Counseling Internship Report

Submitted to:

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Submitted By:

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MS.3rd Semester

Educational Psychology

12-FSS/MSPSY/F08

Department of Psychology
Faculty of Social Sciences

International Islamic University
Islamabad

Counseling Report

By

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Supervised By: DR. ASGHAR ALI SHAH

DEDICATION
TO
The Martyrs of
International Islamic University

Acknowledgement

I have the only pearl of my eyes to admire the blessing of the compassionate and omnipotent because the words are bound, knowledge is limited and time is short to express his dignity. It is one of infinite blessing of Allah that bestowed me with the potential and ability to complete the clinical internship report in time and make a material contribution towards the deep oceans of knowledge already existing. My special praise for the holy Prophet Muhammad (PBHU) who is for even humanity as a whole.

My grateful thanks are given to honorable, cooperative teacher and also my supervisor Sir Dr. Asghar Ali Shah chairman of department of psychology Faculty of social sciences International Islamic University Islamabad for providing all possible help, valuable suggestions and sympathetic attitude throughout my report writing.

I extend my warm thanks to my very dear teachers Dr. Muhammad Javed, Dr. Mzahar Iqbal Bhatti and my dear fellow Mr. Muhammad Akbar Karim, Mr. Rana Ejaz Ahmed Khan, Mr. Masud Akhtar, Mr. Umair Ahmed, who encouraged my efforts.

Once again I pay my heartiest thanks to all who directly or indirectly supported me throughout the work

Ghulam Abbas Khan

CASE NO. 1

IDENTIFYING DATA

Name	M.A
Age	15 Years
Gender	Male
No. of Siblings	4th
Order in sibling	2nd
Education	8th class
Address	Rawalpindi

Informant

Information was provided by the client himself.

Findings

Client has interpersonal relations problems and was not good in studies.Client went out of the home and school several times .And after spent many days, came back at home. Now he came back at home because he had no resources to stay out of home.He was feeling himself depressed and rejected person by the society.

Sessions:

Client belongs to a poor family. His father was deputy registrar in co-operation. His father loved and cared him very much. According to my client' he left home from 3 to 4 months and came back because he was suffered form physical weakness. He had fluctuation in behaviour. He was restless. He was suffered from Insomia. He can't even walk properly and his performance in school was even very poor. His teachers were very restless due to his non-serious attitude towards studies.counsellor ask the client that can u control on yourself , he said that he lives in the world of fantasies. He can,t concentrate in his studies and had no interest in studies and going to school. According to client, his birth was normal. He was born in middle class family. There was not prenatal and post natal complications. He achieved all the milestones appropriately. He started going to school at normal age. He has few friends but all of them have many behavioral problems from his side.

His such kind of behavior started about 4 year before.due to his such kind of behavior he became aggressive, abused, wandering tendency and used to remain out of the home for months. He had self talking and self-laughing behaviour. He became self-neglected, disturb sleep and decrease appetite .His functional activity and relationship was disturbed because of his this attitude.

1. Behavioral observation

My client was co-operative, good eye contact and confident. Sometime, looses his confidence. He had very normal personality and dressing. He was well-dressed without having shave.

ii. Speech

Speech rate was normal and tone was appropriate. But his speech was very brief.He looked restless and having function in behavior.

Session No. 1 **35 Mint**

During session, I asked him about the reason for his problems and built a rapport. There was a little bit problem by the client in establishing the rapport , but atfter a few minutes it got a good rapport.

Session No. 2 **30 Mint**

I assure his confidentiality and asked him about his present illness and personal history.

Session No. 3 **40 Mint**

In this session, he complaint that I did not sleep, I suggested him to focus on bulb with blank mind, you will sleep automatically.

Session No. 4 **50 Mint**:I talk about his daily routine. I gave me some article of mental illness from newspaper and requested her to read this article.

CASE NO. 2

IDENTIFYING DATA

Name	A.T
Age	20 Years
Gender	Female
Religion	Islam
No. of Siblings	6th
Birth order	2nd
Education	B.A
Occupation	None
Marital status	Single
Father's occupation	Policeman
Mother's occupation	House

Reason for Referral

The client was looking restless. Her condition was very worse.she had behavioral problems as weel. She therefore meet with the counselor.The patient has no medical history. There was no significant and medical illness, surgical procedure, head injury, fits or accident in the past.

Family History

The client belonged to a middle class family. Her parents were alive. Her father was policeman. He had enough income to meet the needs of the family. Her father was aggressive by nature. Her mother was housewife. Parent's relations with each other are not good. They had different nature to each other.. They were compromising to each other. Her parent's nature was different from each other. All siblings of my client were students except her elder sister. Her sister left studies because of her younger brother. Basically he is strict and aggressive by nature and didn't want his sister to continue studies.

Personal History

My client birth was normal. There is no complication of prenatal and postnatal development and growth. She achieved her milestone at proper time. Her development in early and middle childhood was normal. She had my friends in school and college. She got good marks in B.A recently, she did B.A she wanted to join university. But her father admission her in Maddarsah. She did not want to join Madarshah. She wanted to join university. She attached to her elder sister. She hated her brother.

1. Behavior Observation

She was looking upset and restless.

i. General Appearance

A young girl had very week face expression. She was wel-combed and wel-dressed. She was co-operative. Her hands were trembling.

ii. Speech

She was speaking rapidly. Her speech was logical. Her volume of voice was normal but little bit loud.

Session 1: **50 minutes**

I built rapport with my client. I asked about her present illness. I advised her to do deep breathing.

. Second session **50 minutes**

I session , I educate the client about her illness and improved her familial attitude.

Session 3: **50 minutes**

In this session, I discuss about her personal hygiene program.

Session 4: **60 minutes**

I requested her family to ignore her during fits and encourage her to cop with her problem.

CASE NO. 3

BIO DATA

Name	I.S
Age	13 Years
Gender	Female
Marital Status	Unmarried
No. of Siblings	4
Birth order	1
Education	House wife
Address	chakwal

REASON OF REFERRAL

Continuously, form last 2 months she was making quarreling with her family. She was irritant by the people.

HISTORY OF PRESENT ILLNESS

According to client some relative came to hurt or injured my father,from that time, I am suffering from fever and jerks.

FAMILY HISTORY

Her mother is household lady and 45 years old and her father is guard in forest and her father is 35 years old. Her parents love her very much. She is the only daughter of her parents. She has 3 brothers. She played with them according t0o client, her mother is very strict and stubborn but love her very much. Her father told us that my wife is stubborn and I am compromising bècause of my children.

PERSONAL HISTORY

Her birth was normal. There was not any prenatal and post natal complication Her milestones was appropriate. She was healthy in her childhood. She is a student of 5^{th} class in Govt. school. Now-a-day, she is enjoying summer vacation and summer vactions are going to its end. Few days remain but she did not complete her homework. She was also afraid of school punish.

1. BEHAVIOUR OBSERVATION

She is cooperative, well manner, well mannered confident girl. She behaved non – cooperative but after strictness she starts behaved or respond properly. Her eye contact was good.

i. General APPEARANCE

She was well – dressed haring beautiful features. She was well – spoken. She was very talkative girl.

Session No. 1

During session 1, I built rapport with client and asked her about her illness.

Session No. 2

I asked client about her present history of illness and personal history.

Session No. 3

I taught her, face your difficulties with full courage. But, she was not serious. I drop the session.

Session No. 4

I assigned activities, like writing stories and read story books. She did.

Session No. 5

I checked her given assignments, and requested her family member, isolate her during fits. Her family co-operates me a lot.

CASE NO.4

IDENTIFYING DATA

Name	F.B
Age	22 Years
Gender	Female
Marital status	Unmarried
No. of Siblings	4th
Order in sibling	2nd
Education	5 th class
Income	Rs. 2000
Address	Multan .

Reason for Referral

One week before she attended the marriage ceremony of her cousin, where, girls laughed at her that she remained unengaged and we were all engaged. That's why she was very nervous and confused.she was also suffering fron inferiority complex.

History of Present Illness:

According to my client one week before at the marriage ceremony of my cousin. All girls laughed at me that I remained unengaged. I couldn't tolerate these issues. Because I am human being that's why I wanted to do so.

According to the informant, one night I entered the room, I was shocked to see that she was standing on the bed and my 3 month grandson was in her hand and she was looking toward her in a very suspicious way. And just going to drop on a floor.

Family History

The client's parents were alive. Client's mother was 50 years old and she worked as a worker of cantt shop. She did Kinari on fabrics. Client's father was 54 years old and was labour. She had two brothers. One brother was married she had only one sister. Her younger sister is very pretty and was engaged. Everyone was worried about her mental condition. All loved her very much.

Personal History

According to informant, her birth was normal. She was born in lower class family. There was not any prenatal and post natal complication. She achieved all the milestones appropriate. She started going school in normal age. She has many friends.

She studied uptill 5th class, working for fabric Kinari for Cantt fabric shop. She had very good relation with her family. One and a half year before she was binded in nikkah. After 3 months my client family came to know that my client's husband was

already married and that people were fraud my client's family tock Khula. Now she demanded for a handsome ,noble and rich husband.

My client was co-operative. She has a very good personality and dressing. She was well-mannered and we-behaved girl.

i. General Appearance and Behavior

She was well dressed, well manner girl. She was in veil. But during session, she put off her veil.

ii. Speech

Speech rate was low and tone was appropriate. She wanted to told me about more and more about her Ex-inlaws and challenge in life. She told that she suffered a lotin her life.

Session No. 1 55 minutes

In session 1, I built a rappo with my client and gave her deep breathing. I asked about her.

