Clinical Internship Report

Submitted to:

Dr.Syed Asghar Ali Shah

Submitted By:

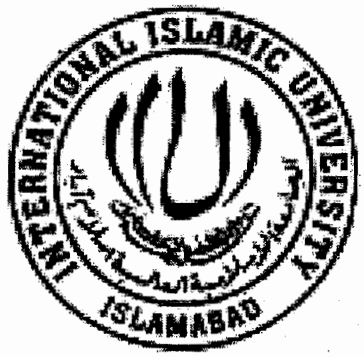
Jawwad Muhammad Shujaat

MS.3rd Semester

Clinical Psychology

03-FSS/MSPSY/F08

Department of Psychology
Faculty of Social Sciences



International Islamic University
Islamabad

1. psychodiagnostics
2. personality assessment

Psycho diagnostic and Therapeutic Report

By

Jawwad Muhammad Shujaat

03-FSS/MSPSY/F08

Supervised By: DR ASGHAR ALI SHAH

DEDICATION
TO
The Martyrs of
International Islamic University

Acknowledgement

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

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

I extend my warm thanks to my very dear teachers Dr. Muhammad Javed, Dr.Anees- ul- Haq and Dr. Mzahar Iqbal Bhatti, and my dear fellow Mr. Muhammad Akbar Karim, Mr. Rana Ejaz Ahmed Khan, Mr. Masud Akhtar, Ghulam Mohy ud Din khan who encouraged my efforts.

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

Jawwad Muhammad Shujaat

CASE	TITLES	Page No.

CASE 1

SUBSTANCE INDUCED PSYCHOSIS

BIO-DATA

Name	Z.G.
Age	29 years
Sex	Male
Education	Graduation
Occupation	Landlord
Marital Status	Unmarried
Birth order	4th born
Religion	Islam
Sibling	Four brothers four sister
Parents	Both alive
Education of Father	Middle
Education of Mother	Illiterate
Residence	Harea
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. Z.G. was tall, serious stature middle aged man of 29 years .His dress was tidy with tidy hair and short beard and he also wanted to look neat and clean as he reported. He answered in appropriate way and had maintained good eye contact during session. He completed tests with great interest and his tone was appropriate. He was showing so much etiquette. Overall his behavior was cooperative.

Presenting Complains

- Grandiosity delusion
- Suicidal ideation
- Persecutory delusion
- Isolation
- Abusive
- Hostility
- Smoking
- Disturb sleep
- Irritable mood
- Fail in love
- Hash dependence
- Alcoholic

FAMILY HISTORY

He belonged to middle class family of four brothers and four sister of Harea. His both parents were alive but his mother had heart problem and father had piles problem. His father problem also transferred into him.

He was 4th 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 but he told that his one brother do not love him.

He was unmarried but he wanted to marry with his cousin as he told "I want to marry with my cousin but my uncle do not like me therefore he rejects my proposal after that he marries his daughter with someone else".

PAST PERSONAL HISTORY

Mr. Z.G. was a middle aged man of 29 years and was the 4th born child of his family. He told that he spent his childhood happily but had high fever once and according to him his birth was normal.

He was an intelligent and position holder student but could not completed his studies due to illness as he told that I had fits problems which started when I was in 1st year and because of it I gave abuses to people." He also reported that I torn my clothes. There was no past history of any medical illness. Friends motivated him to drug addiction as he reported:

"When I spend my time with friends, they insist me to use drugs and also give me money".

He was also fond of pigeons and reading poetry books of Sagar Sadiqqi. In free time he mostly wanted to drive tractor as he reported.

HISTORY OF PRESENT ILLNESS

He was admitted to hospital for 2nd time for the treatment of addiction. His brother took him in Azm hospital but he also visited to PAF, Al-Abbas, Noshervan due to addiction. Due to bad company and loss of love he started this habit. Therefore he had very poor interpersonal and social relationship with others. He became violent. He had suicidal ideation and grandiosity feelings as he reported:

"I attempt suicide because I want to marry with my cousin but could not".

"I have visit visa of all country".

"I have black tongue and therefore if I give pray or curse to anybody it accepted

very soon."

Doctor reported that he came to hospital for 2nd time. The cause may be the drug addiction or the environment of the family or peer company. Because of these three reasons, he may show signs of aggressive behavior.

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

INTELLECTUAL FUNCTIONING

He seemed to have intellectual deficiency. His total score on Ravens was 15 corresponding 5th percentile. This indicates that he lies in v grade and was highly intellectually defective but it does not match with his qualification so it is concluded that he did not do this test with full concentration (See appendix,).

His recent and remote memory seemed to be good as he could recall most of the past and present events easily.

He had good orientation of time, place and person. He know about his name, 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,).

PERSONALITY FUNCTIONING

Mr. Z.G. was a middle aged man of 29 years. He belonged to middle class family. He was the 4th born child in the family of four brothers and four sisters. This was patient's 2nd psychiatric admission to hospital.

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

Patient score on RISB is 114 with a cut score of 135. It indicates that he is well adjusted person (Rotter, 1932) (See Appendix, 1-B).

Drawing of HTP shows that he has alcoholism which is indicated by mouth emphasized (Machover, Levy, Hammer). Finger more than five, eye emphasized and heavy shading show aggression (Hammer, Machover). Feet and hands omitted and internal organs shown indicate schizophrenic symptoms. Compartment of rooms and boundary of walls indicates poor interpersonal relations and insecurity (Buck, 1966, Hammer) (See Appendix,).

CASE FORMULATION

Mr. Z.G. was a middle aged man of 29 years from a middle class family of Harea. He was unmarried. He was the 4th born child in the family of 4 brothers and 4 sister. His education was Graduation. It was patient 2nd time in hospital for treatment of drug addiction.

He had severe symptoms as grandiosity delusion, persecutory delusion, suicidal ideation, abusive, hostility, smoking, disturbs sleep, irritable mood, opiate dependence, alcoholic, fail in love and isolation.

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 grandiosity and persecutory delusion but it is not fulfilling the criteria of schizophrenia as he also use drugs. So we can not diagnose him as schizophrenia disorder.

The essential features of Substance-Induced Psychotic Disorder are prominent hallucination or delusions (Criteria A) that are judged to be due to the direct physiological effects of a substance (Criteria B). hallucinations that the individual realizes are substance induced are not included here and instead would be diagnose as substance intoxication or substance withdrawl with the accompanying specifier with perceptual disturbance. The disturbance must not be better accounted for by a psychotic disorder that is not substance induced (Criteria C). The diagnosis is not made if the psychotic symptoms occur only during the course of a delirium (Criteria D) (DSM IV-TM).

From the drawing of HTP, score on BDI, it is clear that person has schizophrenic symptoms, aggression, alcoholism moderate depression, insecurity, poor interpersonal relations and dependency.

Presenting complains and the results of the test support our diagnosis that the patient tends to have Substance Induce Psychotic Disorder.

TENTATIVE DIAGNOSIS

Axis I	292.12 substance induced psychosis
Axis II	Nil
Axis III	Nil
Axis IV	Interpersonal Relation problem
Axis V	GAF = 41-50

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to Z.G.

1. Supportive therapy
2. Relaxation training
3. Behavior therapy
4. Cognitive Behavioral therapy
5. Group therapy

CASE 2

SCHIZOAFFECTIVE

BIO-DATA

Name	Z.M
Age	27years
Sex	Male
Education	Matric
Marital Status	Unmarried
Birth order	last born
Religion	Islam
Sibling	Six brothers one sister
Parents	Alive
Education of Father	Matric
Education of Mother	Matric
Residence	Sargodha
Referral	CI (crisis intervention)
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. Z.M. was a young man of 27 years old. His complexion was fair and his dressing was appropriate. There were signs of trembling in his hands and his voice tone was not appropriate as well as his affect. He was well combed and his teeth were also brushed. He had poor eye contact and sometime started self talking.

Presenting Complains

Depressed mood

Loose association

Trembling

Abusive

Guilt feeling

Inappropriate affect

Refusal to eat

Aggression

Disturb sleep

Self talking

Obstinate

Irritable mood

FAMILY HISTORY

He belonged to Sargodha from a middle class family of six brothers and one sister. His father and mother education was just matric as reported by client. His parents were alive. His father is businessman and his parents love him very much.

He was last born child in family. The attitude of his siblings was good according to client and he told that his home environment good, peaceful and had joint family system. He was unmarried but wanted to marry. According to client his parents enforce him to work with care.

PAST PERSONAL HISTORY

Mr. Z.M. was a young man of 27 years and he reported that he born at home with normal delivery. Accordingly to client his childhood was good and he spent it happily but once he fell down from wall during playing and got injury on his head. He was not an intelligent student and also had less interest in education therefore he ran away from home with his friends. He gave all attribute of his education to his teachers that they were very nice and helped him a lot.

He was businessman as reported by client. His parents loved him very much but sometime force him to work hard. There was no past history of medical illness. Death of his father depressed him more.

HISTORY OF PRESENT ILLNESS

This was patient's 2nd psychiatric admission to hospital. The main reason behind his admission was his aggressive and depress mood because he had less emotional control as he reported:

"I had came hospital before because I fought with a boy."

Dr Jawad took him in Azm hospital. He was in habit of self talking and liked to eat spicy foods and to drink hot tea.

He liked to go on tombs as he reported "I like to go on tombs because they are pious people of God."

