PSYCHOTHERAPEUTIC INTERNSHIP REPORT

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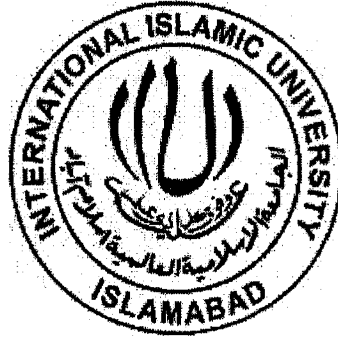

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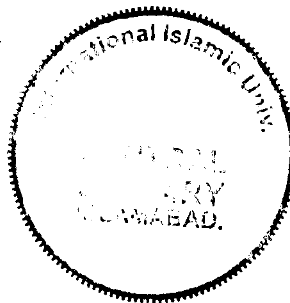

Accession No TH 7624

MS
616.85
NOP

1- Psychotherapy - Case studies

CERTIFICATE

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

Supervisor

Signature:

Dated: 17-6-10

Generalized Anxiety Disorder (300.02)

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:	Matric
Parents:	Both are Alive
Education of Father:	Uneducated
Education of Mother:	Uneducated
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.

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 5th Percentile. This indicates that he lies in V grade and he was intellectually defective.

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.

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.

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	Generalized anxiety disorder (300.02)
Axis II	No diagnosis
Axis III	No diagnosis
Axis IV	Social and occupational problem
Axis V	GAF (65) current

Prognosis:

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

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

3. Explain the nature of the disorder and reassurance that any physical symptoms of anxiety are not caused by physical disease.

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.

SESSIONS

1ST Session

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

2ND Session

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

3RD Session

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

4TH Session

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

5ND Session

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

6TH Session

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

7RD Session

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

8TH Session

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

9TH Session

In this session client was noticeably excited and changed. He admitted that his worries were irrational. I assured the client that he will be able to return back to normal state. The therapeutic contract was terminated by the mutual consent of both the parties. A termination session is very sensitive process. This session was started with a lot of care because it requires a lot of sensitivity. It is a process of ending the therapeutic relationship. It is difficult for patient to accept it at once but after some better realization he got it and understands bout it.

Paranoid Schizophrenic Disorder

(295.30)

Bio Data:

Name:	S.H
Gender:	Male
Age:	30 Year
Religion:	Islam
Marital Status:	Married
Education:	Middle
Occupation:	Store Keeper
No of Siblings:	6 (5 brothers & 1 sister)
Birth order:	4th
No of children:	2 (1 son & 1 daughter)
Informant:	Self

Reason for Referral:

Client was referred to the psychologist by psychiatrist for his low self-esteem, superstitious thinking, fearfulness, dreadful thoughts, agitation, irritability, persecutory thoughts, aloof behavior and suicidal attempts.

Presenting Complaints:

1) ڈر لگتا ہے خاص طور پر جب اکیلا ہو۔
2) لگتا ہے کہ دشمن حملہ کر دیں گے اور مار دیں گے۔
3) محسوس ہوتا ہے کہ کوئی پیچھا کر رہا ہے۔
4) بھائی اور باس پر اعتبار نہیں کرتا۔ سمجھتا ہے کہ وہ دشمن کے ساتھ ہیں۔
5) گھٹن محسوس ہوتی ہے اور کبھی لگتا ہے کہ کان کام نہیں کر رہے۔
6) صرف ماں پر اعتبار ہے انہیں کے ساتھ باہر جاتا ہے۔

History of Present Illness:

Client's problem started 12 years ago. He started fear of loneliness and didn't feel secure. Unknown fear prevails on his mind. He could not go alone in market of any other place. He didn't feel protection outside the home.

He got treatment from a psychiatrist. After 6 months of treatment, he went to Saudi Arabia for some job. He worked there with full concentration for few months. But then constant fear started to disturb him that he would die at some unknown place; No one here to see in which condition he is; What will happen with him in this stranger country?.

He got treatment from a doctor in Saudi Arabia and got better from this fear. After 2½ years, he came back to Pakistan. His condition gradually became very intense. He started to work as Store Keeper. One day, he was coming from his factory, he felt some opponents are chasing him and wanted to kill him. He also reported that his factory owners were also against him and they used to provide information about him to his opponents.

