PSYCHOTHERAPEUTIC INTERNSHIP REPORT

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Submitted by
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Sajid M.d.

CERTIFICATE

It is to certify that **Mr. Sajid Mahmood Alvi** of MS Psychology has carried out his Therapeutic Internship report successfully under the supervision of **Dr. Asghar Ali Shah.**

Supervisor

Signature: _____

Dated: 17-6-10

Major Depression (296.2)

BIO DATA

Name:	AA
Age:	25 Years
Gender:	Male
Education:	BA
Occupation:	Teacher
Marital Status:	Married
No. of Siblings:	5 male, 1 female
Birth Order:	last
Children:	male 1, female 1
Referral Source:	Himself

PRESENTING SYMPTOMS

Loss of interest, poor appetite, headache, burden on head and heart, Helplessness, lack of sleep, Loss of concentration, lack of energy.

HISTORY OF PRESENT ILLNESS:

Patient's current history of illness started 1 year back after the death of his father

PAST PSYCHOLOGICAL AND MEDICAL HISTORY:

Patient having no past psychological & medical history.

PRE MORBID PERSONALITY:

Before this problem his personality was stable.

TESTS APPLIED:

- Depression Scale (BDI)
- Anxiety Scale (MAS)

TEST RESULTS

His test score on BDI was 29 which shows moderate depression but his test score on MAS is 18 which shows that he has no anxiety problem

SCHOOL RECORD

- He was a good student.

FAMILY HISTORY

His father was a business man and they belonged to a well off family but after the death of his father, there was deterioration in their family.

Mental State Examination

- General Appearance: Good
- Motor behavior: normal
- Speech: normal
- Obsessions & compulsions: thoughts of suicide
- Delusions and hallucinations: nil
- Insight: he had insight about his problem

DIAGNOSIS

Axis-I : Major Depression (296.2)

Axis-II : Nil

Axis-III : Nil

Axis-IV : Death of a family member

Axis-V GAF Current: 55

Past: 90

Prognosis

The case is hopeful. The patient will recover by treatment

SESSIONS

1ST Session

In this session a detailed history related to his problems was taken. The rapport was established with the client. Client was guided about his problem and treatment.

2ND Session

During this session, family members of the client were educated about his problem. Their role in the therapeutic process was also explained to them. Remaining history about the problems was also taken. Formal and informal assessment was done in this session.

3RD Session

The client did not have any complaints. He was not so much expressive about his problems. However, the behavioral change contract was got signed and reinforcing agents were identified.

4TH Session

During this session, modeling was applied. The desired behavior was modeled in front of the client and he was asked to practice it.

5TH Session

The therapist explored client's irrational thoughts. Therapist developed insight in client about his problem.

6TH Session

The client was taught to replace his irrational beliefs with rational ones that were disturbing him.

7TH Session

During this session, the client's family members were interviewed. They reported improvement in the client behavior. They were further educated in the matter.

8TH Session

During this session, the client showed improvement. Client was asked whether he had done his assignment activities.

9TH Session

During this session, the client was called for follow up session. MSE was conducted again. His mood was not too much depressed.

10TH Session

During this session, the client was markedly improved. His wife also reported that he has been improved and now takes interest in his daily routine work.

Opioid Withdrawal (292.0)

IDENTIFYING DATA:

Name:	S.A
Gender:	Male
Age:	45 Years
Religion:	Islam
Marital Status:	Married
Education:	Middle
Occupation:	Factory Worker
Monthly income:	4000
No of siblings:	4 (3 sisters & 1 brother)
Birth order:	1st
No of children:	3 (2 daughter & 1 son)
Informant:	Self

Presenting Complaints:

1) جسم میں درد ہوتا ہے۔
2) کسی کام میں صحیح توجہ نہیں دے سکتا۔
3) بھوک نہیں لگتی۔
4) غصہ آتا ہے۔
5) بے چینی رہتی ہے۔
6) جب ہیروین لیتا ہے تو ٹھیک رہتا ہے۔
7) جسم کانپتا ہے۔
8) الٹیاں آتی ہیں۔

History of Present Illness:

Client started taking heroin six years ago. He served in army for eight years but he did not like this job as he fed up undesired strictness. He wanted to start his own business but his financial condition was not strong and his pay was not enough to meet the expenses of his family. So he left army service and started looking for a job.

His financial condition worsened because he could not find any job. Then he started driving a truck, there he started taking heroin with other drivers who were heroin addicts. They asked him to take heroin but first he rejected their offers but later on, he started taking heroin. Then he left truck driving and started job as a factory worker. And he has been taking heroin since six years.

Past Psychiatric Illness:

There was no significance evidence was found regarding the past psychiatric illness.

Family History:

His father is 60 years uneducated old man and is a farmer by occupation. His father is temperamentally cool and has good relations with his children. His mother is 63 years old. She is a housewife and loves her children and takes care of them. She has good relations with the client. He has four sibling; two brothers and two sisters. First sister is 42 years old. She is uneducated and married. Her relations with the client are superficial. Second sister is 37 years old. She is also uneducated and married. She has good relations with her brother and shares his problems. Brother is 35 years old. He is educated up to metric. He is electrician by occupation. He is married and did not like his brother and often quarrel with him.

His home environment was not satisfactory. He wanted to spend most of time out of his home. The client was married 17 years ago. His marriage was arranged. His wife did not take care of him. She often quarreled with him over minor issues and financial

problems. He used to beat his wife off and on. The client had 3 children, two daughters and one son. He did not give full attention to them. Daughter was 15 years old. She was in class 9th. She loved her father a lot. Son was 10 years old, study in class 3rd. All his children loved him, but he did not give full attention to them.

Personal History:

His birth was normal at home and there were no complications. He was the eldest among his siblings, so the patient received much attention and love from his family. He had significant illness in his childhood.

He achieved all his developmental milestones at proper age. He received education in local school. He respected his teachers and elders. The client wanted to continue his studies but left because of poor socioeconomic conditions. He was not a religious-minded person.

The client served in army for eight years. He fed up by strict routine and left job. After this he started driving a truck. Then he left truck driving and started job as a Factory Worker.

Pre-morbid Personality:

Before this condition, the client was a social person. He liked to enjoy the company of his friends. He had a few friends. He also took part in extra curricular activities. Like singing and comparing. He remained happy most of the time. He had some significant leisure activities. The relationship with his family members was good. His character was obedient. His attitude towards his family and other people was positive. His prevailing mood was stable.

INFORMAL ASSESSMENT:

Informal psychological assessment was done by a detailed interview, behavioral observation and MSE.

1. Behavioral Observation:

His general appearance was not good. The client was a middle aged man wearing shalwar kameez with softy. He maintained a good eye contact.

2. Mental Status Examination:

i. General Appearance:

His general appearance was normal. He had mask face. His thoughts were not logical and goal oriented. He had loosening of association. He was speaking slowly. He had no suicidal potential. The degree of alertness was fluctuating. His short term and long term memories were intact. He had a capacity to recognize and understand his own illness.

ii. Speech:

He was speaking in very low tone and hesitantly. His composition of words and sentences format was normal. His speech was understandable. Emotional Expressions:

i. Objective:

Objectively he was appeared angry at different times .his emotional expressions were labile of full range and appropriate to content.

ii. Subjective:

Subjectively he was also reported angry because he was being kept on a locked ward.

4. Thinking and Perception:

At the time of interview, client reported lack of interest and sadness. Overall content of his thought was quite hopeless regarding his life. No hallucination or obsessions were present at the time of MSE.

5. Sensorium:

i. Alertness:

Client was conscious at the time of interview.

ii. Orientation:

Client's orientation was present in all the three domains of time, place and person.

a. Person:

His orientation about person was normal.

b. Place:

His place orientation was also normal.

c. Time:

He told me the time when I asked about time he told quite correct without seeing watch.

iii. Concentration:

His concentration about questions was good.

iv. Memory:

His memory was very good.

a. Immediate:

His immediate memory was good.

b. Recent memory:

His recent memory was also good.

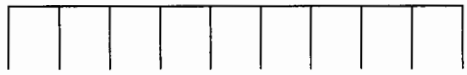
6. Insight:

Client had insight about his addiction.

FORMAL ASSESSMENT:

Pre-testing:

Rating Scale:



1 2 3 4 5 6 7 8 9 10

Pain of body	9
Lack of concentration	8
Lack of appetite	7
Aggression	9
Irritability	8
Shivering	7

TESTS APPLIED

Formal psychological assessment of the patient was done by the therapist by taking following tests:-

1. Rotter Incomplete Sentences Blank (RISB)
2. Clinical Anger Scale (CAS)
3. Hospital Anxiety Depression Scale (HADS)

1. Rotter Incomplete Sentence Blank (RISB):

Conflicts responses

Total response of C3	5
Total response of C2	10
Total response of C1	7

Positives responses

Total response of P1	7
Total response of P2	6
Total response of P3	2

Neutral responses

Total response of N	3

Key

C3=6	N=3	P1=2
C2=5		P2=1
C1=4		P3=0

Total scores of responses

Total score of positive responses	45
Total score of conflict responses	300
Total score of neutral responses	3

2. **Clinical Anger Scale (CAS):**

He got 30 score in this scale which leads to severe clinical anger.

Minimal clinical anger	0-13
Mild clinical anger	14-19
Moderate clinical anger	20-28
Severe clinical anger	29-63

3. Hospital Anxiety Depression Scale (HADS):

In this hospital anxiety test the client got 20 score which shows that he has severe level of Anxiety Depression.

Mild	40-31
Moderate	30-21
Severe	20-11
Very Severe	10-0

DIAGNOSIS

According to DSM-IV-TR, the diagnosis is made as under:-

Axis-I	292.0 Opiod Withdrawal
Axis-II	None
Axis-III	None
Axis-IV	Occupational problem, job dissatisfaction and job change.
Axis-V	GAF = 60 (Current)

MANAGEMENT PLAN

The management plan was made as under:-

Short-term Goals:

1. Establish rapport with the client
2. Educate the client to change his social environment
3. Educate the client to change old drug life style
4. specific duties assigned to the addict
5. Clear rules for behavior are set down and penalties are formulated for the client.
6. Assess the motivation of the client for his treatment

Long-term Goals:

1. Develop a sense of order and responsibility in the client
2. Client is taught to avoid high risk situation
3. Client is taught to modify his thoughts and attitudes
4. Support the client's self efficiency
5. Provide self help programmer to the client

1ST Session

First of all the rapport was developed with the client. For this purpose, he was received with respect and warmth in the hospital. After the introduction we talked on some topics of common interest so that the client feels easy and relax. The history of the client was taken through interview. First he told about the symptoms. Then I asked about his family and his childhood, school, his interest in extracurricular activities about his general health. During the interview his facial expressions, posture, gesture and body movements were observed. All these were necessary for the diagnosis.

