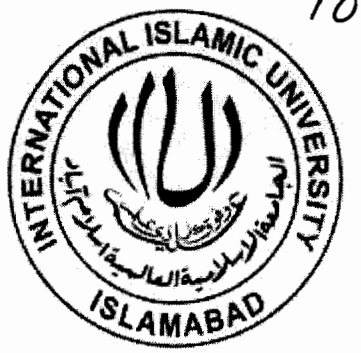
DIAGNOSTIC CASE HISTORIES



Submitted to

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MS
153.85
ALD

1- Attitude (Psychology) - Testing.
2- Behavior modifications.

Table of Contents

CASE 1

(Substance Induced Psychosis)

BIO-DATA

Name	XYZ
Age	29 years
Sex	Male
Education	Middle
Occupation	labor
Marital Status	Married
Birth order	4th born
Religion	Islam
Sibling	four brothers two Sisters
Parents	Both alive
Education of Father	Primary
Education of Mother	Illiterate
Past Psychiatric history in Family	No
Past medical history of patient	No

BEHAVIORAL OBSERVATION

Mr. XYZ was young man of 29 years .His dress was shabby with dirty hair and long beard. He was disoriented to place and answered in inappropriate way and had poor eye contact during session. He totally denied cooperating during tests. Overall his behavior was uncooperative.

Presenting Complains

Persecution delusions

Hallucination

Disturb Sleep

Isolation

Smoking

Irritable mood

Sense of Deprivation

Self Criticism

FAMILY HISTORY

He belonged to middle low class family of five brothers and three sisters. His both parents were alive his mother was healthy. But his father was schizophrenic patient.

He was 4th born child in his family. The attitude of his siblings was un-

cooperative and he told that he had joint family system and home environment was not good. His all brothers and sisters were married. He had good terms with his mother.

PAST PERSONAL HISTORY

Mr. XYZ was a young man of 29 years and was the 4th born child of his family. His birth was normal. He born in a family with very low economic status because of his father irresponsible attitude he started to use drugs at the age of 18 years.. He often stole the things to buy the drugs.

HISTORY OF PRESENT ILLNESS

He had been admitted to hospital by his mother one year ago due to addiction. During the treatment his prognosis was satisfactory. But due to bad company and unsupportive family environment he started this habit again. Now for the second time he was admitted with drugs induce psychotic symptoms. He had a suicidal ideation and persecution feelings.

EVALUATION TECHNIQUES

He totally denied completing the tests.

1. Mental status examination

2. Case History examination

INTELLECTUAL FUNCTIONING

His recent and remote memory seemed to be good as he could recall most of the

past and present events easily.

He had poor orientation of time, place and person. He knew about his name, but he did not know the name of his mohala where he was living. He did not know the name of his father and friends.

CASE FORMULATION

Mr. XYZ was a young man of 29 years from a poor class family. He was married. He was the 4th born child in the family of 4 brothers and 2 sisters. His education was middle. It was patient 2nd admission to hospital for the treatment of drug addiction.

He had severe symptoms as grandiosity delusion, persecutory delusion, suicidal ideation, abusive, smoking, disturbs sleep, irritable mood, heroine dependence,

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

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

The essential features of Substance-Induced Psychotic Disorder are prominent hallucination or delusions (Criteria A) that are judged to be due to the direct physiological effects of a substance (Criteria B). hallucinations that the individual realizes are substance induced are not included here and instead would be diagnose as

substance intoxication or substance withdrawal with the accompanying specifier with perceptual disturbance. The disturbance must not be better accounted for by a psychotic disorder that is not substance induced (Criteria C). The diagnosis is not made if the psychotic symptoms occur only during the course of a delirium (Criteria D) (DSM IV-TM).

Presenting complains and the mental examination status supports our diagnosis that the patient tends to have Substance Induce Psychotic Disorder.

TENTATIVE DIAGNOSIS

Axis I	292.12 substance induced psychosis
Axis II	Nil
Axis III	Nil
Axis IV	Poor Interpersonal Relations
Axis V	GAF = 55 (current)

PROGNOSIS

As his symptoms were severe and have long history, so prognosis is not good.