EVALUATION TECHNIQUES

He was cooperative but he took much time to complete the tests. Following techniques were used

1. Bender Gestalt test
2. Raven Progressive Matrices

3. H.T.P

4. R.I.S.B

5. Mental status examination

6. Case History examination

INTELLECTUAL FUNCTIONING

He seemed to have intellectual deficiency. His total score on Ravens was 13 corresponding 5th percentile. This indicates that he lies in v grade and was highly intellectually defective but it does not match with education, so he did it carelessly and with less concentration (See appendix, 1-C).

Scores of bender indicates that there is no brain damage and these scores are 7 (see Appendix,).

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 good orientation of time, place and person. He know about his name, 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, 1-A).

PERSONALITY FUNCTIONING

Mr. Z.M. was a young man of 27 years. He belonged to middle class family. He was the last born child in the family of six brothers and one sister. This was patient's 2nd psychiatric admission to hospital.

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

Patient score on RISB is 108 with a cut score of 135. It indicates that he is well adjusted person (Rotter, 1932) (See Appendix, 1-B).

On the basis of HTP, it shows that he has aggression indicated by fingers like stick and chin enlarge. He has guilt feeling and security as indicated by no door, hands large and mouth open (Hammer & Levy). He has also auditory hallucination and schizoid traits as indicated by ear emphasized and ear enlarge (Buck, 1966) (see appendix, 1-G).

CASE FORMULATION

Mr. Z.M. was a young man of 27 years old from a middle class family of Sargodha. He was unmarried. He was the last born child in the family of 6 brothers and 1 sister. His education was matric and businessman by occupation.

He had severe symptoms like depressed mood, self talking, trembling, loose association, inappropriate affect, refusal to eat, aggression, disturb sleep and egoist.

People with schizophrenia stands out because of the loose association and self talking, 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 symptom of loose association but these are not as strong and his symptoms are also not fulfilling the criteria of other symptoms of schizophrenia as he has not delusional problem. So we can not diagnose it as schizophrenia disorder.

The major feature of schizoaffective disorder is an uninterrupted period of illness during which, at some time, there is a major depressive, manic, or mixed episode concurrent with symptoms that meet criteria A of schizophrenia (Criteria A). in addition, during the same period of illness, there have been delusions, or hallucinations for last 2 weeks in the absence of prominent mood symptoms (Criteria B). Finally, the mood symptoms are present for a substantial portion of the total duration of the illness (Criteria C). The symptoms must not be due to the direct physiological effect of a substance or a general medical condition (Criteria D) (DSM IV-TM).

From the drawing of HTP, score on RISB, it is clear that person has aggressive and schizophrenia tendency, poor interpersonal relations, insecurity traits.

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

TENTATIVE DIAGNOSIS

Axis I	295.70 Schizoaffective
Axis II	Nil
Axis III	Nil
Axis IV	Interpersonal relationship problem
Axis V	GAF = 21-30

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to Z.M.

1. Supportive therapy
2. Cognitive behavior therapy
3. Relaxation training
4. Behavior therapy

CASE 3

OBSESSIVE COMPULSIVE DISORDER

BIO-DATA

Name	Aslam
Age	25 years
Sex	Male
Education	Matric
Marital Status	Unmarried
Birth order	last born
Religion	Islam
Siblings	seven brothers
Parents	both alive
Education of father	B.A
Education of mother	illiterate
Residence	Sargodha
Past Psychiatric history in family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. Aslam was a young man of 25 years of age. He was unmarried. He had fair complexion with long black beard and he was in tidy dress. He maintained good eye contact and showed confidence during interview. His teeth were brushed and hair was well combed. He showed appropriate affects and pass smile during interview. He was cooperative but he started weeping when he talked about the death oh his nice.

PRESENTING COMPLAINTS

Excessive bathing

Excessive handwash

Loss of sleep

Irritable mood

Smoking

Guilt feeling

FAMILY HISTORY

He belonged to a middle class family of seven brothers of Sargodha. His parents were alive but his father had heart problem and now his brothers and he himself were earning money to fulfill the needs of home.

He was the last born child in the family. The attitude of his siblings was good and he told that his home environment is also good and peaceful, all members of family love each other but he only felt stress when he thinks that his brothers and parents did not support him for business.

And also to think about his beloved niece who died after felling into the water.

PAST PERSONAL HISTORY

Mr. Aslam was a young man of 25 years and he said that his birth was normal. He was sparkling and healthy in childhood and spends his childhood in Khana Khaba. He said that he was very religious and offered five time prayers.

He was bright student and also respects his teachers. According to him he showed good attitude towards his teachers and also towards friends as he had many friends. His memory was so good that he can easily remember even the events which

occurred 13-14 years ago. He was now owner of sweet shops and deal with people for different kinds of sweets.

There was no past history of any serious medical illness but he had psychiatric history .

He told that he fell in love with his cousin but his family was against therefore he could not marry with her and did the attempt of suicide as he reported:

"I wanted to marry with my cousin but my family was against it therefore I try to kill myself with pistol but my brother save me".

HISTORY OF PRESENT ILLNESS

The present complaints were started 6 months ago

EVALUATION TECHNIQUES

He was cooperative but he took much time to complete 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 10 corresponding 5th percentile. This indicates that he lies in V grade and was highly intellectually defective (See appendix, 4-C).

His recent and remote memory seemed to be good as he could recall most of the past and present events easily.

He had good orientation of time, place and person. He know about his name, name of patients, day, time and the name of city where he lived as he matched with the information given by the staff of hospital (see appendix 4-A).

PERSONALITY FUNCTIONING

Mr.Aslam. was a young man of 25 years. He belonged to middle class family. He was the last born child in the family of seven brothers. This was patient's 1st psychiatric treatment.

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

Patient score on RISB is 120 with a cut score of 135. It indicates that he is well adjusted person (Rotter, 1932) (See Appendix, 4-B).

On the basis of HTP, it shows that he has withdrawal, symptom of infantile aggression as indicated by hair emphasis, armed extended from body, large eyes, lines on forehead and heavy thick lines (Machover, Hammer & Levy). Strong roots and fingers indicate symptoms of dependence and desire to be dependent (Machover & Hammer). Internal organ shown and long neck indicates schizophrenic tendency (Hammer & Levy) (see Appendix, 4-G).

CASE FORMULATION

Mr.Aslam was a young boy of 25 years old from a middle class family of Sargodha. He was unmarried. He was the last born child in the family of 7 brothers. His education was matric and businessman by occupation. It was patient 1st time treatment.

He had symptoms of excessive bathing, guilt feeling, irritable mood, , insomnia, suicidal ideation, smoking.

People with OCD stands out because of the irresistible thoughts to do something , at the same time their cognitive skills and affects are relatively intact. According to the DSM IV criteria for OCD, person should have irresistible thoughts for doing something .

From the drawing of HTP, score on RISB, it is clear that person has withdrawl tendency, OCD tendency, poor interpersonal relations and dependency.

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

TENTATIVE DIAGNOSIS

OCD

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment was recommended

1. Relaxation training
2. Behavior therapy
3. Cognitive behavioral therapy

CASE 4

POLYSUBSTANCE DEPENDENCE DISORDER

BIO-DATA

Name	ASAD
Age	23 years
Sex	Male
Education	Under Primary
Occupation	Land lord
Marital Status	Married
Birth order	7th born
Religion	Islam
Sibling	six brothers two sisters
Parents	father deceased, mother alive
Education of Father	Matric
Education of Mother	Illetrate
Residence	Sargodha
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. Asad was tall and young boy of 23 years .His dress was tidy with tidy hair and long beard because he wanted to look neat and clean as he reported. He answered in appropriate way and had maintained good eye contact during session. He completed tests with great interest and his tone was appropriate. He was showing so much etiquette. Overall his behavior was cooperative.

Presenting Complains

- Persecutory delusions
- Aggression
- Obstinate
- Hyperactive
- Hypersomnia
- Perfectism
- Flight of ideas
- Guilt feeling
- Smoking
- Dangerousness
- Irritable mood
- Alcoholism
- Hash dependence
- Suspicious thoughts
- High appetite

FAMILY HISTORY

He belonged to middle class family of six brothers and two sisters of Sargodha. His father was deceased few years ago due to cancer. He was a retired army officer and now he was serving as a head master. He felt sorrow to think about his father as he reported.

He was 7th 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 but sometimes they started to fight due to me.

He was married but had no child. His wife was now living with his mother-in-law because he hit his mother-in-law therefore she took her daughter with herself.

PAST PERSONAL HISTORY

Mr. A.N. was a young boy of 23 years and was the 7th born child of his family. He told that he spent his childhood happily and according to him his birth was normal.

He was not an intelligent student and most of time ran from school therefore could not carry on his studies and left school in two class. There was no past history of any medical illness expect an injury on his foot. He started drug addiction from different tombs as he reported:

"I spent many time on tombs with my friend and started to drink bhang and than drinks from there".

HISTORY OF PRESENT ILLNESS

He was admitted to hospital for 1st time for the treatment of addiction. His 3 brothers and mother took him in Azm hospital. Due to bad company he started this habit. Therefore he had very poor interpersonal and social relationship with others. He became violent. He had suspicious thoughts and persecutory delusions as he reported:

"When I had to go any where, I told a lie in front of people because I think that they will harm me." "Someone has do black magic on me".