2ND Session

I administered psychological tests. First of all RISB was given and asked him to complete the sentences with his real feelings. In start he felt hesitation so I explained him

purpose of testing and try to explain that I do not tell about his feelings. He felt relaxed and cooperate with me and completed the test carefully. After that CAS was administered.

3RD Session

In this session the management plan was made but client did not realize that opiod has some disadvantages. I explained the difference between normal person routine and his routine life. During session, the client anxiety level was so much high so we again discuss on some topic of the common interest. At the end of the session, I asked him to thought about his routine life and normal person routine life and compare with each other. Motivational interview was conducted with the client who showed that the client did not consider addiction is a problem for him. Socratic style was used with him.

4TH Session

In this session, therapist and client decided to routine plan according to the client of interest and taught him how he can relax by applying the relaxation training and contract his anxious level and the home work to follow daily routine plan. In this session, facts and figures were used to develop awareness in him. "How much income you spend for addiction? What problems addiction creates for you? What benefit of addiction to you?"

5TH Session

In this session, I used the refracting technique to change his irrational beliefs and advised him to read it again and again. As a result, he convinced the irrationality of his belief. I advised him to write down the merits and demerits of other beliefs and read them three times a day. He was also advised to write 10 merits and demerits of addiction. He was suggested to remind frequently Strong Coping Statements that addiction is a curse.

6TH Session

In this technique the client was asked to determine the activating event that is responsible for his present health condition. According to the client money is the main problem for him. His family is responsible for recent condition and did not cooperate with him. He reported the following:-

- Family do not support him financially
- They give bad remarks on him.

Client tried to change irrational beliefs and made him aware of the irrationality if his beliefs which he held. He was educated with reference to different verses of Holy Quran that addiction is a sin. Behavioral Self Control Technique was applied for him, which showed positive change in his behavior.

7TH Session

In this session, I decided to use role playing technique. The client was not able to interact with his family. He was asked to act out role of a sociable person before the mirror. He should talk and behave in accordance with social custom and assigned to do this at home. In the end of this session I feel some positive change in his behavior. He was highly motivated to abandon addiction. He made decision to take strong action to stop it.

8TH Session

In this session, I met with his family members and tell them about his condition and performance. I said them to try to cooperate with him in the development of social attitude and avoid explaining his past events in front of him. I also advised to continue his exercise.

9TH Session

In this session, I asked the client to follow all this principles and exercises daily and avoid the high risk situations.

10TH Session

In this last session, I suggested the client for follow-up sessions whenever he needed. Therapeutic contract was terminated at the end of this session.

Social Phobia (300.23)

IDENTIFYING DATA

Name	Imran Sattar
Sex	male
Age	25 years
Education	FA
Occupation	cloth shop
Marital status	unmarried
Siblings	6 (brothers 4, sister 2)
Birth order	3rd
Family structure	joint
Socio economic status	middle
Financial status	dependent
Father education	Matric
Mother education	none
Language known	Urdu
Mother tongue	Punjabi
Religion	Islam

Test Administered

For the client's psychological assessment the following test battery was used.

Standard Progressive Matrices (SPM)

Manifest Anxiety Scale (MAS)

Human Figure Drawing test (HFD)

Solooson Drawing Coordination Test (SDCT)

Stress Scale

Thematic Apperception Test (TAT)

FINDINGS

On mental state examination (MES), the client was looking a young man of 25 years. Apparently he was having a sound health and normal height. He was looking cooperative, attentive. He tried to maintain his eye contact but on some stages he loses his confidence. His volume of speech was clear, but some time due to the blockage of thoughts flow he stopped his communication during interview. He remained obedient and submissive during interview. He was insight oriented and his memory remained normal he explained all his life experiences and events. He complained the some time loss of memory or amnesia. His thoughts and perception about the time, place, and date was correct. He knew each and every thing about his past. During interview he seemed attentive.

For neurological assessment Slooson drawing coordination test was administered on the patient, but no neurological impairment found in the client, and test shows the normal neurological coordination in the client.

For intelligence measurement the SPM was applied on the client, the client got score of 50^{th} percentiles on this test which reveals that the client is having averaged intellectuality

ability. The client explained that he has some unrealistic fears for this purpose MAS and stress scale applied in the client, both test indicated that the client has stress in his mind and having a sever anxiety, because client score on both test 40, and 30 which indicate the anxiety and stress in the client.

For measuring the depression level in the client, beck depression inventory administered on the patient which shows that the client is having depression level, he scored on this test 32.

Projective techniques HFD, and TAT, were applied for personality assessment, on HFD test, shows emotional indicators that are over emphasis on hair over shading poor integration, improper place of organ showing of joint of the body petals type fingers of foot and over extended hand open mouth reveals immaturity oral eroticism body narcissism shyness helplessness poor inner self control, insecurity anxiety, inadequacy of feeling, socially withdrawn and sexual conflicts. While TAT, indicate worried ness, need for progress and achievement, need for success, passivity and conflicts in the client.

The client medical history shows that he was born normal, before coming here he consulted different well-known psychiatrists and he taking drugs he also took EEG,

The school history of the client indicates the he was a normal student in the school days. He studied up to the intermediate class. He participated in every school activities; he has not any sort of communicational problem in school days. His academic performance remained satisfactory.

The client family history indicates that he belongs to a middle class family, he lives with his parents. He has six sibling consisted on two sisters and four brothers. His birth order is third among brothers and sisters. He is having good relations with his brothers and sisters. His father is having an authoritative attitude and style of life in family but he is cooperative also. He runs a cloth shop and client assist his father in this business. His mother is nice lady. She takes full care of him. His elder two brothers are married and led separate life. Some time when his younger brothers do not obey the client he shows aggression with them. Some time he quarrels with them. He does not like to go the

relative homes because he feels shyness and hesitations with the relatives especial with girl of their families. He dislikes female sex. He thinks that person should be alone.

According the sexual history of the client indicates that he has some sexual problems like impotency. He was much worried about his marriage which was helding soon. He has fears about sex how he will perform his sexual activities at the time of marriage, he is of the opinion that his impotency is mainly associated with the taking drugs for psychological rehabilitation. He also express that he had masturbated many times in past.

His occupational history shows that he works on a cloth shops with his father. He feels communication problem with the customers. He loses his confidence at the dealing with the customers on the shop. He can not express the quality of cloth to customer in good manners. He feels hesitation during conversation with the customer on the shop or barraging time

The client history of present illness shows that the client has taken a lot of exercise for improving the mental activities. Due to these exercise he loses his confidence. He can not express his feeling with others. He feels restlessness when some one meats with him. He can not communicate with others face to face. He does not like to mix up with the people. He does not like gathering, functions. He does not like to participate family functions.

DIAGNOSIS

AXIS 1 300.23 Social phobia

302.72 Erectile dysfunction disorder

AXIS 11 301.6 Dependent personality disorder

AXIS 111 None

AXIS 1V Problem related to social environment

AXIS V GAF current 71

Prognosis

The patient has an insight toward his problem. So he has a chance of recovery. He can be recovered thought proper attention or maintaining proper interaction with family, occupational agents etc..

Psychotherapeutic sessions

Session 1-2

During these sessions intake information has taken and filled the history form. In these sessions also asked about his problems and show unconditional positive regard and empathy towards the patient. It was very helpful in developing a rapport. At the beginning of the session he was withdrawal and hesitating to share his problem but with some reinforcement and empathy he looked confident and shares some problems. He was confused about his sharing of his problem. He was made assured that his information will be confidential. Tried to keep him confident and relax. So after that he feels comfortable and discussed about him. He introduces himself in detail and provides all intake information. He was realized that psychologist has a better understanding about his problem so become comfortable and tells about all problems. He realized that psychologist is a well wisher of him and he could be given him better solution of his problem. He believes and discusses more about himself. He said that he feels worried about to face the people. He feels that he can not discuss with others and feels hesitation to shares his feelings with others. At the end of this sessions patient has some confidence and most necessary information has taken that was relevant to him.

Sessions 3-4

In this session tried t get patient's confidence and encouraged him to be happy and relax. He was also encouraged to discuss all of his problems and worried. He wanted to discuss his problem but worried how to share himself. But he was so confident and relaxes when used unconditional positive regard and showed empathy towards him. In these sessions rapport was successfully developed. Patient has developed some

association or attachment. Now patient was full willing to discuss himself. He told about his personal matters without any hesitation. He told that he is unable to communicate his feelings with fluently with others. He faced this problem not only in home environment as well as in his occupation. He stated that he cannot communicate about the rates of cloths on the shop to the customers. He becomes nervous when some one tries to share his problems with him. He feels shyness when he gets opportunity to participate in the social meeting. He thinks that he cannot do any thing with his own willing. He stated that his illness is started from the last six years. He himself tried hard to over come his problem and for this purpose he used different self made strategies to overcome his problem. He told that the attitude of his father is hard and have an authoritative style of life. He likes loneliness and when ever he is isolated he feels satisfaction. The process of developing a rapport was completed during the session of 1-4 sessions. All necessary information about the patient in these sessions has gotten.

Session 5-6

After psychological testing or assessment psychological therapies were applied on the patient. In these sessions cognitive behavior therapy was used t modifies the wrong cognitions which was developed by the patient towards his problem. Through this therapy tried to explore the wrong cognitions of the patient and complexities of the problems, and emphasized the patient to change his cognitions which are developed in his mind about his problem. He was encouraged to make many efforts to remove his hesitations. In this therapy keeps the concentration on the patient's current interpersonal relational difficulties. He was giving idea that he has potential and he cannot each and every thing and can remove his hesitation in communication.

In this session the client was taught relaxation exercises, and make him relaxed him. During this therapy session patient was very attentive. He has better understanding. His attitude was positive and he was also very serious about to become healthier person. He was interested to change his thoughts of to modify running thoughts in his mind.