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to him

1. Supportive therapy

2. Relaxation training

3. Cognitive Behavioral therapy

4.Detoxification

5. Pharmacotherapy

6. Antipsychotic drugs

(Olanzapine, Clozapine)

CASE 2

(Schizoaffective Disorder)

BIO-DATA

Name	ABC
Age	30 years
Sex	Male
Education	FA
Marital Status	Unmarried
Birth order	4th born
Religion	Islam
Sibling	four brothers one sister
Parents	Alive
Education of Father	Middle
Education of Mother	Primary
Referral	mother
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION —>

Mr. ABC. was a young man of 30 years old. His complexion was fair and his dressing was appropriate. There were signs of trembling in his hands and his voice tone was not appropriate as well as his affect. He was well combed and his teeth were also brushed. He had poor eye contact and sometime started self talking.

Presenting Complains

Depressed mood

Loose association

Trembling

Abusive

Guilt feeling

Inappropriate affect

Refusal to eat

Aggression

Disturb sleep

Self talking

Irritable mood

FAMILY HISTORY

He belonged to a middle class family of four brothers and one sister. His father education was just middle. His parents were alive. His father is security guard. His grandfather loved 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 independent family system. He was unmarried but wanted to marry. According to client his parents enforce him to work with care.

PAST PERSONAL HISTORY

Mr. ABC. Was a young man of 30 years and he reported that he born at home with normal delivery. Accordingly to client his childhood was good and he spent it happily but once he fell down from wall during playing and got injury on his head. He was not an intelligent student and also had less interest in education therefore he ran away from home with his friends. He gave all attribute of his education to his teachers that they were very nice and helped him a lot.

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

HISTORY OF PRESENT ILLNESS

This was patient's 2nd psychiatric admission to hospital. The main reason behind

his admission was his aggressive and depress mood because he had less emotional control. He liked to go on tombs.

EVALUATION TECHNIQUES

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

1. Bender Gestalt test
2. H.F.D
3. R.I.S.B
4. Mental status examination
5. Case History examination

INTELLECTUAL FUNCTIONING

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.

PERSONALITY FUNCTIONING

Mr. ABC. was a young man of 30 years. He belonged to middle class family. He was the 4th born child in the family of four brothers and one sister. This was patient's 2nd psychiatric admission to hospital.

RISB, HFD was administered to check the personality functioning of patient.

Patient score on RISB is 106 with a cut score of 135. It indicates that he is well adjusted person (Rotter, 1932).

On the basis of HFD, it shows that he has aggression indicated by fingers like stick and chin enlarge. He has guilt feeling and security as indicated by hands large and mouth open (Hammer & Levy). He has also auditory hallucination and schizoid traits as indicated by ear emphasized and ear enlarge (Buck, 1966).

CASE FORMULATION

Mr. ABC was a young man of 30 years from a middle class family. He was unmarried. He was the 4th born child in the family of 4 brothers and 1 sister. His education was FA and army person by occupation.

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

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

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

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

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

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

TENTATIVE DIAGNOSIS

Axis I	295.70 Schizoaffective
Axis II	Nil
Axis III	Nil
Axis IV	Poor Interpersonal relationship
Axis V	GAF = 21-30 (current)

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to W.A.

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

5. Anipsychotic drugs

(Respredon, Clozapine)

CASE 3

Disorganized schizophrenia

IDENTIFYING DATA:

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

Reason for Referral:

Client was referred to Psychiatrist, with the symptoms of headache, blurred vision, self laughing, self talking, and aggressive, hearing voices, abusive and bizarre & stubborn behavior.

Presenting Complaints:

Duration of symptoms (5 year)

History of Present Illness:

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

Her younger sister had very pleasant social life with many friends; meanwhile client started developing inferiority complex. Client had no social life or friends. This

was the main cause of tension for her. Her younger sister was college student. Her younger sister used to wear beautiful dresses at college functions. She started having inferiority complex that her sister was living better life than her. During education her younger sister got married and spending a happy life.

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

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

Client treatment started in Social Security Hospital. She was admitted there for 20 days. Psychiatrist of Social Security Hospital Lahore referred to psychologist at Khawja Farid Social Security Hospital Multan for client convenience, as its near client's home.

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 and homocidal thought were present in his mind. Delusions were also present in his mind.

iii. Perception:

There were auditory hallucinations and illusions were reported.

5. Sensorium:

i. Alertness:

Client was conscious at the time of interview.

ii. Orientation:

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

iii. Concentration:

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

vi. Memory:

Her memory was good.

a. Immediate:

To check his immediate memory I asked her to repeat the words.

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

b. Recent memory:

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

v. Calculations:

Simple arithmetic calculations were done like:

2 + 2 = 4

4 + 4 = 8

8 + 8 = 16

16 + 16 = 32

She had difficulty in complex questions.