Due to his feelings that people were chasing him, he temporarily discontinued his job. He always felt that opponents would harm him. Her mother reported that most of time he told that some people were chasing him, when he goes to factory. She also told that we have some clashes with my sister-in-law, but they never harmed our family. Client reported that he remained suspicious about his cousins that they will kill him. He also reported that in his opinion his younger brother was also a partner of my opponents. He did not have any trust on his brother.

Past Psychiatric History:

There was no any psychiatric illness in the client.

Family History:

Client belongs to a lower middle class family. His father died at the age of 70. His mother is 60 years old lady. He has good relationship with his mother.

He has four brothers and one sister. His elder brother is psychiatric patient and getting his treatment. He did not have trust on his younger brother. He felt that he was against him.

The client was married 6 years ago. The client has 2 children (one son & one daughter). His wife criticizes him for not doing proper duty in factory. His wife was used to quarrel with him that he had not any problem and he was making lame excuses for his illness. His home environment was disturbed due to clashes with his wife. His wife was a short tempered lady. She was used to quarrel with him to fulfill domestic necessities at every cost. It was precipitating factor to increase his illness.

Personal History:

His education level was middle. He failed in matriculation exam repeatedly. Then he discontinued his studies and started search for job. The history of client's birth and milestones were normal. He was 4th among his siblings. He received attention and love from his family. He had no significant illness in childhood

Pre-morbid Personality:

Before this condition, the client was a religious-minded person. He used to spend his all time in religious activities. He used to do "Wazeefa" and "Chilla". Due to excessive spiritual activities, he got very disturb. He was not social and friendly. He was only concerned to his own work.

PSYCHOLOGICAL ASSESSMENT:

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

INFORMAL ASSESSMENT:

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

1. Behavioral Observation:

The client was a thin young man. He was well groomed. Rapport was built easily. He established eye contact during conversation.

2. Mental Status Examination:

i. General Appearance:

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

ii. Speech:

He was speaking slowly and fluently. Volume was occasionally slow. Rhythm and expressive intonation was normal.

3. Emotional expression:

i. Objective:

Objectively he was emotionally stable, but sometimes his irritating emotions were present on his face.

ii. Subjective:

He reported his mood remains sad.

4. Thinking and Perception:

i. Thought form:

His thoughts were generally logical but there was a big evidence of loosening of association and thought blocking.

ii. Thought content:

He had low self esteem. Obsessions were present about his Boss and his younger brother. Suicidal and homicidal thought were present in his mind. Delusions were also present in his mind.

iii. Perception:

There were visual hallucinations and illusions were reported.

5. Sensorium:

i. Alertness:

Client was conscious at the time of interview.

ii. Orientation:

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

a.. Person:

His person orientation was normal.

b. Place:

His place orientation was also normal.

iii. Time:

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

iii. Concentration

His concentration about questions was good.

iv. Memory:

His memory was very good.

a. Immediate:

His immediate memory was accurate.

b. Recent memory:

His recent memory was correct.

c. Remote memory:

His remote memory was intact.

6. Insight:

Client had no insight about his ailment.

FORMAL ASSESSMENT:

TESTS APPLIED

The following tests were administrated.

1. RISB

2. CAS

1. Rotter Incomplete Sentence Blank (RISB):

Quantitative Analysis:

Conflicts responses

Total response of C3	7
Total response of C2	9
Total response of C1	4

Positive responses

Total response of P1	2
Total response of P2	3
Total response of P3	3

Neutral responses

Total response of N	12

Key

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

Total scores of responses

Total score of positive responses	24
Total score of conflict responses	300
Total score of neutral responses	36

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

He got 24 score in this scale which leads to moderate clinical anger.

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

DIAGNOSIS

Axis-I Schizophrenia Paranoid Type (295.3)

Axis-II None

Axis-III None

Axis-IV Problems with primary support group.

Axis-V GAF = 50 (Current)

MANAGEMENT PLAN

The management plan was made as follows:

Short-term Goals:

1. To develop rapport with the client
2. Educate his family about his illness and their role in therapeutic process.
3. Marinating a base line about his personal hygiene, social skills and for his headache as well.
4. Keeping him busy in some jobs by arranging an activity schedule.
5. Enabling the client to do his work by himself.
6. Identifying the rein forcers of the client.