Doctor reported that he came to hospital for 1st time. The cause may be the drug addiction or the environment of the family or peer company. Because of these three reasons, he may show signs of aggressive behavior.

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 18 corresponding 5th percentile. This indicates that he lies in v grade and was highly intellectually defective and it matches with his qualification so it is concluded that he did this test with concentration (See appendix, 5-C).

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

He had good orientation of time, place and person. He know about his name, 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. Asad was a young boy of 23 years. He belonged to middle class family. He was the 7th born child in the family of 6 brothers and 2 sisters. This was patient's 1st psychiatric admission to hospital.

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

Patient score on RISB is 101 with a cut score of 135. It indicates that he is well adjusted person (Rotter, 1932) (See Appendix, 5-B).

Drawing of HTP shows that he has depression, withdrawal tendency, inadequacy indicated by feet omitted, narrow neck, small same sex figure, tiny drawing and excessive symmetry (Machover, Levy, Hammer). Incomplete house, compartment of rooms, boundary of walls and high-on-page figures indicates poor interpersonal relations and insecurity (Buck, 1966, Hammer). Omission of parts and break lines indicates his conflict to that area (Hammer, Levy). More circles and mouth emphazied indicates alcoholism and oral fixation (Hammer, Machover). Symptom of infantile aggression as indicated by fingers without hands, fingers like stick, hair emphasis, armed extended from body, many sharp edges, straight lines, heavy thick lines and saw like features (Machover, Hammer, levy). (See Appendix, 5-F).

CASE FORMULATION

Mr. Asad. was a young boy of 23 years from a middle class family of Sargodha. He was married. He was the 7th born child in the family of 6 brothers and 2 sisters. His education was under primary and landlord by occupation. It was patient 1st time in hospital for treatment of drug addiction.

He had severe symptoms as persecutory delusions, perfection, hypersomnia, aggression, dangerousness, hyperactive, obstinate, irritable mood, suspicious thoughts, smoking, alcoholism and hashish dependence.

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 persecutory delusions but it is not fulfilling the criteria of schizophrenia as he also use drugs. So we can not diagnose him as schizophrenia disorder.

The essential features of Substance-Induced Psychotic Disorder are prominent hallucination or delusions (Criteria A) that are judged to be due to the direct physiological effects of a substance (Criteria B). hallucinations that the individual realizes are substance induced are not included here and instead would be diagnose as substance intoxication or substance withdrawl with the accompanying specifier with perceptual disturbance. The disturbance must not be better accounted for by a psychotic disorder that is not substance induced (Criteria C). The diagnosis is not made if the psychotic symptoms occur only during the course of a delirium (Criteria D) (DSM IV-TM).

From the drawing of HTP, score on RISB, it is clear that person has withdrawl tendency, inadequacy, moderate depression, insecurity, poor interpersonal relations, alcoholism, oral fixation and dependency.

Presenting complains and the results of the test support our diagnosis that the patient tends to have Substance Induce Psychotic Disorder.

TENTATIVE DIAGNOSIS

Polysubstance Dependence Disorder

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to Asad

1. Supportive therapy

2. Relaxation training

3. Behavior therapy

4. Cognitive Behavioral therapy

5. Group therapy

CASE 5

SCHIZOPHRENIA

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
Residence	Chawk 96, South
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 Azm 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	292 Schizophrenia
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.

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to M.N.

1. Relaxation training
2. Behavior therapy
3. Cognitive Behavioral therapy

CASE 6

ANTISOCIAL PERSONALITY DISORDER

Bio Data

Name:	A.B
Sex:	Male
Education:	Metric fail
Marital Status:	Unmarried
Religion:	Islam
Sibling:	4 brothers and 3 sisters
Parents:	Both are alive
Birth Order:	5th one
Education of Father:	Uneducated
Education of Mother:	Uneducated
Residence:	Sargodha
Past psychiatric history:	Nil
Past medical history:	Nil

Behavioral Observation:

Mr. A.B was a young man of 32 years old. He was a handsome man. He had fair complexion, straight hairs, and appropriate height and had appropriate hygienical condition. He looked like a sluggish and lazy. His tone was inappropriate. His body was trembling during the conversation.

Presenting Complaints

Addiction:

Irresponsibility: میں

کام کر کے کیا کرنا ہے ابھی میری شادی نہیں ہوئی اس وجہ سے کوئی کام نہیں کرنا لیکن میں شادی کے بعد بھی نہیں کروں گا۔

Recklessness: مجھ

غصے میں میرا دل کرتا ہے، یا خود مر جاؤں یا پھر اگلے بندے کو مار دوں۔ میں نے آٹھویں کلاس میں اپنے کلاس فیلو کا سر پھاڑا تھا۔

Aggressivness:

مجھے بہت زیادہ غصہ آتا ہے جب کوئی میرے خلاف بات کرتا ہے یا مجھے کسی کام سے روکتا ہے۔

Impulsiveness:

میں ہر کام بغیر سوچے سمجھے کرتا ہوں۔

Mr. A.B was born in a middle class family of 4 brothers and 3 sisters. His father and mother both were uneducated. His mother loved him, but according to him his father and brother hate him. He was 5th born child in his family. The attitude of his sibling was not good with him.

He said that he has great interest in education but his father and brother did not like his education. His father wanted that he earned money.

Past Personal History:

Mr. A.B was a young man of 32 years. He was aggressive in his childhood and had good health. He said that in his childhood he fought various time and beat his class fellows. He was not a good student. As he reported I was not a good student and teachers often punished me.

He said that when he was in 8th class he broke the head of his class fellow and ran away from the school. He went jail in many times. He went jail first time at the age of 14 in the case of 307 when he injured his neighbor with knife. In jail he engaged in bad company.

He came from jail after 6 moths on bail. He started drinking and used other drugs such as charace, opium, and cocaine at the age of 15 years. He ran away from the house because his parents and elder brothers did not like him. He said that at that time he wanted to kill every person.

He came in Lahore and he had various love stories but he made sexual relationship with his girl friends. He arrested for 2 times in theft case. He worked in different shops as a salesman but he could not work for a long time at one place because he had poor occupational functioning.

He met with his parents after 7 years at the age of 24. He came back in home. His mother loved him but his father and brothers still did not like him. His most of the time was spent in drinking and other illegal activities. At last his parents admitted him in PIMH.

History of present illness:

This is patient's 1st psychiatric admission to the hospital. Now he had been in the hospital since last 25 days. The cause of admission, he reported:

"I was aggressive I often fought with others on little things."

He was also the drug addict. He used drug first time at the age of 15 and still he used to drink and different types of drugs. The patient said that he is not able to work at one place so his social and occupational functioning was also disturbed.

In hospital his behavior with other patient was aggressive. Even then when I was taking his interview a patient came and Mr. A.B used abusive language with that patient.

Evaluative Techniques:

MSE

Case history interview

HTP

RISB

RPM

Intellectual Functioning

Mr. A.B seemed to have average intellectual functioning but sometimes he seemed to be careless. His total score on Ravens was 12 with corresponding 25th percentile. This indicates that he lies in III grade and has an average level of I.Q.

His recent and remote memory seemed to be intact as he could recall most of the past and present events. He completed RISB, Ravens standard progressive matrices, and HTP with full interest and concentration. He had good orientation of places and persons. He knew about his name, name of other patients and name of city where he lived.

Personality Functioning:

Mr. A.B was a young man of 32 years. He belonged to a middle class family. He was the 5th born child in the family of 4 brothers and 3 sisters. This is patient's 1st psychiatric admission to the hospital.

RISB, HTP, MSE, RPM and were administered to check the personality functioning of the patients. Patient score on RISB is 137 with a cut off score 135. It indicates this patient is highly maladjusted. C responses in RISB are very high than positive and neutral responses are indication of maladjusted frame of mind. These indicate aggressive reactions, negativism, hostility and violence.

The interpretation of HTP also indicated the main features of his personality. Closed door of house shows that he had weak social relations. Compartmentalization showed that Mr. A.B has poor interpersonal relationships. (Buck, 1966).

In the drawing of tree, the sword like branches and leaves showed that patient is aggressive. 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. (Buck, 1966).

In human drawing eyes without pupil showed that patient has guilt feeling and violence tendency. Knife in the belt showed his aggressive personality. Neck long and strong indicates the strong ego and rigid personality. Arms extended indicate externalized aggression. Open mouth indicates the patient has alcoholic tendency. (Buck, 1966). Emphasis on eyes and lips of opposite sex indicate his sexual tendency. (Buck, 1966).

Overall, we can say that patient had adjustment problem, social and occupational problem, aggressive and violence tendency, guilt feeling, sexual tendency and negative frame of mind.

Case Formulation

Mr. A.B was a young man of 32 years. This is patient's 1st psychiatric admission to the hospital. He came to the hospital for the treatment of his aggressive and addicted behavior.

He had symptoms like irritability and aggressiveness, impulsivity or failure to plane ahead, poor impulse control, poor insight into the problem, guilt feeling and addictiveness.

When antisocial behavior in an adult is associated with substance related disorder the diagnosis of antisocial personality disorder is not made useless the sign of antisocial personality disorder were also present in childhood and had continued into adulthood. (DSM IV TM)

Other personality disorder may be confused with antisocial personality disorder because they have certain features in common. It is important to distinguish among these disorders based on differences in their characteristic features.