In these sessions family therapy was also used. This therapy is necessary to aware the family members about the patient, feelings and problem. The family member his father was taught that how to deal with patient. In this therapy father was realized that they should support to change the wrong thoughts about that he cannot do any thing. The father was asked to develop a caring behavior towards the patient.

Session 7-8

In this session behavior therapy was applied on the patient. In this therapy the patient was kept in relaxed state, and also was giving relaxation exercises. He was also taught the deep breathing exercises. And other some specific body movements under my supervision. After this therapy patent felt comfortable. His fear about he cannot do any thing was reduce. Reinforcement was also giving to the patent in the form of admiration which promotes the client's confidence and create a realization in the patient his problem can be minimized. Through this therapy the patient shows a good behavior. Systematic desensitization technique was also applied in these sessions. Hierarchy was constructed and from bottom to flatten one by one step was presented to the patient and he was asked to visualize or imagine that he is speaking with others; he is also facing people and gaining confidence. During these sessions he was encouraged to take healthy steps for health life and described his feeling in front of others. He was reinforced for good attitudes and thoughts.

Sessions 9-10

In these sessions it was tried to change the irrational thoughts and beliefs which was established that he can not do any thing, he has not ability to do some thing in front others. So rational emotive behavior therapy was used. Patient said that he is worthless. He lacks of self esteem he is inferior to others, he has not ability to communicate with others. He was assured that no body in this world in worthless it is our own thinking and all of us has some importance in this world. We can do each and every thing. We have a hidden qualities we should utilize our potentials for over coming our problems. God has created every human being in this world with greater qualities and it our duty to apply our

potentials in this regard. He was giving home work assignment that he has try to communicate and discuss his feeling with his mother and siblings. And in family therapy perspective his father was asked to give him spare time and communicate with him and share his feeling.

Session 11-12

In these sessions interpersonal psychodynamic therapy was used this therapy used to explore the patient complexities of his problem and emphasized on the patient relation ship with his colleagues on his cloth shop with peers and siblings. He was encouraged to make specific behavioral changes. In this therapy keeps the concentration on the patient's current interpersonal difficulties and discuss them.

Termination session

After the application of different therapies patient was stable. A termination session is very sensitive process. This session was started with a lot of care because it requires a lot of sensitivity. It is a process of ending the therapeutic relationship. It is difficult for patient to accept it at once but after some better realization he got it and understands bout it. But during the session patient develop some transference. He was realized during the therapies session that it is a professional relationship and nothing. Son in the termination of the session he was aging realized that I, am his psychologist or therapist. He was made assured that psychologist always available for him if he has some problems. He was also made assured that he could contact for his problems. He will take better solution for his problems. Patient felt anxious at the start but after description he felt comfortable and he realized about the patient or psychologist relationship.

Major Depressive Disorder without Psychotic Features (296)

IDENTIFYING DATA:

Name:	A.B.C
Age:	40 years
Gender:	male
Education:	primary
Occupation:	govt employee
Marital status:	married
No of children:	four
Siblings:	eight
Birth order:	second
Religion	Islam
Referral source:	brother
Dependent/independent	independent
Father alive/dead	alive

8594 H1

Presenting complaints

Pain in head. Burden on head and heart. Lack of appetite. Lack of sleep. Sad mood most of the time. Hopeless from life. Fatigue.

Behavioral observation

The client's appearance was dissatisfactory. Signs of hopelessness were seen through his low mood. His clothes were not clean and hair was uncombed. His hygienic condition was not good. His facial expression was sad. He had no hallucination. He was cooperative.

Symptoms

- Lack of appetite
- Lack of interest in daily activities
- Hopelessness
- Helplessness
- Lack of sleep

- Burden on head and heart
- Weeping spells

Personal and family history

The client belonged to a middle class family. His father was a farmer. He had eight siblings. His birth order is second. All were married. His birth was normal. He was married. His wife was a house wife. He had four children. He had one daughters and one son. He was employed in C.D.A. six months back his brother-in-law was murdered. He was closely attracted with his brother in law.

History of present illness

History of present illness goes back to six months when the client's brother in law was murdered. He had very close attachment with him. Initially his worry about th murder was not very severe but the case became very complicated, he became worried about it. He thought that his enemies will be free on legal bail and he cant take revenge of his brother in law's murder. That makes him hopeless and started suffering from headache. Gradually signs of lack of interest. Insomnia and lack of appetite were seen.

One month back the symptoms were become severe that people noticed a noticeable change. He was brought to the hospital by his brother and here he was treated with medicine and psychotherapy as well.

Pre morbid personality

Before illness client was living like a normal person. He was very social, healthy and friendly. He was very extrovert and interested in daily activities. He was very active and energetic about his work. He loved to obtain parties and solve the problems of his family. He was very responsible and easily make decisions.

Onset of illness

Onset of illness was at the age of forty and the severity of symptoms appears six month back.

Medical/psychiatric history

Before the ailment the client had no psychological problem. After the appearance of psychological symptoms he was brought to the hospital by his brother for the treatment and was treated with anti depressants and tranquilizers.

Psychological assessment

Beck depression inventory

It was administered on the client. He scored 36 on BDI which falls in the severe category of .depression.

DIAGNOSIS

Axis I	Major Depressive Disorder without Psychotic Features (296)
Axis II	nil
Axis III	nil
Axis IV	problem with primary support group
Axis V	GAF (60) current

Prognosis

The patient is recovering gradually. The treatment given to the patient is very effective which are antidepressants as well as therapies.

SESSIONS

1ST Session

In this session a detailed history related to his problems was taken. The rapport was established with the client. Client was guided about his problem and treatment.

2ND Session

During this session, family members of the client were educated about his problem. Their role in the therapeutic process was also explained to them. Remaining history about the problems was also taken. Formal and informal assessment was done in this session.

3RD Session

The client did not have any complaints. He was not so much expressive about his problems. However, the behavioral change contract was got signed and reinforcing agents were identified.

4TH Session

During this session, modeling was applied. The desired behavior was modeled in front of the client and he was asked to practice it.

5TH Session

The therapist explored client's irrational thoughts. Therapist developed insight in client about his problem.

6TH Session

The client was taught to replace his irrational beliefs with rational ones that were disturbing him.

7TH Session

During this session, the client's family members were interviewed. They reported improvement in the client behavior. They were further educated in the matter.

8TH Session

During this session, the client showed improvement. Client was asked whether he had done his assignment activities.

9TH Session

During this session, the client was called for follow up session. MSE was conducted again. His mood was not too much depressed.

10TH Session

During this session, the client was markedly improved. His wife also reported that he has been improved and now takes interest in his daily routine work so the therapeutic contract was terminated at the end of this session by the mutual consent.

Cannabis Dependence (304.30)

IDENTIFYING DATA:

Name:	Syed Asad Abbas
Gender:	male
Age:	28 years
Education:	matric
Occupation:	driver
No of siblings:	3
Birth order:	last
Marital status:	married
No of children:	2
Father alive/dead	alive
Mother alive dead	alive
Dependent/independent	independent
Religion	islam
Referral source:	father

Presenting Complaints

Headache. don't want to eat anything. Vomiting. Restlessness. Pain in body. Laziness. Numbness. When used drugs then felt comfortable. Now withdrawal symptoms.

Behavioral observation

The client's appearance was not good. The clothes were untidy and hair was not combed. He was restless. He had little eye contact. He had insight of his problem.

Symptoms

- Headache
- Nausea and vomiting
- Muscle aches
- Loss of appetite

- Restlessness
- Fatigue
- Body aches

Personal and family history

The client belonged to a middle class family, his father was employ in POF. He had 3 siblings 2 brothers and 1 sister. Client is the last child of his parents as he was the last child.

His birth was normal, he was breast fed for two years. His toilet training was normal; he didn't face any injury or accident in his childhood. He had good memories related to his childhood.

He started schooling at the age of 5. He was average student in his class. He studied up to materic and then left his education. He started his job as a driver in in govt sector. At the age of 22 he got married. He had two children, one daughter and one son. He lived in a joint family system. After three years of marriage he started taking Cannabis (marijuana) because of his bad company. No one in his family knew about his addiction. After some period of time his father came to know that his son was addicted. His father admitted him in hospital where he was being treated. He spent about twenty days in hospital.

History of present illness

This was the second admission of the client in hospital. Now this time he himself was motivated to get rid of his bad habit and wanted to live a healthy life.

At the age of 18 he started taking cigarettes. In the beginning he used to take cigarettes only but after four years he started taking marijuana under the pressure of his friends.

Pre morbid personality

Before the onset of this problem the client was sociable and a normal person. He didn't have economical problem.

Onset of illness

His present illness started when he was 27 years old.

Medical and psychiatric history

Before the ailment he didn't have any psychological or medical problem. He had no medical history before the problem.

Test Administered

Manifest anxiety scale

On manifest Anxiety Scale his score was 35 which shows high level of anxiety

Rotter's incomplete sentence blank (RISB)

The total score on RISB was 136 which show that he was maladjusted towards life.

DIAGNOSIS

Axis I	Cannabis dependence (304.30)
Axis II	none
Axis III	none
Axis IV	problem related to social environment
Axis V	GAF=65 (current)

Prognosis

Prognosis of the client seems favorable because he had insight of his problem and also wants to get rid of his problem. Studies have shown that such patients will recover if proper treatment is continued.

SESSIONS

1ST Session

First of all the rapport was developed with the client. For this purpose, he was received with respect and warmth in the hospital. After the introduction we talked on some topics of common interest so that the client feels easy and relax. The history of the client was taken through interview. First he told about the symptoms. Then I asked about his family and his childhood, school, his interest in extracurricular activities about his

general health. During the interview his facial expressions, posture, gesture and body movements were observed. All these were necessary for the diagnosis.

2ND Session

I administered psychological tests. First of all RISB was given and asked him to complete the sentences with his real feelings. In start he felt hesitation so I explained him purpose of testing and try to explain that I do not tell about his feelings. He felt relaxed and cooperate with me and completed the test carefully. After that CAS was administered.

3RD Session

In this session the management plan was made but client did not realize that opiod has some disadvantages. I explained the difference between normal person routine and his routine life. During session, the client anxiety level was so much high so we again discuss on some topic of the common interest. At the end of the session, I asked him to thought about his routine life and normal person routine life and compare with each other. Motivational interview was conducted with the client who showed that the client did not consider addiction is a problem for him. Socratic style was used with him.

