DIAGNOSTIC CASE HISTORIES

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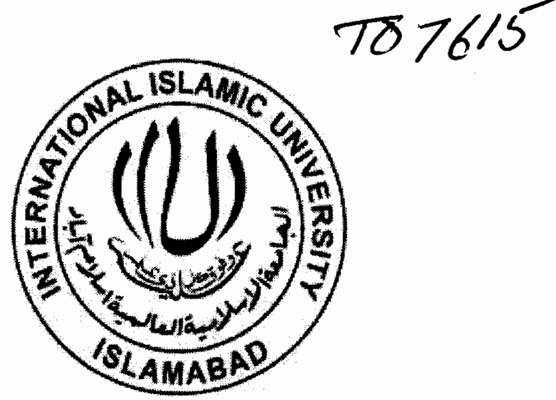

Submitted to

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1. Affective disorders
2. Depression – Congresses

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CASE NO. 1

Major Depressive Disorder

IDENTIFYING DATA:

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

Presenting complaints

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

Behavioral observation

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

Symptoms.

- Lack of appetite
- Lack of interest in daily activities

- Hopelessness
- Helplessness
- Lack of sleep
- Burden on head and heart
- Weeping spells

Personal and family history

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

History of present illness

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

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

Pre morbid personality

Before illness client was living like a normal person. He was very social, healthy

and friendly. He was very extrovert and interested in daily activities. He was very active and energetic about his work. He loved to obtain parties and solve the problems of his family. He was very responsible and easily make decisions.

Onset of illness

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

Medical/psychiatric history

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

Test Administered

1. Beck depression inventory

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

2. Rotter Incomplete Sentence Blank Test

He attempted 36 items out of 40 items and scored 135 which shows that he was maladjusted.

Case formulation

A case of 40 years old male client belongs to lower middle class family. Ha had eight siblings and his birth order was second. His mother and father were alive. All his siblings are married and living with their own families.

He is married and father of four children. He had no addiction like smoking or drugs etc. Six months back his brother in law was murdered. From that time he gradually

developed the symptoms of headache, hopelessness, lack of interest etc but gradually these symptoms became sever that's why he was admitted to hospital for treatment. According to psychoanalytical theory of depression Freud theorized that after the loss of loved one whether by death or most commonly separation or withdrawal many develop the symptoms of depression. This theory is the basis for widespread psychodynamic view of depression. As anger turned against oneself. Some researchers analyzed dreams and projective tests of depressed individuals reasoning that they should be mans of expressing unconscious needs and fears.

In the perspectives of cognitive theories of depression Beck defines that in childhood and adolescence depress individuals acquired a negative schema a tendency to see the word negatively through loss of parents social rejection of peers and criticism of teachers are acquired by depressed person are activated.

Whenever they encounters a new situation that resemble in some way perhaps only remotely. The following list describes some of the principle of cognitive development basis of the depressed individuals according to Beck.

Arbitrary influences which are drawn in the absence of sufficient evidence. The selective abstraction is that which drawn on the basis of many elements in a situation. The overgeneralization is a sweeping conclusion drawn on the basis of single trivial events.

MULTIAXIAL ASSESSMENT

Axis I	major depressive disorder without psychotic features (296.2)
Axis II	nil
Axis III	nil
Axis IV	problem with primary support group
Axis V	GAF (60) current

Therapeutic recommendations

1. Cognitive Behavior Therapy
2. Drug therapy
3. Relaxation training

Prognosis

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

Cannabis Dependence Disorder

IDENTIFYING DATA:

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

Presenting Complaints

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

Behavioral observation

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

Symptoms

- Headache
- Nausea and vomiting
- Muscle aches
- Loss of appetite
- Restlessness
- Fatigue
- Body aches

Personal and family history

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

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

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

History of present illness

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

At the age of 18 he started taking cigarettes. In the beginning he used to take

cigarettes only but after four years he started taking marijuana under the pressure of his friends.

Pre morbid personality

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

Onset of illness

His present illness started when he was 27 years old.

Medical and psychiatric history

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

Test Administered

1. Manifest anxiety scale

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

Rotter's incomplete sentence blank (RISB)

the total score on RISB was 136 which shows that he was maladjusted towards life.

Case formulation

This is the case of 28 years old male. He belonged to a middle class family. The client had one sister and two brothers. His birth order was last.. His father was a govt employ. He didn't have any psychological or neurological problem before the ailment. And he didn't face any accident in his childhood.

At the age of 22 he got married. It was his love marriage. He didn't have any economical problem. He had been addicted due to the bad company he kept. He become

addicted at the age of 23. This was the second admission of the client. At this admission he himself wanted ti get rid of marijuana. According to client he started taking drug under the pressure of his friends.

According to social theorists environment pressure causes individual to become addicted. Socio cultural variables play a vital role in drug abuse. From the effect of peers and parents to the influence of the media and what is considerable acceptable behavior in a particular culture. The social world can effect people interest in and access to drugs.

MULTIAXIAL ASSESSMENT

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

Therapeutic recommendations

Individualized drug counseling

It has been researched that drug addicts who add individualized drug counseling as a part of their drug rehabilitation programs are more successful than recovering addicts who merely cease use. The role of the drug counselor is to help the client deal with the emotional and environmental consequences of disease.

Controlled environment

The client should be placed in controlled environemnt where access to the drug is restricted . This environment should closely be monitored and supervised like free jails

therapists communities or lock hospital units.

Detoxification and managed withdrawal

Detoxification is generally considered a precursor or a first stage of treatment because it is designed to manage acute and potentially dangerous physiological effects of stopping drug use.

Relapse prevention training

For this client's relapse prevention program is compulsory as he fist lefts his habit of addiction and started again marijuana. Relapse is understood to be regression in a person medical condition after they have been in recovery from a particular illness for a period of time. In the world of addiction, substance abuse addiction relapse is understood to be when one returns to using drugs after a period of abstinence. Some drugs addiction relapse prevention guidelines are

1. Regularly attend groups
2. Embrace a daily regimen of exercise and healthy eating
3. Get involved in supportive therapy
4. Maintain a relationship with a primary addiction treatment provider
5. Speak to other recovering people several time a day.

