Appendix No. 1.

Case-Study Schedule.

All India Institute of Mental Health Bangalore

Note on Case Taking.

(Modified from the notes of the Institute of Psychiatry, London by Drs. Uma Sreenivasan, S. Dutta Roy and Jaswant Singh Neki.)

1. General Introduction.

The headings and methods outlined in the attached Scheme should be followed for the sake of uniformity and acceptability, but the data may of course be collected initially in the most convenient way.

Facts and evidence should be stated in detail (even though negative) rather than technical terms and conclusions such as "Patient has auditory hallucinations" or "memory is normal."

Subjective and objective data should not be mixed up, neither should the history and the present mental state. It is also undesirable to make the greater part of the record as
a mere transcript of what the patient has said, the physician's observations, summaries and conclusions should be recorded as well.

An account of the history, the mental state and the physical state should be recorded within three days of the patient's admission. This preliminary account should not be regarded as exhausting the discoverable information. Subsequent notes will amplify it along whatever lines appear profitable. It gives an indispensable general survey, upon the basis of which a provisional opinion can be formed about the illness.

This provisional opinion should be stated with the brevity or fullness appropriate to the particular case, as the 'formulation' which should be drawn up at the end of the initial notes. For this purpose one arranges the facts in a significant rather than a formal order and discusses them from the point of view of etiology, diagnosis, further investigations, prognosis, treatment.

A provisional treatment sheet should be drawn up (as a rule within a week of patient's admission) outlining what is proposed. Progress Notes should be fully and reasonably taken, at least once a fortnight. Notes must be signed. When Progress notes are voluminous, periodical summaries of progress should be drawn up.

At the ward rounds, a summarised presentation taking into account all the information obtained from the patient, relatives,
3. etc. Psychiatric social worker, Psychologist, etc., of any
case will be required. On no account should the full record
be read out to them (as though every detail could be equally
relevant). This initial presentation should commonly take no
longer than 20 minutes. Further details if necessary can be
brought out during the course of the discussion. The first
assistant will arrange for the presentation of the class.

In a Psychiatric case-record, the following are required.

1. Account of history.
2. Mental state on admission-physical state.
3. Formulation.
4. Provisional treatment sheet.
5. Summary.
6. Progress.

Whenever the case is shown to a senior member of the
staff, his opinion together with the suggestions should be
entered in the case sheets giving the data of consultation.

II. History Informant.

Specify the informant's name, his relation to the
patient, intimacy and length of acquaintance, your impression
of informant's reliability etc. etc. (Do not collect the
accounts from several informants, nor include information
obtained from the patient, unless it is clearly stated as such.
If information is obtained from several sources, put the
additional information separately, again adding to it a description of the new informant complaints, or reason for admission and their duration.

**Present Illness.**

Detailed, coherent account, in chronological order of the illness from the earliest time at which a change was noticed until admission to hospital. Give data which will permit the sequence of various symptoms to be dated approximately. Mention specifically whether such tendencies as suicidal, epileptic or physical illness were present.

**Medical History.**

Previous physical health, illness, operation and accidents chronologically and in detail. Ask specifically for tuberculosis and epilepsy.

Previous mental health; details of all psychiatric conditions for which treatment has been received, giving dates, duration and nature of treatment given; in what hospital or out patient department. Details of all psychiatric symptoms for which treatment has not been received (e.g. hysterical disturbances, preoccupation with bodily functions, suicidal attempts, insomnia, mood variation, psychosomatic disturbances, obsessions, anxiety and subjective symptoms noticed after child birth). If the patient has
contacted non-qualified practitioners, this should be entered giving details of those practitioners' opinion and treatment. Details of all psychiatric disturbances or character-abnormalities noted by friends and relatives, but not by the patient.

**Personal History.**

Date of birth and place. A determined attempt should be made to obtain the data of birth. Mother's condition during pregnancy. Full time birth; normal delivery - ? Breast or bottle fed - ? Time of weaning - ? Feeding difficulties. Whether time or other circumstances of birth considered inauspicious.

**Early development.**

Delicate or healthy baby. Precocious or retarded. Time of supporting neck, sitting up, crawling, standing, walking, wearing and toilet difficulties, teething, talking, cleanliness, etc. Habit training difficulties - ? who was mainly looking after the baby - mother, grandmother or other person. Whether brought up mainly in parents house or relatives house - give details.