4TH Session

In this session, therapist and client decided to routine plan according to the client of interest and taught him how he can relax by applying the relaxation training and contract his anxious level and the home work to follow daily routine plan. In this session, facts and figures were used to develop awareness in him. "How much income you spend for addiction? What problems addiction creates for you? What benefit of addiction to you?"

5TH Session

In this session, I used the refracting technique to change his irrational beliefs and advised him to read it again and again. As a result, he convinced the irrationality of his

belief. I advised him to write down the merits and demerits of other beliefs and read them three times a day. He was also advised to write 10 merits and demerits of addiction. He was suggested to remind frequently Strong Coping Statements that addiction is a curse.

6TH Session

In this technique the client was asked to determine the activating event that is responsible for his present health condition. According to the client money is the main problem for him. His family is responsible for recent condition and did not cooperate with him. He reported the following:-

- Family do not support him financially
- They give bad remarks on him.

Client tried to change irrational beliefs and made him aware of the irrationality if his beliefs which he held. He was educated with reference to different verses of Holy Quran that addiction is a sin. Behavioral Self Control Technique was applied for him, which showed positive change in his behavior.

7TH Session

In this session, I decided to use role playing technique. The client was not able to interact with his family. He was asked to act out role of a sociable person before the mirror. He should talk and behave in accordance with social custom and assigned to do this at home. In the end of this session I feel some positive change in his behavior. He was highly motivated to abandon addiction. He made decision to take strong action to stop it.

8TH Session

In this session, I met with his family members and tell them about his condition and performance. I said them to try to cooperate with him in the development of social

attitude and avoid explaining his past events in front of him. I also advised to continue his exercise.

9TH Session

In this session, I asked the client to follow all this principles and exercises daily and avoid the high risk situations.

10TH Session

In this last session, I suggested the client for follow-up sessions whenever he needed. At the end of the session the contract of therapy was terminated.

Post Traumatic Stress disorder (309.81)

IDENTIFYING DATA:

Name	XYZ
Age	40 Yrs
Gender	Female
Education	F.A
Martial Status	Married
Dependent/Independent	Dependent
No of siblings	4 Brothers,4 Sisters
No of Children	1 Daughter
Parents alive/dead	Alive
Religion	Islam
Informant	Herself

PRESENTING COMPLAINTS: -

Pain in half head, sleeping not properly, too much feeling of thrust. Remedially remembers her daughter and weeping continually. Reputedly splitting, no interest in any time of work. Do something at once but UN concisely, too much aggressive. Blood pressure is high I fell that there is some deficiency in me

BEHAVIOURAL OBSERVATION: -

The patient was attentive. Her appearance was according to her age. Although, she was Dressed properly, but was self neglected towards personal hygienic condition. She Maintained an eye contact, but her speech was quite strange and irrelevant to the topic. The tone of her voice was low. Sometimes during the session. She showed rather Exaggerated or startle responses. As she had prominent weeping spells. In order to divert Attention, she continuously tapped her both legs and with regular intervals, she spitted Around her bed.

SYMPTOMS:

a. Person experienced, witnessed or was confronted with an event that involved Actual threat to the physical integrity of self.
b. Recurrent intrusive distressing recollections of that traumatic event.
c. Efforts to avoid thoughts, conversation or feelings associated with the trauma.
d. Marked diminished interest or participations in the significant activities.
e. Feelings of detachment or restricted range of affect and having sense of Foreshortened future.
f. Persistent symptoms of increased arousal such as,
    1. Difficult falling asleep
    2. Irritability and outburst of anger
    3. Difficulty in concentrating
    4. Exaggerated startle responses
    5. Significant impairment in daily functioning.

PERSONAL HISTORY

Patient basically belonged to the lower class family. There were no prenatal and postnatal complications with her. She achieved her developmental milestone normally. She had four sisters and four brothers. She was eldest of all. being eldest She was very short tempered and bossy. She could not continue her studies after Her F.A. because of financial problems. At the age of 35 years, she got married. Her husband was in army that's why he had a very limited salary. She was the second wife of her husband and had a son of her husband to bring him up. Age differences were very obvious in this marriage. Quite unfortunately, her husband did not prove to be a good responsible Husband. He was an alcohol and heroine addict so could not pay of due attention to His family. After 5 years of her marriage, she delivered a baby girl. That was very shocking News for her husband and in response to the situation, he became totally Unconcerned about the family affairs. That unexpected attitude of her husband Proved to be an important stressor in her life. In-spite of the facts, she brought her daughter up with extra care, attention and love but her happiness was very short lived. Because when her

daughter was 2 years Old, her physical conditions and health started deteriorating. She was very shocked to receive the news that her daughter was suffering from Sever breathing problem and coronary heart problem. She simply collapsed and then suddenly, there was a twist in her life when she witnessed her daughter having so much difficulty in breathing in ICU and just in a few moments later, she saw her died because of congested and troubled breathing. That scene was then, Impersonalized on her memory as" A Permanent Scar" that can never ever be Abolished or removed. That was the time when she desperately needed her Husband's moral support but she was deprived of that. She was preoccupied with the themes of being persecution and self-accusation. She started blaming herself all her miseries and bad luck. There started a battle (sever conflict) between her Mind and the body, which was, worsened her Physical and Psychological health And the onset of symptoms manifested quite clearly.

HISTORY OF PRESENT ILLNESS:

The problem started about one month earlier when the patient witness that death Scene of her 2 years old daughter. Her daughter died old troubled breathing and Heart problems .Her daughter was under the medical treatment in ICU of local Hospital, when she witnessed her daughter who was striving very hard against The upcoming death and the patent saw that entire scene so helplessly that she could do nothing for her daughter in order to relieve her from her problem. That scene raged the feelings of guilt and self-blaming or self-accusation in her. Secondly, that was the time, when her husband should have been there to console Her but she was also deprived from the primary moral and emotional support of Her husband .So, these stressors combined together to make a big drastically Blow. That was quite obvious in her current personality. Then with the passage of time, symptoms became very obvious (prominently frequent recalling the death scene of her daughter and weeping spells) and her conditions started worsened. So much so, that she became vulnerable for Psychiatric treatment. So she was referred to the MH Hospital and she is Receiving Psychiatric treatment over there.

PREMORBID PERSONALITY:

Patient's premorbidity has confirmed that she was very depressed in her husbands House because their conjugal relations were not favorably pleasant (or on good Terms), but at the same time, she proved to be a very loving, caring and Responsible mother and wife. She took keen interest in her household chores and performed them with due responsibility. Her premorbidity has confirmed that she was quite normal with a strong and Healthy body and mind.

ONSET OF PRESENT ILLNESS:

Onset of present illness was manifested for the first time when she witnessed her 2-year-old daughter with troubled breathing and striving terribly against the up Coming death. Quite naturally, that was simply unbearable for the patient but the Symptoms manifested because she could never ever forget that scene as that Scene was simply a" Permanent Scar" that seems to be un-removable as far as The case of patient was concerned. This was a really a trauma for the patient that She faced so helplessly She could not come out of this traumatic incident. So the symptoms which she Exhibited were quite similar to the symptoms which were normally exhibited by Patient of Posttraumatic stress disorder. In response to these symptoms she was Hospitalized and was under the treatment.

PHYCHIATRIC TREATMENT:

According to her medical report; No case of her prior psychological or physiological problems was registered.

CASE FORMULATION:

The present case is about a middle class married woman of 40 years who Suddenly collapsed at the sudden terrible death of her only daughter Suffering from coronary heart disease and breathing problem This was the main traumatic incident for the patient because she had witnessed The last stage of her 2 years old daughter .she could never forget her daughter Who had a great difficulty in breathing and she was just looking her so Helplessly. These all factors contribute to the development of PTSD.

DIAGNOSIS

Axis 1	Post Traumatic Stress disorder (309.81)
Axis 2	Nil
Axis 3	Nil
Axis 4	Lack of social support
Axis 5	GAF 65 (current)

PSYCHOLOGICAL ASSESSMENT:

To assess her personality, formal and informal assessment was used.

FORMAL ASSESSMENT:

Formal assessment includes case history interview.

INFORMAL ASSESSMENT:

Informal assessment includes different tests.

1. MAS. (MAINIFEST ANXIETY SCALE)
2. RISB. (ROTTER INCOMPLETE SENTENCE BLANK TEST)

1. MAS:

The MAS score of the patient was 35. This shows her highly anxious state of mind. This has also contributed to her mal-adjusted personality.

2.RISB:

Score of RISB is 183 that indicate her severe maladaptive personality. She has given many answers against her husband. She has the feelings of self Neglecting and also misses her daughter.

PROGNOSIS:

Through general attitude of the patient, it reveals that she want herself to Improve her physical, mental and psychological health.

SESSIONS

1ST Session

The client was referred by psychiatrist to the therapist. I met him and tried to build rapport as soon as possible. I talked in very friendly manner, asked his name, hobbies etc. The client was hesitated but I continued to treat in a friendly manner and made him feel that I had a great sympathy for him. At the end I asked him to visit me next day.

2ND Session

During this session the remaining history was completed. Family was educated about their role in therapeutic process. Formal and informal assessment was done in this session.

3RD Session

During this session, nature of the disorder of the client and time required for treatment was explained to the family members.

4TH Session

During this session, client was asked to practice the relaxation exercise regularly because the client was complaining of headache. He was told it will reduce headache.

5ND Session

In this session, the client talked with me in a relaxed manner, which showed her trust on me. The client was feeling well after taking the medicine because he thinks that without drugs he felt restlessness. In this session, therapy was focused to develop insight in client about his irrational attitude. At the end I asked him to visit me next day.

6TH Session

During this session, she was told about how he can convert his irrational beliefs into rational beliefs by challenging them and collecting data in support of rational beliefs. The client gave a positive response to it.

7RD Session

In this session, relaxation training was suggested for client who showed a great deal of physical tension and seems amenable to this treatment. Relaxation technique was used to reduce muscular tension.

8TH Session

This session was a review by the client and the therapist of the issues and goals, client had targeted. Therapy began by first discussing the specific issues that were of immediate concern to client.

9TH Session

In this session client was noticeably changed. He admitted that his worries were not rational. I assured the client that he will be able to return back to normal state. By the mutual consent the therapeutic contract was terminated.