Individual with antisocial personality disorder and narcissistic personality disorder share a tendency to be tough-minded, glib superficial, exploitative and unempathic. However, narcissistic disorder does not include the symptoms of impulsivity, aggression and deceit.

Individual with antisocial personality disorder may not be needy of admiration of others and person with narcissistic personality usually lacks the history of conduct disorder in childhood or criminal behavior in adulthood.

Individual with antisocial personality disorder and histrionic personality disorder share tendency to impulsive, superficial, excitement seeking, reckless seductive, and manipulative but person with histrionic personality disorder tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behavior. (DSM IV TM)

Individual with histrionic and borderline personality disorders are manipulative to gain nurturance, whereas those with antisocial personality disorder are manipulative to gain profit power or some material gratification.

Individual with antisocial personality disorder tend to be less emotionally unstable and more aggressive than those with borderline personality disorder. (DSM IV TM)

From the drawing of HTP, score on RISB, score on Ravens standard progressive matrices and case history interview, it is clear that person has aggressive, violence and sexual tendency and has poor social, occupational and interpersonal relationships. Person ahs feeling of reckless, poor impulse control, impulsivity and irresponsibility and negative frame of mind.

Presenting complaints and result of the test support our diagnosis that patient may be tend to have Antisocial Personality Disorder.

Diagnosis

Axis I	V 71.09
Axis II	301.7 (Antisocial Personality Disorder)
Axis III	V 71.09
Axis IV	Social and occupational problem
Axis V	GAF (11 – 20)

Prognosis

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

CASE 7

PARANOID SCHIZOPHRENIA

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	(295.30) Paranoid Schizophrenia
Axis II	V71.90
Axis III	V71.90
Axis IV	Problem related to the social environment
Axis V	GAF (21-30)

Prognosis:

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

CASE 8

GENERALIZED ANXIETY DISORDER

Bio Data:

Name:	S.H
Age:	38
Sex:	Male
Marital Status:	Married
Religion:	Islam
Children:	2 Sons & 1 Daughter
Siblings:	4 Brothers & 3 Sisters
Birth Order:	3rd One
Qualification:	Metric
Parents:	Both are Alive
Education of Father:	Uneducated
Education of Mother:	Uneducated
Residence:	Lahore
Psychiatric Admission:	1st
Past Psychiatric History:	Nil
Past Medical History:	Nil

Behavioral Observation:

Mr.S.H was a young man of 38 years old. He had fair complexion and his appearance matched with his chronological age. His hygienic condition was inappropriate. His hair were not properly done and had in dirty dress. He had poor eye contact during the session. He looked worry during interview.

Presenting Complaints

Autonomic Reactivity

کئی دفعہ میرا دل زور زور سے دھڑکتا ہے اور پسینا آجاتا ہے سانس کی رفتار تیز ہو جاتی ہے اور بار بار پیشاب آتا ہے۔

Apprehensive Feelings about Future

میں سوچتا ہوں کہ مستقبل میں میرا کیا ہوگا میرے بچوں کی پرورش کون کرے گا اور پتا نہیں میں اپنے بیوی بچوں سے مل بھی سکوں گا یا نہیں

Sleep Disturbance

مجھے بہت کم نیند آتی ہے اور رات میں زیادہ تر سوچتا رہتا ہوں اور سو بھی جاؤں تو بار بار جاگتا رہتا ہوں۔

Difficulty in Concentrating

میں کوئی کام توجہ سے نہیں کر سکتا کیونکہ بار بار میری سوچ اپنے بچوں کی طرف چلی جاتی ہے۔

Fatigue

Family History:

Mr. S.H was borne in a middle class family of 4 brother and 3 sisters. He was married and had 2 sons and 1 daughter. His father and mother both were alive. His father and mother both were uneducated. He was the 3rd borne child in the family. His attitude his sibling was not good, as he reported.

"My 2 elder brothers and 1 younger brother used to beat me many times. He said that my parents loved me but my brother hated me"

His relations with his wife were not good. He and his wife got separated before 2 months and her wife lived with her own parents.

Past Personal History

Mr. S.H was a young man of 38 years old. He was healthy in his childhood. As he reported

"I was very healthy in my childhood and took part in different games" He was not a good student in his childhood. He was metric but he passed metric with very less marks. As he reported

"I was not a good student in my childhood because I had great interest in games"

After the metric he worked an auto workshop. He said that de did work there about 3 years and at that time he was considered to be a good auto mechanic. He felt in love with a girl who lived near the workshop. He said that he wanted to marry her but she did not like him.

He was depressed due to the failure of love but he controlled himself easily. He said that he had loss the concentration in his work after marriage.

History of Present Illness:

This is patient's 1st psychiatric admission to the hospital. Now he had been in the hospital since last 27days. The cause of admission he reported:

I was worry most of the time. I am worry about the future of my children because my wife left me. I am worry about my work because I know that I cannot do anything. I feel tied when I want to do work. I think that my life is aimless and who would bring up

my children. I think that my wife was not good because she had left me. He has lack of concentration in his work. He had poor relations with his family.

He was unable to control his worry and anxious feeling so her social and occupational functioning was also disturbed. He had sleep problem as he reported.

"I cannot take sleep properly because I awake many times in night" he also reported that the attitude of his brothers made him depressed. He said that he was disturbed in most of time and thought about the future of his children. Therefore his parents admitted him in the hospital.

Evaluating 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's was 15 with corresponding 5^{th} Percentile. This indicates that he lies in V grade and he was intellectually defective. (See Appendix 3-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 3-A).

Personality Functioning

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

Patient score on RISB is 141 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 unhealthily hostility reaction, anxiety, pessimisms, hopelessness and negativism (Rotter 1932). As he reposted to item no 3, 5, 8, 9, 12, 13, 15, 18, 20, 21, 22, 24, 25, 27, 28, 30, 32, 33, 34, 38, 39, 40.(See Appendix 3-C).

In the drawing of house, clouds show anxiety. Absence of window in the drawing of house indicates defensive personality second door back side of the house indicates that person has strong desire of 2nd marriage. Exhaust fan in the drawing of house shows that person has anxiety feelings. Compartmentalization shows that person has week inter personal relations with his family. Close door shows that person has poor social relations. (Buck 1966).

In the drawing of tree, strong trunk shows that person has strong ego. Shadows indicate the anxiety feelings. Ground lines indicate that person has desire to maternal dependency with feelings of isolation and helplessness. Cloud like tree indicates confuse and immature thinking (Buck 1966).

In the drawing of person, eyes without pupil in the male drawing indicate the guilt feelings. Arm extended from the body in both figure show externalized aggression (Hammer, Levy). Emphasis on the lips and eyes in female drawing indicate the person has sexual tendency towards opposite sex. Inappropriate here in both male and female drawing indicate the person's anxiety.

Feet omitted in both male and female drawing are a sign of withdrawal dependency and discouragement. Broken lines indicate the anxiety and insecurity (Machover).

Overall we can say that patient has feeling of dependency, insecurity, helplessness, aggression, maladjusted, sexual tendency and anxiety.

Case Formulation

Mr. S.H was a young man of 38 year old. This is patient's 1st psychiatric admission to the hospital. He had the symptoms like excessive anxiety and worry, irritability; sleep disturbance, muscle tension, restlessness and lack of concentration.

Mr. S.H does not meet the criteria of anxiety disorder due to a general medical condition because in this disorder the anxiety symptoms are judged to be a direct physiological consequence of specific general medical condition.

A substance induced anxiety disorder is distinguished from generalized anxiety disorder by the fact that a substance is judged to be etiologically related to the anxiety disturbance. For example, severe anxiety that occurs only in the context of heavy coffee

consumption would be diagnose as caffeine- induced anxiety disorder with generalized anxiety disorder.

Several features distinguish the excessive worry of generalized anxiety disorder from the obsessional thought of obsessive-compulsive disorder.

Obsessional thought are not simply excessive worries about everyday or real life problems but rather are ego-dystonic intrusions that often take the form of urges, impulses and images in addition to thoughts. Finally, most obsessions are accompanied by compulsion that reduces the anxiety associated with the obsessions.

Anxiety is invariably present in posttraumatic stress disorder. Generalized anxiety disorder is not diagnosed if the anxiety occurs exclusively during the course of posttraumatic stress disorder. Anxiety may also be present in adjustment disorder but the residual category should be used only when criteria are not met for any other anxiety disorder. Moreover in adjustment disorder the anxiety occurs in response to a life stressor and does not persist for more than 6 months after the termination of stressor or its consequences. Generalized anxiety is a common associated features of "Mood disorder" and psychotic disorders and should be diagnosed separately if it occurs exclusively during the course of these conditions.

From the drawing of HTP, score on RISB, score on RPM and case history interview, it is clear that patient has excessive anxiety and worry, restless, irritability social and occupational problems due to the lack of concentration, sleep disturbance and fatigue.

Presenting Complaints and results of the tests sport our diagnoses that many be patient tend to have generalized anxiety disorder.