6. Insight:

Client had no insight about her ailment.

7. Judgment:

Her judgment about environment, social norms, herself and other persons was not good.

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)

3. 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

DIAGNOSIS

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

Axis-I 295.10 Schizophrenia Disorganized type

Axis-II None

Axis-III None

Axis-IV Problems with primary support group, Neglect of child, Problem related to social environment inadequate social support.

Axis-V GAF=50 (current)

CASE FORMULATION

Miss Anees Fatima is 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:

The goals were attained through the following therapies:-

1. Behavior Therapy
2. Supportive Therapy
3. Earplug Therapy

Post-testing:

Rating Scale:

1 2 3 4 5 6 7 8 9 10

Headache	3
Self laughing	3
Self talking	4

Auditory Hallucinations	4
Irritability and Agitation	5
Sadness	2

CASE 4

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)
Informant:	Self

Reason for Referral:

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

Presenting Complaints:

Duration of symptoms (1 year)

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 [redacted] 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:

[redacted] 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.

[redacted] 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.

a. Immediate:

To check her immediate memory I asked her to repeat the words:

b. Recent memory:

To check her recent memory:

2, 6, 1, 4, 7

7, 5, 4, 2, 1

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

v. Calculation:

Client attention and concentration was normal as manifested by appropriate answers. She successfully completed 07 Serial tests.

100-7=93

93-7=86

86-7=79

6. Insight:

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

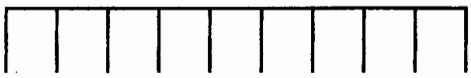
7. Judgment:

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

FORMAL ASSESSMENT:

Pre-testing:

Rating Scale:



1 2 3 4 5 6 7 8 9 10

Headache	7
Fatigue	6
Laziness	8
Lack of Appetite	5
Lack of sleep	6
Pain of body	7

Symptoms check list-R:

Scales	Raw scores	SD	Significance

III	74	2	40

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

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
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

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

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

DIAGNOSIS

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

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

1. **Behavior Therapy**

   Relaxation training

2. **Supportive Therapy**
3. **Drug therapy**

CASE 5

Dysthmic 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

REASON FOR REFERRAL:

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

Presenting Complaints:

Duration of symptoms (6 year)

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.

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. As when I asked her:

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.

a. Immediate:

To check her immediate memory I asked her to repeat these words:

b. Recent:

To check her recent memory

2, 6, 1, 4, 7
6, 7, 4, 2, 1

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

v. Calculation:

About his calculation:

$$300 + 600 - 700 + 300 + 600 = 1100$$

5. Insight:

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

7. Judgment:

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

FORMAL ASSESSMENT:

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

Pre-testing:
Rating Scale:

	1	2	3	4	5	6	7	8	9	10

Lack of sleep	10
Lack of Appetite	8
Irritability	4
Lack of energy	9
Poor Concentration	9

Headache	8

Symptoms check list-R:

Scales	Raw scores	SD	Significance
I	50	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. Hospital Depression Scale (HDS)
3. The Hamilton Rating Scale for Depression (HAM-D)
4. Beck Hopelessness Scale (BHS)
5. 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

Hospital Depression Scale (HDS):

Client got 11 score in this scale, which indicates severe depression in the client.

Mild	40-31
Moderate	30-21

Severe	20-11
Very Severe	10-0

2. The Hamilton Rating Scale for Depression (HAM-D):

Client got 25 score in this scale which indicates moderate depression in the client.

Absence range	0-7
Mild	8-17
Moderate	18-25
Severe	26-onwards

3. Beck Hopelessness Scale (BHS):

Quantitative analysis:

This table is showing the quantitative analysis of BHS.

Score	Severity level	Obtained score
4-8	Mild	7

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.

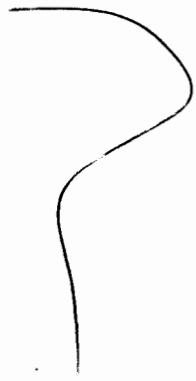
5. Rotter Incomplete Sentence Blank (RISB):

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.

DIAGNOSIS

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

Axis-I	300.4 Dysthymic disorder
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).