Generalized Anxiety Disorder (300.02)

IDENTIFYING DATA:

Name:	ABC
Gender:	male
Age:	54 years
Education:	matric
Occupation:	Govt. employee
No of siblings:	9
Birth order:	2nd
Marital status:	married
No of children:	6
Father alive/dead	alive
Mother alive/dead	alive
Dependent/independent	independent
Referral source:	son

Presenting complaints

Headache, become angry, restlessness. Fatigue. Disturbed sleep. Heart beat is fast. Stiffness in muscles. Palpitation.

Behavioral observation

He was in a disturbed condition. He was nervous and restless. He had difficulty to talk and concentrate. Hygienic condition was good and was well dressed up. Initially he had difficulty to talk but gradually his mood and behavior was changed. His body and voice was trembling.

Symptoms

- Aggressive behavior
- Restlessness
- Fatigued
- Difficulty to concentrate
- Palpitation

- Muscle tension
- Sleep disturbance
- Irritability

Personal and family history

The client belonged to a middle class family. His brother and father were alive. They were 9 siblings and his birth order was second. All of his brothers and sisters were married. The client was married and had 6 children, four daughters and two sons.

Whenever the client had burden of work in the office his sleep become disturbed and was not able to sleep for many days. That was happening to him six months back when his boss assigned him a project. He remained tense for two days because of that project he couldn't sleep. After the completion of that project he couldn't sleep for six days. He used to keep sweating and could not pay attention to anything. He easily became aggressive. His sleep was disturbed and cant slept.

History of present illness

Its history goes back to 6 months. The reason was that he had a project in his office which he had to complete in two days. He slept only for 3 hours in two days. After the completion of this project, he could not sleep. He used to keep sweating and had poor concentration. Whenever anyone assigns him any office work, he easily became fatigued, irritated and aggressive. Pressure on head increases, became restless and gradually his condition become severe. He was brought to hospital by his son.

Pre morbid personality

Before this illness the patient was a normal person, responsible and regular in his work. He could work standing alone without the help of anyone. He was very humble, social and friendly. He showed full attention and full concentration in his work in office as well as without office.

Onset of illness

The illness started 6 months back

Medical/Psychiatric history

No significant medical or psychiatric history

Tests Administered

1. Beck Anxiety Scale

It was administered on the patient. He was instructed before the test. He scored 29 which fall in the severe category of anxiety.

2. Rotter's incomplete sentence blank (RISB)

He attempted 39 items and his score was 137 which shows that he was maladjusted. Also the conflicts are shown by some items.

3. House Tree Person

Anxiety is shown by the line quality. Drawing shows that the person is aggressive. Whereas with poor interpersonal relationships. He is not very social. Weak ego is shown by the weak trunk. He is sensitive to social criticism.

DIAGNOSIS

Axis I	Generalized Anxiety Disorder (300.02)
Axis II	no diagnosis
Axis III	no diagnosis
Axis IV	occupational problem
Axis V	GAF 75(current)

Prognosis

The patient had good insight about his problem. He was cooperative, so he will recover.

SESSIONS

1ST Session

The client was referred by psychiatrist to the therapist. I met her and tried to build rapport as soon as possible. I talked in very friendly manner, asked her name, hobbies etc. The client was hesitated but I continued to treat in a friendly manner and made her feel that I had a great sympathy for her. At the end I asked her to visit me next day.

2ND Session

During this session the remaining history was completed. Family was educated about their role in therapeutic process. Formal and informal assessment was done in this session.

3RD Session

During this session, nature of the disorder of the client and time required for treatment was explained to the family members.

4TH Session

During this session, client was asked to practice the relaxation exercise regularly because the client was complaining of headache. She was told it will reduce headache.

5ND Session

In this session, the client talked with me in a relaxed manner, which showed her trust on me. The client was feeling well after taking the medicine because she thinks that without drugs she felt restlessness. In this session, therapy was focused to develop insight in client about her irrational attitude. At the end I asked her to visit me next day.

6TH Session

During this session, she was told about how she can convert her irrational beliefs into rational beliefs by challenging them and collecting data in support of rational beliefs. The client gave a positive response to it.

7RD Session

In this session, relaxation training was suggested for client who showed a great deal of physical tension and seems amenable to this treatment. Relaxation technique was used to reduce muscular tension.

8TH Session

This session was a review by the client and the therapist of the issues and goals, client had targeted. Therapy began by first discussing the specific issues that were of immediate concern to client.

9TH Session

In this session client was noticeably changed. She admitted that her worries were irrational. I assured the client that she was a sensible lady. By observing her condition and through the mutual consent the therapeutic contract was dissolved.

Substance Related Disorder

Mr. M.N was born in a middle class family of 4 brothers and 3 sisters. His mother deceased due to diabetes in 2003. His father has a meat shop but these days his father was not feeling well and has operation of bypass now his younger brother was running the shop.

He had good interpersonal relations with his parents and siblings. As he reported. "My parents love me a lot and I really miss my mother. The attitude of my sibling was also good with me as my elder brother give money to my wife."

Mr. M.N is a married man and spends 11 years of his married life. He had well relations with his wife. As he reported: "Me and my wife studied together in metric and had love marriage. My relationship with my wife is good."

Patient gives contradictory statement as he reported earlier that he is happy with his wife but later on he says that the demands and behavior of his wife make him depressed.

Past Personal History:

Mr. M.N was a young man of 29 years. He was sparkling and healthy in his childhood. As he reported: "I have passed metric with an average marks." He fought with some people due to which his right hand does not work well. As he reported: "some boys of town had fought with my younger brother; I also fought with them due to which 4 bullets hit my right hand."

After this incident he was not able to work which disappointed him and he started to take chars. He also engaged in bad company of friends and he started drinking and opium.

History of present illness:

This is patient's 1st psychiatric admission to the hospital. Now he had been in the hospital since last 2 weeks. The cause of admission, he reported:

"I started to take chars in the beginning but gradually I started drinking and also heroin because of that my brother admitted me in PIMH."

He had addicted in chars, heroin, wine and opium from the age of 20 to 21 and was still used to it. He was not feeling well when he did not take chars. As he reported: "When I did not take chars my nerves were not working well and I also feel pain in my legs."

Bio Data:

Name:	M.N
Age:	29
Sex:	Male
Education:	Metric
Marital Status:	Married
Religion:	Islam
Sibling:	4 brothers and 3 sisters
Parents:	Father alive and mother deceased
Birth Order:	6th one
Education of Father:	Uneducated
Education of Mother:	Uneducated
Residence:	Lahore
Past psychiatric history:	Nil
Past medical history:	Nil

Behavioral Observation:

Mr. M.N was a young man of 29 years old. He was a handsome man. He had fair complexion, straight hairs, and appropriate height and had appropriate hygienic condition. He maintained an appropriate eye contact during the session. His speech pattern was appropriate as he talked in normal tone.

Presenting Complaints

Addiction

میں وقت میں پانچ چھ پڑیاں ہیروئین کی پی لیتا ہوں میں نے دو سال تک ہیروئین پی ہے اور شراب بھی پیتا ہوں۔

Appetite Disturbance

کھانا ٹھیک طرح سے نہیں کھا سکتا ایک وقت کا کھانا کھاتا ہوں۔

Insomnia

مجھے نیند ٹھیک نہیں آتی رات کو دو سے تین گھنٹے سوپاتا ہوں۔

Regret Feeling

اس بات کا افسوس ہے کہ نشہ کیوں شروع کیا۔

Patient now wants to leave the habit of addiction. As he reported:

"My cousin also had the habit of addiction, he used chars 30 years and at the age of 48 he died, after this I came on right path and now I want to leave this habit."

Evaluative Techniques:

MSE

Case history interview

HTP

RISB

RPM

Intellectual Functioning

In order to assess the intellectual functioning of the patient Raven's was applied. His total score on Raven was 14 with corresponding 5th percentile. This indicates that he lies in V grade and he was intellectually defective. (See Appendix 5-B)

On the basis of Mental Status Exam, it is clear that the patient has intact recent and remote memory as he was very well knew about his past event and he had good orientation of time and place, as he knew about day, date, year and place. (See Appendix 5-A)

Personality Functioning:

RISB, HTP and MSE were administered to check the personality functioning of the patient.

Patient score on RISB is 138 with a cut off score 135. it indicates that patient is maladjusted. C responses in the RISB are more than positive and neutral responses. Conflict responses are indication of unhealthy hostility reaction, pessimisms, hopelessness and negativism (Rotter 1932). As he respond to item no 3, 5, 6, 9, 11, 12, 14, 18, 20,21, 22, 23, 25, 26, 28, 29, 30, 32, 33, 36, 39 (See Appendix 5-C)

The interpretation of HTP also indicated the main features of his personality. In the drawing of house lots of birds show depression. Sun indicates that person wants warm and affection from someone. Walkway means that people are ready to having good interpersonal relations but they are not happy with their domestic life. Absence of door

indicates that they want to spend secret life. Absence of window in the drawing of house indicates defensive personality (Buck, 1966).

Cloud like tree indicates confuse and immature thinking. The strong trunk emphasizes the strong ego (Buck, 1966).

In the human drawing mouth omitted in female figure shows possible scolding maternal figure (Machover). Hair emphasis shows infantile sex drives. (Hammer, Machover). Arms extended from the body in both figures show externalized aggression. Ear emphasize in both figures show auditory hallucination, paranoid or schizoid (Machover). Foot phallic in female figure shows sexual inadequacy and preoccupation. Buttons in midline in male figure show maternal dependency. (See Appendix 5-D).

Overall, we can say that patient had paranoid tendency, aggressive and alcoholic tendency, feeling of hopelessness and maladjusted frame of mind.

Case Formulation

Mr. M.N was a young man of 29 years. This is patient's 1st psychiatric admission to the hospital. He had the symptoms like addiction, guilt feeling and sleep disturbance and appetite problem.

The major features of substance abuse is (Criteria A) A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one of the following occurring with in a 12 months period: (1) recurrent substance use resulting in failure to fulfill major role obligation at work, school or home (2) recurrent substance use in situation in which it is physically hazardous (3) recurrent substance related legal problems (4) continued substance use despite having persistent or recurrent social or interpersonal problem (A Criteria). The symptoms have never met the criteria for substance dependence for this class of substance (B Criteria). (DSM IV TM).

Patient M.N doesn't meet the criteria of substance abuse because the symptoms of patient also met the criteria of substance dependence.