Diagnosis

Axis I	300.02 (generalized anxiety disorder)
Axis II	V 71.09
Axis III	V 71.09
Axis IV	Social and occupational problem
Axis V	GAF (81-90)

Prognosis:

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

CASE 9

POSTTRAUMATIC STRESS

DISORDER CHRONIC

Bio Data

Name:	R.Z
Age:	25 Years
Sex:	Female
Education:	Primary
Marital Status:	Divorces
Religion:	Islam
Sibling:	3 Brothers 1 Sister
Parents:	Both are deceased
Birth Order:	2nd one
Education of Father:	Uneducated
Education of Mother:	Uneducated
Residence:	Sialkot
Children:	1 Son 2 Daughter
Referral:	Brother
Past Psychiatric History:	Nil
Past Medical History:	Nil

Behavioral Observation

Miss R.Z was a young lady of 25 years old. She had hair complexion. Her hygienic condition was not appropriate. She had good health. Her tome was slow during the interview. Her mood was appropriate. Her affect was congruent with her mood. Her eye contact was also appropriate. She was cooperative and provided detailed information about her life.

Presenting Complains:

Sleep Disturbance

نیند نہیں آتی گولیاں دیتے ہیں تو سوتی ہوں۔

Poor Appetite:

مجھے بھوک نہیں لگتی کھانے کو دل نہیں کرتا۔

Poor Insight into the Problem:

میں سمجھ نہیں سکی کہ میرے پہلے شوہر نے مجھے طلاق کیوں دی اور پھر دوسرے نے بھی دی۔

Traumatic Events:

میرا بیٹا فوت ہو گیا اور اس کے بعد میرے شوہر نے مجھے طلاق دے دی۔ کچھ عرصہ بعد میری والدہ کا انتقال ہو گیا اور پھر ایک سال بعد میرے والد بھی فوت ہو گئے۔

Miss. R.Z was a young lady of 25 years old. She was 2nd borne child of the middle class family of 3 brothers and 1 sister. She said that her parent's lover her and attitude of her sibling was also good as she reported. "My parents gave me great love and care". She said that she was healthy in her childhood. She was getting 2 marriages but her marital status was divorces. She had primary education. Her father and mother both were deceased.

Past Personal History

Miss. R.Z was a young lady of 25 years. She belonged to a middle class family of 3 brothers and 1 sister. She was 2nd borne child in her family. She was getting 2 marriages. She fell in love with her cousin. She wanted to marry with him but she had to marry with another person. This marriage was getting at the age of 18 years. She had 2 daughters but she had divorces after 3 years of marriage. She did not mention any solid reason of divorces. She was getting 2nd marriage with her beloved. She had son but she became mentally ill. She was again divorces after the 2 years if marriage.

History of present illness:

This is patient first psychiatric admission to the hospital. She had been in the hospital for last year. She was admitted to the hospital for the treatment of aggressive behavior, dissolved thinking, irritability, and impaired social and occupational life and poor reality contact.

She had symptoms like loss of interest in social life, cry, severe mood changes, appetite disturbance and low self-esteem.

Evaluative Techniques:

MSE

Case History Interview

RISB

HTP

RPM (Raven Standard Progressive Matrices)

Intellectual Functioning:

Miss R.Z seemed to have poor intellectual functioning. Her total score on Raven was 7 with corresponding 5th percentile. This indicates that she lies in V grade and below average (See Appendix 3-E). She couldn't recall past and present events easily. She couldn't recall the name of doctor and patient easily. So her remote and recent memory was poor. She felt difficulty to recall date of events (See Appendix 3-A).

She completed RISB, WAT, HTP and Raven with full concentration. She had bad orientation about time and place. She felt difficulty to remember the past events and she also had poor insight into the problem. But she knew about that village where she lived.

Personality Functioning:

Miss R.Z was a young lady of 25 years old. She belonged to a middle class family. She was the 2nd borne child in the family of 3 brothers and 1 sister. This is the patient's first psychiatric admission to the hospital. RISB, HTP and WAT were administered to check the personality functioning of patient. Patient's score on RISB was 138 but of score 135. it indicates that patient is highly defensive. C responses are more than P responses and it is the indication of hopelessness, unhealthy state of mind and hostility.

The interpretation of house has also represents main feature of her personality. In the drawing of house compartmentalization indicated the feeling of insecurity and poor interpersonal relationship. (Buck 1966), absence of window is the indication of her defensive represents main feature of her personality. In the drawing of house compartmentalization indicated the feeling of insecurity and poor interpersonal relationship. (Buck 1966), absence of window is the indication of her defensive personality. It is strengthen by the result of RISB. Door omitted indicate that she does not want to share her feelings with others and also indicated the neurosis. (Machover)

Two- dimensional tree indicated mature adjustment. Thick and short branches of tree indicate her suicidal tendency (Buck 1966). Weak trunk of tree indicates that has ego and low self-esteem. No line base on trunk showed that patient seems to have strong opposional tendencies. Vertical drawing of tree below the mind point indicated that patient seems to have insecure feeling (Buck 1966).

Younger figure of female drawing indicates that patient seemed to have emotional fixation and immaturity. Fingers omitted are indicated that patient seems to have feeling of masturbation guilt (Anderson, Machover). Eye circle are indication of egocentric. Mouth omitted is the indication of possible scolding maternal figure (Anderson, Machover). Large nose is the indication of melancholia, sexual impotency (Hammer, Leavey). Arms away from the body are the indication of externalized aggression. Neck omitted is the indication of immaturity, lack of impulse control and regression (Machover). Top and centre drawing showed that patient is emotional and self-centered.

Feet small in male drawing indicated the feeling of insecurity. Fingers without hand are the indication of assaultivness (Hammer). Geometrical figure of male is the indication of negativism. Eye doted is the indication of ideas of references and paranoia (Anderson, Machover).

Case Formulation

Miss R.Z was a young lady of 25 year. She was married and has 3 children. This is patient first psychiatric admission to the hospital. She did not like her 1st husband so after the birth of 2 daughters she was divorce. She was getting 2nd marriage with her beloved.

She had son from that husband but her son was died and after the death of her son she was mentally disturbed and at the same time her second husband divorced her. She has also faced the trauma of her mother's death. After one-year mother's death her father had also died. So these traumatic experiences leaded him toward mental problem.

Her younger brother admitted her to the mental hospital. After the scoring of tests and case history interview she was diagnosed as posttraumatic stress disorder. Posttraumatic stress disorder was diagnosed if following symptoms expose to an extreme traumatic stressor involving direct personal experience of an event hat involve threatened health or injury, serious harm, death of family member or other close relative (Criteria A-1).

The response of events must involve intense fear, helplessness, or horror (Criteria A-2). The traumatic symptoms resulting from the exposure of the extreme trauma including the persistence experiences of the traumatic events (Criteria B).

The disturbance must sauce clinically significant distress or impairment in social, occupational or other important area of functioning (Criteria F).

For diagnosing posttraumatic stress disorder the stressor must be of an extreme nature. In contrast in adjustment disorder the stressor can be off any severity. The diagnosis of adjustment disorder is appropriate both for situation in which the response to an extreme stressor does not meet the criteria for posttraumatic disorder occurs in responses to a stressor that is not extreme (DSM IV TR).

Obsessive-compulsive disorders there are recurrent intensive thoughts but experiences as inappropriate and are not related to an experienced traumatic event (DSM IV). The traumatic event can be re-experienced in various ways.

Presenting complaints and results of the test support our diagnosis that patient may tending to have posttraumatic stress disorder chronic.

Diagnosis

Axis I	309.81 (Posttraumatic Stress Disorder Chronic)
Axis II	V 71.09
Axis III	V 71.09
Axis IV	Problem with primary support group
Axis V	GAF (61-70)

Prognosis

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

CASE 10

DYSTHYMIC DISORDER

BIO DATA

Name	U.S
Age	28 years
Sex	Male
Education	Under metric
Marital status	unmarried
Birth order	3rd born
Religion	Islam
Siblings	three brothers, four sisters
Parents	alive
Education of father	metric
Education of mother	illiterate
Residence	Sialkot
Past psychiatric history	nil
Past medical history	nil

BEHAVIORAL OBSERVATION

M.R U.S was a young boy of 28 years age. The was well-disciplined person. He answered in a proper way. He has good eye contact which he maintained during the

whole session. He was well dressed, confident, he showed enthusiasm for giving the interview and also the test.

FAMILY HISTORY

U.S belonged to Sialkot. The family was economically lower class. His parents were alive. He had brothers and four sisters. He told that his family environment was not satisfactory and relationships between family members was disturbed and disputed. U.S sometimes became harsh and show aggressive behavior.

Presenting Complain:

Over eating

Aggressive behavior:

Feeling of hopelessness:

Depressed mood:

Impulsive behavior:

Irritable mood:

Suicidal ideation:

Home sickness:

PAST PERSONAL HISTORY

He told that illness started 13 years back. Financial condition of the family was very poor. When the illness started the following complains were disturbed sleep, poor appetite, aggressiveness, restlessness. Once, suddenly without without any specific reason he started to beat his father with hammer. Once, he told that he also set fire in his house. In starting his family took him to the Pir-faqeers but their was nothing any change.

HISTORY OF PRESENT ILLNESS

He told that many times he ran away from their house without any reason and also many times admitted in the hospital. He told that he became very aggressive most of the time, his brother and sisters don't love him even fight with him. He was very confused to tell about the feelings towards their parents. Sometimes he said his parents love him and sometimes said NO, they don't love me, He said because of my aggressive nature they don't care for me. He told that my grand mother, their daughter and also my father fight with my mother than because of the family environment he became upset. I

EVALUATING TECHNIQUES

Following techniques were used to tell about her functioning these are

- Case history interview
- W.A.T
- RAVENS
- B.D.I
- H.T.P
- R.I.S.B

INTELLECTUAL FUNCTIONING:

To ravens test was given to him, he starter and took great interest. He completed easily and his scores was 29, 10 percentile with IV-grade which indicates intellectual deficiency.

