status examination gauges the individual's capabilities. Both of these are reliable and reasonable sources of information when it comes to getting the clinical picture of an individual's illness.

The participant chosen was a 30 year old woman who was from a fairly decent earning family. The rapport was built and the preliminary information was obtained. She was instructed to answer as many questions as she could to the best of her abilities. The observed symptoms included visible struggle in solving Grade II level mathematics, her misinterpretation of social relationships wherein she called her bully her best friend. She also

indicated frequent headaches paired with back and neck pain. She is the only one in the family to have mental health issues but her mother too had a history of migraine.

There seemed nothing out of the ordinary with her but after talking to her, there was a realisation that her mind had not developed more than that of someone very young. She showed remarkable abstract thinking but her future seemed bleak, there was hyper
dependence on her parents for her age and she was unaware if something was amiss. She did not have the realization that people her age have very different roles in society. She was perfectly content with the fact that she lived with her parents and they pampered her as a child.

In her file and after talking to the practitioner, it was brought to notice that she has also had episodes of rage wherein she is agitated and likely to throw tantrums when things do not go as per her. She was also diagnosed with delusions of persecution wherein whenever
someone talked near her, she automatically assumed it to be threatening or a scheme against her.

During the case history and mental status examination, she was cooperative and eager to answer all the questions. She was easily distracted by outward disturbances if any and seemed to maintain eye-contact rarely. Her orientation of time was impaired and her personal judgement for her future aspects did not show much change from her current scenario. Her attention was aroused but not sustained and her calculations seemed to be that of a second
grade student. There were instances where there was a need for explanation of the questions multiple times and her answers were not relevant. Mostly, she understood what was being said but there were moments where she seemed stumped by the questions.

11. Conclusion

The individual was diagnosed with intellectual disability and cerebral palsy. They are currently seeking treatment for both but it is highly unlikely in cases like this that she might lead a typical lifestyle wherein she has a family of her own. The very concept of dating and marriage remain unknown to people with mental disorders because of the stigma attached.

Limitations

1. One meeting is not enough to define a person or know everything about them.
2. Their current mood cannot define their temperament.
3. Mental health issues are not always observable.
4. The individual may be unable to provide all the information required and there is no way of knowing if their recall is accurate or not.

12. Future Implications

Studies like these are a step closer to a deeper understanding of an individual; how a mental health issue comes to arise in the person be it genetic or environmental. There is a need for such endeavours to delve into a particular mental health concern to understand more about the disorder as well as the individual.

References

1. Morris, C. (2007). Definition and classification of cerebral palsy: a historical perspective. *Developmental Medicine & Child Neurology*, *49*, 3-7.
2. Russman, B. S., & Ashwal, S. (2004, March). Evaluation of the child with cerebral palsy. In *Seminars in pediatric Neurology* (Vol. 11, No. 1, pp. 47-57). WB Saunders.
3. American Psychological Association. (2015). APA Dictionary of Psychology (2nd ed.).
4. Wark, S., & Kingstone, M. (2019). The complexity of lifelong comorbidities with severe intellectual disability. *Journal of Intellectual & Developmental Disability*, *44*(4), 431-438.
5. Kishore, M. T., Udipi, G. A., & Seshadri, S. P. (2019). Clinical practice guidelines for assessment and management of intellectual disability. *Indian journal of psychiatry*, *61*(Suppl 2), 194.

Appendix

Name: **Age:** **Date:** **Sex: Male/ Female/ other**
Reason for referral (if any):

Occupation:

Highest level of education: School/ Graduation/Post Graduation/other

Current symptoms and behavior	History of the problem ● When did the problem begin? ● What is the intensity/frequency/duration of the problem? ● What, if any, attempts have been made to solve the problem?

Impairments in life functioning

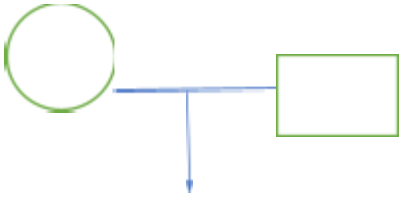
- Issues with home, school, work, relationships

Psychological/psychiatric history

- Such as previous treatment, hospitalizations, etc.

Current risk and safety concerns

- Thoughts of harming self or others.
- Substance abuse.

Family History
a. Family Type: **(Nuclear/ joint/ broken family/ any other)**  **b. Psychiatric illness/ mental illness/legal cases/ History of psychoactive substance in family** **c. Family dynamics and structure:** **1. Finantial stressor/ inadequacy/debt Yes/no** **2. Client's relation with parents/guardian** **3. Current socioeconomic status (upper class/ upper middle class/ upper middle class/ lower middle class/ lower class)**

Mental Status Examination
Identification: Tattoo on wrist/ fingers/ arms/ neck/other Clean/ unclean/ shabby/ hygienic/ unhygienic/ any other
Cut scars: Yes/No ● Self-inflicted/ inflicted by others ● Fresh injury/ bruises/ any other
Height: Average/Tall/Below Average/ Dwarfism
Physical Built: Masculine/ Fragile/Malnourished/Average/Healthy/Obesity

Attitude towards counsellor: Cooperative/ Coerciveness (forced) / Non-Cooperative/ Hostile/ Guarded
Eye Contact: Maintained eye contact/ avoided eye contact/ maintained eye contact at times
Speech: Rapid/Slow/Goal Directed and Relevant/ Monotonous/ Clear and Audible/Unclear/Stuttering/Coherent (Logical)/ Stammering
Orientation: ● Time-Intact/ Impaired/ Poor ● Place- Intact/ Impaired/ Poor Person- Intact/ Impaired/ Poor
Memory: ● Immediate- Intact/ Impaired/ Poor ● Remote- Intact/ Impaired/ Poor ● Recent- Intact/ Impaired/ Poor
Attention & Calculation: Aroused & sustained/ Aroused but not sustained/ Not attentive/ other
Abstract & Ability: Concrete/ semi abstract/ Abstract
Mood & Affect: Fluctuation of mood/ Low mood/ Anxious/ Irritable/ Guilt & Remorse/ Anhedonia (inability to experience pleasure)/ Apathy (not interested)/ Flat Affect/ Restricted/ Labile effect (repeated, rapid, and abrupt shifts)/ Euthymia/ Reactive/ Communicable/ Stable/ Angry/ Hopeless
Judgement: ● Test- Intact/ Impaired/ Poor ● Social- Intact/ Impaired/ Poor

● Personal- Intact/ Impaired/ Poor
Thought Disorder: No formal thought disorder observed/ Obsessions/ Compulsions/ Delusions/ Flight of ideas/ Suicide thoughts/ Deliberate self-harm/ thought of harm to others/any other
Perceptual Disorder: Hallucinations/ Illusions/ Somatic passivity/ No perceptual disorder observed/ Any other

Personal history

- Infancy – developmental milestones, amount of contact with parents, toilet training, early medical history
- Early and middle childhood — adjustment to school, academic achievement, peer relationships, hobbies/activities/interests
- Adolescence — early dating, reaction to puberty, presence of acting out
- Early and middle adulthood — career/occupation, satisfaction with life goals, interpersonal relationships, marriage, economic stability, medical/emotional history, relationship with parents
- Late adulthood —medical history, reaction to declining abilities, economic stability

Miscellaneous

- Self-concept (like/dislike), happiest/saddest memory, fears, earliest memory, noteworthy/reoccurring dreams

Summary and clinical impression

Recommendations

- Therapy, referral to psychiatrist, drug treatment, etc.