Long-term Goals:

1. Enabling the client to feel responsible about his duties and work
2. Educate his family about high expressed emotions
3. Helping him in a better adjustment in the environment

SESSIONS

1ST Session

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

2ND Session

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

3RD Session

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

4TH Session

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

5TH Session

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

6TH Session

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

7TH Session

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

8TH Session

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

9TH Session

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

10TH Session

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

11TH Session

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

12TH Session

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

Schizophrenia Disorganized type

(295.10)

TH 7624

IDENTIFYING DATA:

Name:	A.F
Gender:	Female
Age:	24 Year
Religion:	Islam
Marital Status:	Single
Education:	Middle
Occupation:	Maid
No of siblings:	5 (3 brothers & 2 sisters)
Birth order:	2nd
Informant:	Elder brother and self

Reason for Referral:

Client was referred to Clinical Psychologist hospital for the assessment and management by the Psychiatrist, with the symptoms of headache, blurred vision, self laughing, self talking, aggressive, hearing voices, abusive and bizarre & stubborn behavior.

Presenting Complaints:

1) سر میں درد ہوتا ہے۔
2) خود بخود ہنستی ہے۔
3) خود سے باتیں کرتی ہے۔
4) کانوں میں آوازیں سنائی دیتی ہیں۔
5) اکتاہٹ محسوس کرتی ہے۔
6) اداس رہتی ہے۔
7) ضد کرتی ہے۔

History of Present Illness:

Client was all right 5 years ago, when she was studying in class 8th. She was not good in studies. She failed in class 8th and her younger sister passed class 7th and promoted to class 8th. Both sisters became class fellow in class 8th. Her younger sister was intelligent and a shining student, while client was a dull and slow learner in studies. Her teacher many time complained to her family members that she was not able to continue her studies. She failed in class 8th three times. Teachers got fed up with her and sometime they punish her due to her bad performance in studies. While her younger sister achieved significant success in studies, all family members appreciate her sister.

Her younger sister had very pleasant social life with many friends; meanwhile client started developing inferiority complex. Client had no social life or friends. This was the main cause of tension for her. Her younger sister was college student. Her younger sister used to wear beautiful dresses at college functions. She started having

inferiority complex that her sister was living better life than her. During education her younger sister got married and spending a happy life.

During class 8th the client showed stubborn behavior. Her family members observed her self laughing and self talking. Her brother reported that she showed irritable and stubborn behavior. When her family members asked her for doing any household activities, she always did the contrary. Her brother reported that she did only that work, which she liked herself. She never did imposed tasks. She kept her dresses, shoes and jewelry in a much arranged way. She had greatest wish having friends but girls in her neighborhood avoided her due to her illness. Her family members avoided her due to her low performance and dull attitude.

Her problem becomes more intensive when she discontinued her studies after failure. She started having complaints of headache, stubborn behavior, hearing voices, self laughing, self talking and abusive & aggressive behavior towards mother. She loved too much with her eldest brother who took much care of her.

Past Psychiatric Illness:

There was no evidence of past psychiatric illness.

Family History:

.Client belongs to a middle class living in joint family system. Her father is 50 years old and employee of a textile mill. She had good relationships with him. Her mother is a 45 years old housewife. She had a disturbed relationship with her due to her irritable behavior. She has 3 brothers and 1 sister. Her eldest brother is 27 years old well educated with whom client had good relationship. Her younger sister is 23

years old. She has cold relationship with her younger sister. She was jealous of her younger sister. With other younger three siblings she has normal relationship.

She reported that her home environment was a cause of distress. Her mother used to appreciate her younger sister due to her significant performance in studies and this was the main cause of annoyance for her. She did not feel secure relationship with her sister.

Personal History:

The information about her birth and early development was reported by her elder brother and client herself. According to that information her birth was normal at home and no complications were related. She studied up to 8th class. Her academic performance was unsatisfactory. She failed three times in class 8th. She discontinued studies after class 8th due to her illness. She did not take much interest in her daily home activities. She showed boredom, when any task was assigned to her. She had bad interpersonal social relationship with her mother and younger sister. She offered her prayer regularly. She reported that her menstrual cycle is normal. She did not report any history of addiction.