Prognosis

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

CASE NO. 3

Generalized Anxiety Disorder

IDENTIFYING DATA:

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

Presenting complaints

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

Behavioral observation

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

Symptoms

- Aggressive behavior
- Restlessness
- Fatigued
- Difficulty to concentrate
- Palpitation
- Muscle tension
- Sleep disturbance
- Irritability

Personal and family history

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

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

History of present illness

Its history goes back to 6 months. The reason was that he had a project in his office which he had to complete in two days. He slept only for 3 hours in two days. After

the completion of this project, he could not sleep. He used to keep sweating and had poor concentration. Whenever anyone assigns him any office work, he easily became fatigued, irritated and aggressive. Pressure on head increases, became restless and gradually his condition become severe. He was brought to hospital by his son.

Pre morbid personality

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

Onset of illness

The illness started 6 months back

Medical/Psychiatric history

No significant medical or psychiatric history

Tests Administered

1. Beck Anxiety Scale

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

2. Rotter's incomplete sentence blank (RISB)

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

3. House Tree Person

Anxiety is shown by the line quality. Drawing shows that the person is

aggressive. Whereas with poor interpersonal relationships. He is not very social. Weak ego is shown by the weak trunk. He is sensitive to social criticism.

Case formulation

The client belonged to middle class family. His mother and father were alive. They were 9 siblings and his birth order was second among them. All his brothers and sisters were married. The client was married and had 6 children, 4 daughters and two sons.

He had a project in his office which he had to complete in two days. He slept only for 3 hours in two days. After the completion of this project, he could not sleep. He used to keep sweating and had poor concentration. Whenever anyone assign him any office work, he easily became fatigued, irritated and aggressive.

Multi Axial Assessment

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

THERAPEUTIC RECOMMENDATIONS

Behavior therapy

Relaxation training

Cognitive behavior therapy

Drug Therapy

aggressive. Whereas with poor interpersonal relationships. He is not very social. Weak ego is shown by the weak trunk. He is sensitive to social criticism.

Case formulation

The client belonged to middle class family. His mother and father were alive. They were 9 siblings and his birth order was second among them. All his brothers and sisters were married. The client was married and had 6 children, 4 daughters and two sons.

He had a project in his office which he had to complete in two days. He slept only for 3 hours in two days. After the completion of this project, he could not sleep. He used to keep sweating and had poor concentration. Whenever anyone assign him any office work, he easily became fatigued, irritated and aggressive.

Multi Axial Assessment

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

THERAPEUTIC RECOMMENDATIONS

Behavior therapy

Relaxation training

Cognitive behavior therapy

Drug Therapy

Prognosis

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

CASE NO. 4

Bipolar II (hypomania)

BIODATA

Name	Tanveer
Age	33years
Sex	Male
Education	Middle
Marital Status	Married
Birth order	4th born
Religion	Islam
Sibling	Three brothers three sisters
Parents	Alive
Education of Father	Primary
Education of Mother	Illiterate

Referral	Father
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. Tanveer was 33 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 a village. He belonged to a middle class family of three brothers and three 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 4th 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. Tanveer was 33 years old 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 hospital 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

1 Mental status examination

2 Case History examination

3 H.T.P

4. R.I.S.B

5 B.D.I

INTELLECTUAL FUNCTIONING

He seemed to have intellectual deficiency. His total score on Ravens was 6 corresponding 5th 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.

8. Relaxation training
9. Behavior therapy

CASE NO. 5

Schizophrenia Disorganized type

IDENTIFYING DATA:

Name:	AF
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

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Presenting Complaints:

Duration of symptoms (5 year)

سر میں درد ہوتا ہے ۔

کانوں میں آوازیں آتی ہیں ۔

اداس رہتی ہے ۔

ضد کرتی ہے ۔

خود سے باتیں 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 problems become 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 at Bahawalpur. 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 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.

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.

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):

Quantitative Analysis:

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	N=3	P1=2
C2=5		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

Qualitative Analysis:

1: Familial Attitude:

Her attitude towards her family was positive. She said that she wants to go back her home. She likes her mother and father also. According to her she likes her home that is why he wants to go home.

2: Character Traits:

According to the client she could not bear failure in her life and she remains disturb all the time. She also said she does not about marriage because she has no idea about it.

3: General Attitude:

Client said she could not study regularly due to her failure generally he remains always depressed because her younger sister is intelligent.

4: Social & Sexual Attitude:

According to the client she likes herself and she also said that he when he was a child he was a good girl.

2. Emotional Quotient Test (EQT):

Her score of this test is 4 and it lies in below average.

1-6	Below Average
7-9	Average
10-12	High
13-15	Very High

MULTI AXIAL ASSESSMENT

Axis-I	295.10 Schizophrenia Disorganized type
Axis-II	None
Axis-III	None
Axis-IV	Problems with primary support group, Problem related to social environment
Axis-V	GAF=50 (current)

CASE FORMULATION

■ Miss AF 24 years old unmarried girl with the complaints of self laughing, self talking, aggressive behavior, for last 5 years. He was a patient of Disorganized Type Disorder. Following studies suggest that:-

"The excessive life stresses during 10 weeks prior to and actual schizophrenia break down caused schizophrenia" according to Brown (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006). In this case there was the family stress on client before the onset of the illness.

"Several studies shave shown that Schizophrenia is over represented among people of lower social class" according to Hallingshead and Relick (as cited in Michael

Gelder, Paul Harrison & Philip Cowen, 2006).