Session No. 2 50 minutes

I took personal history and gave her progressive relaxation technique and talked to her family about her illness. During this session she became aggressive and run in whole ward without duppatta. I waited 15 minutes and end this session with deep breathing.

Session No. 3 50 minutes

I improved her familial attitude towards her mother. In first three sessions, her mother wept bitterly. I gave my client personal hygenic shedule and activity schedule.

Session No. 4 55 minutes

I gave her homework, to do progressive relaxation technique and deep breathing. I checked her personal hygenic schedule and activity schedule.and encouraged her for her cooperation in treatment.

Session No. 5 50 minutes

I gave her a tip, when you feel. When you feel sad worthless, helpless, give some positive affirmation to yourself like.

"I am happy"

"I can do it"

"I am strong"

She looked satisfied in this session. And I felt that this case was my achievement.

CASE NO. 5

IDENTIFYING DATA

Name	A.H
Age	25 Years
Gender	Male
Religion	Islam
Birth order	1st
No. of Siblings	3rd
Education	Middle
Occupation	None
Marital status	Single
Father's occupation	Died
Mother's occupation	House wife
Address	taxila

Reason for Referral

He was referred to psychologist due to disturbed behavior.

Family History

His mother was housewife. His father died when client was 3 year old. He belonged to middle class family. He had one brother and one sister. He had good relation with his brother but not with his sister. He loved his mother very much. The family drug history was positive. His mother is also addicted of "Neswar". And his father was chain smoker.

Personal History

According to informant, her birth was normal. He was born in middle class family. There was not any prenatal and post natal complication He achieved his milestones at proper time. He had no serious illness in infancy early and middle childhood. He started his studies at the age of 5 years. He has good relations with his friends. He escaped from home at the age of 11 years. He was forcibly taken back to home and requested him to go school regularly. He left bad company and join school . . He started smoking and in taking heroin when he was 13 years old and again join bad company. He was inhaling heroin and till age of 18. when he got admission in middle school he left the dugs. He started drugs when he was 20 years old and continued it at the age of 22. He remained under treatment in Nai Zindagi for 3 month when he was 22 year old. He became healthy and started doing job and helped his family. He again started inhaling heroin at the age of 24 years. After deceived by her beloved. He had good

relation with brother and mother. But he had not good relation with her sister. He had no forensic history but he involved in sexual activities in past he went on "Kottha" and enjoyed "Mujra". He had sexual relation with prostitutes, because of sexual relations, he had suffered from some sexual problems. His leg was swelled because he injected morphine. According to client ,i felt difficulty to face my relatives.

1. BEHAVIOR OBSERVATION

He was co-operative but some time he was looking sad and depressed.

i. General Appearance

His behavior during sessions was co-operative. The patient was muscular young man with a normal height, wearing Shalwar and Qameez, with religious bracelet. He was unshaven and non-comb. He made good eye contact. He had a mixed mood during sessions.

Session 1: **15 Minutes**

In 1St session I introduced my self to him but he did not say anything .After pause 5 minutes he replied, I did not want to talk to you. I asked him, please be relax .If you didn't want to talk. I would come tomorrow. I told her, I am your psychologist and wanted to help you and leave the session

Session 2: **40 Minutes**

This session I tried to maintain his confidentiality. Then he told me about his bio-data and with the help of his brother, I came to know his presenting complaints.

Session 3: **40 Minutes**

In third session. Alhumdulilah I digged out his detailed history of present illness from him and his mother. After that I asked him about past psychiatric history and medical history. In the end I applied deep breathing to relax him, when I ended session.

Session 4: **40 Minutes**

In 4th session he met me cheerfully. I was gald to see his improvement and I started 4th session. He told family and personal history.

Session 5: **50 Minutes**

In the 6th session I tried to change his irrational beliefs in rational. For that I did disputing. I requested for performing progressive relaxation technique His answer was not satisfactory about my session.

Session 6: **60 Minutes**

I observed that his hygiene improved. I educated him with verses of Holy Quran that addiction is Haram and prohibited in Islam. I gave him Urdu translated terjama of Quran for understanding of Islam. I ended session.

Session 7: **50 Minutes**

In session I educated his family about hazards of addiction and taught them how to look after him.

Session 8: 40 Minutes

In this session I checked his hygiene schedule I applied home work technique of REBT that I asked him to read Islamic books.

CASE NO. 6

IDENTIFICATION DATA:

Name	:	FA
Age	:	30 Years
Gender	:	Female
Marital Status	:	Single
Religion	:	Islam
Education	:	Primary
Occupation	:	house maid
No. of sibling	:	4 brothers 2 sisters

REASON FOR REFERRAL:

Patient brought to the counselor by her mother , due to the intense and severe aggressive behavior , excessive and repetitive talking, lack of appetite and some times excess of eating behavior she have also complain of quarrelling with family member on minor issues. She has hostile attitude and suicidal thoughts many times.

PRESENTING COMPLAINTS:

Client is thirty years old girl. She belongs to lower class family. She lived in village with her mother and elder sister. She has defect in her one eye and has glaucoma.

Due to which she is very depressed she thought just because of this defect she would never approved by any one other wise she is perfectly all right. She had a strong desire for the treatment of her eyes, but due to financial problem she can't do it and she has a very bad feeling about it. She is very close with her elder sister where she lives with her mother. She is also close with her real brother who is driver in a company. She is also worried about his job and their future. Due to financial constraints and one defected eye she always worry about her marriage and she thinks these reasons are liable for her single status until she is now 30 years old. Most of the time she has suicidal thoughts and even she tried for one time but failed. Due to financial crises she started to work in different houses as house maid but due to her aggressive and talkative behaviors she is fired out from many places.

FAMILY HISTORY:

The client belongs to lower class family. There are three sister and four brothers. Two of them are step brothers her mother did two marriages and she has very close relationship with her real sisters and brothers. Her one sister died due to illness in her childhood and the elder sister is nurse in hospital and she has two kids and she is divorced. One of her step brother behaviors towards her is very harsh and it really depressed her and she hates him. Her father was a retired army soldier and mother work as servant in houses. She lives with her mother and elder sister and she is very close with her sister. Her family is supported by her elder sister and her bother who is driver and whom she has good relationship.Client was born at home with normal delivery. She had no illness during infancy no complication and traumatic event was happened but when

she was three years old she had suffered from severe illness and it damaged her one eyesight and cause glaucoma. Due to low financial status they couldn't treat her eyes and her one eyesight is completely damaged and incurable. Hers growth and weight was normal. Her schooling period was good she was slow learner during her school time. She enjoys her school period with her sisters, most of the time she helps in completing her homework. She used to play with her sister and she has unforgettable memories with her. Client has insecure feeling from her childhood till now and she is so defensive and has guarded personality. She avoid to more conversation with us when conversation goes towards her personality but she likes to talk on irrelevant topics with extra details. She has sad feelings about her studies that she can't study further. This reason also leads her towards depression.

1. Behavioral Observation:

Client was talkative but defensive while communicating she gives extra and relevant details. Her eye contact was good. She uses to laugh without any reasons and flight of ideas at many moments.

SESSION REPORTING

Session I (25 Minutes):

In order to reporting session of my client, I conduct first session with my client. In the first session I tried to develop good relations with my client. I also develop good relations with my client's mother who helped me in her case history my patient was with

manic episodes. After introduction with my client and his family, I ended the first session.

Session II (35 Minutes):

Next day, I started second session with my client my client was very defensive rapport . In this session so I have to take help from my client's mother who told me about the condition of the client. My client also helps me in his case history. She told me about her eyes problems which is one of source of depression for her also. My client was 30 years old lady, still unmarried who is responsible for her such condition. . She left her studies after class 4th .which is one of most regretful feeling for her. All her family members worried about her and want to see her well. I tried to ensure them that INSHALLAH very soon she will recover from this condition.

Session III (30 Minutes):

After the end of the second session, next day I started third session with my client. My client takes 35 minutes during the second session and becomes tired so I leave the work on next day. Next day I started with present complaints noted them. I also was looking after the family history and personal psychiatric history and personal history as well. My client is very talkative and give extra detail sometime it creates trouble for me. She most of the time interrupt her mother while communicating. In all these data gathering session the client's smother and she herself help me. After knowing all these things. I ended the third session.

Session IV (30 Minutes):

When the fourth session, I conducted all histories and decided to know about the mental status of my client through mental status examination. Her mental level was not bad. She give correct answer most of my questions and knows about things very well. During this session I also tried to fulfill the psychological tests and gave her activity schedule RISB and HTP. My client gave so much time so I ended the session and leave the work on the next day.

Session V (35 Minutes):

When I started the fifth session with my client I again started from the fulfillment of the psychological tests. My client's score was normal. He showed moderate depression and anxiety level in his assessment through tests. My client take 35 minutes to fulfill them is normal. Her mother helped him in fulfilling them because some things are not understandable for her. After that I ended the session.

Session VI (45 Minutes):

Next day, I started sixth session and give exercise to my client of deep breathing and relaxation training to reduce her tension and anxiety. When firstly I applied their result had been normal but when I applied them again then the result was satisfactory. My client reduced her tensions and anxieties through these techniques, I advised her to do this exercise daily for the betterment of her problem and health.

Session VII (45 Minutes):

In the seventh session, I applied therapies from clinical psychology on my client to reduce his tension as well. In these therapies, I use rational emotive behavior therapy, cognitive therapy, light therapy, and gestalt therapy as well. The results of these therapies had been good and condition of my client was also satisfactory. I also done management plan. I include short-term plans as well as long-term plans.