Pre-morbid Personality:

Client brother reported that before her illness she was socially isolated. Most of the time, she remained alone. She was a slow learner. She showed irritability towards her siblings and peer groups.

PSYCHOLOGICAL ASSESSMENT:

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

INFORMAL ASSESSMENT:

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

1. Behavioral Observation:

A young 24 years of medium built and height. She was cleanly dressed with head covering duppata. Her facial expressions were anxious. Rapport was easily developed with the client and eye contact was maintained. Her behavior was cooperative and communicative.

2. Mental Status Examination:

i. General Appearance:

Client was well kempt and properly combed. She was sitting on a chair in anxious manner. However she responded to the queries of the therapist properly.

ii. Speech:

Flow of the speech was rapid.

Emotional Expression:

i. ***Objective:***

Objectively she remains sad.

ii. Subjective:

Subjectively she was also looking sad.

4. Thinking and Perception:

i. Thought form:

His thoughts were generally logical but there was a big evidence of loosening of association and thought blocking.

ii. Thought content:

He had low self esteem. Obsessions were present about his Boss and his younger brother. Suicidal and homicidal thought were present in his mind. Delusions were also present in his mind.

iii. Perception:

There were auditory hallucinations and illusions were reported.

5. Sensorium:

i. Alertness:

Client was conscious at the time of interview.

ii. Orientation:

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

iii. Concentration:

Client concentration was very poor at the time of the interview.

vi. Memory:

Her memory was good.

a. Immediate:

Her immediate memory was good.

b. Recent memory:

Ask her to repeat a fictitious name and address given in her own language as was asked to repeat it. She repeated well.

6. Insight:

Client had no insight about her ailment.

FORMAL ASSESSMENT:

Rating Scale:

Headache	6
Self laughing	6
Self talking	7
Auditory Hallucinations	8
Irritability and Agitation	9
Sadness	10

Symptoms check list-R:

Scales	Raw scores	SD	Significance
VI	20	2	17

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

TESTS APPLIED

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

1. Rotter Incomplete Sentences Blank (RISB)
2. Emotional Quotient Test (EQT)

1. Rotter Incomplete Sentence Blank (RISB):

Conflicts responses

Total response of C3	9
Total response of C2	5
Total response of C1	6

Positive responses

Total response of P1	3
Total response of P2	3
Total response of P3	3

Neutral responses

Total response of N	11

Key

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

Total scores of responses

Total score of positive responses	9
Total score of conflict responses	94
Total score of neutral responses	33

DIAGNOSIS

Axis-I	Schizophrenia Disorganized type (295.10)
Axis-II	None
Axis-III	None
Axis-IV	Problems with primary support group
Axis-V	GAF=50(current)

MANAGEMENT PLAN

The management plan was made as follows:-

Short-term Goals:

1. Establish rapport with the client
2. Family education about the illness of the client and therapeutic process.
3. Enable the client to do her work by herself
4. Improve impulse control
5. Improve self-esteem

Long-term Goals:

1. To improve her social and interpersonal relationships.
2. To promote her sense of control and responsibility.
3. To improve her occupational skills.

4. Helping her for a better adjustment in the environment.
5. Educating the family about high expressed emotions.

SESSIONS

1ST Session:

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

2ND Session:

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

3RD Session:

The client was not feeling much. She was not so much expressive about her problems. However, the behavioral change contract and rein forcers were identified.

4TH Session:

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

5TH Session:

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

6TH Session:

In this session, the therapist introduced the Token Economy Technique to the client.

7TH Session:

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

8TH Session:

During this session, the client showed improvement. Client was asked to do her assigned activities. She told me about earplug therapy and I asked her to repeat again.

9TH Session:

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

10TH Session:

During this session, the client showed much improvement and by considering her condition therapeutic relationship was terminated.