THERAPEUTIC INTERVENTION:

1. Behavior Therapy
2. Supportive Therapy
3. Drug therapy

CASE NO. 6

Major Depression

IDENTIFYING DATA

Name:	ABC
Age:	25years
Gender:	male
Education:	BA
Occupation:	teacher
Marital Status:	married
No. of Siblings:	male, 1 female
Birth Order:	last
Children:	ale 1, female 1
Referral Source:	himself
Parents alive/dead	father deceased
Dependent/independent	independent
Religion	Islam

Presenting symptoms:

- Loss of interest
- headache
- burden on head and heart
- hopelessness
- lack of sleep
- loss of concentration

- Lack of energy.

History of present illness:

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

Past psychological and medical history:

Patient having no past psychological & medical history

Pre morbid personality:

Before this problem his personality was stable

Tests applied:

- Beck Depression Inventory (BDI
- Manifest Anxiety Scale (MAS)

Test Results

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

School Record

He was a good student

Family History

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

Mental State Examination

- General Appearance: Good

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

MULTI AXIAL ASSESSMENT

Axis-I : Major Depression (296.2)

Axis-II : Nil

Axis-III : Nil

Axis-IV : Death of a family member

Axis-V GAF: 65 (Current)

THERAPEUTIC RECOMMENDATIONS

Cognitive therapy

Cognitive therapy is aimed at altering maladaptive thought pattern. The therapist tries to help the depressed person to change his or her opinion about the events and the self. Cognitive psychotherapy takes the form of helping patients become aware of their cognitive distortions or cognitive errors and the underlying assumptions of theses thoughts. The patient is then encouraged to seek evidence by which to support or refute these cognitive assumptions and to modify assumptions based on a more balanced view of all available information.

Drug therapy

Anti depressants are prescribed along with the psychotherapy. To find the most effective antidepressant medication with tolerable or fewest side effects, the dosage can be adjusted and if necessary, combinations of different classes of antidepressants can be

tried. People with chronic depression may need t take medication indefinitely to avoid relapse.

Prognosis

The patient had insight of his problem. He was responding well and cooperative so his chances of recovery seem to be favorable.

Opioid Withdrawal

IDENTIFYING DATA

Name:	ABC
Age:	22 Years
Gender:	Male
Education:	matric
Occupation:	-
Marital Status:	single
No. of Siblings:	7
Birth Order:	2nd
Children:	-
Dependent/independent	dependent
Father alive/dead	alive
Father's occupation	conductor
Mother alive/dead	alive
Religion	Islam
Referral Source:	mother

Presenting Complaints:

Anger, wants to leave drug addiction. When do not take drug, then feels pain in the body. Becomes aggressive sometimes. When the drug is not available then can do anything to take it.

Behavioral observation

The patient was young with normal height and body. His dress was clean. He had appropriate look, cleaned body, face and hair combed. He was cooperative.

Symptoms

- Headache
- Nausea and vomiting
- Muscle aches
- Loss of appetite
- Restlessness
- Fatigue
- Body aches

Personal and family history

The patient was born in attock. He had six sisters and he was the only brother of them. He was second born. His father is a bus conductor. His elder sister was married. He started to take heroine from last year. He started heroine due to the bad company of his peers. He was taking three cigarettes of heroines per day. Now he wanted to take rid of it. He worked for five years in POF hospital. But now he lost his job. His sleep was disturbed. His appetite was low.

He was friendly in nature. He had good recent memory. He was feeling guilty due to this bad habit of heroine addiction. He was cooperative to get treatment so that he was

showing much progress in his treatment.

History of present illness

The patient started heroine from last year. He started this because of the bad habit of heroine due to the pressure of his peer group. Because of this he suffered a lot.

Pre morbid personality

He was social and friendly before this problem. He was hard working. He was a responsible person. He was very caring before this bad habit.

Onset of illness

This problem started one year back. Patient started to take heroine.

Medical and psychiatric history

The patient had no previous medical and psychiatric history.

Case formulation

This was the case of young boy of 22 years of age. He was born in attock. His father was a conductor and mother was house wife. He was doing job in POF hospital from 5 years. He started to take heroine from the last one year. He started heroine due to the pressure of his peer group. He was taking three cigarettes of heroine everyday. This addiction disturbed his social and occupational functioning. He lost his job. He was feeling tiredness, decreased sleep and loss of appetite. . The patient was motivated to get rid of this addiction.

MULTI AXIAL ASSESSMENT

Axis I	Opioid withdrawal (292.0)
Axis II	no diagnosis
Axis III	no diagnosis
Axis IV	problem related to social environment
Axis V	GAF 65(current)

THERAPEUTIC RECOMMENDATIONS

Individualized drug counseling

Detoxification and managed withdrawal

Behavior Therapy

CASE NO. 8

Dysthymic Disorder

IDENTIFYING DATA:

Name:	Shamim Bibi
Sex:	Female
Age:	45 Year
Religion:	Islam
Marital Status:	Married (since 30 years)
Education:	None
No of siblings:	10 (3 brothers and 7sisters)
Birth order:	3rd
No of children:	6 (2 daughters and 4 son)
Informant:	Self

Presenting Complaints:

Duration of symptoms (6 year)

(1 سر میں درد ہوتا ہے

(2 نیند نہیں آتی

(3 کسی کام پر توجہ نہیں رہتی

(4 بھوک نہیں لگتی

(5 اکتاہٹ رہتی ہے

(6 کوئی کام کرنے کو دل نہیں کرتا۔

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 is 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 also intact.

■6. Insight:

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

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

Qualitative analysis

This result of the client shows that BHS scores of 7. This result also shows that the subject had some negative view of the self, some negative view of present functioning and less negative view of the future.

2. Rotter Incomplete Sentence Blank (RISB)

Quantitative Analysis:

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

Qualitative Analysis:

1: Family Attitude:

Her attitude towards her family was positive. She said that she feels loneliness in her home but she likes her children. According to her, her husband abused her a lot.

2: Character Traits:

She said that I want to know about my illness and her illness annoys her. She also said that people are good that it shows she is social. She said that her greatest fear is her health and greatest worry is also health.