Session VIII (30 Minutes):

This is my last session with the client after applying therapies and done management plans. In this session I first of all make her aware of her problem and advised to my client how to cope with the problem. I told her that these problems are created by her and she herself can remove her all problems. I advised her to over come aggressive and assault behavior which is dangerous form her and all her family. I also advised his mother to help her in the recovery of her problem. I also advised her "prays" and recite the verse of "Holy Quran" daily in morning .At the end of sessions i said "Allah Hafiz"

CASE NO. 7

IDENTIFICATION DATA:

Name	:	KT
Age	:	17 Years
Gender	:	Male
Marital Status	:	Single
Religion	:	Islam
Education	:	4th Class
Occupation	:	Student
No. of sibling	:	4 brothers

REASON FOR REFERRAL:

Patient brought to the hospital by his grandmother, due to the use of drug . He was suffering from headache and pain in his whole body and his eye side became weak due to intake of drug. His sleep and appetite was disturbed.Client is 17 years young boy. He started using drugs in the age of 15 after the separation of his parents. He most of the time identifies his father and his father was also addict when he used to go School in his childhood in class 4th. He had bad company there and than smoking cigrates. With the passage of time when he became used to cigarette, his addiction bends towards chrush. Most of the time to fulfill his need he start steal things. He is living with his grandmother

after the separation of his parents. At the time of separation of he was only five years old. After separation his mother got divorced from father and she marries with someone else and his father also marries with another lady. His father has 2 children and mother have 3 children due to their 2nd marriages. Due to this broken family the client fell in depression and to avoid this phase he start keeping bad company and spend his most of the time with them by playing video games Billiard, watching movie and taking drugs.

His grandmother was very disturbed by his such behavior and aggressive manner. At last see convinced him for treatment. He himself was fed up with his condition since four month before he had symptoms of lack of appetite, disturbed sleep and agitated personality. His eye side became weaker and weaker due to the use of drug.

FAMILY HISTORY:

The client belongs to middle class family. He belongs to Muzafabbad and is urdu speaking. They are 2 brothers only and his brother is 2 years older than him. When he was 5 years old his fathers gave divorced to his mother and marry again with someone else. As a result of this separation he starts living with his grandmother. His father sometime visits him and gave some money to his grandmother. His father runs a mobile shop in Dubai and he spent 3 or 4 months with them. His elder brother is also habitual smoker but he avoids drugs. He has also introverted and antisocial personality. His father is an authorative and dominant person. He also wants to identify himself and wished to go Dubai like his father and he wanted to earn lots of money. He also faced economical crisis due to separation of his parents. Due to this crisis he starts stealing things and

money for his drug desires. He has warm feelings with his grandmother because he spent his childhood with her

PERSONAL HISTORY:

Client was born in Muzafabbad. He was born at home by normal delivery. No birth trauma was happened. He belongs to urdu speaking family. He had no serious illness in his infancy period development. His parental and postnatal development was normal.. He has average height and weight according to his age. He had no interest in studies during his childhood. After 5th class he joined bad company and start using cigarette and with the passage of time he use drugs churs. He started to spent nights with his bad friends by watching movies, playing games etc.

1. Behavior Observation:

Client's behavior was co-operative. He has some problem with his throat and he was continuously spitting and complaining that he has dryness of throat, due to the drug side effect. His communication level and eye contact was good.

(i) General Appearance:

Client was dressed up normally. His hygienically condition is normal. He has little bit trimness in his hands due to the side effect of drugs cure medicine which was giving him as a medicine.

SESSION REPORTING

Session I (25 Minutes):

In order to reporting session of my client, I conduct first session with my client. In the first session I tried to develop good relations with my client. I also develop good relations with my client's Grandmother who helped me in his case history my patient was drug addict. Due to this case of drugs he complaints his physical problem also. After introduction with my client and his family, I ended the first session.

Session II (35 Minutes):

Next day, I started second session with my client my client was very sensitive and he hide his some personal activities from me , despite of having good rapport . In this session so I have to take help from my client's Grandmother who told me about the condition of the client before come into the hospital. My client also help me in his case history. He told me about his physical problems also. My client was young beautiful boy of age 17. He left his studies after class 4th. He loved his Grandmother so much. All his family members worried about him and want to see him well. I tried to ensured them that INSHALLAH very soon he will recover from this condition.

Session III (30 Minutes):

After the end of the second session, next day I started third session with my client. My client take 35 minutes during the second session and becomes tired so I leave the

work on next day. Next day I started with present complaints noted them. I also looking after the family history and personal psychiatric history and personal history as well. In all these things the client's Grandmother and he himself help me. After knowing all these things. I ended the third session.

Session IV (30 Minutes):

When the fourth session, I conducted all histories and decided to know about the mental status of my client through mental status examination. His mental level was not bad. He give correct answer most of my questions and knows about things very well. During this session I also tried to fulfill the psychological tests and gave him activity schedule. My client gave so much time so I ended the session and leave the work on the next day.

Session V (35 Minutes):

When I started the fifth session with my client I again started from the fulfillment of the psychological tests. My client's score was normal. He showed moderate depression and anxiety level in his assessment through tests. My client take 35 minutes to fulfill them is normal. His Grandmother helped him in fulfilling them because some things are not understandable for him. After that I ended the session.

Session VI (45 Minutes):

Next day, I started sixth session and give exercise to my client of deep breathing and relaxation training to reduce his tension and anxiety. When firstly I applied their

result had been normal but when I applied them again then the result was satisfactory. My client reduced his tensions and anxieties through these techniques, I advised him to do this exercise daily for the betterment of his problem and health.

Session VII (45 Minutes):

In the seventh session, I applied therapies from clinical psychology on my client to reduce his tension as well. In these therapies, I use rational emotive behavior therapy, cognitive therapy, and gestalt therapy as well. The results of these therapies had been good and condition of my client was also satisfactory. I also done management plan. I include short-term plans as well as long-term plans.

Session VIII (30 Minutes):

This is my last session with the client after applying therapies and done management plans. In this session I advised to my client how to cope with the problem. I told him that these problems are created by himself and he himself can remove his all problems. I advised him to over come his habit of addicting drugs because this is dangerous form him and all his family. I also advised his Grandmother to help him in the recovery of his problem. I also advised him "prays" and recite the verse of "Holy Quran" daily in morning .At the end of sessions i said "Allah Hafiz"

CASE NO. 8

IDENTIFICATION DATA:

Name	:	M.saleem
Age	:	40 Years
Gender	:	Male
Marital Status	:	Married
Religion	:	Islam
Education	:	M.A (English)
Occupation	:	none
No. of sibling	:	1 brothers 2 sisters
No. of Children	:	1 boy, 1 girl

Reason for referral:

The client was suffering from depression.

The client thinks that his problem is parental anxiety. He belongs to lover class family. It was difficult for his parents to fulfill his needs. He says that he has not got parental care and attention so he has developed delusions about his parent's identity. He thinks that famous cricketer imran khan is real father and famous

personality moneza hashmi is his real mother. They left him and his acting mother and father adopted him.

He got married when he was at the age of 27. His marriage was forced and disagreed. He got married according to the desire of his parents. His attitude was normal towards marriage. After marriage he became conscious about marital issues. But his joblessness and disturbed parentage anxiety developed troubles fro him to continue this marriage. His economic condition was very poor. He had interpersonal conflicts with his wife. He has two children and both are sons. His marriage ended in divorce . He thinks that his parent's attitude was the reason of his divorce. He had pleasant sexual relations with his wife. But he could not adjust with his marital life because of his disturbed family orientation and jobless condition. He says after marriage he felt responsibility and he could not get opportunities to fulfill these responsibilities so he became psychotic. . He says due to disturbed parentage anxiety and joblessness he got depression and psychotic illness.

FAMILY HISTORY:

Client's total number of family members are 6. He has 2 sisters and one brother. Then he is on last number. His mother died when he was 33 years old. He has not good feeling about his father and mother. He has not heartly and happy relations with his siblings. He says that his mother and father are trouble for him. They have not give him the care of parenthood. He don't like to talk about his family. There is no mental and physical illness present in his family. His father is the

only person that influences his family. He has serious conflicts with his family. He has not happy and pleasant interpersonal relations with his family.

PERSONAL HISTORY

MS's birth was normal he is youngest in his family. He started walking when he was one year old and started talking when he was 2 years old. He had no childhood handicap, His wearing was scheduled. When he was 2 years old, he was not punished for toilet training and method was flexible. His childhood recollections are unpleasant. He did not like to talk about his childhood experience.

He says he did not get parental care and attention in his childhood. The institutions from which he got education were good and provided him good education. Religious teaching was taught to him when he was 6 years old. He was not forced to follow religion. He feels that he is intellectually unfit as compare to his peers.

Saleem's hobby is reading books and poetry. He thinks that his hobbies express his feelings adequately. He has never dine a job because of his psychotic condition. He is not satisfied with his joblessness.He Says:I feel regret of joblessnessHe also says:I don't like to waste my time in fountain house.

The fountain house is like hell. He says due to disturbed parentage anxiety and joblessness he got depression and psychotic illness. Now he is in fountain house and he does not feel comfortable here.

Behavior Observation

Client's behavior was not so co-operative. He was looking depressed and upset. He try to avoid when he gave the answer of my question he looks tired and lazy. His eye contact was not good. He has some problem in his throat due to drug side effect and looks not normal during the conversation. Motor behavior was restless impulsive aggressive

General Appearance:

When I met him first he was in tidy clothes & his hair were neatly combed. But he had flat facial expressions. His eye contact was not good and was not so co-operative and communicative. But he was not willing or feels pleasant to talk about his family.