Generalized Anxiety Disorder (300.02)

IDENTIFYING DATA:

Name:	A.P
Gender:	Female
Age:	32 Year
Religion:	Islam
Marital Status:	Married
Education:	Primary
Occupation:	House Wife
No of siblings:	4 (3 sisters & 1 brother)
Birth order:	2nd
No of children:	4 (2 daughters & 2 sons)
Informant:	Self

Reason for Referral:

Client was referred by the psychiatrist for the assessment and management of the complaints of headache, shortness of breath, wildly racing heartbeat, profuse sweating, low self esteem & loss of appetite.

Presenting Complaints:

Duration of symptoms (1 year)

1) سر میں درد ہوتا ہے۔
2) جسم میں درد کی وجہ سے پریشان رہتی ہے۔
3) تھکاوٹ محسوس ہوتی ہے۔
4) اپنے آپ کو کم تر محسوس کرتی ہے۔
5) سستی چھائی رہتی ہے۔
6) دل کی دھڑکن تیز رہتی ہے۔
7) پسینہ بہت آتا ہے۔
8) بھوک نہیں لگتی ہے۔
9) نیند کم آتی ہے۔

History of Present Illness:

Client stated that her problem started one 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.

Past Psychiatric Illness:

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

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. 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.

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.

Pre-morbid Personality:

Before her illness, she was very active to perform her routine work and was cooperative towards her family. She was cool and calm by nature and did not interfere in others life. She was religious-minded and offered her prayers regularly.

PSYCHOLOGICAL ASSESSMENT:

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

INFORMAL ASSESSMENT:

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

1. 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.

4. Thinking and Perception:

i. Thought form:

Her thought form was generally logical and goal oriented. There was some evidence of loosening of association or thought blocking.

ii. Thought content:

She had low self-esteem. She was preoccupied with thoughts that her relatives are enemy of her.

iii. Perception:

No hallucinations and illusions were present in client.

5. Sensorium:

i. Alertness:

Client was conscious at the time of interview. Eye-to-eye contact was maintained.

ii. Orientation:

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

a. Person:

Her orientation about person was normal.

b. Place:

Her place orientation was also normal.

c. Time:

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

iii. Concentration:

Her concentration about questions was not good.

iv. Memory:

Memory was also intact.

b. Recent memory:

She repeated with the mistakes but over all it was normal.

v. Calculation:

Client attention and concentration was normal as manifested by appropriate answers.

6. Insight:

Client had insight about her ailment and recognized the severity of her problem.

TESTS APPLIED

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)

1. Beck Anxiety Inventory (BAI):

In the anxiety test her score was 47, which leads to the severe anxiety.

0-7	Absence of anxiety
8-15	Mild anxiety
16-25	Moderate anxiety
26-63	Severe anxiety

2. Rotter Incomplete Sentence Blank (RISB):

Conflicts responses

Total response of C3	7
Total response of C2	11
Total response of C1	1

Positive responses

Total response of P1	4
Total response of P2	2
Total response of P3	1

Neutral responses

Total response of N	6

Key

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

Total scores of responses

Total score of positive responses	21
Total score of conflict responses	284
Total score of neutral responses	18

DIAGNOSIS

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

MANAGEMENT PLAN

The management plan was made as under:-

Short-term Goals:

4. Establish good rapport with the client and giving her unconditioned positive regard.
5. To teach her deep muscle relaxation technique to reduce anxiety
6. Explain the nature of the disorder and reassurance that any physical symptoms of anxiety are not caused by physical disease.

Long-term Goals:

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

SESSIONS

1ST Session

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

2ND Session

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

3RD Session

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

4TH Session

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

5ND Session

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

6TH Session

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

7RD Session

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

8TH Session

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

9TH Session

In this session client was noticeably excited and changed. She admitted that her worries were irrational. I assured the client that she was a sensible lady. I

explained that the family problems are not of such matter to destroy of her life. At the end of this session the therapeutic contract was terminated.

Dysthemic Disorder (300.4)

IDENTIFYING DATA:

Name:	S.B
Sex:	Female
Age:	45 Year
Religion:	Islam
Marital Status:	Married
Education:	None
No of siblings:	10 (3 brothers and 7sisters)
Birth order:	3rd
No of children:	6 (2 daughters and 4 son)
Informant:	Self

REASON FOR REFERRAL:

Client was referred to the clinical psychologist by psychiatrist for the assessment and management of the complaints of headache, restlessness, low appetite, lack of interest, lack of sleep, self injurious behavior and crying spells.