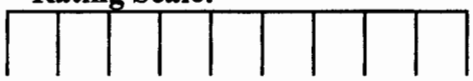
"Depression is associated with stressful life events and risky environment" according to Kendler et al. (as cited in Michael Gelder, Paul Harrison & Philip Cowen, 2006)

THERAPEUTIC INTERVENTION

The goals were attained through the following therapies:-

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

Post-testing:
Rating Scale:

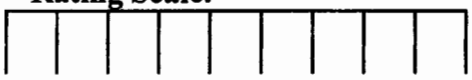


1 2 3 4 5 6 7 8 9 10

Lack of sleep	3
Lack of Appetite	2
Irritability	3
Lack of energy	4
Poor Concentration	5
Headache	2

Post- Testing:

Rating Scale:



1 2 3 4 5 6 7 8 9 10

Headache	3
Fatigue	2
Laziness	1

Lack of Appetite	3
Lack of sleep	2
Pain of body	1

CASE 6

Major Depressive Disorder

IDENTIFICATION OF DATA

Name	:	ABC
Sex	:	Female
Age	:	37 Years
Education	:	Illiterate
Martial status	:	Married
Occupation	:	House Wife
No of Children	:	7
No of Sibling	:	4
Birth order	:	1st
Dependent/independent	:	Dependent
Father alive/dead	:	Alive
Father's occupation	:	Driver
Mother alive/dead	:	Alive
Mother's occupation	:	House wife
Informant	:	None
Religion	:	Islam
Bed#	:	16

PRESENTING COMPLAINTS

Low mood, lack of appetite, loss of energy, lack of sleep. Headache. Fatigue. Disappointed. Hopelessness.

BEHAVIORAL OBSERVATION

A middle aged woman with normal height. Her dress was clean but hair was not combed. She had no established eye contact.

She was inactive, looked tired. she was depressed. She was silent type, just replying for what was being asked. She was not talking interest in interview. His mood was depressed.

She was showing passivity in her thoughts. She had suicidal ideation.

SYMPTOMS

- Depressed mood most of the day, nearly every day, as indicated by either subjective report(e.g., fees sad or empty) or observation made by others (e.g, appears tearful)
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
- Fatigue or loss of energy nearly every day.
- Diminished ability to think or concentrate.

ROTTERS INCOMEPLETE SENTENCE BLANKS

This test was developed by rotters. It is used to measure a person's adjustment level. This test has 21 items. It is widely used & recognized.

When the scores of patient were calculated, she got a score of 142.

BECK DEPRESSION INVENTORY

Back depression inventory was developed by beck. This is very good test to measure depression level in a person. This test is widely used & recognized.

The score of patient was 30-39 , which shows sever depression on her.

CASE FORMATION

This is the case of a middle age women, she was born in Mansehra. Patient has 2 sisters & one brother. Her father is driver as a profession. Her mothers is house wife. she had married with her cousin in 1987. she has 7 children. Her life going happily but before 12 months, her husband settled in abroad become of his job. This made her very depressed. She was not ready for all this, she become isolated. She feels alone all the time.

Patient was feeling depressed all day long. Her mood was sad. She doesn't want to talk anyone. She lost her interest in all activities of life's. she was even properly noticing her children. She often shout on her children.

Before this problem, she was spending a happy married life. She was social & like to meet with others. Her attitude to wards work was responsible. She had a positive world view. Patient was very sensitive, so she felt her husband's reparation very deeply. She had disturbed sleep & loss of appetite. She easily fatigued. For her treatment, she came in Pakistan institute of medical sciences she admitted there & was getting medications & sessions with psychologist.

MULTI AXIAL ASSESSMENT

Next Page.

Axis 1	Major depressive episode (296.2)
Axis II	V71.09 diagnosis
Axis III	None
Axis IV	Problems related to social environment.
Axis V	GAF=50 current

THERAPEUTIC RECOMMENDATION

- **Interpersonal Therapy**
- **Cognitive Behavioral Therapy**
- **Psychoanalytically Oriented Therapy**
- **Family Therapy**
- **Medical Therapies**

Prognosis

Patient has chances to recover. But it needs her own will & a strong will power. She need to control her negative feelings. She should cooperate with doctors.

Her family should try to give her more attention & care. So that she will record very soon.

CASE 7

Obsessive Compulsive Disorder

IDENTIFICATION OF 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.