SESSION REPORTING

Session I (25 Minutes):

In order to reporting session of my client, I conduct first session with my client. In the first session I tried to develop good rapport with my client. He was looking depressed and upset. He try to avoid when he gave the answer of my question he looks tired and lazy.His motor behavior was restless impulsive aggressive. He has some problem in his throat due to drug side effect and looks not normal during the conversation. After introduction with my client and his family, I ended the first session.

Session II (35 Minutes):

Next day, I started second session with my client my client was very s stubborn and aggressive.He has disturbed parentage anxiety and joblessness he got depression

and get psychotic illness. In this session so I have to take help from my client's therapist who told me about the condition of the client before come into the hospital. My client also help me in his case history. He told me about his physical problems also. My client was of age 41. He has severe deiiusion. All his family members worried about him and want to see him well. I tried to ensured him that INSHALLAH very soon he will recover from this condition.

Session III (30 Minutes):

After the end of the second session, next day I started third session with my client. My client take 35 minutes during the second session and becomes tired so I leave the work on next day. Next day I started with present complaints noted them. I also looking after the family history and personal psychiatric history and personal history as well. In all these things the client's therapist and he himself help me. After knowing all these things. I ended the third session.

Session IV (30 Minutes):

When the fourth session, I conducted all histories and decided to know about the mental status of my client through mental status examination. His mental level was not so good. He was not able to answer most of my questions and show rigidity in most cases. During this session I also tried to fulfill the psychological tests and gave him activity schedule. My client gave so much time so I ended the session and leave the work on the next day.

Session V (35 Minutes):

When I started the fifth session with my client I again started from the fulfillment of the psychological tests. My client's score was severe. He showed severe depression and anxiety level in his assessment through tests. My client take 35 minutes to fulfill them is normal. He take help helpe from psychologist in fulfilling them because some things are not understandable for him. After that I ended the session.

Session VI (45 Minutes):

Next day, I started sixth session and give exercise to my client of deep breathing and relaxation training to reduce his tension and anxiety. When firstly I applied their result had been normal but when I applied them again then the result was satisfactory. My client reduced his tensions and anxieties through these techniques, I advised him to do this exercise daily for the betterment of his problem and health.

Session VII (45 Minutes):

In the seventh session, I applied therapies from clinical psychology on my client to reduce his tension as well. In these therapies, I use rational emotive behavior therapy, cognitive therapy, and behavioral therapy/token economy and modeling as well. The results of these therapies had been good and condition of my client was also satisfactory. I also done management plan. I include short-term plans as well as long-term plans.

Session VIII (30 Minutes):

This is my last session with the client after applying therapies and done management plans. In this session I advised to my client how to cope with the problem. I

told him that these problems are created by himself and he himself can remove his all problems. I advised him to over come his habit of inconsistency with job because this leads problem for him and all his family.. I also advised him "prays" and recite the verse of "Holy Quran" daily in morning .At the end of sessions i said "Allah Hafiz"

CASE NO. 9

IDENTIFICATION DATA:

Name	:	M.S
Age	:	51Years
Gender	:	Male
Marital Status	:	Single
Religion	:	Islam
Education	:	B.A.
Occupation		none
No. of sibling	:	4 brothers 3 sisters
No. of Children	:	1 boy, 1 girl

REASON FOR REFERRAL:

M.S. is 51 years old man. He has psychiatric illness.

HISTORY OF PRESENT ILLNESS:

He has schizoid effect in his personality and is a very much depressed individual. His parents never gave attention, care, and love to him. He never enjoyed close relationships with his father, mother as well as with his siblings. He is an educated individual, but some severe life crisis change his life totally, when his father did second

marriage as well as when he failed in his educational career. He is such an individual who loves beauty. He likes beautiful girls but still he is unmarried. He belongs to a very rich family .He never face any type of financial & economical problems but he became disturbed in his life when he felt that there is no love, no importance, and no care for him.

FAMILY HISTORY:

The total number of the client's siblings is 7 and the ages of siblings are the elder brother who died at the age of 39, then he has two step sister because his father also had 2nd marriage, then the client himself who is 51 year old, then there is the number of his real sister then again his younger brother then at last the youngest sister. He said that his father did two marriages, and the first marriage was arranged & 2nd was love marriage. He said his parents did love him first but the conflict occurred because of the steps siblings. They often created difficulties for him but he has great affection and love for his real brothers and sisters but he had no importance in his family.

He said that his family has diabetes as genetic illness and when he was young, he used to smoke. His elder brother also took cigarettes and because of smoking, he got ill due to cancer and then he died at the age of 39 because of this ailment. He said that his stepmother was influencing figure in their family and his father take all suggestions from her, which create great conflict in his family.

PERSONAL HISTORY:

M.S.'s birth was normal and he is the 2nd born in his family. He does not know

when he started walking and talking. There was not any specific problems related to his childhood period and there was not any problem related to his toilet training .His mother taught him about toilet training. He said that his mother feed him when he was child. He had not any handicap in his childhood. He said that he was very found of to made sweet dreams and likes to remain in fantasy world. His mother wanted him to become a doctor and he was an intelligent student too but he had not much interest in studies. He said that his childhood period was pleasant as well as unpleasant also because, in his home; there was not any importance and attention for him by his parents rather they remained totally busy in their activities but sometimes, he got appreciation by his mother when he had done something good. Sometimes his mother kissed him as well as punished also when he had done something wrong and his mother used to stand him all the day as punishment.

He said whenever he create disturbance for their helper his mother punished him. The most favorite stories of the client during his childhood period were "Snow White" and "Cinderella". He said he was sleeping with his aunt until the age of 6 years. His favorite game is cricket and according to him:

He became sexually aware at the age of 10 in his childhood and source of awareness was the books. He played hide and seek with his maid and enjoyed a lot in her company. He said that sometimes my mind think about shameful situations or things and enjoy doing so and these was his pleasant feelings at that time but his parents attitude towards sex was very strict. His relationship with girls was very strong and he likes attractive and beautiful girls. He said that at college time, I had many girl friends and he

liked his teacher "Ghazala" because she was very pretty and taught him "anatomy" but now he has realized that our religion does not like to made relationships with girls so I became aware of all vicissitudes of life now.

He said **"He is the best all rounder in cricket."**

Behavioral Observation

Client's behavior was no so co-operative. He was looking depressed and upset. He try to avoid when he gave the answer of my question he looks tired and lazy. His eye contact was not good. He looks not normal during the conversation with therapist. Motor behavior was restless impulsive aggressive .

SESSION REPORTING

Session I (25 Minutes):

In order to reporting session of my client, I conduct first session with my client. In the first session I tried to develop good rapport with my client after introduction with my client and his family, I ended the first session.

Session II (35 Minutes):

Next day, I started second session with my client my client was very sensitive and has restricted personality .He has difficulty in making relations with his parents and siblings.. He said that his stepmother was influencing figure in their family and his father take all suggestions from her, which create great conflict in his family. Due to these

conflicts he almost chooses solitary activities or hobbies that do not include interactions of others, and it impaired his occupational functioning. I tried to ensure him that INSHALLAH very soon he will recover from this condition.

Session III (30 Minutes):

After the end of the second session, next day I started third session with my client. My client take 35 minutes during the second session and becomes tired so I leave the work on next day. Next day I started with present complaints noted them. I also looking after the family history and personal psychiatric history and personal history as well. In all these way client co operate with me. After knowing all these things. I ended the third session.

Session IV (30 Minutes):

When the fourth session started, I conducted all histories and decided to know about the mental status of my client through mental status examination. His mental level was not bad. He give correct answer most of my questions and knows about things very well.

Session V (35 Minutes):

When I started the fifth session with my client I again started from the fulfillment of the psychological tests.. He showed severe depression and anxiety level in his assessment through tests. My client take 35 minutes to fulfill them is normal. He takes

Session VI (45 Minutes):

Next day, I started sixth session and give exercise to my client of deep breathing and relaxation training to reduce his tension and anxiety. When firstly I applied their result had been normal but when I applied them again then the result was satisfactory. My client reduced his tensions and anxieties through these techniques, I advised him to do this exercise daily for the betterment of his problem and health.

Session VII (45 Minutes):

In the seventh session, I applied therapies from clinical psychology on my client to reduce his tension as well. In these therapies, I use empty chair technique, role playing the results of these therapies had been good and condition of my client was become satisfactory. I also done management plan. I include short-term plans as well as long-term plans.

Session VIII (30 Minutes):

This was my last session with the client after applying therapies and done management plans. In this session I advised to my client how to cope with the problem. I told him that these problems are created by him and he himself can remove his all problems. I advised him to be social and mostly interact with people it will develop confidence in him, if never quit his habit of socially inept and self absorbed behavior then

it will be painful form him and all his family. I also advised him "prays" and recite the verse of "Holy Quran" daily in morning .At the end of sessions i said "Allah Hafiz"

CASE NO. 10

IDENTIFICATION DATA:

Name	:	SK
Age	:	21Years
Gender	:	Female
Marital Status	:	Single
Religion	:	Islam
Education	:	Masters
Occupation	:	student
No. of sibling	:	2 brothers 1 sister

REASON FOR REFERRAL:

ABC is 21 years old girl. She has no physical and psychiatric illness, but she has conflict in her personality that she is not utilizing her talents and abilities to fulfill her duties especially in studies. She has confused thinking.The institution from which she got education was great and provides good education. She has regret feelings that her ambitions are not completed. She enjoyed her college and School time very much and pay less time for studies. Whenever she memorize those moments she feels happy. Religious teaching was taught to her at age of 8 years old and she was never forced to follow religion. She feels that she is less hardworking than her peers she never took

studies so serious, she is very intelligent but she think she is not utilizing her talent. She is totally different from her friends in others manners that she is somehow kind hearted to poor people but they don't bother them. She thought that she had a soft corner for poor and needy people. She is impressed by her teacher as she has brilliant and charming personality. She is very devoted and polite teacher. She tried her best to be like her and to copy her.