Presenting Complaints:

1) نیند نہیں آتی۔
2) سر میں درد ہوتا ہے۔
3) کسی کام پر توجہ نہیں رہتی۔
4) کوئی کام کرنے کو دل نہیں کرتا۔
5) بھوک نہیں لگتی۔
6) اکتاہٹ رہتی ہے۔

History of Present Illness:

Client stated that before marriage she was quite calm and less talkative lady. After marriage she could not adjust herself due to harsh behavior of her in-laws. Her husband and mother-in-law had critical attitude towards her. Her mother-in-law was very sharp and cunning. She used to insult her all time and disliked her. Her mother-in-law wanted to do remarriage of her husband with her niece and insisted her son to divorce the patient.

Past Psychiatric Illness:

There was no significance history of past psychiatric illness.

Family History:

Client belongs to a lower middle class family. Her father died 10 years ago and mother is alive and 65 years old. She had good relationship with her mother. She has six sisters and three brothers. She had good relationship with all siblings.

Her home environment is very disturbed. After marriage, she faced many problems. Her husband quarreled all time and beat her harshly. Her eldest son had habit of gambling, which was a cause of distress for her. Her husband blamed her for bad habits of eldest son.

Client is a married woman having two daughters and four sons. She stated that she had not satisfactory relations with her husband but she loved with her children. Her ability to maintain relationship was deteriorating.

Personal History:

Client did not receive any formal education. Her personality was sluggish and careless. Her birth and development milestones were normal. She had no complication in her childhood. She did not report any history of drug addiction and menstrual problems.

Pre-morbid Personality:

Before her illness she was less talkative, but she was cooperative and caring. She also took interest in home affairs. She was socially active. She enjoyed meeting people and their company. She used to offer prayers regularly. She was responsible and independent to make her decision.

INFORMAL ASSESSMENT:

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

1. Behavioral Observation:

Her behavior with the therapist was very cooperative though she seemed tired and lethargic. She was speaking very slowly but her eye contact was intact. It was easy to build rapport with the client.

2. Mental Status Examination:

i. General Appearance:

Client was not well kempt. She was wearing dopatta with head covered. She was of normal height with smart body. She was not sitting comfortable. She appeared tired and lethargic during the 1st session.

ii. Speech:

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

3. Emotional Expressions:

i. Objective:

Her mood was very low and sad.

ii. Subjective:

She remains sad all the time.

4. Thinking and Perception:

i. Thought form:

Her thought form was generally logical and goal oriented. There was some evidence of loosening of association or thought blocking.

ii. Thought content:

She had low self-esteem. She was preoccupied with thoughts that her husband always abused her.

iii. Perception:

No hallucinations and illusions were present in client.

5. Sensorium:

i. Alertness:

Client was not much alert at the time of interview.

ii. Orientation:

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

a. Person:

Her orientation about person was normal

b. Place:

Her place orientation was also normal.

c. Time:

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

iii. Concentration:

Her concentration about questions was not good.

iv. Memory:

Memory was intact.

6. Insight:

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

FORMAL ASSESSMENT:

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

TESTS APPLIED

1. Beck Depression Inventory (BDI)
2. Rotter Incomplete Sentence Blank (RISB)

1. Beck Depression Inventory (BDI):

In the depression inventory the score of the client was 43, which cause severe depression and this score shows the severe depressed condition of the client.

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

2. Rotter Incomplete Sentence Blank (RISB):

Conflicts responses

Total response of C3	5
Total response of C2	10
Total response of C1	14

Positive responses

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

Neutral responses

Total response of N	5

Key

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

Total scores of responses

Total score of positive responses	8
Total score of conflict responses	135
Total score of neutral responses	15

DIAGNOSIS

Axis-I	Dysthymic disorder (300.4)
Axis-II	None
Axis-III	None
Axis-IV	Problems with primary support group
Axis-V	GAF = 50 (current)

MANAGEMENT PLAN

The management plan was made as under:-

Short-term Goals:

1. Establish rapport with the client
2. Family education about the illness of the client and therapeutic process.
3. Maintaining a base line about her personal hygiene and social skills.
4. Keeping her busy in activity schedule.
5. Enable the client to do her work herself.