3: General Attitude:

She said that at bedtime I become depressed and can't sleep. She likes the sports and she said that she can not sleep. She said that I need health. It means he spent his life with narrow limits. He likes girls and boys and she said that dancing is good.

4: Social & Sexual Attitude:

She said that boys are good. She likes people it means she likes social gathering. Her attitude towards marriage was positive it means she was satisfied with her marital life but her husband was not good with her.

MULTI AXIAL ASSESSMENT

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

CASE FORMULATION

Ms. Shamim Bibi is 45 years old married woman with complaints of unworthiness, crying spells for last 6 years. She was a patient of Dysthymic Disorder. Following studies suggest that:-

"Depressed people hold extremely negative views of themselves" according Joiner et al. (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006)

According to psychoanalytic "Depression is result of aggressive behavior and unconscious conflicts occurring in childhood" (Benjamin James Sadock, M.D., 2003).

"Depression is associated with stressful life events and risky environment" according to Kendler et al. (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006)

THERAPEUTIC INTERVENTION

The goals were attained through the following therapies:-

1. Cognitive Therapy
2. Rational Emotive Behavior Therapy
3. Interpersonal Therapy
4. Insight Oriented Therapy

CASE NO 9

Obsessive Compulsive Disorder

IDENTIFYING DATA

Name	:	xyz
Sex	:	Female
Age	:	17 Years
Education	:	Metric
Martial status	:	Single
Occupation	:	None
No of Children	:	None
No of Sibling	:	5
Birth order	:	1st
Dependent/independent	:	Dependent
Father alive/dead	:	Alive
Father's occupation	:	Property dealer
Mother alive/dead	:	Alive
Mother's occupation	:	House wife
Informant	:	Father & Mother
Religion	:	Islam
Bed#	:	20

PRESENTING COMPLAINTS

Hand washing again and again, aggressive, after attending wash room feelings that my clothes are not clean,. Obsessions about dirtiness.

BEHAVIORAL OBSERVATION

She was a young girl, heighten & bulky. She was un-clean. No makeup was applied on her face. She had established eye contact. Level of report was adequate. She had psychomotor over activity level.

She was reserve in nature. Her attention aroused easily. Her abbeys command. She was inactive. Patient's speech quantity was in between, neither talkative nor silent. The quality of speech was loud her mood was anxious. She had obsessions & compulsions in her thoughts. Her memory was good.

SYMPTOMS

Recurrent & persistent thoughts impulses or images that are experienced, at some line during the disturbance, as intrusive & inappropriate & that cause marked anxiety or distress.

- Repetitive behaviors (e.g., hand washing, ordering , checking)
- The obsessions or compulsions cause marked distress, are time consuming (take more then 1 hour), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.
- The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

PERSONAL & FAMILY HISTORY

Patient was born in Rawalpindi. She has three sisters & one brother. She was the 1st child. Her father is a property dealer. Her mother is a house wife.

Relation with her family was normal. Her father & mother was very friendly & cooperative. She had bit conflicts with her siblings some time don't obey her.

Patient was the student f class 10th. She was not friendly. She had no any friend. In school she seated quietly & don't respond to teachers.

She was showing such attitude from I year back. She thought that her sister & brother

will be happy if she go some other place. She wanted to go to her aunt's home.
She takes interest in cooking & other home task. She become aggressive on small issues.
She was showing such attitude from 1 year back. She thought that her sister & brother will be happy if she go some other place. she wanted to go to her aunts home.
She takes interest in cooking & other home task. She becomes aggressive on small issues.
She felt fear to bit alone. She was not very talkative. She had repetitive behavior like hand washing & re-checking doors & windows. She felt that she need to wash herself after coming from washroom.
Her appetite was increased. She had disturbed steep. She often had horrible dreams.
In her family there is a 2nd cousin of patient who was suffering with the same disorder. In mother & father, & all other siblings there is no such kind of problem.

HISTORY OF PRESENTING ILLNESS

Patient was completely symptom-free & was enjoying physical, psychological & social health form 1 year before. She had started treatment since last 4 months form psychiatry department of Pakistan institute of medical sciences.
She had taken weekly sessions & showed remarkable recovery.
The problem had started from, mild symptoms like obsessions of good & bad & then increased gradually.
Her symptoms affected on her social & occupational functioning. Her biological functioning like sleep & appetite also affected.

PRE MORBID PERSONALITY

When the patient was well, she was social. She liked to meet with others. She liked to make friends.
Before this disorder, she had a very good academics record. She was not aggressive at that time. But now she becomes aggressive socially detached & irresponsible. She had no

confidence. She can't make decisions. She becomes so lethargic now, takes too long to do a thing.

ONSET AT ILLNESS

Patient has suffering with this problem from last year. She has obsession thoughts. She has negative behavior about other.

Patients become very aggressive. She is very lethargic, has repetitive. She is very lethargic, has repetitive behavior like hand washing etc.

MEDICAL & PSYCHIATRY HISTORY

At the age of three, patient fall while playing with sibling & friends she got head injury. After that she got very stibbom. Her C7 Scan was clear.

Now with this problem. She is getting treatment from Pakistan institute of medical sciences. She is taking weekly session with psychologist & showed remarkable progress. Her obsessions reduced very much.

INFORMATION ASSESSMENT

- HTP
- RISB

FORMAL ASSESSMENT

House –Tree-Person

Patients drawing show avoidance to meet people. She is not an open personality & is not willing to interact with other even with some family members. Three are also some signs of aggression.

ROTTERS INCOMPLETE SENTENCE BLANK

This test developed by rotters. It measures the person's level of adjustment.

When patient's responses were calculated. He got a score of 139. Which shows a clear difficulty in this adjustment level?

CASE FORMUATION

This is the case of a young girl with 17 years of age, who had obsessions & compulsions in her thoughts & behavior

She has three sister one brother. She is the 1st child. Her father is a property dealer. Her mother is house wife. Her father & mother are very friendly & cooperative.