**Neurotic symptoms in childhood.**
Night terrors, sleep walking, wetting the bed, thumb-sucking, nail biting, faddiness about food, stammering fear-states, model child.

Health during childhood.

Infectious (specially if associated with high fever or mental symptoms), chorea, infantile convulsions. Play spontaneous games in childhood, make believe, organized games especially during adolescence.

School.

Age of beginning and finishing. Standard reached. Reasons for termination of studies. Evidence of ability or backwardness. Special abilities, hobbies and interests. Relationship to schoolmates or friends (nickname). Attitude to teachers. Attitude to work. If not attended school give reasons. Disadvantages, dissatisfaction or anxiety caused by illiteracy.

Occupation.

Age of starting work. Jobs held in chronological order with wages, dates, reasons for change. Satisfaction
in work. Present economic circumstances. Ambitions. Satisfaction or reasons for dissatisfaction.

**Menstrual History.**

Age at first period. Regular duration and amount. Pain. Psychic changes - rituals connected with menstruation (e.g. seclusion from rest of family etc.). Abnormal attitudes to menstruation (resentment, disgust, etc.). Date of last period. Climaeteric systems.

**Sexual Inclinations and Practices.**

It may not be possible to take this part of history during the first interview. In this case it should be entered later. Sexual information, how acquired, of what kind, how received. Masturbation, age, frequency, guilt. Sexual phantasies, prudery. Homosexuality. Hetero-sexual experiences, apart from marriage. Sexual seduction. Venereal disease. In female patients, whether strictly kept at home after attaining puberty or allowed to mix freely.

**Marital History.**

Attitude to marriage while yet unmarried. Duration of
acquaintance before marriage and of engagement. How was the marriage arranged? If love marriage, whether approved by parents and friends, if disapproved reasons for disapproval. If arranged marriage, by whom arranged? Was the consent of patient and spouse obtained. Where there difficulties (e.g. dowry, community of spouses, matching of horoscopes, social status etc.). Is the spouse a blood relative? Husband's or wife's age at marriage, occupation, personality. Compatibility. When was the marriage consumated. Mode and frequency of sexual intercourse. Sexual satisfaction or frigidity. Contraceptive measures. Marriage forced by pregnancy. Fidelity partners. Attitude to other members of the spouse's family. Joint family system? Does the couple stay alone or do they share accommodation - with whom.

Children.

Chronological list of children and/or miscarriages (or abortions) giving ages, names, personality, etc. Attitude to wards children psychiatric state of children. Medical data of children.

Personality before illness.

a. By patient.
In this description of the personality prior to the beginning of the patient's illness, do not be satisfied with a series of statements. As information on this subject involves a great deal of subjective assessment on the part of the informant, several witnesses including the patient should be interviewed and the information kept separate. The discrepancies any should be assessed by the doctor. Aim at a picture of an individual, not a type. In assessing the patient's attitudes compare them to the behavior of other persons in the patient's surroundings. The following is merely a collection of hints, not a scheme:

1. **Social relations to family (attachment dependence):**
   - To friends (group, societies, clubs), to work and workmates (leader, follower, organiser, aggressive, submissive, adjustable). Friends few and close; few and superficial — many and close many and superficial. Preference of own sex. Prefers opposite sex.

2. **Intellectual activities and interests.** Book, plays, pictures preferred. Memory, observation, judgement, critical faculty. Spends leisure time alone, with one or two friends, with many friends.

3. **Mood.** Cheerful, despondent, anxious, worrying. Optimistic, pessimistic. Self-depreciation, satisfied — over confident. State: fluctuating (with or without
any occasion ), controlled, demonstrative.

4. Character. Timid, sensitive, suspicious, jealous, quarrelsome, irritable, impulsive, selfish, egocentric, reserved, shy, self conscious, strict, fussy, rigid, lacks confidence, superstitious.


6. Energy. Initiative. Out put sustained or fitful. Fatiguability power of decession. Rhythm : Is there any regular or irregular rhythmicity of fatigue e.g. morning/evening, cycles, weather changes, seasonal changes, menstrual changes etc.