6. Identifying the reinforcing agents of the client

7. Improving her personal hygiene and social skills.

Long-term Goals:

1. Enable client for better adjustment in the environment.

2. Enable the client to feel responsible about her duties and work.

3. Educating the family about high expressed emotions towards her.

4. Home Work Assignments

5. Activity Schedule

SESSIONS

1ST Session

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

2ND Session

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

3RD Session

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

4TH Session

The therapist explored client's irrational thoughts. In these sessions it was tried to change the irrational thoughts and beliefs. So rational emotive behavior therapy was used. Insight was developed in client about her problem.

5TH Session

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

6TH Session

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

7TH Session

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

8TH Session

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

9TH Session

During this session, the client improved a lot and the therapeutic contract now be terminated, so it was terminated by the mutual consent of both the parties.

Major Depressive Disorder Single Episode (296.2x)

IDENTIFYING DATA:

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

Reason for Referral:

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

Presenting Complaints:

The client reported the following symptoms/complaints:

Duration of symptoms (03 years)

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

History of Present Illness:

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

She gradually developed many symptoms like disturbed sleep, low appetite, crying spells, sadness, feeling of unworthiness, lack of interest and death wishes. She seemed that life was useless. Another precipitating factor regarding her illness was that she was issueless. This promoted feeling of helplessness. She was too much worried who will take care of her in old age. Her elder brother is a client of paralysis.

He was not able to perform his minor activities. This was also cause of worry for her. She had to take care of her brother. She also remained upset and tense that who will take care of her brother if she died.

Past Psychiatrist Illness:

The client has no past psychiatric history.

Family History:

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

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

Personal History:

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

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

Pre-morbid Personality:

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

PSYCHOLOGICAL ASSESSMENT:

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

INFORMAL ASSESSMENT:

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

1. Behavioral Observation:

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

2. Mental Status Examination:

i. General Appearance:

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

ii. Speech:

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

3. Emotional Expressions:

i. Objective:

She was looking depressed.

ii. Subjective:

As client reported:

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

4. Thinking and Perception:

i. Thought form:

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

ii. Thought content:

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

iii. Perception:

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

5. Sensorium:

i. Alertness:

She was not much alert at the time of interview.

ii. Orientation:

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

a. Person:

Her orientation about person was normal

b. Place:

Her place orientation was also normal.

c. Time:

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

iii. Concentration:

Her concentration about questions was good.

iv. Memory:

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

6. Insight:

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

FORMAL ASSESSMENT:

Pre-testing:

Rating Scale:

1 2 3 4 5 6 7 8 9 10

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

Symptoms check list-R:

Scales	Raw scores	SD	Significance
I	60	2	37

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

TESTS APPLIED

1. Beck Depression Inventory (BDI)

2. Beck Hopelessness Scale (BHS):

3. Rotter Incomplete Sentence Blank (RISB)

1. Beck Depression Inventory (BDI):

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

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

2. Beck Hopelessness Scale (BHS):

This table is showing the quantitative analysis of BHS.

Score	Severity level	Obtained score
Greater than 14	Severe	17

3. Rotter Incomplete Sentence Blank (RISB):

Quantitative Analysis:

Conflicts responses

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

Positive responses

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

Key

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

Total scores of responses

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

DIAGNOSIS

Axis-I Major Depressive Disorder with single episode (296.2)

Axis-II None

Axis-III None

Axis-IV Death of family members, inadequate social support

Axis-VI GAF =50 (current)

MANAGEMENT PLAN

The management plan was made as follows:

Short-term Goals:

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

Long-term Goals:

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

SESSIONS

1ST Session

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

2ND Session

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

3RD Session

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

4TH Session

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

5TH Session

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

6TH Session

The client was taught to replace her irrational beliefs with rational ones. In these sessions it was tried to change the irrational thoughts and beliefs which was established that he can not do any thing, he has not ability to do some thing in front others. So rational emotive behavior therapy was used. Patient said that she is worthless

7TH Session

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

8TH Session

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

9TH Session

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

10TH Session

During this session, the client was markedly improved. Her sister also reported that she has been improved and now takes interest in her daily routine work. So at the end of this session the therapeutic contract was terminated.