Patient doesn't meet the criteria of substance intoxication because in criteria of substance intoxication because in criteria A the development of a reversible substance specific syndrome due to the recent ingestion of a substance while patient uses it from 9 to 10 years. So we cannot diagnose it in substance intoxication.

The diagnostic criteria for substance withdrawal are the development of a substance specific syndrome due to the cessation of substance use that has been heavy and prolonged. (Criteria A). The substance specific syndrome causes clinically significant distress or impairment in social, occupational or other important areas of functioning. (Criteria B). The symptoms are not due to the general medical condition and are not better accounted for by another mental disorder. (Criteria C). (DSM IV TM).

Patient doesn't seem to fall in criteria substance withdrawal because no substance specific syndrome develops due to the reduction of substance that is heavy and prolonged.

Patient M.N seems to fall in category of Substance Dependence because the patient often use increase amount of substance to achieve intoxication, he is also unable to perform social and occupational functioning. Patients also use it despite of the knowledge having persistent psychological and physical problem. Patient most of the time spends in activities to obtain the substance.

From the drawing of HTP, score on RISB and RPM person has feeling of helplessness, aggression, alcoholic and negative frame of mind.

Presenting complaints and result of the tests support our diagnosis that person tends to have Substance Dependence.

Diagnosis

Axis I	Substance Dependence
Axis II	no diagnosis
Axis III	no diagnosis
Axis IV	Family and occupational problem
Axis V	GAF (61 – 70)

Prognosis

Patient has long history of symptoms and prognosis seemed to be unfavorable

SESSIONS

1ST Session

First of all the rapport was developed with the client. For this purpose, he was received with respect and warmth in the hospital. After the introduction we talked on some topics of common interest so that the client feels easy and relax. The history of the client was taken through interview. First he told about the symptoms. Then I asked about his family and his childhood, school, his interest in extracurricular activities about his general health. During the interview his facial expressions, posture, gesture and body movements were observed. All these were necessary for the diagnosis.

2ND Session

I administered psychological tests. First of all RISB was given and asked him to complete the sentences with his real feelings. In start he felt hesitation so I explained him purpose of testing and try to explain that I do not tell about his feelings. He felt relaxed and cooperate with me and completed the test carefully. After that CAS was administered.

3RD Session

In this session the management plan was made but client did not realize that opiod has some disadvantages. I explained the difference between normal person routine and his routine life. During session, the client anxiety level was so much high so we again discuss on some topic of the common interest. At the end of the session, I asked him to thought about his routine life and normal person routine life and compare with each other. Motivational interview was conducted with the client who showed that the client did not consider addiction is a problem for him. Socratic style was used with him.

4TH Session

In this session, therapist and client decided to routine plan according to the client of interest and taught him how he can relax by applying the relaxation training and

contract his anxious level and the home work to follow daily routine plan. In this session, facts and figures were used to develop awareness in him. "How much income you spend for addiction? What problems addiction creates for you? What benefit of addiction to you?"

5TH Session

In this session, I used the refracting technique to change his irrational beliefs and advised him to read it again and again. As a result, he convinced the irrationality of his belief. I advised him to write down the merits and demerits of other beliefs and read them three times a day. He was also advised to write 10 merits and demerits of addiction. He was suggested to remind frequently Strong Coping Statements that addiction is a curse.

6TH Session

In this technique the client was asked to determine the activating event that is responsible for his present health condition. According to the client money is the main problem for him. His family is responsible for recent condition and did not cooperate with him. He reported the following:-

- Family do not support him financially
- They give bad remarks on him.

Client tried to change irrational beliefs and made him aware of the irrationality if his beliefs which he held. He was educated with reference to different verses of Holy Quran that addiction is a sin. Behavioral Self Control Technique was applied for him, which showed positive change in his behavior.

7TH Session

In this session, I decided to use role playing technique. The client was not able to interact with his family. He was asked to act out role of a sociable person before the mirror. He should talk and behave in accordance with social custom and assigned to do this at home. In the end of this session I feel some positive change in his behavior. He

was highly motivated to abandon addiction. He made decision to take strong action to stop it.

8TH Session

In this session, I met with his family members and tell them about his condition and performance. I said them to try to cooperate with him in the development of social attitude and avoid explaining his past events in front of him. I also advised to continue his exercise.

9TH Session

In this session, I asked the client to follow all this principles and exercises daily and avoid the high risk situations.

10TH Session

In this last session, I suggested the client for follow-up sessions whenever he needed for his betterment. The contract of treatment was dissolved at the end of this session.

Disorganized Schizophrenia (292.10)

BIO-DATA

Name	M.N.
Age	46 years
Sex	Male
Education	Primary
Occupation	Land lord
Marital Status	Unmarried
Birth order	2nd born
Religion	Islam
Sibling	Four brothers four sister
Parents	Alive
Education of Father	Illiterate
Education of Mother	Illiterate
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. M. N was serious stature middle aged man of 46 years .His dress was tidy with tidy hair. He answered in appropriate way and had maintained good eye contact during session. He completed tests with less interest and his tone was inappropriate. He had less vocabulary of words therefore repeat many sentences again and again. Overall his behavior was cooperative.

Presenting Complains

Hallucination

Insomnia

Self talking

Guilt feeling

Alogia

Disturb sleep

Delusions

FAMILY HISTORY

He belonged to middle class family of four brothers and four sisters of Chawk 96. His both parents were alive and they love him as reported by him.

He was 2nd born child in his family. The attitude of his siblings was good and he told that he had joint family system and home environment was good, peaceful. He was unmarried.

PAST PERSONAL HISTORY

Mr. M.N. was a middle aged man of 46 years and was the 2nd born child of his family. He told that he spent his childhood happily and according to him his birth was normal. He was not more intelligent student therefore could not carry on his studies.

HISTORY OF PRESENT ILLNESS

He was admitted to hospital for 1st time for the treatment of schizophrenia. His brother took him in hospital. He had very poor interpersonal and social relationship with others.

Doctor reported that he came to hospital for 1st time. The cause may be the schizophrenia because of this reason, he may show signs of hallucination and delusions.

EVALUATION TECHNIQUES

He was cooperative and took great interest in completing the tests.

Following techniques were used

1. Raven Progressive Matrices
2. Mental status examination
3. Case History examination
4. H.T.P
5. R.I.S.B

INTELLECTUAL FUNCTIONING

He seemed to have intellectual deficiency. His total score on Ravens was 11 corresponding 25th percentile. This indicates that he lies in iv grade and was intellectually defective and it also matches with his qualification so it is concluded that he do this test with concentration (See appendix, 5-C).

His recent and remote memory seemed to be not much good as he could not recall most of the past and present events easily.

He had poor orientation of time, place and person. He know about his name but did not know name of patients, day, time and the name of village where he lived as he matched with the information given by the staff of hospital (see appendix, 5-A).

PERSONALITY FUNCTIONING

Mr. M.N. was a middle aged man of 46 years. He belonged to middle class family. He was the 2nd born child in the family of four brothers and four sisters. This was patient's 1st psychiatric admission to hospital.

HTP, MSE, CHE was administered to check the personality functioning of patient.

Drawing of HTP shows that he has schizophrenic tendency indicated by confusion full face, ear emphasis, emphasis on joints, giraffe neck and very faint lines (Machover). Incomplete house, compartment of rooms and boundary of walls indicates poor interpersonal relations and insecurity (Buck, 1966, Hammer). Omission of parts and break lines indicates his conflict to that area (Hammer, Levy) (See Appendix, 5-F).

CASE FORMULATION

Mr. M.N was a middle aged man of 46 years from a middle class family of Chawk 96. He was unmarried. He was the 2nd born child in the family of 4 brothers and 4 sisters. His education was primary and he was landlord by occupation. It was patient 1st time in hospital for treatment of schizophrenia.

He had severe symptoms as hallucination, delusions, insomnia, self talking, Alogia, guilt feeling and disturb sleep.

People with schizophrenia stands out because of the delusions and hallucination, at the same time their cognitive skills and affects are relatively intact. They generally have disorganized speech and flat affect. According to the DSM IV criteria for schizophrenia, person should have persecutory or grandiosity delusions and auditory hallucination. Other type of delusion can also be present. Associative features are anxiety, aloofness, anger and argumentation (DSM IV-TM).

Patient has the symptoms of hallucination and delusions and it is fulfilling the criteria of schizophrenia as he does not use drugs. So we can diagnose him as schizophrenia disorder.

From the drawing of HTP, it is clear that person has schizophrenic tendency, conflicts, insecurity, poor interpersonal relations and dependency.

Presenting complains and the results of the test support our diagnosis that the patient tends to have schizophrenic disorder.

TENTATIVE DIAGNOSIS

Axis I	Disorganized Schizophrenia (292.10)
Axis II	Nil
Axis III	Nil
Axis IV	Interpersonal Relation problem
Axis V	GAF = 41-50

PROGNOSIS

His symptoms were much severe and have long history, so prognosis was impossible.

SESSIONS

1ST Session

During this session a detailed history was taken related to client's mother and father. The rapport was also build and client was guided about his problem and treatment.

2ND Session

During this session the family members of the client were educated about his problems. Their role in the therapeutic process was also explained to them and remaining history was also taken. Formal and informal assessment was done in this session.

3RD Session

During this session the client was not feeling much better. He was aggressive and abusive. However, the behavioral change contract was signed and rein forcers were identified.

4TH Session

During this session the rein forcers identified in the previous session were paired with the tokens i.e. stars of green and red colors were used (this was done because of the non availability of the tokens in the ward). The activities were paired with secondary rein forcers (stars) which could be exchanged with the primary rein forcers.

5TH Session

During this session the modeling was applied. The desired behavior was modeled in front of him and he was asked to practice it. During this session he reported improvement in his aggression and abusive behavior.

6TH Session

During this session his family was interviewed and they reported great improvement in the client according to them he had started washing his mouth and taking bath himself and started brushing daily. Beside this, his anger was also controlled. Then the family members were further educated about his problem.

7TH Session

In this session the he showed improvement. The social reinforcement was used to encourage him to do his assigned activities.

8TH Session

In this session the client was counseled about the possible problems that he could face while leaving the hospital. He was also told about how he could manage.

9TH Session

During this session client was feeling well. There was improvement in personal hygiene. Beside this, he had started to talk with other family members. The mother was interviewed about his problem and she also reported improvement.