Patient had obsession thoughts & impulses. Her behavior was repetitive like washing hands again & again & checking door, windows & lights etc.

She was showing the attitude like this from 1 year back. She got aggressive on small issues at home. She had fear to go some where alone.

She is not friendly, had no any friend. She had increased appetite. Her sleep had decreased . she often had horrible dreams.

Patient is taking treatment Pakistan institute of medical sciences from last 4 months. Now she is very satisfied with her treatment & showed noticeable progress. Now she is much better & her obsessions & compulsions had reduced.

MULTI AXIAL ASSESSMENT

Axis I	Obsessive Compulsive disorder (300.2)
Axis II	no diagnosis
Axis III	no diagnosis
Axis IV	psychosocial problem
Axis V	GAF 60 (current)

THERAPEUTIC RECOMMENDATIONS

- **Psychotherapy**
- **Behavior therapy**
- **Cognitive behavior therapy**

PROGNOSIS

Patient has favorable chances to recover. She needs the cooperation of her family. She showed try to improve her will-power. Patient should also cooperate with doctors & psychiatrist.

CASE NO. 10

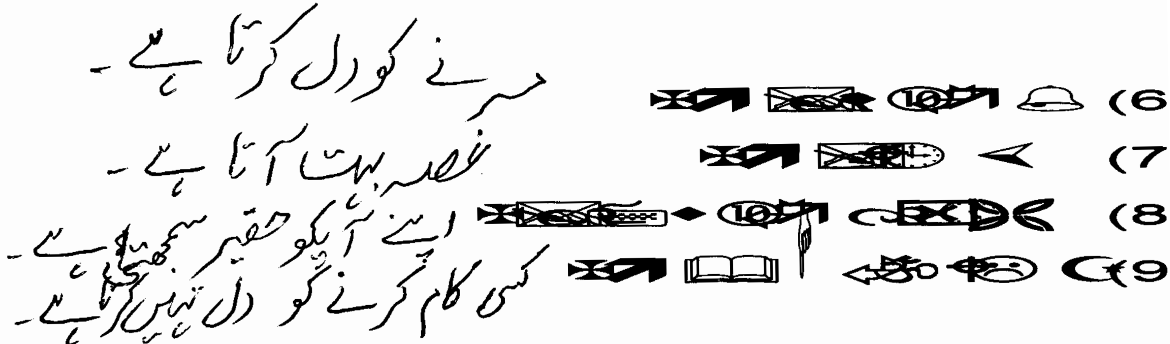
Major Depressive (single episode)

IDENTIFYING DATA:

Name:	NM
Gender:	Female
Age:	47 Year
Religion:	Islam
Marital Status:	Widow (since 04 years)
Education:	Nil
Occupation:	Household lady
No of siblings:	5 (2sisters & 3 brothers)
Birth order:	2nd
No of children:	Nil
Informant:	Self

Presenting Complaints:

1) نیند نہیں آتی۔
2) بھوک نہیں لگتی۔
3) ہر وقت روتا رہتا ہے۔
4) اداس رہتا ہے۔
5) اپنے آپکو بے یارو مددگار سمجھتی 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 خود کشی 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.

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.. 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

2. Rotter Incomplete Sentence Blank (RISB):

Quantitative Analysis:

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

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

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

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

Qualitative Analysis:

1: Family Attitude:

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

2: Character Traits:

She said that I want to know everything and everything annoys me. She also said that people annoy me that it shows she is not social and everything teases her. She said that her greatest fear and greatest worry is her brother and financial insecurity because he belongs to a poor family.

3: General Attitude:

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

4: Social & Sexual Attitude:

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

MULTI AXIAL ASSESSMENT

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

CASE FORMULATION

Ms. NMa is a 47 year old widow. She complained crying spells and unworthiness. She was a patient of Major Depressive Disorder. Following studies suggest that:-

■"Depression is associated with stressful life events and risky environments" according to Kendler et al. (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006).

"Depressed people hold extremely negative views of themselves" according to Joiner et al. (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006).

According to Interpersonal Therapist "The disease of depression occurs when individuals do not have proper socialization." (Michael Gelder, Paul Harrison & Philip Cowen, 2006).

According to Cognitive Therapist "The decease of depression is a result of wrong thinking." (Michael Gelder, Paul Harrison & Philip Cowen, 2008).

THERAPEUTIC INTERVENTION

The goals were achieved by using the following therapies.

1. Cognitive Therapy
2. Rational Emotive Behavior Therapy
3. Insight Oriented Therapy

CASE NO. 11

Post Traumatic Stress Disorder

IDENTIFYING DATA

Name	ABC
Age	55years
Sex	male
Education	Matric
Occupation	POF employee
Siblings	3
Marital status	Married
Birth Order	1st
No. of Children	Nil
Mother Alive or Dead	Dead
Father Alive or Dead	Dead
Father Occupation	Subedar
Religion	Islam
Referral Source	Brother

PRESENTING COMMPLAINTS

Headache, Sleep disturbance. Irritability, Feelings of Worthlessness, Flashbacks of events, Restlessness, Aggression. Trembling

BEHAVIORAL OBSERVATION

General appearance of the client was neat and tidy. He was a beard man of medium build. He had little eye contact. He had decreased activity with pauses in a very low tone. He was not disturbed with his noise but distracted with the presence of other people and their conversation. He had no orientation of month but had orientation of time and place. He had an insight of his problem. He showed irritative behavior throughout the time. He showed restlessness.