7. Fantasy life: day dreaming, frequency, contents.

8. Habits: Eatings, sleepings, excretory functions. Alcohol, tobacco, drugs, specify amount taken recently and earlier.

Family History.

Father: Health, age, or age at time of death and cause of death. Personality, education, occupation.

Mother: Health, age, or age at time of death and cause of
death. Personality, education, occupation. Are
the patients blood relatives and if so how?
( Genetic diagram ).

**Siblings:** Enumerate in chronological order of birth with
names, ages, marital conditions, personality,
occupation, health or illness. Miscarriages and
still birth to be included.

**Social position:** General efficiency of family, diseases,
alcoholism, abnormal personalities, mental dis-
orders, epilepsy ( state whether unknown or known).
Participation of the family members in cultural,
political or religious institutions of the locality.

**Home Atmosphere and Influence.** Any salient happening among
parents during patients early year. Emotional
relationships to parents, siblings, nurse, etc.
Note particulars which might enquiries e.g. names
of hospitals where relatives have been treated.

**Circumstances Prior to Admission:** State briefly if the
patient had been working right up to the day of
admission, or how long he had been out of work.
Had he drawn any benefit? What was his income?
Where did he stay prior to admission with parents,
family, etc. Did he have a room to himself only or
was it over crowded? Who were the other persons staying with him. As this information will be of importance from the point of view of later disposal of the patients this aspect should be noted e.g. will the job remain open? and if so, for how long? Can he return to his previous lodging? Under what condition? etc.

III. Examination

A. Physical.

The result of a thorough examination should be entered under the appropriate headings.

Summary: This should consist of the positive findings only, which are extracted from the full report.

B. Mental State.

General Behaviour: Description as complete, accurate and life like as possible, or what we and the nurses observe in the patient's behaviour, especially anything abnormal. The following points may be considered though not exclusively.

Does the patient look ill? Is he in touch with his
surroundings in general and in particular? Relationship to other patients, to the nurse, to the doctors who examine and treat him. How does he respond to various requirements and situations? What gestures, grimaces or other motor expressions? Tics. Much or little activity. Is it constant or abrupt or fitful? Spontaneous or how provoked. Free or constrained? Slow, stereotyped, hesitant or fidgety? Tension. Scratching or rubbing. Do movements and attitudes have an evident purpose or meaning? Do real or hallucinatory perceptions seem to modify behaviour? Does the patient, if inactive, resist passive movements, or maintain an attitude, or obey commands or indicate awareness at all? Eating, sleep, cleanliness in general and as to excrete. Way of spending the day. Does the patient adhere to any particular diet. If the patient does not speak, the description of his mental state may be limited to a careful report of his behavior (see special sheet).

Talk: The patient's mother tongue, the form of the patient's utterances rather than their content is here considered. Does he say much or little, talk spontaneously or not in answer, slow or fast, hesitantly or promptly to the point or avoid it. Talks coherently, discursively, loosely, with interruptions, sudden sickness, changes of topics, comments or happenings and things at hand, appropriated
using strange words. How does the form of his talk vary with its subject?

**Sample of Talk:** Conversation should be recorded with physicians’ remarks on left side of page and patients’ on right. It should be representative of the form of his talk, his response to questioning and his main preoccupations. Its length will depend on its individual significance. In later selection of the mental state, it will be desirable to record the patient’s reported experiences (e.g. hallucinations, delusions, attitude to illness) in his own words, but the sample required at this point need not aim at being comprehensive.

**Thought:** The formal process of thinking is here considered fore-most. A description should be given first of the patient’s own introspective observations and then the thought processes as elicited by the examiner, from the patient’s over behaviour, blocking, should be recorded. Repeated interruptions may suggest retardation, etc. Loss of power of abstraction should be tested by proverbs, comparisons, etc.

**Mood:** The patients’ appearance may be described, so far as it is indicative of his mood. His answers to, "How do you feel in your self", "what is your mood?" How about your spirit? or some similar enquiry should be recorded.
15.

Many variations of mood may be present not merely happiness or sadness, but such states or irritability, suspicions, fear, unreality, worry, restlessness, bewilderment and many more which is convenient to include under this heading. Observe the constancy of the mood, the influence which change it. The appropriateness of the patients' apparent emotional state to what he states.