FAMILY HISTORY:

Subject's total numbers of family are six and age of her siblings is: brother is 27 years old and then the sister of 25 years old and then she is 21 years old and her younger brother is 19 years old. Her home was never broken by divorce or separation. She explains that her father is a great man and generous man. He is so friendly and frank with them. She was very impressed by her mother personality and said that she is lucky because she has mother like her, and further said, "She is a Gem". She had very good relation with her brothers and sisters.

She said that her sister is very innocent and brothers are loving. They discussed each thing with each other. She thought that she has little bit serious in her family rather than in friends and her parents used to take suggestions from her and she can communicate with her parents easily. Her mother is suffering from disease since one year ago she is a patient of Hepatitis. There was no conflicting situation in her family between her father and mother and other relatives. She said that my mind is changed with my peers.

PERSONAL HISTORY

Subject birth was quite normal and she is the 2nd last in her family, she started walking and talking at the age of two years old. she had no such habit of nail biting and thumbs sucking and her wearing schedule was normal. She was not punished while being toilet training and the method was quite simple and flexible. She did not have any childhood handicap. Her childhood recollections were pleasant but she had not remember all the events. Her approved behavior when she work hard and did good deeds, and she is highly disapproved when she didn't obey the order of her parents and did mistakes. The method of punishment was beating by her mother and reward was giving money by her father. Her favorite story was Cinderella and the favorite character was Cinderella. She used to sleep with her father when she was in 5th and after this she used to sleep with her mother till now. Her favorite game was Gulli Danda and Cricket, which she used to play with her brother.

1. Behavioral Observation:

Client's was well mannered decent girl she has an outspoken personality. Her eye contact was good. She has impressive way of communication.

SESSION REPORTING

Session I (25 Minutes):

In order to reporting session of my client, I conduct first session with my client. In the first session I tried to develop good relations with my client and show some empathy. After introduction with my client and his family, I ended the first session.

Session II (35 Minutes):

Next day, I started second session with my client my client was very outspoken so I never face any problem while communicating . My client helps me in her case history. She told me about her problem which is one of source of depression for her also. My client was 21 years old young girl..I tried to ensure her that INSHALLAH very soon she will recover from this condition.

Session III (30 Minutes):

After the end of the second session, next day I started third session with my client. My client takes 35 minutes during the second session and becomes tired so I leave the work on next day. Next day I started with present complaints noted them. I also was looking after the family history and personal psychiatric history and personal history as well. In all these data gathering session the client herself help me. After knowing all these things. I ended the third session.

Session IV (30 Minutes):

When the fourth session, I conducted all histories and decided to know about the mental status of my client through mental status examination. Her mental level was good. She gives correct answers all of my questions and knows about things very well. During

this session I also tried to fulfill the psychological tests and gave her activity schedule RISB and HTP OTIS, DASS. My client gave so much time so I ended the session and leave the work on the next day.

Session V (35 Minutes):

When I started the fifth session with my client I again started from the fulfillment of the psychological tests. My client's score was normal. He showed moderate depression and anxiety level in her assessment through tests. My client take 35 minutes to fulfill them is normal. After that I ended the session.

Session VI (45 Minutes):

Next day, I started sixth session and give exercise to my client of deep breathing and relaxation training to reduce her tension and anxiety. When firstly I applied their result had been normal but when I applied them again then the result was satisfactory. My client reduced her tensions and anxieties through these techniques, I advised her to do this exercise daily for the betterment of her problem and health.

Session VII (45 Minutes):

In the seventh session, I applied therapies from clinical psychology on my client to reduce his tension as well. In these therapies, I use behavioral therapy, cognitive therapy, catharsis, modeling and insight therapy as well. The results of these therapies had been good and condition of my client was also satisfactory. I also done management plan. I include short-term plans as well as long-term plans.

Session VIII (30 Minutes):

This is my last session with the client after applying therapies and done management plans. In this session I first of all make her aware of her problem and advised to my client how to cope with the problem. I told her that these problems are created by her and she herself can remove her all problems. I advised her to over come her irrational beliefs and self which is dangerous for her and her educational career. I also advised his mother to help her in the recovery of her problem. I also advised her "prays" and recite the verse of "Holy Quran" daily in morning .At the end of sessions i said "Allah Hafiz"

CASE NO. 11

Gender	Female
Age	35 years
Religion	Islam
Marital status	Married
Education	F.Sc
Occupation	House wife
No. of siblings	10
Birth order	1st

REASONS FOR REFERRAL

The client was ,referred to the psychologists for the assessment and management of her complaints of aggressive behavior, our burst, abusive language and odd behavior as well as self laughing.

FAMILY HISTORY

The client belongs to a nuclear family with 12 members. Their monthly income was only 8,000 because her father has a general store in jehlum. The father of the client is 60 years old. He is very nice and religious person. He loves his daughter because as she was her elder daughter. He is very depressed for her daughter condition.

The mother of the client is 50 years old, illiterate and is housewife. The relation of the client with her mother is loving and caring. She cares for her daughter but sometimes because of illness. Client has a negative attitude towards her mother.

The client has a 9 sisters and 1 younger brother. The client is elder among them.

The client has a satisfactory relationship with her all sisters. Her mother says that their daughters love each other very much and take care of each other. She has no significant conflict with her sisters. Infect, her sister respect her.

The client's only brother is 17 years old; who is doing F.Sc. the client loves her brother. She waits for her brother whole day for meet him.

The overall family environment is good and healthy relationship with each other but now days tense and strained because of client's condition

PERSONAL HISTORY

The birth of the client is through normal deliver. The milestones are at appropriate time. She has no significant illness at childhood. She started to go to school at age of 4 years. She was very found of study. He wants to become doctor. But because of her illness. She is not able to continue. She has been an intelligent student. She still wants to study and expressed her desire during sessions.

Her mother says she has a very good childhood. She was very active and intelligent girl. She has many friends and do many activities.

She got married at the age of 25 years with her cousin. She has a healthy and satisfied marital life with 2 daughter. Her husband know about her illness. But now he said that he can not afford her medicine and treatment. She sent her to her mother's home. The daughter of client was with her husband. She miss her daughter and also her husband. She want to go her own home, her husband's home.

1. BEHAVIORAL OBSERVATION

The client was a heavy built middle age women. She was wearing clothes but of three different colors. Her mother takes care of her clothes otherwise she likes to be dirty. Her gaze were averted, looking down and starring at floor. Her face has blunting of affect.

I. GENERAL APPEARANCE

She was sitting quietly on a bed. Her gestures were very harsh. She has also very bad face expression. She was looking angrily to very one. Her mother was taking care of her Dopatta. She did want to wear it.

SESSION REPORT

Session No. 1 (30 Minutes)

In the very first session, it was very difficult to built rapport with the client because he was mute and not supportive. So n the first session, I just tried to developed rapport.

Session No. 2 (40 Minutes)

In the next session, I was able to get his trust by doing his interesting activity as he was found of studding I asked him to make a picture of house, tree and person. In this way I applied HTP test after that I take identifying data.

Session No. 3 (45 Minutes)

In the third session he was looking much better and become cooperative with me now, she replied everything which I asked her, in this session, I also took her family history.

Session No. 4 (40 Minutes)

In this session, the client came with smiling face. She was calm under the influence of medicines. She told me about the event which happened to her when she was

in F.Sc this was the triggering event of her life and it was the reason for ending his studies .

Session No. 5 (45 Minutes)

In this session, I made his activity schedule so that he can engage himself in activity rather than thinking about his irrational beliefs. After that, we develop pleasure predicting sheet for client.

Session No. 6 (50 Minutes)

On next day, we started the session by exchanging few words of greeting. Today, client told me that he was feeling restless and fatigue so I demonstrated progressive relaxation to him. The session was ended soon because he is not feeling fresh.

Session No. 7 (30 Minutes)

On the next session, client was very happy. She was improving a lot. Today, she told me that she take a bath, brushes her teeth and combed her mother. When I saw that she was now able to understand and can face the past negative events, I made ABC model by her and try to replace her beliefs.

Session No. 8 (35 Minutes)

In this session, she told me that, she was going home today because they were not able to afford the expenses of hospital. I avoided her to take good care of herself and follow my instructions.

CASE NO. 12

IDENTIFYING DATA

Name	M.A.
Gender	Male
Age	20 years
Religion	Islam
Marital status	Single
Education	B.A
Occupation	Student
No. of siblings	4
Birth order	3rd

REASONS FOR REFERRAL

The client was referred to psychologist for the assessment and management of his psychogenic symptoms.

FAMILY HISTORY

The client belongs to nuclear family system with 5 members. He belongs to a poor family and living in a tensile of Mianwali. The client's father is 45 years old, who is a farmer. The client has a healthy relationship with his father. The client used to support and work with his father in the field. The client's mother is 40 years old. He is alive. He was also obedient and cooperative with his mother. He has a healthy relationship with his mother.

The 1st brother, of the client is 24 years old. He was doing a job in private company and supports his family. The client loves his brother and have healthy relationship with each other.

The 2nd sister, the client is 23 years old. She is married ad does not lives with them. The 3rd sister of the client is 21 years old. She is his younger sister the client has a close relationship to her.