SYPMTOMS

- Sad mood
- Headache
- Insomnia
- Irritability
- Feelings of Worthlessness
- Flashbacks of events
- Restlessness
- Aggression
- Trembling

PERSONAL AND FAMILY HISTORY

The client belonged to a middle class family. He had two sisters and one brother. His birth order was 1st. his birth was normal. He was breast feeded for two years. His toilet training was normal. His milestones were normal. His mother was a house wife

and his father was a subedar. Client's family was not highly educated. He had not faced any incident, brain injury or any surgery in childhood. His father loved him very much. He was also very much attached to his father. After passing matriculation examination he started job at POF Sanjwal as a worker. His memory was very good. At the age of 27, he got married. His was a house wife. After 8 years of his marriage, he had a son. It was a great time of happiness for him. He loved him very much. He fulfilled all his requirements. He wanted to make his son happy all the time.

There was a quarrel between his family and some other family of his village due to some property. Unfortunately, when his son was of 20, the opponents came to his house and they murdered his son in front of him. This was so sudden that he could not do any thing.

After the death of his son (omer), client lost interest in nearly all activities. After 2 weeks, his relative was murdered. He became sad after his death. There were flash backs of events.. he showed restlessness, insomnia and aggressive behavior. He has been in this condition for the last 3 months.

His brother brought him to psychologist where he is now being treated.

HISTORY OF PRESENT ILLNESS

The client was 55 years old male. The problem started 3 month ago. He was having insight of his problem. Client was alright about 3months back and was regularly doing all his activities. About 3 months back he had faced his son's death and after his murder he repeatedly faced another such type of incident in his family. It makes his mind disturbed and he showed all symptoms of his illness. He was very much attached to his son, after his death he had sad feelings and even suicidal ideation.

The client persistently reported headache and dizziness. And painful thoughts came to his mind. The client became aggressive after his illness. The client had frequent flash back of his son's death and he dreamed about that event. Client felt detachment from

his son.

PREMORBID PERSONALITY

Before illness he was healthy, normal and social personality. He was very loving and caring to his family and friends. He was an extrovert person. He was good looking and well dressed person before the event of his son's murder.

ONSET OF ILLNESS

The client had chronic illness at the age of 55, about 3 months back.

MEDICAL AND PSYCHIATRIC ILLNESS

Before illness, he had no mood disturbance and any psychological problem. There is no psychological problem in his family. He had faced a road accident four years back, but he was treated well, so he had no medical problem now. There was no past medical or surgical history in client as he was quite healthy.

ASSESSMENT

To assess the client's problem following methods were being used.

- Informal assessment
- Formal assessment

INFORMAL ASSESSMENT

- Case history method
- Behavioral Observation

FORMAL ASSESSMENT

Following tests were administered in order to assess his problem.

- Rotter Incomplete Sentence Blank
- House Tree Person (HTP)

ROTTER INCOMPLETE SENTENCE BLANK

To assess the personality functioning of the client RISB was administered. The total score was 148 and cut off score is 135 and client's score shows his maladjustment.

HTP

On HTP, client has showed closed door which means he has feeling of insecurity. When windows are missing the individual is usually feeling anxious. Absence of pathway reveals difficulty in inters personal relationship. Roof shows his fantasy life. The tree drawing show individual has limited ego strength. There is no base which shows his feeling of insecurity. In male figure client didn't draw arms and omission of arms may indicate extreme depression and withdrawal from environment. There is no neck which shows his lack of impulse control.

CASE FORMULATION

This is a case of 55 years old man belonging to a middle class family. He had 2 sisters and 1 brother. His birth order was 1st. his milestones were normal. His father loved him very much and he also loved his father very much his mother was a housewife. After passing his matriculation examination, he joined POF as worker. At the age of 27 he got married and after 8 years of marriage he was bestowed with a son. He loved him very mush and fulfilled all his desires. He was attached very much with his son but unfortunately he was murdered in front of his eyes due to some property clashes. After his death he remained sad all the time and again after 2 week his relative was also murdered. This made him too much disturbed. His mother and father both were already died. There were flash backs of the events and he showed restlessness, aggressive behavior and insomnia. He has been in this condition from last 3 months therefore his brother took him to psychologist for treatment. He had suicidal ideation in his mind after the death of his beloved son.

The psychodynamic theory proposed by Horowitz Posits, that memories of traumatic events occur constantly in the person's mind and are so painful that they are either consciously suppressed or repressed. The individual is believed to engage in a kind of internal struggle to integrate the trauma into his or her existing beliefs about himself and the external world to make sense out of it. Same is the case with the client that such painful thoughts come into his mind about the incident that he repressed them and so he become aggressive.

Learning theorists assume that PTSD arises from a classical conditioning of fear. Based on the classical conditioned fear, avoidances are built up, and they are negatively reinforced by the reduction of the fear that comes from not being in the presence of conditioned stimulus.

MULTIAXIAL ASSESSMENT

Axis I	Post Traumatic stress Disorder (309.81)
Axis II	None
Axis III	None
Axis IV	Other Psychosocial and Environmental Problems
Axis V	GAF=75 (current)

THERAPEUTIC RECOMMENDATIONS

Following therapies are recommended for the patient.

Social Skill Training is useful for the patient. It can be used to treat people with marked impairment in social life. In this technique, patients are helped to learn social relations.

Relaxation Therapy includes the muscle relaxation. It is useful to reduce tension, anxiety and fatigue. In case of this patient relaxation training is also useful to reduce the anxiety about the event.

Covert flooding along with **Relaxation Therapy** has been proved very useful in the treatment of PTSD. The combination of these therapies help in reducing night mares and flash backs of the event. So this combination of therapies can be used for the treatment of patient.

PROGNOSIS

Prognosis seems good. First of all he wants to be healthy person and he willingly came to hospital with his brother and the second thing whish goes in his favor is that he is taking medicines regularly.

CASE NO. 12

Paranoid Schizophrenia

IDENTIFYING DATA:

Name:	Shoukat Hussain
Gender:	Male
Age:	30 Year
Religion:	Islam
Marital Status:	Married
Education:	Middle
Occupation:	Store Assistant
No of Siblings:	6 (5 brothers & 1 sister)
Birth order:	4th
No of children:	2 (1 son & 1 daughter)
Informant:	Self
Parents alive/dead	both alive
Independent/dependent	independent
Religion	Islam

Presenting Complaints:

low self-esteem, superstitious thinking, fearfulness, dreadful thoughts, agitation, irritability, persecutory thoughts, aloof behavior and suicidal attempts.