Delusions and misinterpretations :- What is the patients' attitude to the various people and things in his environment? Does he misinterpret what happens, give it special or false meaning, or is he doubtful about it. Does he think if any one pays special attention to him? Treats him in a special way, persecutes or influences him bodily or mentally in ordinary or scientific or natural ways? Laughs at him? Admires him? Tries to kill, harm, annoy him? Does he depreciate himself in any way regarding his morals, possessions, health? Has he grandiose beliefs?

These matters may be complicated or concealed and may require much investigation. If a whole conversation with them is reported have resume of the main points at the end.

Hallucinations and other Disorders of Perception :- Auditory visual, olfactory, gustatory, tactile, visceral. The source, vividness in reality, manner of reception, content and all
other circumstances of the experience are important. Its content specially if auditory or visual, must be reported in detail. When do these experiences occur? At night when falling asleep, when alone? Any peculiar bodily sensations, feeling of deadness?

**Compulsive Phenomena**: Obsessional thoughts, impulses, or acts. Are they felt to be from without or part of the patient's own mind. Does their insistence distress him? Does he recognize their inappropriateness? Relation to his emotional state. Does he repeat actions? Such as washing unnecessarily to reassure himself?

**Orientation**: Record the patients' answers to questions about his own name and identity, the place where he is, the time of day and date. As many normal persons from rural areas cannot state the date, alternative questions are necessary, such as, how many days have passed the full moon? What religious festivals happened recently or are expected soon? Circumstances of the patient's ambition, duration of stay, description of the meals eaten at various times, breakfast, lunch etc. Is there anything unusual to him in the way in which time seems to pass? Are there any qualitative changes in his appreciation of time, place or person.

**Memory**: This may be tested by comparing the patients'
account of his life with that given by others or examining his account for evidence or gaps or inconsistencies. Information which he gives about his previous life, his personality, sexual experiences, etc. should not be inserted here but included as a supplementary part of the history, and its source indicated. There should be special enquiry for recent events such as those of his admission to hospital and happenings in the ward. Since where there is selective impairment of memory for special incidents, periods, recent or remote happenings, this should be recorded in detail and the patient's attitude towards his forgetfulness and the things forgotten specially investigated. Record the patient's success or failure in grasping, retaining and being able to recall spontaneously or on demand, three or five minutes later, number, and name, and address or other data. Tell the patient, 'Fox and the grapes', or 'Donkey and salt', story and ask him to repeat it in his own words, record his repetition of the story if possible and say whether he sees the point of it. See how many items of the logical memory test he can repeat immediately, and how many after an interval of five minutes. Give him digits to repeat forward and then alter to repeat backward and record how many he can repeat immediately after being told.

(In describing of the patient's memory, do not merely record the conclusions reached but give the evidence first,
in full and desirable appropriate length. Such facts of behavior as seem to indicate whether he was attending, trying his hardest being distracted by the stimuli, etc.

Attention and concentration:— Is his attention easily aroused and sustained? Does he concentrates? Is he easily distracted? Ask him to tell the days or the months in reverse order or to do simple arithmetics problems requiring 'carrying over' (112 - 2 - 25). Subtraction of serial sevens from 100 (given answers and time taken).

General Information:— Tests for general information and grasp should be varied accordingly to the patient's educational level and his experiences and interests, but the answers to the following should be recorded in all cases.

Name of the Prime-minister, the Chief-minister of the patient's state. Date of beginning and end of the war. Six large cities in India, rivers, hills and places of pilgrimage near the patient's residence. Names of noted film stars of his state.

Intelligence:— Assess the patient's intelligence. Use his history, his general knowledge, problems of reasoning. You may employ standardised tests. Observe discrepancies in the results of various methods and try to interpret them.
19.

Can the patient read and write? (enquire whether he could before the illness. In what language can he read and write. Obtain sample of writing.

**Insight and judgement:** What is the patient's attitude to his present state. Does he regard it as an illness, as mental or nervous as needing treatment? Is he aware of mistake made spontaneously or in response to tests? How does he regard them and others, details of his condition? How does he regard previous experiences, mental illness, etc.? What is his attitude towards social, financial, domestic, ethical problems? Is his judgement good? What does he propose to do when he has left the hospital? Formulation (as outlined above).