10TH Session

In this session some occupational activities were applied. For example the client was asked to do some wooden work and he made a decoration piece. He was very pleased with this and showed a keen interest in this.

11TH Session

The client was called on for follow-up session after 10 days. During this session the MSE was conducted again. His mood was normal and he was active and alert for most of the time. Orientation and memory was intact. Attention and concentration was normal. No delusion and hallucination or compulsion phenomena are observed. He had insight about his problem. Talk was relevant and at a normal pace.

12TH Session

In this session the client was markedly improved. The mother reported that he brushed his teeth almost daily. But took bath only once a week and also changed his clothes once a week. He talked to his sister and talked relevantly. However yet they could not arrange for his earning. Overall he remained better.

Paranoid Schizophrenia (295.30)

BIO DATA

Name	K.Q
Age	45
Sex	Female
Marital Status	Unmarried
Religion	Islam
Siblings	2 brothers and 3 sisters
Birth order	3rd born
Qualification	M.S.C Math
Parents	Mother alive and father deceased
Education of father	Metric
Education of Mother	Illiterate
Residence	Gujranwala
Psychiatric admission	1st
Past psychiatric history	Nil
Past medical history	Nil

Behavioral Observation:

Miss. K.Q was a middle age lady of 45 year with fair complexion. Her appearance matched with her chronological age. She had good hygienic condition because she was neatly dressed and her hair was properly done. She maintained an appropriate eye contact during the session. Her speech pattern was appropriate but she talked in a low tone. She was in a depressed mood and her mood was congruent with her affect.

Presenting Complaints:

Grandiosity Delusion

Persecutory Delusion

Sleep Disturbance

Irrational Beliefs

Auditory Hallucination

Vision Hallucination

Family History:

Miss K.Q was middle age lady of 45 year. She was residence of Gujranwala. She belonged to middle class family. Her father was deceased and mother is alive. She has 2 brother and 3 sisters. She is the 3rd one among siblings.

Her father had a small medical store to run. She has poor interpersonal relations with her parents. As she reported:

"My mother used to beat me and my father was also not good toward me."

She also had poor interpersonal relations with her siblings.

Past Personal History:

Miss K.Q was middle age lady of 45 year. She reported her past history that she was not a social woman. Her childhood was not good she doesn't enjoy in her childhood. As she reported:

"I did not enjoy in my childhood. My sister and brother used to play in the street but I remained in the house and most of the time thinking why my name is not Allah."

She was a very bright student in her academic career. She was M.S.C Mathematics and also did course in Arabic from Agricultural University of Faisalabad. As she reported;

"I was very good student throughout my academic career. I have passed M.S.C with very good grades."

She taught Arabic and Mathematics in Faisalabad College. She said that principle of the college told that she is mentally ill so she should stop teaching there but this thing doesn't discourage me at all and I continued teaching privately.

She had an unsuccessful love affair with Raja Nazim. As she reported:

"I wanted to have a meeting with Raja Nazim at jinnah garden to decide whether I shall marry with him or not but Khalid mahmood the cousin of Freha Pervaiz did not let me meet and took Raja Nazim in his prison."*

History of Present Illness:

This is Patient's 1st psychiatric admission to the hospital. She has been in the hospital for last 7 month. She was admitted in the hospital for several reasons. She had

feelings of grandiosity, feelings of persecution, auditory hallucination and irrational beliefs. As she reported:

"I am god but society doesn't admit it and this thing really disturbs me."

At the same time she reported:

"I am chief justice of Supreme Court and people come to me for their decision."

She also told that the attitude of her family made her depressed. Her mother often beat her and her father had no affection for her at all.

Evaluating Technique:

Following technique were used in order to assess the intellectual and mental functioning of the patient.

Mental Status Examination

Case history interview

HTP

RISB

RPM (Raven Standard Progressive Matrices)

Intellectual Functioning:

In order to assess the intellectual functioning of the patient Raven's was applied. Miss K.Q seemed to have good intellectual functioning. Her total score on Ravens was 27 with corresponding 50^{th} percentile. This indicates that she lies in III grade and has an average I.Q level. (See appendix 1-B)

On the basis of her Mental Status Examination it is clear that his recent memory is good but remote memory is not good, as she couldn't remember any of his pleasant and sad events. She had good orientation of time and place as he knew about day, date and place (See appendix 1-A)

Personality Functioning:

RISB, HTP and MSE were administered to check the personality functioning of the patient.

Patient score on RISB IS 139 with cut off score of 135. It indicates that patient is highly maladjusted. C responses in the RISB are more than positive and neutral responses. Conflict responses indicate unhealthy maladjusted form of mind. They

indicate hostility, pessimisms, hopelessness and negativism (Rotter 1932). As she responded to item No 7, 13, 20, 22, 27, 37, 39 (See Appendix 1-C).

Miss K.Q seemed to have poor interpersonal relations as indicated by the compartmentalization in the house. (Buck, 1966). Absence of door in the drawing indicates that these people like to spent secret life and these people have a tendency of Paranoid Schizophrenia. (Buck, 1966)

In the drawing of tree, hand like shape shows aggressiveness in a person. The strong trunk emphasize in the drawing of tree is the feeling of the basic strength of her ego but dim line show lack of emotion and depression. Fruit drew by her show a desire to be a pregnant. (Buck, 1966)

In the drawing of the person, broken line indicates the anxiety and insecurity (Hammer, Buck). Absence of ear in both male and female drawing shows presence of auditory hallucination (Buck, 1966). Feet omitted in both male and female figure are a sign of withdrawal dependency and discouragement (Hammer, Levy). Absence of leg in male figure suggests strong feeling of constriction (Buck, 1966). In male figure long nose is a sign of impotency (Mach over). Arms extended from the body in male figure show externalized aggression (Hammer, Levy). Claw like figure in both male and female drawing is a sign of overt aggression and paranoid (Mach over). Hair in the drawing of female half on one side and half on other side shows split ego (Buck, 1966). Arms close to the body in a drawing of female indicate tension (Mach over) Eyes without pupil in female drawing is a sign of voyeuristic tendency with guilt. Face of male figure turned toward the page is a sign of withdrawal tendency. (Hammer) (See Appendix 1-D)

She seemed to be in elated mood during the whole session of interview and testing. Her tone was appropriate. She had thought disturbance like feeling of grandiosity and feeling of persecution. (See Appendix 1-A)

Overall we can say that she had hopelessness, depression aggression and maladjusted frame of mind.

Case Formulation:

Miss K.Q was a middle age lady of 45 year. She was the 3rd born child in the family of 2 brother and 3 sisters. She was an M.S.C. She had an unsuccessful love affair. This is patient 1st psychiatric admission to the hospital.

She had the symptoms like grandiosity delusion, feeling of persecution, auditory hallucination, sleep disturbance and irrational beliefs.

The major feature of disorganized type of schizophrenia is disorganized speech, disorganized behavior, flat or inappropriate affect (Criteria A). The criteria are not met for catatonic type. (DSM IV TM)

Patient K.Q doesn't meet the criteria of disorganized type because she doesn't have disorganized speech, behavior and effect.

The diagnostic criteria for Catatonic type of Schizophrenia are presence of motric immobility, excessive motor activity, extreme negativism, peculiarities of voluntary movement (DSM IV TM)

Patient K.Q does not fulfill the criteria of catatonic type so that's why she cannot diagnose as Catatonic Schizophrenia patient.

Residual type diagnose as absence of prominent delusion, hallucination, disorganized speech (Criteria A). There is continuous evidence of the disturbance as indicated by the presence of negative symptoms. (Criteria B). (DSM IV TM)

Patient K.Q cannot diagnose in the residual type because in-patient disorganized speech is absent but hallucination and delusion are the prominent feature in patient that are absence in residual type.

Diagnostic criteria for Paranoid Schizophrenia are preoccupation with one or more delusion or frequent auditory hallucination (Criteria A). None of the following is prominent: disorganized speech, disorganized or catatonic behavior or flat or inappropriate affect. (Criteria B). (DSM IV TM)

Patient K.Q seems to fall in category of Paranoid Schizophrenia because the patient has grandiosity delusion, persecutory delusion and auditory hallucination, which are the major feature of Paranoid Schizophrenia. Patient also has an inappropriate speech and disorganized behavior.

From the drawing of HTP, score on RISB and RPM it is clear that patient had paranoid tendency, depression aggressive and negative frame of mind.

Presenting complaints and results of the tests support our diagnosis that patient tends to have Paranoid Schizophrenia.

DIAGNOSIS:

Axis I	Paranoid Schizophrenia (295.30)
Axis II	no diagnosis
Axis III	no diagnosis
Axis IV	Problem related to the social environment
Axis V	GAF 30 (current)

Prognosis:

Patient has long history of symptoms and prognosis seems to be unfavorable.

SESSIONS

1ST Session

During this session a detailed history was taken related to client's mother and father. The rapport was also build and client was guided about his problem and treatment.

2ND Session

During this session the family members of the client were educated about his problems. Their role in the therapeutic process was also explained to them and remaining history was also taken. Formal and informal assessment was done in this session.

3RD Session

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11TH Session

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12TH Session

In this session the client was markedly improved. The mother reported that he brushed his teeth almost daily. But took bath only once a week and also changed his clothes once a week. He talked to his sister and talked relevantly. However yet they could not arrange for his earning. Overall his condition was improved a lot.

Major Depressive Disorder Recurrent (296.3x)

IDENTIFYING DATA:

Name:	N.M
Gender:	Female
Age:	57 Year
Religion:	Islam
Marital Status:	Widow
Education:	Nil
Occupation:	Household lady
No of siblings:	5 (2sisters & 3 brothers)
Birth order:	2nd
No of children:	Nil
Informant:	Self

Reason for Referral:

The client was brought to Hospital with the symptoms of disturbed sleep, low appetite, crying spells, lack of interest, helplessness, pessimism, feelings of unworthiness, sad feelings, death wish and aggressive behavior. She was referred by the psychiatrist for psychological assessment and therapeutic intervention.

