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A Case History and MSE Overview of a Juvenile Delinquent

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Abstract

Using solely the Case History and Mental Status Examination, this case study investigates the participation of Master G, a 14-year-old boy from Saharanpur, in a sexual assault case. Master G and two of his peers attacked a little girl in their community. Master G and another companion carried out the attack in a desolate area while one accomplice captured the event. They were arrested because, unbeknownst to them, a bystander recorded the incident on camera and reported it to the police. Mr. G showed no sorrow for his acts, only sadness for getting caught, despite the seriousness of the crime. His lack of remorse or sorrow reveals a troubling psychological state that was probably impacted by twisted moral thinking and peer pressure.

Keywords: *Juvenile Crime, Juvenile Delinquency, Peer Pressure, Sexual Assault, Stress*

Vol. 2, Issue 10 October 2024 ISSN: 2584-0142

INTRODUCTION

Case History

A case history is a detailed account of a person's past that emphasizes on possible factors that may have contributed to their current state of behaviour or mental health. In therapeutic or clinical settings, it is commonly collected to help understand the client's life history and the possible relationships between their past experiences and present situation. While, case studies cannot provide specific therapy recommendations for future patients, they can document clinical experiences that help develop research topics for more well-thought-out clinical trials. Case studies are another helpful teaching tool that may be used to challenge practitioners with both conventional and non-traditional presentations (Budgell, 2008).

Mental Status Examination (MSE)

An individual's current mental health can be systematically evaluated and described using the Mental Status Examination (MSE). It provides a summary of their behaviour at the time of the examination and covers a number of mental functioning domains. Internal medicine, emergency medicine, general medicine, and psychiatry all employ the mental status evaluation. Typically taught at the student level, the assessment is modified according to the practice situation, the clinician's values, and the long-term patient-clinician relationship. The generally accepted approach of mental status evaluation covers the areas where medical information is gathered through a clinical interview to determine the patient's mental condition. Using this approach, mental illness signs and indicators are identified, diagnosed, and monitored. While each physician organizes the mental state examination differently, the main sections remain the same (Vos & Das, 2024).

Vol. 2, Issue 10 October 2024 ISSN: 2584-0142

Juvenile Delinquency in India

The English term juvenile comes from the Latin word "juvenis," which means young. In 1889, the legal term "juvenile delinquency" was first used. Juvenile delinquency is the term used to describe the antisocial behaviour of youngsters under the age of 18. Since they go through a number of physical and mental changes throughout this period, young people who participate in socially inappropriate behaviour are considered to be participating in juvenile delinquency. Some children find it difficult to balance their behaviour and lifestyles as a result of these changes, and they are more likely to engage in antisocial behaviour (Bhardwaj, 2021).

In recent years, juvenile delinquency has been increasing daily. Young kids adopt this practice from their classmates, family, relatives, and other community members, as is widely known. Juvenile delinquency is caused by a wide range of factors, including socioeconomic disadvantage, a large household size, illiteracy, inadequate parental attention, family conflict, peer group, media, community environment, academic performance, retaliation, drug abuse, unemployment, anger, and more. These factors all contribute to juvenile antisocial behaviour (Bhardwaj, 2021).

“The states of Delhi, Madhya Pradesh, Chandigarh, Chhattisgarh, Maharashtra, and Puducherry had the highest crime rates, while Meghalaya, Telangana, and A&N Island had the lowest. Additionally, compared to the previous year, there was a rise in juvenile delinquent cases in Haryana. It's also important to note that Haryana's bordering states, like Punjab and Himachal Pradesh, have very low rates of youth crime in the same year. The vast majority of the young offenders lived with their parents and were literate. The percentage of homeless respondents was rather low” (Bhardwaj, 2021).

Vol. 2, Issue 10 October 2024 ISSN: 2584-0142

Presenting Case

The present case study pertains to a thorough examination of a case that encompasses many domains. The case used in this investigation came from an observation home in Uttar Pradesh, India. The case study comprises case formation based on behavioural observations made during the internship, a thorough Case History, and an MSE.

Master G, a 14-year-old boy, was charged with sexual assault and was admitted to the juvenile center two months ago. He had three of his acquaintances and one of them recorded him sexually abusing a girl who was five years younger than him. But they were apprehended after a stranger recorded them attacking her. From the beginning, his move into the jail had a detrimental impact on him. After spending a considerable amount of time in the jail, adjusting to the environment, and making new acquaintances, he began to lose his appetite and sleep. He began participating in the jail's offered activities and tried to speak with everyone there. In contrast to his behaviour of feeling uncomfortable sharing this information, the client admitted during the in-depth case history session that he was influenced by his peers to assault the girl who lived in his neighborhood. However, he expressed regret for only getting caught and going to jail, not for the act itself.

According to his Mental Status Examination he was restless and fidgety. He was well-groomed and kept himself clean. Although he cooperated with the questioning, he was evasive on several of the topics during the narrative. He seemed a bit frustrated, but he was well-oriented. His speech has a clear structure and cadence. The mood was somber and depressed, like affect. He was clearly able to understand and did not exhibit any indicators of psychosis or suicidal and homicidal thoughts. Despite some minor language and abstraction issues, his memory and cognitive abilities were unaffected. His judgement was unflawed and had insight of level 3.

Vol. 2, Issue 10 October 2024 ISSN: 2584-0142

Impression

Master G's provisional diagnoses focus on Acute stress reaction (F43.0) and Problems related to other legal circumstances (Z65.3) according to ICD.

Techniques suggested for reducing stress

- Journal writing- the client was suggested to write his thoughts and feelings on paper
- Exercise- engaging in daily exercises to keep his mind clear and not clustering with overthinking

Suggested Treatment

- Use Cognitive Behavioural Therapy (CBT) to help Master G become more emotionally aware and take culpability for his behaviours.
- Empathy coaching sessions to assist him in comprehending the psychological effects of his offence on the victim.
- Attend therapy sessions with Mr. G's family to foster better communication and an understanding of the gravity of the issue. Examine the potential roles that the family may have played in Mr. G's conduct, paying particular attention to the development of positive reinforcement strategies.
- Introduce Mr. G to behavioural change-focused rehabilitation programs that specifically target impulsivity and criminal thought patterns. Include a community service component to foster prosocial behaviour and a sense of responsibility (Hunter, 2010).

Vol. 2, Issue 10 October 2024 ISSN: 2584-0142

Conclusion

On the basis of Case History, MSE and behavioural observations Master G's provisional diagnoses focus on Acute stress reaction (F43.0) and Problems related to other legal circumstances (Z65.3). However, there was a desire to get out more than any regret for the deed done.

A qualified and licensed mental health professional should be consulted because the research had limitations as well, such as limited exposure and time limits to handle the medico-legal elements of the case. Specific symptoms such as stress levels could not be determined and though case history and MSE provided with important information they cannot be the sole determinant of a diagnosis. The case can also be subjected to clinician bias and in-depth emotional state of the person may not be ascertained.

Vol. 2, Issue 10 October 2024 ISSN: 2584-0142

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