PERSONAL HISTORY

There were no disturbance his developmental process. Client was born in Multan through normal deliver. His early physical and mental development was normal. He achieved all milestones at appropriate age levels. There was not history of physical and

illness in early and late childhood. There was also no psychological disturbances in his childhood. He started to go to school at the age of 5 years. He was an intelligent child. He wants to become doctor but he can not be able to get admission in medical college. Later, she got admission in B.A.

The triggering event for the client is the cruel attitude of the head of the village.

The head of the village is very cruel and rude person. He had no regard for other's property and life. He was normally corrupt. Client was very tense about all this. He wanted to improve this state of affairs but he can not do anything because he was poor. once ruler led police to arrest his brother under a false case because client would not obey his order. These entree things, ill legal deals of the ruler and client's inedibility to do something for himself and for the miserable people of his village led him to develop psychogenic symptoms.

1. BEHAVIORAL OBSERVATION

Client appeared in Shalwar Qamiz. He was wearing neat and clean clothes. He behaved in a good manner and answer correctly.

I. GENERAL APPEARANCE

The client was in a good condition. He was a thin built boy with short beard. He behaved warmly. He was talking in a educated way.

SESSION REPORT

Session No. 1 (40 Minutes)

In the 1st session, it was not difficult to establish the rapport with a client. Because client is very cooperative. So, I completed all the history taking with the client. He told me everything without hesitation about his family. But he shows little resistance about the triggering factor of his problems, which is given to us by his brother.

Session No. 2 (45 Minutes)

On the next day, the session was started from the greetings. He was very curious for his session. So, I decided to apply RISB because he wants to do some activity which he done RISB, I made activity schedule for the client.

Session No. 3 (50 Minutes)

In the third session, he looks depressed and anxious. He told me that last night, he can not take proper sleep and he also has a fitts last night. So, I demonstrated progressive muscle relaxation with the addiction of imagination. He was now feeling better. I asked him whenever he felt depressed, he practiced it by himself. I also identify the stressors of the client through his help and introduced rational copying statements to him. His statements is

I can overcome my problems.

I should do it.

I am strong enough to cope with stressors.

Session No. 4 (45 Minutes)

After two, days, the next session was conducted. He told me that with the help of PMR and rational copying statements he is feeling much better. Today, I checked his activity schedule. Personal hygiene and nutritional chart. Home work assignments were given to him were given to him. I asked him to identify his irrational though and make its rational responses by himself at home.

Session No. 5 (40 Minutes)

In the 5th session, the clients shows his homework, which he performed out of the session. He that he is feeling very much comfortable today. He is now able to control himself. He spent much of the time in activities shown in schedule.

Session No. 6 (30 Minutes)

In this session, client told me, that he is going home today because he has a lot of improvement now and he is now able to cope his stressors. I advised him to take medicine regularly. Educate his brother to strictly check his activity schedule in order to ensure that he is following it.

PART- II

Case No. 1

BIO DATA

Name	K. A
Age	58 Years
Sex	Female
Religion	Islam
Occupation	House Wife
Education	Masters
Marital status	Married
No. of Siblings	6th
Birth order	5th
No. of children	5
Monthly Income	50,000
Residence	Islamabad

Informant

Client provided all the information to the counsellor during the sessions herself.

Reason for Referral

Client lost interest in every. day life. Lost appetite and liked to be isolated even from her own children and could not sleep all night.Client is facing all these difficulties severely from last one year feelings of worthlessness disturbed her a lot. She herself decided to visit Psychologist in order to get rid of this condition.

From last three years client felt least interest in every day activities. Appetite is lost, and she wanted to be alone and could not bear any body's company for a long time.

Client became aggressive and developed irritable mood after the birth of her third child i.e. in 1984. But she did not express it much and tried to keep herself busy in household work. She did not ever had medication for her this disturbance. But from last few months she is facing severe problem in managing house hold work and her relationships. All the symptoms present at the moment were also present then but their intensity varied.

Personal History

Client's started her education career at the age of 5 and had keen interest, in education, she was considered as a brilliant student. Client wanted—to join medical field but after her father's death could not do so due to family pressure. According to the client this was the first shock. She got in her life. After that she lost interest in her studies and had a feeling of helplessness. Client had a healthy relationship with her parents and

siblings.Her husband used to be very authoritative and had some habits which were very much disliked by the client. Their relationship between them was average but they lacked mutual understanding due to which client became severely upset most of the time.Before the onset of these symptoms client used to be quite lively but very sensitive lady. The client had few friends.

Family History

Client belonged to a Pathan family. Client's husband was a retired Government officer and had their own business and land. The major problem client faced in his family was that the client's eldest son got addicted to alcohol in his early adulthood, due to which client became very tensed and this situation is persistent until today

Behavioral Observation

Her general appearance was very hygienic and tidy. Through out the session she sat in comfortable posture.

Speech

Her speech was organized and easy to understand. Ideas were coherent and well associated.

Mood

Client's external emotions expression was normal. She seemed to be a warm person. The client reported that she was emotionally warm. She felt affection for her near and dear ones.

Thought

The thought form of the client was logical; her ideas were logical and coherent. The thought content of the client was quite problematic, as it contained severe regrets and feelings of self worthlessness.

Perception

Client's perception was good but often she used to perceive things negatively especially under stress.

Alertness

Client was alert and she was attentively answering my questions and she was fully aware of her surroundings.

Concentration

Client was concentrating on the specific questions. I asked from her and answering me appropriately. I do not have to repeat the questions.

MEMORY

In order to check the immediate memory of the client I asked her to repeat the following series of numbers.

5, 9, 4, 3, 21, 2

She repeated exactly the same number in same sequence. So her immediate memory was good.

Recent Memory

In order to check the recent memory I told the client number and after 15 minutes asked her to repeat it, she repeated the number exactly.

Remote Memory

In order to check the client's remote memory I asked her to tell me about her first day at university After thinking for some time she told me an interesting event .it shows remote memory was good.

REPORTING OF SESSION

Session 1 **45 min**

It was quite easy to me to build rapport with the client as she was very friendly and cooperative. After taking identifying data she started giving me the history of his own life. There was no need to probe her because she wanted to express her thoughts fully. Through out the session she gave me detailed answers of the questions asked. I managed to complete history section during the first session.

Session 2 **40 min**

Second session was conducted right after the first section. I asked her about her routine life. She remained a little bit nervous during the whole session.

Session 3 **45 min**

During this session client seemed to me to much disturbed and restless. I applied progressive relaxation technique. I also gave her activity plan, which I have constructed for her and instructed her to follow it to reduce the stress. As she seemed to me over fatigued after this I ended the session.

Session 4 **50 min**

During this session I asked the client if she had something to share with me, at first she was quite hesitate but after few moments she began to share her problems which were disturbing her a lot. She had a very disturbing relationship with her husband and

disliked his several habits which irritated her a lot. I did not interrupted her while she was sharing her problems. I gave the client cognitive homework I end the session over here.

Session 5 **45 min**

In this session client had done her cognitive home work and listed her problems on a piece of paper, her views about the problem and the solutions she had thought element of disappointment and regrets was prominent in the client through out the session.

Session 6 **35 min**

In this session I checked the cognitive homework by the client and discussed it with her. I observed that the client had no. of regrets and had faced may disappointment in the life.

Session 7 **40 min**

In this session I applied deep breathing therapy on the client because she was complaining of headache and tired so I applied this therapy.

Session 8 **45 min**

It was the last session with the client. She was advised to continue relaxation training in the future and continue to think positively and rationally.

Case No. 2

BIO DATA

Name	:	A.G
Sex	:	Male
Age	:	40
Religion	:	Islam
Marital Status	:	Married
No. of siblings	:	11
No. of Child	:	5 (2 son, 3 daughters)
Birth Order	:	1st
Occupation	:	Hawker (Sales bed sheets) and Imam Masjid
Income	:	No fixed monthly income but often gets to 700 to 800/ months.

INFORMANT

Client provided all information to the counsellor.

Reason for referral.

15 days back client grew they severely aggressive, towards his neighbors, because he thought that they wanted to harm him, for this reason he got out of the house beat them and began to shout in the middle of the street. His father brought to the psychologist.. His speech was also disorganized during this period.

Client reported that he could not sleep properly and used to hear voices which were unfamiliar to him, but he obeyed them and he thinks that these are the voices of the saints. Client father reported that client's behavior was odd before admission in the hospital.

It was the first time that client had been ever admitted in the hospital for psychological problem. But he indeed faced severe behavioral and cognitive problem but no treatment was administered on him. According to the client's father he had been very aggressive through out his life, but it was the first time that he intended to hurt others especially his neighbors. All the above mentioned symptoms were present in him.

PERSONAL HISTORY

Client's father reported that the client was born through normal delivery and there was no complications in the delivery. According to him his infancy period was normal like other children. Client had been a normal child like other children. Client joined school at the age of six. According to client he had not many friends there. He did ever like going to school because he thought that the environment of the school was not worth learning and the teachers were not good ever like going to school because he thought the

environment in the school was not worth learning. He left school at the age of 7 and never joined again. He also did not liked the environment of Madrassa. He loved his younger siblings but according to the client they disappointed him, and disturbed him a lot. Client was a very religious man.

Client reported that he used to be very aggressive and often he badly harmed (or intended to harm) the people or objects, which annoyed him. He said that he wanted to get rid of this severe anger.

Client loved his mother and said that he shares everything with her. Client has normal relationship with her wife. .

According to the client before the onset of these symptoms he used to be.

1. Elements of aggression was present in him since adolescence.
2. He was quite stubborn about his particular beliefs and did not tolerated any action against them.
3. He was inclined towards religious activities since adolescence.
4. He had very few friends. He had been very selective about walking friend with.