PERSONALITY FUNCTIONING:

On the basis of H.T.P, W.A.T, R.I.S.B, B.D.I and the presenting complaints shows that, he had depression.

In his drawing of tree, that showed his depression that is indicated by shading on tree. Insecure feeling is indicated by long roots. Depression is indicated by shading on house and human figure.

On applying W.A.T his scores where high on close related reaction which tend to indicator simple schizophrenia. On applying B.D.I his total scores were 24 that indicates the moderate depression.

On R.I.S.B the score was 123 , cut of scores was 135-140. 121 was near to the cut of scores that indicates that he was less adjusted.

CASE FORMULATION:

He was many times admitted in hospital, for the treatment of aggression, hopelessness, restlessness, sleep disturbance. His home environment was very disturbing, he did not have good relation with their family members, he had tendencies of aggression since 13 years before, and he became harsh most of the time. Once he started to beat his father with hammer and also he set a fire in his house. He told that he had a problem of money. He did not fulfill the families need.. he many times runaway from their house because his family environment was very disturbed.

TENTATIVE DIAGNOSIS:

Axis I	300.4x dysthymic disorder
Axis II	Nil
Axis III	Nil
Axis IV	Nil
Axis V	G.A.F 61-70

Prognosis:

Her symptoms were moderate. And know U.U was recovering

TREATMENT RECOMMENDATION:

Following techniques were applied on her treatment

I. relaxation training

II. behavioral modification techniques

III. cognitive behavioral techniques

CASE 11

BIPOLAR DISORDER

BIODATA

Name	H.M.G.S
Age	23years
Sex	Male
Education	Primary
Marital Status	Married
Birth order	2nd born
Religion	Islam
Sibling	Three brothers four sisters
Parents	Alive
Education of Father	Primary
Education of Mother	Illiterate
Residence	Kasoor
Referral	Father
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. H.M.G.S was a young boy of 23 years old. His complexion was not fair and his dressing was appropriate. There were signs of trembling in his hands and his voice tone was not appropriate as well as his affect. He was well combed and with long bread and his teeth were also brushed. He had poor eye, he was gazing here and there and had less interest in interview and in completing tests. He showed some signs of hyperactivity because he stood up for many time during interview and also laid on the grass.

Presenting Complains

Depressed mood

Feeling of Hopelessness

Trembling

Loss of beloved

Guilt feeling

Hallucination

Mood change

Refusal to eat

Aggression

Disturb sleep

Sexual inadequacy

FAMILY HISTORY

He belonged to Kasoor's village name, Chawk 56 from a middle class family of three brothers and four sisters. His father education was just primary while mother was uneducated as reported by client. His parents were alive. His father is landlord and his parents love him very much.

He was 2nd born child in family. The attitude of his siblings was good according to client and he told that his home environment good, peaceful and had joint family system. He was married and had passed 1 year of his married life. According to client, his

wife was now pregnant and she lived with her parents because she did not want to live with him as she had relationship with someone else.

PAST PERSONAL HISTORY

Mr. H.M.G.S was a young man of 23 years and he reported that he born at home with normal delivery. Accordingly to client his childhood was good and he spent it happily. He was an intelligent student and after gaining good marks in primary he joined an institute to become Hafiz-e-Quran and he reported that I am very religious. He gave all attribute of his education to his teachers that they were very nice and helped him a lot.

He was landlord as reported by client. His parents loved him very much but his marital relation was not much satisfied. There was no past history of medical illness. Death of his two brothers depressed him more.

HISTORY OF PRESENT ILLNESS

This was patient's 1st psychiatric admission to hospital but he had come PIMH for many times for treatment. The main reason behind his admission was his poor marital relations and had less emotional control as he reported:

"My wife is not satisfied with me and she leave me and now living with her parents and have elations with other boys."

His father took him in mental hospital and was living with him his father told that "He offers 5 times prayers. His problem starts after his marriage because he thinks that his wife has sexual relations with others."

He was not himself sexually satisfied with his wife. He told that giants order him to leave his wife. He wanted to marry now with someone else. He told that he can manage relationship with 2 wives at a time.

EVALUATION TECHNIQUES

He was cooperative but he took much time to complete the tests. Following techniques were used

7. Mental status examination
8. Case History examination
9. H.T.P
10. R.I.S.B
11. W.A.T
12. B.D.I
13. Raven Progressive Matrices
14. Bender Gestalt test

INTELLECTUAL FUNCTIONING

He seemed to have intellectual deficiency. His total score on Ravens was 6 corresponding 5^{th} percentile. This indicates that he lies in v grade and was highly intellectually defective but it does not match with education as he was also Hafiz-e-Quran, so he did it carelessly and with less concentration (See appendix, 1-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 good orientation of time, place and person. He know about his name, 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, 1-A).

PERSONALITY FUNCTIONING

Mr. H.M.G.S. was a young man of 23 years. He belonged to middle class family. He was the 2nd born child in the family of three brothers and four sisters. This was patient's 1st psychiatric admission to hospital.

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

Patient score on RISB is 101 with a cut score of 135. It indicates that he is well adjusted person. C responses in the RISB less than positive and neutral responses so positive responses are indication of healthy adjusted from the mind 9Rotter, 1932) (See Appendix, 1-B).

On the basis of HTP, it shows that he has depressive feeling as indicated by omitted arms, legs, very faint lines and hole in trunk (Hammer & Levy). He has also poor interpersonal relationships with his family as indicated by separate rooms (Buck, 1966) (see appendix, 1-G).

His high scores on definition in WAT indicate obsessive traits, and object naming indicates depression tendency (see appendix, 1-F).

High scores on BDI are indicator of severe depression which are 33 (Beck) (see appendix, 1-D), and on Bender are indicator of brain damage, high constricted drawing indicates depression (See appendix, 1-E).

CASE FORMULATION

Mr. H.G.S was a young boy of 23 years old from a middle class family of Chawk 56, district Kasoor. He was married and now his wife was pregnant. He was the 2nd born child in the family of 3 brothers and 4 sisters. His education was primary and landlord by occupation. It was patient 1st time in hospital for treatment of bipolar depression and hypomania.

He had severe symptoms like depressed mood, feeling of hopelessness, trembling, guilt feeling, hallucination, refusal to eat aggression, disturb sleep, sexual inadequacy and less control on emotions.

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 symptom of hallucination but these are not as strong and his symptoms are also not fulfilling the criteria of other symptoms of schizophrenia as he has not delusional problem. So we can not diagnose it as schizophrenia disorder.

The essential feature of Major depressive disorder is a clinical course that is characterized by one or more major depressive episodes without a history of Manic, Mixed, or Hypomanic episodes (Criteria A and C). Episodes of Substance-Induces mood disorder (due to the direct physiological effects of abuse, a medication, or toxin exposure) or of mood disorder due to a general medical condition do not count toward a diagnosis of major depressive disorder. In addition, the episodes must not be better accounted for by schizoaffective disorder and are not superimposed on schizophrenia disorder, delusional disorder, or psychotic disorder not other wise specified (Criteria B) (DSM IV-TM)

Patient does not meet the criteria of major depressive disorder because he has also symptoms of hypomanic episodes as he has symptoms of irritable mood, decreased need for sleep, disturbance in mood. So we can't diagnose it, patient with major depressive disorder.

The major feature of Bipolar II disorder is a clinical course that is characterized by the occurrence of one or more major depressive episodes (Criteria A) accompanied by at least one hypomanic episodes (criteria B). Hypomanic episodes should not be confused

with the several days of euthmia that may follow remission of a major depressive episode. The presence of the manic or mixed episode precludes the diagnosis of bipolar II disorder (criteria C). Episodes of substance-induces mood disorder or of mood disorder due to general medical condition do not count toward a diagnosis of bipolar II disorder. In addition, the episodes must not be better accounted for by schizophrenia disorder and are not superimposed on schizophrenia. Schizophreniform disorder, delusional disorder, or psychotic disorder not other specified (Criteria D). The symptoms must cause clinically significant distress or impairment in social, occupation, or other important area of functioning (Criteria E) (DSM IV- TM).

The patient has symptoms of insomnia, depressed mood, diminished interest, feeling of restlessness, loss of energy, social and occupational impairment, irritable mood, disturbance in mood. So he fall in the criteria of bipolar II but with the specified of hypomanic.

From the drawing of HTP, score on RISB, score on BDI, WAT, it is clear that person has depressive and hypomanic tendency, poor interpersonal relations, and obsessive traits.

Presenting complains and results of the test support our diagnosis that the patient tends to have bipolar II disorder with hypomania.

TENTATIVE DIAGNOSIS

Axis I	296.89	Bipolar II (Hypomania)
Axis II	Nil	
Axis III	Nil	
Axis IV	Problem related to social environment	
Axis V	GAF = 21-30	

PROGNOSIS

His symptoms were not much severe and have no long history, so prognosis was possible.

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to G.S.