Presenting Complaints:

The client reported the following symptoms/complaints:

Duration of symptoms (03 years)

1) نیند نہیں آتی۔
2) بھوک نہیں لگتی۔
3) ہر وقت روتا رہتا ہے۔
4) اپنے آپ کو بے یار و مددگار سمجھتا ہے۔
5) اداس رہتا ہے۔
6) مرنے کو دل کرتا ہے۔
7) غصہ بہت آتا ہے۔
8) کسی کام کرنے کو دل نہیں کرتا۔
9) اپنے آپ کو حقیر سمجھتا ہے۔

History of Present Illness:

The client's problems started 03 years ago. Her husband died 04 years ago and her father died thereafter. All this was very shocking to the client. After her husband and father's death and also some frequent deaths occurred in her family.

She gradually developed many symptoms like disturbed sleep, low appetite, crying spells, sadness, feeling of unworthiness, lack of interest and death wishes. She seemed that life was useless. Another precipitating factor regarding her illness was that she was issueless. This promoted feeling of helplessness. She was too much worried who will take care of her in old age. Her elder brother is a client of paralysis. He was not able to perform his minor activities. This was also cause of worry for her. She had to take care of her brother. She also remained upset and tense that who will take care of her brother if she died.

Past Psychiatrist Illness:

The client has no past psychiatric history.

Family History:

Client belongs to a lower middle class family. Her father died 04 years ago and she had good relationship with him. Her mother died 10 years ago and she had good relationship with her. Patient has two sisters and four brothers. Her relationship with her siblings and relatives was good. Her elder brother was suffering from paralysis and she took care of him.

Due to frequent deaths in family, she always remained sad and disturbed. Her eldest brother was a client of paralysis and when she saw him, she got tense. She feared that no one would take care of her and her brother because she was issueless.

Personal History:

Client was uneducated and belongs to a lower socio-economic status family. Her delivery was normal at home and no prenatal and post-natal complications were reported. She passed her milestones smoothly. She liked to respect everyone and had kind attitude towards her family members. She was much worried about the health of his brother and future of his children. She had also fear that she was issueless and in old age who will take care of her. She did not report any history of addiction. She reported to be at menopause.

She was a widow. She was a loving and caring lady. Her husband died 04 years ago. Her husband was very kind and caring towards her. She reported that she was issueless. Husband's death was unbearable grief for her. She reported that her life was full of misery. She was a household lady.

Pre-morbid Personality:

Her sister reported that before her symptoms started, she was very social. She participated in household affairs actively. She was considered as an important member of the family. Her relatives consulted her for making family decisions.

PSYCHOLOGICAL ASSESSMENT:

Both informal and formal psychological assessment of the patient was done by the therapist.

INFORMAL ASSESSMENT:

Informal psychological assessment was done by a detailed interview, behavioral observation and MSE.

1. Behavioral Observation:

She was of medium height and built. She was well kempt but seemed anxious. She was talking in murmuring voice that was not easily understandable.

2. Mental Status Examination:

i. General Appearance:

Client was well dressed and groomed. She was looking disturbed. She was brought to the therapist's room with the help of her sister. Her eyes nervously scanned the room. She was sitting restless and showed boredom. However, she responded to queries of the therapist properly.

ii. Speech:

She was speaking slowly in a very low tone. Her composition of words and sentence format was normal.

3. Emotional Expressions:

i. Objective:

She was looking depressed.

ii. Subjective:

As client reported:

میری طبیعت ہر وقت اداس رہتی ہے دل کرتا ہے خودکشی کرلوں۔

4. Thinking and Perception:

i. Thought form:

Her thoughts were generally logical and goal oriented. There was no evidence of loosening of association or thought blocking.

ii. Thought content:

She had very low self esteem. Obsessions were presents about the death of her father. Suicidal thoughts were present in his mind. Delusions were not present.

iii. Perception:

No illusions and hallucinations were present regarding her perception and thought pattern.

5. Sensorium:

i. Alertness:

She was not much alert at the time of interview.

ii. Orientation:

Her orientation was intact in all the three domains of time, place and person.

a. Person:

Her orientation about person was normal when I asked:

سوال: میں کون ہوں؟

جواب: آپ ماہر نفسیات ہوں۔

b. Place:

Her place orientation was also normal. When I asked him:

سوال: آپ کس جگہ ہیں؟

جواب: سوشل ہسپتال۔

c. Time:

She told me the time when I asked about time, she told me quite correct without seeing watch.

سوال: آپ کے خیال ں کیا وقت ہو رہا ہے؟

جواب: صبح کا وقت، تقریباً 12 بجے ہوں گے۔

iii. Concentration:

Her concentration about questions was good.

iv. Memory:

Her memory was good. I checked client's immediate, recent and remote memory

a. Immediate:

To check her immediate memory I asked question to her:

ان الفاظ کو دہرائیں۔

سیب، کیلا، انگور، خربوزہ، آم

سیب، کیلا، انگور، خربوزہ، آم

She repeated these words in sequence that shows her immediate memory was good.

b. Recent memory:

To check her recent memory:

ان نمبرز کو سن لیں اور تھوڑی دیر میں آپ سے پوچھوں گی۔

3, 5, 7, 1, 4

3, 5, 7, 1, 4

She repeated these numbers without any mistake, so it was good.

c. Remote memory:

I asked her:

سوال: اپنے بچپن کی کوئی بات بتائیں۔

جواب: میں ابو کے ساتھ سودے لینے جاتا تھا۔

She gave the correct answer.

v. Calculation:

About her calculation:

$$200 + 400 + 700 + 300 - 600 = 1000$$

She replied correct answer.

vi. Fund of knowledge:

سوال: پاکستان کب بنا تھا؟

جواب: 14 اگست 1947ء

vii. Abstract Reasoning:

She had knowledge about proverbs and metaphors:

نیم حکیم خطرۂ جان نیم ملا خطرۂ ایمان۔

محدود علم نقصان دہ ہوتا ہے۔

6. Insight:

She had insight about her ailment and she recognizes the severity of her problem.

7. Judgment:

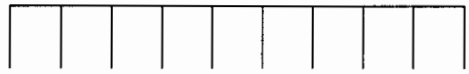
Her judgment about the person, situation and environment was good.

میں اپنے رسم و رواج سے واقف ہوں۔

FORMAL ASSESSMENT:

Pre-testing:

Rating Scale:



1 2 3 4 5 6 7 8 9 10

Lack of interest	8
Depressed mood	10
Pain in body	8
Loss of appetite	8
Suicidal thoughts	9
Lack of Sleep	9

Symptoms check list-R:

Scales	Raw scores	SD	Significance
I	60	2	37

This score shows the highly significance in symptoms of the client, which can be very dangerous.

TESTS APPLIED

1. Beck Depression Inventory (BDI)

2. Beck Hopelessness Scale (BHS):

3. Rotter Incomplete Sentence Blank (RISB)

1. Beck Depression Inventory (BDI):

In the depression inventory the score of the client was 40, which cause severe depression and this score shows the severe depressed condition of the client.

Less then 3	Denial of depression
5-9	Consider normal
10-18	Mild to Moderate
19-29	Severe Depression

2. Beck Hopelessness Scale (BHS):

Quantitative analysis:

This table is showing the quantitative analysis of BHS.

Score	Severity level	Obtained score
Greater than 14	Severe	17

Qualitative analysis

This result of the client shows that BHS scores of 17 were predictive of eventual suicide in depressed suicidal ideation followed for 5-10 years after discharge from a hospital.

This result also shows that the subject had negative view of the self, negative view of present functioning and negative view of the future.

3. Rotter Incomplete Sentence Blank (RISB):

Quantitative Analysis:

Conflicts responses

Total response of C3	13
Total response of C2	11
Total response of C1	5

Positive Responses

Total response of P1	2
Total response of P2	2
Total response of P3	2

Key

C3=6	N=3	P1=2
C2=5		P2=1
C1=4		P3=0

Total scores of responses

Total score of positive responses	18
Total score of conflict responses	435
Total score of neutral responses	15

Qualitative Analysis:

1: Family Attitude:

Her attitude towards her family was positive. She said that she feels loneliness in her home but she likes her family. According to her, her brother was the greatest worry of her.

2: Character Traits:

She said that I want to know everything and everything annoys me. She also said that people annoy me that it shows she is not social and everything teases her. She said

that her greatest fear and greatest worry is her brother and financial insecurity because he belongs to a poor family.

3: General Attitude:

She said that at bedtime I become depressed. She likes the sports and he said that reading is not my specialty. She said that I need money. It means he spent his life with narrow limits.

4: Social & Sexual Attitude:

She said that boys are good. She also said that girls are also good. There are not those items which belong to the social attitude because the client was not so much social and avoid gathering due to her illness.

DIAGNOSIS

According to DSM-IV, the diagnosis is made as under:-

Axis-I	296.2 Major Depressive Disorder with single episode
Axis-II	None
Axis-III	None
Axis-IV	Death of family members, inadequate social support
Axis-VI	GAF =50 (current)

MANAGEMENT PLAN

The management plan was made as follows:

Short-term Goals:

1. Establish rapport with the client

2. Educate the family about the illness of the client and induction therapeutic treatment.
3. Maintaining a base line about her personal hygiene and social skills.
4. Keeping her busy in daily routine activity schedule.
5. Enable the client to do her work independently.
6. Identifying the reinforcing agents of the client
7. Improving her personal hygiene and social skills.

Long-term Goals:

1. To enable client for better adjustment in the environment.
2. Make the client feel responsible about her duties and work.
3. Educate the family about hazards of high expressed emotions.
4. Home Work Assignments
5. Improvement of Activity Schedule

SESSIONS

1ST Session

In this session a detailed history related to her problems was taken. The rapport was established with the client. Client was guided about her problem and treatment.

2ND Session

During this session, family members of the client were educated about her problem. Their role in the therapeutic process was also explained to them. Formal and informal assessment was done in this session.

3RD Session

The patient did not have any complaints. She was not so much expressive about her problems. However, the behavioral change contract and reinforcing agents were identified.

4TH Session

During this session, modeling technique was applied. The desired behavior was modeled in front of the client and she was asked to practice it.

5TH Session

The therapist explored client's irrational thoughts. Therapist developed insight in client about her problem.

6TH Session

The client was taught to replace her irrational beliefs with rational ones.

7TH Session

During this session, the client's family members were interviewed. They reported improvement in the client behavior. They were further educated regarding this matter.

8TH Session

During this session, the client showed improvement. Client was asked about her assigned activities.

9TH Session

During this session, the client was called for follow up session. MSE was conducted again. Her mood was euthymic.

10TH Session

During this session, the client was markedly improved. Her sister also reported that she has been improved and now takes interest in her daily routine work.