FAMILY HISTORY

Client belonged to the lower socio-economic class and faced great financial problems. Client father was 63 years old and client mother is 65 years old. They had no proper source of income. Client's have normal relationship with his siblings and loved children epically daughters a lot.

No psychological problems were reported in client's family according to the provided information. Client's family has been facing severe financial problems and there is no proper source of income since last two years. Client father has retied from his job in the private firm.

Behavioral Observation

On the very first day of the interview session, client was laying on the bed and was totally unaware of his surroundings. It seemed that he had no energy to talk. His dress and hair were not tidy. But even then he was quite cooperative. He answered to my questions in vary low voice which was hard to understand. But gradually in latter sessions his condition was much better and he listened to me attentively and answered me appropriately. His speech was some what organized but often got confused. He seemed to be withdrawn and preoccupied evident. Aggression in his eyes was very much.

GENERAL APPEARANCE

Client's general appearance was not very hygienic. He gradually used to sit in a comfortable posture. His over all general appearance was normal.

SPEECH

His speech was very much detailed but it was organized. In his speech religious

aspect was very dominant and he often talked with many religious references.

EMOTIONAL EXPRESSIONS

His emotional expression was below normal. He was resistant in expressing himself. The client seemed to be emotionally normal person and according to him he felt affection for his children specially daughters and loved them thinking very much. His thought were generally logical and his ideas were logically associated. But thought blockage was evident. The thought content of the client was somewhat problematic, he had obsessions regarding religious activities, delusions of prosecution were evident.

He was preoccupied with the thought that throughout his life he had faced injustices. He thought that he was being punished for his sins. There were no suicidal thoughts. Client was not very much alert generally but when any one communicated with him directly he responded well.

I set these plans to tackle with that client.

1. To build rapport with the client.
2. To manage or to develop eye contact with him.
3. Educate the client about the illness.
4. Teach him appropriate communication skills.
5. To avoid relapse
6. To arrange follow-up sessions.

REPORTING OF SESSION

Session 1 **40 min**

In the very first session it was very difficult to develop rapport with him as his eye contact were very poor. And his speech was in very low tune it was hard to understand. He was not answering the questions. At the end of the session he started to consecrate answered me.

Session 2 **45 min**

On the very next day of the first session, I had a sitting with him. He was in the same condition his eyes were closed most of the time during the session. He began to answer me while his eyes being closed or staring on the floor. In this session although I couldn't manage to develop eye contact but he began to talk to me and answered me very briefly. I managed to complete history portion in this session.

Session 3 **50 min**

This was the third session with the client. When I greeted him, his responses was positive. He was able to conversant in a better way. He told me about the complaint he is having. I apply deep breathing method to help the client relax as he was looking exhausted after my questions. I ended the session.

Session 4 **45 min**

In this session client was in a clock condition than before. He looked now and

then to me, in this session he talked about the several stressful events of his life. I completed the informal assessment..

Session 5 **45 min**

In this session I began to know that the client had several very irrational beliefs due to which stress was aroused in him, which ultimately grave rise to psychological distress. I tried to change them with rational beliefs.

Session 6 **35 min**

In this session I applied deep breathing therapy on the client as he was restless and complained of headache and tiredness. I applied this therapy to calm him down.

Session 7 **45 min**

During this session client was in comparatively better condition his eyes were open through out the session his eyes were open and he had an eye contact. I applied social skills training technique on him. After that I ended the session.

Session 8 **35 min**

It was the last session with the client and he was advised to continue relaxation training in future and continue his medicines till prescribed.

Case No. 3

IDENTIFYING DATA

Name	:	KS
Age	:	40 years
Gender	:	Female
Religion	:	Islam
Marital Status	:	Married
Education	:	5th
Occupation	:	Housewife
Monthly income	:	3000 to 4000
No. of siblings	:	4
Birth order	:	3rd
No of Children	:	Seven

INFORMANT

Information was provided by the client herself and by her daughter.

Since last 7 months client had been suffering from severe headache. During this she also tried to end her life. At name she has very aggressive attitude towards her kids and husband.4 Months back she tested for suicide by jumping out of running vehicle she

had been admitted in the hospital for 2day and remained unconscious.

Client belonged to the lower-socio economic class and often face financial crisis. Clients parents were not alive, relationship between them was normal. Client had two brothers and two sisters. They, along with the client lived in the same town. They all were normal.

Client's husband had very strict attitude towards her, they often had quarrels regarding household issues. No psychological problems were reported in the client's family. Client's children were studying at different religious seminaries.

According to the client she had a healthy childhood and had a several friends. Adolescence was also reported normal but after marriage, especially after the birth her first kid, some twenty years back, had severe headaches and episodes of depression.At present client did not want to meet or talk to anybody including her own children she had no contact with her siblings.

According to clients daughter client's husband was very strict and have very aggressive attitude towards her. Client managed to escape from her house several times and they also had her once. Client husband is uneducated and harsh man.Client used to beat her children.

1. Before the onset of these symptoms client had several friends and enjoyed normal relationship with the relatives.
2. Aggression was present.
3. After her marriage client remained tensed and under stress.

Behavioral Observation

During the first interview session client was lying on her bed uncomfortably. Her eyes were partially closed. She talked to me while partially closed. She talked to me while lying on her bed she seemed to be over stressed for a quite a long period of time. She was answering my questions in a very sad and low mood. She continuously complained about severe headache and pressed her head against the wall.

General Appearance

Her general appearance was not very hygienic. Her hair was not combed, it seemed that she had not taken shower for several days.

Client's conversation was normal and was understandable. Here speech was correct but slow.

EMOTIONAL EXPRESSION

Her emotional expression was normal. She expressed feeling towards other people.

Thoughts

Thought form of the client was not so logical and her ideas were not logically associated. The thought content of the client was somewhat problematic. She had just one through on here mind that she want to die. Strong suicidal thoughts were present.

PERCEPTION

His perception was below average.

Alertness

Client was not very much alert generally but when any one communicated with her she responded.

CONCENTRATION

Client's over all concentration was poor because she was unable to concentrate on the type of question .I asked her and I had to repeat the specific question for 2 to 3 times.

My plan was to firstly

- To develop rapport with the client
- educate the client about her illness
- To discourage her over generalized statement
- To make the new born rationale thought in client permanent for the rest of her client imagine herself in more stressful situations.
- Motivate her to have some activity of her interest.

REPORTING OF SESSIONS

Session 1 **45 min**

I introduced myself and tried from the very moment to built rapport with the client. As the client was in a very low mood and she hardly opened her eyes to pay attention. At first it was very difficult to communicate with the client but after 20 minutes she was communicatory in a better war. I was ask to take identifying data, presenting complaints, reasons for referral and past psychiatric history. Then I ended the session.

Session 2 **40 min**

Next session with the client was conducted the very next day, client was lying on her bed she seemed to be over stressed and tense. After greeting her I completed the remaining history of the client. Through the client spoke very slowly yet tried to express her internal distress. Through out the session she complained about severe distress and headache. I applied progressive relaxation training in order to relax her after that she felt relaxed and wanted to sleep. I needed the session to let her sleep.

Session 3 **35 min**

On the very next session with the client. I greeted her questioned about his condition she reported that she has been suffering from headache. So I taught her again the progressive relaxation technique and advice her to repeat it twice a day.

During the session I started the informal assessment of the client, but was unable to complete because she seemed over fatigued at the moment was under sedative medication which was prescribed by the doctor. I ended the session.

Session 4 **40 min**

On the very next day of the 3rd session. I managed to arrange the next sitting with the client. She lying on her bed staring on the roof of the hospital room. After greeting her I finished the rewarding informal assessment.

Session 5 **45 min**

As she wanted to place from his home environment. I asked her to remain with whatever fear or poor. She is experiencing at home a encourage him to go deeper into the feeling and behavior of her husband she wished to avoid. This would help her to endure the pain necessary for unblocking and making way for new levels of growth. Weeping episode were observed during this session. She wept and out the end of the session I made her to do "deep breathing" exercise to normalize her. I ended this session here. Client was bit relaxed.

Session 6 **40 min**

In this session I applied first of all progressive relaxation therapy. She her general appearance was much better as compared to the first drop of the session. But during this session I initially asked her to pin point and define her major problems relationally and tell in the next session. I ended this session here.

Session 7 **45 min**

During the session I asked her about the cognitive homework I asked her to tell me about her problems and the solutions she had thought about. I noticed that element of hopelessness were much dominant in her thoughts and the way she thought about their solutions.

Session 8 **45 min**

This was the last session with the client, in this session I advised her to continue prescribed medicines and also to continue progressive relaxation training.

Case No. 4

IDENTIFYING DATA

Name	:	F.B
Age	:	23 years
Gender	:	Male
Religion	:	Islam
Marital status	:	Unmarried
Education	:	Student of masters
Occupation	:	Student
Monthly income	:	Monthly income of his father was 40 Thousand
No of sibling	:	Five
Birth order	:	4th

INFORMANT

Client himself and his uncle who was staying with him in the hospital.

According to client himself, 4 years back client got addicted to cannabis during his high school years, after the separation from his first girl friend. Two years back he abandoned the use of cannabis and switched to heroine. He often had suicidal thoughts and attempted once tried to drink insecticide spray (finis), but got frightened and did not do so.

FAMILY HISTORY

Client belongs to a Punjabi family from Jhang. Client belonged to upper middle socio-economic class. Client parents were alive. His father, Mr. M (52 years) was an educated man and was working as chief security in charge of Islamabad. Father's over all relationship with the family was good.