5. Relaxation training
6. Behavior therapy

CASE 12

CATATONIC SCHIZOPHRENIA

BIODATA

Name	A.Y
Age	31 years
Sex	Male
Education	Metric
Marital Status	Unmarried
Birth order	1st born
Religion	Islam
Siblings	two brothers, one sister
Parents	mother alive, father deceased
Education of father	B.A
Education of mother	Illiterate
Residence	Khushab
Past Psychiatric history in family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr A.Y was a young man of 31 years of age. He had fair complexion and green eyes. He maintained good eye contact during session. His speech was appropriate whereas his was mildly depressed. His hygenical condition was appropriate and his hair was properly done. His teeth were not brushed and he started gazing during all session.

PRESENTING COMPLAINTS

Auditory hallucination

Visual hallucination

Lack of appetite

Abusive

Hyperactive

Spontaneous speech

Sexuality

Dangerousness

Loss of energy

Loss of sleep

Suspicious thoughts

Nerve stretch

FAMILY HISTORY

Mr. A.Y was born in middle class family of 2 brothers and 1 sister in Khusbhab. His father was deceased 2 years ago but his mother was alived. He was agriculturist and it was the source of their income. His brother and sister were married and he lived in joint family system.

He was 1st born child in family. The attitude of his mother and sibling was not good. He told that his home environment not much good and peaceful, all members of family remain harsh for most of time and show aggressive behavior as he reported."We

always fight with each other and use abusive language and now I mostly live in guest room".

PAST PERSONAL HISTORY

Mr. A.Y was a young man of 31 years and according to him, his birth was normal. He told about his childhood that he spent quite happily and He was average student and mostly ran away from school due to fear of his teacher. He wanted to become officer but without any effort. His mother loved him but his father did not love him more because he was dull students and his father think that he can not become an officer like him.

There was no past history of any medical illness. He told that he had been aggressive since his childhood and hit a stone to girl and an axe to a boy because he hated to talk and listen the talking related to love and romance as he reported:

"I hit a stone on girl head and it starts bleeding, I do it because I can not bear his talking as she was talking about love".

He was sexually abused at the age of 10 years by a rich man of his colony and now he abused other boys and girls. He also abused animals and he thought that by doing that we can show our superiority as he reported:

"As that rich man makes me inferior I also feel superiority to abuse other and make them inferior and abuse a lot of boys that registers can be filled with by writing their names".

"I even do with hen, goat, donkey and bitch but can not do with buffalo due to his height.'

HISTORY OF PRESENT ILLNESS

He was admitted to mental hospital for 3rd time and it became the patient got relapse of diseased for two months and refused to take medicine. Now he had been in hospital for last 7 months. The main reason behind his admission was his aggressive and

sexual behavior when his brother and father came with his and admitted him into the hospital, he reported:

"I mostly remained busy in abusing boys and also abused animals (bitch, hen, goat, and donkey) and hit a stone to a girl and axe to a boy".

He first start abusing after the age of 10 and at age of 10 he was abused by a rich boy as he reported:

"A rich boy took me and abused me and when I come back to home I did not told to any body about it because I am feeling inferior and I thought that others laugh on me".

According to him now there was sexual inadequacy because doctors give him medicine and he saves all sexual material for his wife.

Doctors reported that he came to hospital again and again. The cause may be the dangerousness, sexuality, hallucination or the family environment of his family and for this reason he showed such type of behavior.

EVALUATION TECHNIQUES

He was cooperative but he took much time to complete the tests. Following techniques were used

1. Mental status examination
2. Case History examination
3. H.T.P
4. R.I.S.B
5. W.A.T
6. Raven Progressive Matrices
7. Bender Gestalt test

INTELLECTUAL FUNCTIONING

He seemed to have intellectual deficiency. His total score on Ravens was 8 corresponding 5th percentile. This indicates that he lies in v grade and was highly intellectually defective therefore he has low tendency to become a good student (See appendix, 2-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 good orientation of time, place and person. He know about his name, 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, 2-A).

PERSONALITY FUNCTIONING

Mr. A.Y. was a young man of 31 years. He belonged to middle class family. He was the 1st born child in the family of two brothers and one sister. This was patient's 3rd psychiatric admission to hospital.

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

Patient score on RISB is 122 with a cut score of 135. It indicates that he is well adjusted person. C responses in the RISB not much high than positive and neutral responses so positive responses are indication of healthy adjusted from the mind (Rotter, 1932) (See Appendix, 2-B).

HTP shows that he has aggressive tendencies and schizophrenia as indicated by extended arm, strong hand and broad shoulder (Levy, Hammer). He has also sexual inadequacy as indicated by long nose and mutations (Machover). One dimension of tree shows sheltering experience in life (Machover). Strong ego is indicated by strong walls of the house and trunk of the tree and no interpersonal relations as windows are omitted and rooms are separate of family members (Buck, 1966) (see appendix. 2-F).

High scores on definition in WAT indicate Obsessive traits which are 35 and high score of clang association indicates Schizophrenia tendency as scores are 4(see appendix, 2-E)

Scores of Bender indicates that he has no brain damage as his scores are 6 (see Appendix, 2-D).

CASE FORMULATION

Mr. A.Y was a young man of 31 years old from a middle class family of Khushab. He was unmarried. He was the 1st born child in the family of 2 brothers and 1 sister. His education was Metric and landlord by occupation. It was patient 3rd time in hospital for treatment of schizoaffective and aggressive behavior.

Now he had the symptoms of auditory hallucination, visual hallucination, lack of appetite, abusive, hyperactive, sexuality, dangerousness, loss of energy, insomnia, suspicious thoughts, and nerve stretch.

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).

The patient has auditory hallucination, visual hallucination and suspicious thought but his is not fulfilling the major criteria of schizophrenia, so we can not diagnose him as schizophrenia disorder.

The major feature of schizoaffective disorder is an uninterrupted period of illness during which, at some time, there is a major depressive, manic, or mixed episode concurrent with symptoms that meet criteria A of schizophrenia (Criteria A). in addition, during the same period of illness, there have been delusions, or hallucinations for last 2 weeks in the absence of prominent mood symptoms (Criteria B). Finally, the mood

symptoms are present for a substantial portion of the total duration of the illness (Criteria C). The symptoms must not be due to the direct physiological effect of a substance or a general medical condition (Criteria D) (DSM IV-TM).

From the drawing of HTP, score on RISB, WAT it is clear that person has aggressive and schizophrenia tendency, sexual inadequacy, poor interpersonal relations, obsessive traits.

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

TENTATIVE DIAGNOSIS

Axis I	Catatonic Schizophrenia
Axis II	Nil
Axis III	Nil
Axis IV	Interpersonal relationship problem
Axis V	GAF = 21-30

PROGNOSIS

His symptoms were severe and were present since three years. Prognosis seems to be unfavorable.

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to A.Y.

1. Relaxation training
2. Behavior therapy

CASE 13

MAJOR DEPRESSIVE DISORDER

BIO DATA

Name	M.F
Age	32 year
Sex	Female
Education	primary
Marital status	married
Birth order	4th born
Religion	Islam
Sibling's	three brothers, nine sisters
Children	two sons
Parents	alive
Education of husband	Hafiz-e-Quran
Education of mother	illiterate
Residence	Karachi
Past psychiatric history	nil
Past medical history	nil

BEHAVIORAL OBSERVATION

M.F was a middle-aged woman with an aged of 35 years. Her dress was untidy. His hairs were grey. She answered in a proper way. She has good eye contact which she maintained during the whole session, she was not too much confident; she gave test very hardly.

PRESENTING COMPLAINS:

Loss of appetite

Irritated behavior

Depressed mood

Loss of interest

Suicidal ideation

Suspicious thoughts

Loss of energy

Withdrawal tendency

FAMILY HISTORY

M.F belonged to Karachi. The family was economically lower class. Her parents were alive. She had three brothers and nine sisters. M.F was married, she had two sons. He told that his family environment was satisfactory and relationships between family members were good. She sometimes fought with her husband in the matter of property.

PAST PERSONAL HISTORY

She told about her childhood that she spent happily. She spends her marriage life very happily. Problem started when her husband bought some property by cheating other. She told her husband that was not right. She many times exchange blows with her husband, she told why you cheated others. After that she became depressed. Her in-laws also took the side of their husband and fought with her. There was no past history of any medical illness.

HISTORY OF PRESENT ILLNESS

She was 3rd time came to the doctor for the treatment of depressed mood, suspicious thoughts. She thought that all bad things happened because of her. She loved her husband a lot. She told that her husband bought the property because of that property someone kill me, she didn't do any kind of work. She every time laid on the bed. She told that she want to run away from the house, she had poor appetite. She didn't take any kind of decisions. She completely interest in other people.

EVALUATING TECHNIQUES

Following techniques were used to tell about her functioning these are

- Case history interview
- RAVENS
- B.D.I
- H.T.P
- R.I.S.B
- W.A.T

INTELLECTUAL FUNCTIONING:

To ravens test was given to her, she started and took great interest in test. She completed test and her scores was 11, 10 percentile with IV grade which indicates intellectual deficiency.

PERSONALITY FUNCTIONING:

On the basis of H.T.P, W.A.T, R.I.S.B, B.D.I and the presenting complaints shows that, she had depression.

In his drawing of tree, that showed her dependent personality that is indicated by flower like figure. Weak lines of the house indicated that she had dependent personality, withdrawal depression indicated by omitted arms.

On applying W.A.T her scores were high on definition which tends to indicator of OCD. On applying B.D.I his total scores were 38 that indicate the severe depression.