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 Assistant in Three Star Hosiery. 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 is 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 thoughts were present in his mind. Delusions were also present in his mind.

iii. Perception:

There were visual hallucinations and illusions were reported.

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 good.

Insight:

Client had no insight about his ailment.

TESTS ADMINISTERED

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	N=3	P1=2
C2 =5		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

Qualitative Analysis:

1: Familial Attitude:

His attitude towards his family was positive. He said that he wants to go back his home. He likes his mother and father also. According to him he wants to do work that is why he wants to go home.

2: Character Traits:

According to the client he could not bear abusive language and he remains disturb all the time because he has delusions. He also said he is against of marriage because his wife is not good with him.

3: General Attitude:

Client said he offers his prayers regularly generally he remains always depressed and thinks about his children very much.

4: Social & Sexual Attitude:

According to the client, he likes people and girls as well and he also said that he when he was a child he was a good boy.

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

MULTIAXIAL ASSESSMENT

Axis-I	295.3 Schizophrenia Paranoid Type
Axis-II	None
Axis-III	None
Axis-IV	Problems with primary support group.
Axis-V	GAF = 50-41 (Current)

CASE FORMULATION

Mr. Shoukat Hussain is a 30 year's old married man. He complained constant fear that his some opponents want to kill him and they chase him. He was a patient of Paranoid Type Disorder. Following studies suggest that:-

There is a small but clear environmental contributions to Schizophrenia" according to McGrath & Murray (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006).

"First degree relative with Schizophrenia studies provide clear evidence of a familial etiology" according to Kendler et al. (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006).

THERAPEUTIC INTERVENTION:

The goals were attained through the following therapies:-

1. Behavior Therapy
2. Cognitive Therapy
3. Rational Emotive Behavior Therapy
4. Drug Therapy

CASE NO 13

Generalized Anxiety Disorder

IDENTIFYING DATA:

Name:	Azra Parveen
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)
Parents alive/dead	alive
Independent/dependent	independent
Religion	Islam
Informant:	Self

Presenting Complaints:

Headache, shortness of breath, wildly racing heartbeat, profuse sweating, low self esteem.

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.

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 (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.

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.

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)
3. Hospital Anxiety Scale (HAS)

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

Neutral responses

Total response of N	6

Key

C3 =6	N=3	P1=2
C2 =5		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

26-63	Severe anxiety

2. **Rotter Incomplete Sentence Blank (RISB):**

Quantitative Analysis:

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

Qualitative Analysis:

1: Familial Attitude:

Her attitude towards her family was not positive. She likes her husband but he beats her very much. She also likes her children, but she is depressed.

2: Character Traits:

She said that she wants to live alone. It means she is not social and she does not like to meet others. She said that she feels sadness all the time. She likes sports and don't want to read books.

3: General Attitude:

She liked her school life. She said that I want to recover. She was totally dishearten and hopeless from her disease.

4: Social & Sexual Attitude:

She said that she does not like boys and has no interest on boys. She does not like to meet others and talk to others. She is not social and wants to live alone, but she likes dancing. Before her illness, she liked people.

3. Hospital Anxiety Scale (HAS):

In this hospital anxiety scale, the client got 13 score which shows that he has Severe Anxiety.

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

MULTIAXIAL ASSESSMENT

■	Axis-I	Generalized Anxiety Disorder (300.02)
	Axis-II	None
	Axis-III	None
	Axis-IV	Problems in primary support group
	Axis-V	GAF=60 (current)

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)

THERAPEUTIC RECOMMENDATIONS

1. Cognitive Behavioral Therapy.
2. Rational Emotive Behavior Therapy
3. Drug Therapy

CASE NO 14

Opioid Withdrawal

IDENTIFYING DATA:

Name:	Shoukat Akram
Gender:	Male
Age:	45 Years
Religion:	Islam
Marital Status:	Married
Education:	Middle
Occupation:	Factory Worker
Monthly income:	4000

No of siblings:	4 (3 sisters & 1 brother)
Birth order:	1st
No of children:	3 (2 daughter & 1 son)
Informant:	Self

Presenting Complaints:

Pain in the body. Cant concentrate in any kind of work. Low appetite. Anger. When take heroine then feels comfortable. Vomiting.

History of Present Illness:

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

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

Past Psychiatric Illness:

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

Family History:

His father is 60 years uneducated old man and is a farmer by occupation. His father is temperamentally cool and has good relations with his children. His mother is 63

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

His home environment was not satisfactory. He wanted to spend most of time out of his home. The client was married 17 years ago. His marriage was arranged. His wife did not take care of him. She often quarreled with him over minor issues and financial problems. He used to beat his wife off and on. The client had 3 children, two daughters and one son. He did not give full attention to them. Daughter was 15 years old. She was in class 9th. She loved her father a lot. Son was 10 years old, study in class 3rd. All his children loved him, but he did not give full attention to them.

Personal History:

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

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

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

Pre-morbid Personality:

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

INFORMAL ASSESSMENT:

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

1. Behavioral Observation:

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

2. Mental Status Examination:

i. General Appearance:

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

ii. Speech:

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

Emotional Expressions:

i. Objective:

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

ii. Subjective:

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

4. Thinking and Perception:

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

5. Sensorium:

i. Alertness:

Client was conscious at the time of interview.

ii. Orientation:

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

a. Person:

His orientation about person was normal.

b. Place:

His place orientation was also normal.

c. Time:

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

iii. Concentration:

His concentration about questions was good.

iv. Memory:

His memory was very good.

Insight:

Client had insight about his addiction.