Client's mother (40years) house wife and was uneducated. Client's other siblings were in proper physical and mental health other than his younger brother. Who was also addicted to heroine and was admitted in the same hospital.

PERSONAL HISTORY

Client was born by normal delivery and there were no complications during and after birth. But during early childhood client suffered from asthma and was treated properly at this time. He had no symptoms of asthma.

Other than the respiratory problem client's development was normal and developmental milestones were achieved at appropriate time.

At home he was most frank with his eldest sister who was a doctor was living in Lahore.

Often he was aggressive towards his siblings. According to the client his parents give him a lot more importance on their other children.

At school he had good time and was an average student. While at high school he had a company with boys at one time or another were addicted to some drug. But now he was prepared to leave them.

Client had a very strong intimate relationship with a girl named fiza.At the moment they both were separated due to parental pressure on both the sides. They both once escaped from their house and were together for two days and one night.

Client's personality before present illness, according to his uncle was normal but he did not ever tolerate anything against his mood and will. He used to express his aggression out outwardly. He had friends at school.

Behavioral observation

Client was little bit confused during the first interview. He was lying on his bed in comfortable posture.

General appearance

General appearance of the client was very hygienic. He was dressed properly throughout the sessions. He had hair properly combed and dressing up to the latest fashion.

SPEECH

He spoke politely and his speech was coherent.

EMOTIONAL EXPRESSION

His emotional expression was normal; he seemed to be a warm person.The client was emotionally warm person. He felt affection for his parents and his girl friend.The thought form of the client was logical and his ideas were logically associated.The thought content of the client was somewhat problematic. He had developed some irrational plan regarding his girl friend.

PERCEPTION

His perception was good

Alertness

Client's alertness was normal during the whole sessions with the counselor.

My plans were following to deal with that client.

- To establish good rapport in order to make the client express him fully.
- To give the client relaxation training.
- Behavioral hygiene to improve his hygiene and maintain his health
- Disputing to change his IBs into RBs.
- To counsel his parents regarding their inadequate behavior and home environment.
- Give the patient an activity plan so that he would be able to follow some routine.

- Continuation of skills learned
- Family counseling
- Arrange a follow up session

- To teach stress management techniques to the client family so that it would help the client from relapse.

REPORTING OF SESSION

Session 1 **30mins**

The first session was conducted with the client at 11:00a.m I firstly introduced myself to the client as the client had a friendly nature so it was easy to build rapport with the client. I managed to complete the history session during the first session.

Session 2 **30 min**

I applied progressive relaxation training on the client to make him feel better as he was under antipsychotropic medications, which were creating some restlessness in him. He was tried and complaining of dry throat. He was not able to communicate properly due to sedative medication. So I ended the session.

Session 3 **45min**

Third session was held on the very next day of the second session. I began to talk about his previous life. He tried to maintain the theoric impression and lied to me about several things which I reconfirmed from his uncle who was stay with him. I completed rest of the history in the session.

Session 4 **40 min**

In the session after greeting the patient I applied progressive relaxation training, as he served to me restless and mentally disturbed. After 5 minutes I completed the mental status examination.

Session 5 **35 min**

In this session I gave him cognitive homework to identify major problems in his life and the solutions he had thought previously. By giving him this assignment. I ended the session.

Session 6 **40 min**

In this session I applied the technique of logical disputing. As the client had very irrational demands from her girl friend that had asked him to end this relationship. I tried to make him understand that his demands from life were not real. Throughout the session he listened carefully and he was concerned and asked me how to cope with his girlfriend problem and other occupational problems.

Further I asked him to make his long-term goals and short-term goals and show me the next time and I ended the session right there.

Session 7 **45 min**

This session was a very important session as the client had to tell his short-term goals and long-term goals, I checked his long term goals and short-term goals, in which I noticed some problem, discussed it with the client. I discussed both the goals with him and we together made many conclusions in it also. I ended the session over there.

Session 8 **50 min**

This was the last session with the client.. He was quite optimistic about his future and postponed his plan to marry or force his girl friend to marry him. Because there were the chances of relapse of the client faced an unexpected stressful situation to free from that situation. He quit the use of cannabis and any other kind of drug.

I ended the session by instructing him and training and prescribed medication.

Case No. 5

Client reported that he could not sleep for many days and due to this reason he got under stress and he took so me sleeping pills. So that he could sleep. Actually he was addict of those pills and without taking them he could not remain calm and that time he took more amount of the pills which made him unconscious and his father took his to psychiatry ward of PIMS.

The client was addict of these sleeping pills (8ivan) one of his class fellow was addict of this medicine he told the client that when you feel stress have it and you will feel relaxed and the client started taking these pills. In the beginning. He took only one pill it made him relaxed but gradually he increased the amount of it for the sake of more relaxation and he became addict of them.

Once client had a fight with his father and he attempted to commit suicide by taking 5 pills at a time and by cutting his nerves. His father took him to the hospital on time and his life was saved. Then again he attempted to commit suicide by taking 20 pills at a time; his father took him to the psychiatrist and was admitted in hospital.

Family History

Client belonged to a middle class family. His father was an assistant professor HBS and a landlord. His age was 51. The client reported friendly relations with him except in the matter of his addition.

His mother was 48 years old, Metric and a house wife. Client reported that he had average relations with hers. His mother was also addict of the same medicine which he was taking and this was another reason for his addiction.

Client had 3 sisters and one brother and he was the 1st born among them. His brother was 20 years old and was doing ICS. The client reported good relations with him. His 3rd born sister was 17 years old and she studied till Metric. Client had normal relations with her his 4th born sister was 13 years old and was in grade 8 and client reported normal relations with her. According to him his sisters were scared of him 5th born sister was 11 years old was in grade 5. He coved his sister.

Personal History

Client was born normal there were no complications in his mother's delivery. His early physical and mental development was normal. So history of significant illness in early and later childhood was reported.

Client started his educational career when he was 5 years old. As client had an introvert type of personality he was unable to have good friendships. He made one friend from his childhood who was his cousin and he loved him and he trusted him a lot. When he was in grade 8, He ran away from the school for the 1st time and after that it became his habit. Client had no interest in studies and was an average student. He continuously changed his statement. He was lying.

Sexual History

When I asked client about his sexual history he behaved very strangely and he strictly asked me to not to discuss it with me because he did not like to discuss this topic with anyone. I tried to probe him but he kept on saying sorry and he did not even tell me a single word about it. Then had a conversation with one of his friends. I was able to know that he did not like girls. I thought he was homosexual but there was not even a with proof about it.

Behavioral Observation

When client entered the room, where he was to be interviewed. His was totally expressionless. He was very serious. He was properly dressed up. His hair was combed. He sometimes had aggressive behavior. He seemed an introvert person. He did not talk much. He was sitting in an easy posture. His hand was trembling. He was moving back and forth in the sitting position. He was not cooperative.

Speech

His speech was normal, there was no utterance. There was a flow in his speech. He seemed emotionally cold. His face was emotionless. He wanted to go to home. So he showed warm emotions. His ideas were logical. His thoughts were the same questions which I asked his. He had suicidal thoughts.

Perception

His perception was normal. He perceived the things accurately. When I asked about different things in room e.g. table, chair water cooler etc. his answers were right.

Alertness

He was quite alert. He was fully aware of the surroundings. He was very sharp. He was listening to me attentively.

Concentration

Client was trying to concentrate on my questions; he was attentively listening to my words.

MEMORY

Immediate Memory

In order to check his immediate memory I used seven serial Tests, Which is used to check immediate memory. I ask client to tell the names of the days in back ward from.

I also I asked him to tell the names of some vegetable and instructed him to listen carefully and them tell me.

The counselor had the following plans to deal with that client.

1. To build rapport with the client.
2. To gain his confidence
3. To make him see the world in positive way.
4. To make him speak truth

5 To avoid the relapse of his drug intake.

6 To make follow-up sessions

7 To maintain short term goals.

Reporting of Sessions

Session 1 40m

Client was very much confident when he entered the room. Where he was to be interviewed. In this session I tried to build rapport with the client. He did not want to tell me a single word. He was not cooperating with me. I tried to complete history portion in this session few questions from client, he said that he was tried and wanted to sleep then I told him to go and take rest. This was the end of 1st session.

Session 2 40m

In the second session I continued taking history from the client. He was continuously changing his statements. He was lying. He was not cooperating I tried hard to pore him but he stacked to his words and did not tell me anything special except the ordinary routine. I tried to confuse him to tell me the truth It was very much difficult to complete history. In this session I could only complete history portion except for his sexual history.

Session 3 40m

In this session I tried to ask the client about his sexual life. But he refused to tell me. He strictly told me not to ask about his sexual life because he did not like to discuss it with anyone. I tried to probe but he did not even tell me a single word about it. I forced him a lot his mood got off and left the room by saying that sorry he can not tell anything about it. This was the end of session3.

Session 4 **40m**

In this session I did informal assessment. I checked his memory, concentration, perception etc by asking different questions I completed my informal assessment in this session.

Session 5 **35m**

In this session when I was about to start psychometry, the client refused to recognize me, he started telling lei that he was meeting for the first time. He did not want me to apply test on him) his behavior was very rude, he did not want to share anything with me and he said that he was feeling very sleepy and he wanted to go this was the end of session.

Session 6 **40m**

In this session I again started psychometrics. By chance one of his friends came to see him. He told me the truths of his life, which he laid to me his friend, told me in front of him. This was the end 0f 6th session.

Session 7 **35minutes**

In this session I have got the desirable results. I also gave him the home assignment of thought stopping technique when ever come in his mind he can use this method.