On R.I.S.B the score was 145, cut of scores was 135-140. That indicates that she had severe maladjustment. She had not good interred personal relations.

CASE FORMULATION

She was second time to daughter for the treatment of depressed mood, hopelessness, and inability to take decision, suspicious thoughts. Her home environment was not adequate, she had not interest in life, and she thought that somebody kills her and all bad things happened because of her. She had withdrawal tendencies, she avoids meeting with people.

TENTATIVE DIAGNOSIS:

Axis I	296.3x Major depressive disorder
Axis II	Nil
Axis III	Nil
Axis IV	Nil
Axis V	G.A.F 50-41

Prognosis:

Her symptoms were severe. And know M.F was started treatment, she recover if she properly takes antidepressants.

TREATMENT RECOMMENDATION:

Following techniques were applied on her treatment

- relaxation training
- cognitive behavioral techniques

CASE 14

CYCLOTHYMIC DISORDER

BIO DATA

Name	P.S
Age	26 years
Sex	Female
Education	metric
Marital status	widow
Birth order	2nd born
Religion	Islam
Sibling's	four brothers, four sisters
Parents	alive
Education of husband	primary
Education of mother	illiterate
Residence	Sargodha
Past psychiatric history in family	nil
Past medical history of patient	nil

BEHAVIORAL OBSERVATION

Mrs. P.S was a woman of 26 years age. She was well-disciplined women. She maintained eye contact during the session. She answered in a proper way. She was looking very upset. Her dress was untidy, she was not too much confident. She was not sitting comfortably on the chair.

PRESENTING COMPLAINS:

Loss of sleep

Loss of appetite

Withdrawal tendency

Suicidal ideation

Loss of energy

Depressed mood

Inability to think

FAMILY HISTORY:

P.S belonged to Sargodha. The family was economically lower class. Her parents were alive. She had 4 brothers and four sisters. She was widow. She had 1 son and two daughters. She told that her family environment was unsatisfactory. She had not good relations with their In-laws after the death of their husband. P.S in-laws torture her. They think if she marries then she doesn't take care of their children.

PAST PERSNAL HISTROY:

She told about her childhood that she spent happily. She said when I try to remember my school days but I failed, she told that her memory was very weak; dilemma was started after the death of her husband. After the loss of her husband P.S told, she every time crying, she tries to sleep but failed, and also didn't have hunger. P.S said she was helpless. She had no interest in people, she lost her energy, and she could not do any kind of work, she want to do some job but she failed.

PRESENT PSYCHATRIC ILLNESS:

She was second time came to doctor. She said after the death of her husband the attitude of their in laws became changed. She told after the loss of her husband her thoughts were not normal. She didn't get marry for their children. She didn't perform any kind of work; she told that she didn't take care of their children, if any body talks in front of her she didn't like. She neither laughs nor cries. P.S told that, she thinks that her life became ended. She had no hope for their future. She lived in the world of imagination.

EVALUATING TECHNIQUES

Following techniques were used to tell about her functioning these are

- Case history interview
- RAVENS
- B.D.I
- H.T.P
- R.I.S.B
- W.A.T

INTELLECTUAL FUNCTIONING:

To ravens test was given to her, she started and gave test very hardly. He completed test and her scores was 6, 5 percentile with V grade which indicates the intellectual deficiency

PERSONALITY FUNCTIONING:

On the basis of H.T.P, W.A.T, R.I.S.B, B.D.I and the presenting complaints shows that, she had depression.

In his drawing of tree, that showed his depression that is indicated by shading on tree by red and brown color and dependency by flower like figure. In house double lines indicated the tendency of dependency. In her human figure breast and belly button also indicated her tendency of dependency.

On applying W.A.T his scores were high on opposite reactions. On applying B.D.I his total scores were 37 that indicate the severe depression.

On R.I.S.B the score was 158, cut of scores was 135-140. That indicates that she had severe maladjustment. She had not good interpersonal relations.

.CASE FORMULATION:

She was second time to doctor for the treatment of depressed mood, hopelessness, and inability to think. Her home environment was not adequate, she had not interest in life, she had withdrawal tendencies, she avoids meeting with people. She told that in-laws tortured her. They think if she marry, then she leave their children. She could not marry because of their children. She didn't take care of their children because of their depressed mood.

TENTATIVE DIAGNOSIS:

Axis I	Cyclothymic Disorder
Axis II	Nil
Axis III	Nil
Axis IV	Problem with primary support group
Axis V	G.A.F 50-41

Prognosis:

Her symptoms were severe. And know P.S was started treatment, she recover if she properly came to doctor

TREATMENT RECOMMENDATION:

Following techniques were applied on her treatment

- relaxation training
- cognitive behavioral techniques
- Behavioral medication technique

CASE 15

GENERALIZED ANXIETY DISORDER

BIODATA

Name	Azra Parveen
Age	32 years
Sex	Female
Education	Primary
Occupation	House Wife
Marital Status	Married
Birth order	2nd born
Religion	Islam
Sibling	One brother Three sister
Parents	Deceased
Education of Father	Matric
Education of Mother	Primary
Residence	Khanpur
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Her behavior with the therapist was very cooperative though she looked nervous and was speaking very slowly. She answered each question of the therapist in detail. It was easy to build rapport with the client.

2. Mental Status Examination:

i. General Appearance:

She was middle aged with medium built and average height. She was well kempt. Her manners and posture revealed that she is nervous. Her speech was barely audible, marked by hesitation and wavering. Her eyes nervously scanned the interview room.

ii. Speech:

Client was speaking very low and lazily. Her composition of words and sentences format was normal.

3. Emotional expressions:

i. Objective:

Objectively to some extent she was emotionally stable, but some times her irritating emotions were present on her face.

ii. Subjective:

She reported her angry feelings and she was disturbed.

Presenting Complains

Duration of symptoms (1 year)

(1

(2

(3

(4

(5

(6

(7

(8

(9

FAMILY HISTORY

She belongs to a lower middle class family. Her father died 12 years ago and mother is alive and has good relationship with her. She has five sisters and one brother. She has good relationship with all sisters. She did not have good relationships with her sister-in-law (Jethani). She reported that her brother was mentally retarded and was lost 7 years ago. This is also painful for the client and her family.

She reported that her home environment was very stressful due to strict attitude of her husband. Her husband used to criticize even that the routine activities at home e.g. cooking, raring of children & discipline of home. This is the main cause of annoyance for

her. She did not feel secure relationship with her husband and due to this she remained upset.

PAST PERSONAL HISTORY

Her education level was primary. She respected everyone and had kind attitude towards her family. The history of client's birth and milestones was normal. She had no complication during her childhood. She did not report any history of addiction or menstrual problems.

Client is a married woman having two daughters and two sons. She stated that she was not happy with her husband, who had very strict and critical attitude towards her. He imposed a lot of pressure as well as extra responsibilities. Consequently she had low self esteem and low confidence. Constant rejection from husband interfered with her interpersonal relationships and her day to day tasks. Her ability to maintain relationship was deteriorating.

HISTORY OF PRESENT ILLNESS

Client stated that her problem started 1 year ago. She particularly reported that her husband attitude was strict and critical towards her and children. Due to this, she felt great pressure to be perfect in his eyes. She had great difficulties in carrying out her routine tasks such as washing, cooking and care of her children. She felt overwhelming dread of making mistakes.

She received tease from her eldest sister-in-law. She was a cause of trouble for client. Most of time, she quarreled with the client and tortured her mentally. She felt that her sister-in-law did not like her children.

She felt utterly unable to overcome her problems. She took great pain to avoid situations that may bring them on. She was very tense and always felt nervous. She was easily distracted and irritated by minor talks and problems. Overriding fear of disapproval from husband and hatred from sister-in-law crippled her social functioning as well as her

ability to perform everyday routine work. She manifested anxiety by a number of psychological symptoms including constant vigilance, distractibility and irritability and muscle tension.

EVALUATION TECHNIQUES

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

1. Beck Anxiety Inventory (BAI)
2. Rotter Incomplete Sentences Blank (RISB)
3. Hospital Anxiety Scale (HAS)

CASE FORMULATION

Mrs. Azra Parveen is 32 years old married woman with complaints of shortness of breath, profuse sweating and wildly racing heartbeat. She was an Anxiety patient. Following studies suggest that:-

"Generalized Anxiety Disorder often begins in relation to stressful events and some become chronic when stressful problem persists. Stressful events involving threat are particularly related to Anxiety disorder" according to Finley-Jones and Brown (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006).

"Generalized Anxiety Disorder arises from a tendency to worry unproductively about problems and to focus attention on potentially threatening circumstances" according to Wells and Butler. (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006)

TENTATIVE DIAGNOSIS

Axis-I	300.02 Generalized Anxiety Disorder
Axis-II	None
Axis-III	None
Axis-IV	Problems in primary support group – disruption of family.
Axis-V	GAF=60

MANAGEMENT PLAN

The management plan was made as under:-

Short-term Goals:

1. Establish good rapport with the client and giving her unconditioned positive regard.
2. To teach her deep muscle relaxation technique to reduce anxiety

Long-term Goals:

1. Enable the client to face stressful life environment and difficulties of life
2. Enable the client to solve her problems properly.

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to M.H.

1. Relaxation training

2. Behavior therapy

3. Cognitive behavioral therapy