TESTS APPLIED

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

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

1. Rotter Incomplete Sentence Blank (RISB):

Conflicts responses

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

Positives responses

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

Neutral responses

Total response of N	3

Key

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

Total scores of responses

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

Qualitative Analysis:

1: Familial Attitude:

His attitude towards his family was very positive and he wants to join his family again. He also loves his children very much and attached with them. He loves his family very much.

2: Character Traits:

He said that he used drugs but feels regression on it and wasted his time in using drugs. He also said that he could not stop himself to taking drugs. He said that I am best when I was not taking drugs.

3: General Attitude:

He said that at bed time I can't sleep and my greatest fear is that I don't want to take drugs again. He was very afraid of taking drugs and he wants to withdrawal drugs. According to him, his mind and nerves are very weak.

4: Social & Sexual Attitude:

He said that he does not like the boys and people because they started him drug. He said he likes the girls and he is satisfied from his marital life

2. Clinical Anger Scale (CAS):

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

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

3. Hospital Anxiety Depression Scale (HADS):

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

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

MULTI AXIAL ASSESSMENT

Axis-I	292.0 Opioid Withdrawal
Axis-II	None
Axis-III	None
Axis-IV	Occupational problem.
Axis-V	GAF = 60 (Current)

CASE FORMULATION

Mr. Shoukat Akram is 45 years old married man with the complaints of pain in body, tremors, diarrhea for last 6 years. He was heroin addict. This was a case of Opiod Withdrawal. Following studies suggest that:-

"Study reported thus drug use by individual is influenced by the substance use of their peers. There are also links between drug misuse and indices of social deprivation such as unemployment and homelessness" according to Gill et al. (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2007).

THERAPEUTIC RECOMMENDATIONS

1. Detoxification
2. Behavior Therapy
3. Cognitive Therapy
4. Religious Therapy
5. Relaxation Training

CASE NO 15

Post Traumatic Stress disorder

IDENTIFYING DATA:

Name	-
Age	45 Yrs
Gender	Female
Education	B.A
Martial Status	Married
Dependent/Independent	Dependent
No of siblings	4 Brothers,4 Sisters
No of Children	1 Daughter
Parents alive/dead	Alive
Religion	Islam
Informant	Herself

PRESENTING COMPLAINTS: -

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

BEHAVIOURAL OBSERVATION: -

The patient was attentive. Her appearance was according to her age. Although, she was Dressed properly, but was self neglected towards personal hygienic condition. She Maintained an eye contact, but her speech was quite strange and irrelevant to the topic. The tone of her voice was low. Sometimes during the session. She showed rather

Exaggerated or startle responses. As she had prominent weeping spells. In order to divert Attention, she continuously tapped her both legs and with regular intervals, she spitted Around her bed.

SYMPTOMS:

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

PERSONAL HISTORY:

Patient basically belonged to the lower class family. There were no prenatal and Postnatal complications with her. She achieved her developmental milestone

Normally. She had four sisters and four brothers. She was eldest of all. being eldest

She was very short tempered and bossy. She could not continue her studies after Her B.A. because of financial problems.

At the age of 35 years, she got married. Her husband was in army that's why he

Had a very limited salary. She was the second wife of her husband and had a son Of her husband to bring him up. Age differences was very obvious in this Marriage. Quite unfortunately, her husband did not prove to be a good responsible Husband. He was an alcohol and heroine addict so could not pay of due attention to His family.

After 5 years of her marriage, she delivered a baby girl. That was very shocking News for her husband and in response to the situation, he became totally Unconcerned about the family affairs. That unexpected attitude of her husband Proved to be an important stressor in her life.

In-spite of the facts, she brought her daughter up with extra care, attention and love

But her happiness was very short lived. Because when her daughter was 2 years Old, her physical conditions and health started deteriorating.

She was very shocked to receive the news that her daughter was suffering from Sever breathing problem and coronary heart problem. She simply collapsed and Then suddenly, there was a twist in her life when she witnessed her daughter Having so much difficulty in breathing in ICU and just in a few moments later, she

Saw her died because of congested and troubled breathing. That scene was then, Impersonalized on her memory as" A Permanent Scar" that can never ever be Abolished or removed. That was the time when she desperately needed her Husband's moral support but she was deprived of that. She was preoccupied with The themes of being persecution and self-accusation. She started blaming herself All her miseries and bad luck. There started a battle (sever conflict) between her Mind and the body, which was, worsened her Physical and Psychological health And the onset of symptoms manifested quite clearly.

HISTORY OF PRESENT ILLNESS:

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

PREMORBID PERSONALITY:

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

ONSET OF PRESENT ILLNESS:

Onset of present illness was manifested for the first time when she witnessed her

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

PHYCHIATRIC TREATMENT:

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

CASE FORMULATION:

The present case is about a middle class married woman of 45 years who suddenly collapsed at the sudden terrible death of her only daughter suffering from coronary heart disease and breathing problem This was the main traumatic incident for the patient because she had witnessed the last stage of her 2 years old daughter .she could never forget her daughter Who had a great difficulty in breathing and she was just looking her so Helplessly. These all factors contribute to the development of PTSD.

MULTI AXIAL ASSESSMENT

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

Axis 5 GAF 65 (current)

Tests Administered

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

1.MAS:

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

2.RISB:

Score of RISB is 182 that indicate her severe maladaptive personality. She has given many answers against her husband.

THERAPUTIC RECOMMENDATION:

Following suggested therapies can be helpful for the patient in alleviating anxiety.

FAMILY THERAPY:

Family therapy can be the best source of remedy for a dejected and depressed Person .

COGNTIVE BEHAVIORAL APPROACH:

These approaches have attempted to teach the PTSD victims new skills for coping so that they can more effectively manage and re-establish social ties with others who can provide on going support.

Adopting and learning different coping skills making her self-busy in mantel physical activity can improve patient. This will be very beneficial for patient of PSTD..

Behavior Therapy

Relaxation Training

DRUG THERAPIES:

Drug therapies include drugs to reduce anxiety.

PROGNOSIS:

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