ROOTERS 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 50 (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 8

Bipolar-II (Hypomania)

BIODATA

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

BEHAVIORAL OBSERVATION

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

Presenting Complains

Depressed mood

Feeling of Hopelessness

Trembling

Loss of beloved

Guilt feeling

Hallucination

Mood change

Refusal to eat

Aggression

Disturb sleep

Sexual inadequacy

FAMILY HISTORY

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

He was 2nd born child in family. The attitude of his siblings was good according to client and he told that his home environment good, peaceful and had joint family system. He was married and had passed 1 year of his married life. According to client, his wife was now pregnant and she lived with her parents because she did not want to live with him as she had relationship with someone else.

PAST PERSONAL HISTORY

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

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

HISTORY OF PRESENT ILLNESS

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

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

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

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

EVALUATION TECHNIQUES

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

6. Mental status examination
7. Case History examination
8. H.T.P
9. R.I.S.B
10. W.A.T

11. B.D.I

12. Raven Progressive Matrices

13. Bender Gestalt test

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 (current)	

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.

6. Relaxation training
7. Behavior therapy

CASE 9

Post Traumatic Stress Disorder

IDENTIFYING DATA:

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

PRESENTING COMPLAINTS: -

Pain in half head, sleeping not properly, too much feeling of thrust. Remedially

remembers her daughter and weeping continually. 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. Exaggerated startle responses
    5. Significant impairment in daily functioning.

PERSONAL HISTORY:

Patient basically belonged to the lower class family. There were no

prenatal and Postnatal complications with her. She achieved her developmental milestone
Normally. She had four sisters and four brothers. She was eldest of all. being eldest
She was very short tempered and bossy. She could not continue her studies after Her F.A. because of financial problems.

At the age of 35 years, she got married. Her husband was in army that's why he Had a very limited salary. She was the second wife of her husband and had a son Of her husband to bring him up. Age differences 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 MH Hospital and she is Receiving Psychiatric treatment over there.

PREMORBID PERSONALITY:

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

ONSET OF PRESENT ILLNESS:

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

PHYCHIATRIC TREATMENT:

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

CASE FORMULATION:

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

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 183 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.

CASE 10

Opioid Dependence Disorder

IDENTIFYING DATA:

Name:	SAA
Gender:	male
Age:	32 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 Govt. employ. 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 matric and then left his education. He started his job as a driver in govt sector. At the age of 28 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 opioid 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 opioid under the pressure of his friends.

Pre morbid personality

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

Onset of illness

His present illness started when he was 27 years old.

Medical and psychiatric history

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

Test Administered

Manifest anxiety scale

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

Rotter's incomplete sentence blank (RISB)

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

Case formulation

This is the case of 32 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 28 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 becomes addicted at the age of 18. This was the second admission of the client. At this admission he himself wanted to get rid of this addiction. 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 affect people interest in and access to drugs.

Tentative Diagnosis

Axis I	Opioid dependence (304.0)
Axis II	none
Axis III	none
Axis IV	problem related to social environment
Axis V	GAF=65 (current)

Therapeutic recommendation

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 environment 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 11

Social Phobia

Next page.

IDENTIFYING DATA

Name	Mohammad Ali
Sex	male
Age	19 years
Education	FA
Occupation	cosmetic shop
Marital status	unmarried
Siblings	6 (brothers 4, sister 2)
Birth order	5th
Family structure	joint
Socio economic status	middle
Financial status	dependent
Father education	Matric
Mother education	none
Language known	Urdu
Mother tongue	Punjabi
Religion	Islam
Date of Assessment	11 July 2009

Test Administered

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

1. Standard Progressive Matrices (SPM)
2. Manifest Anxiety Scale (MAS)
3. Human Figure Drawing test (HFD)
4. Soloson Drawing Coordination Test (SDCT)

FINDINGS

On mental state examination (MES), the client was looking a young man of 19 years. Apparently he was having a sound health and normal height. He was looking cooperative, attentive. He tried to maintain his eye contact but on some stages he loses his confidence. His volume of speech was clear, but some time due to the blockage of thoughts flow he stopped his communication during interview. He remained obedient and submissive during interview. He was insight oriented and his memory remained normal he explained all his life experiences and events. He complained the some time loss of memory or amnesia. His thoughts and perception about the time, place, and date was correct. He knew each and every thing about his past. During interview he seemed attentive.

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

For intelligence measurement the SPM was applied on the client, the client got score of 50^{th} percentiles on this test which reveals that the client is having averaged intellectuality ability. The client explained that he has some unrealistic fears for this purpose MAS and stress scale applied in the client, both test indicated that the client has stress in his mind and having a sever anxiety, because client score on both test 40, and 30 which indicate the anxiety and stress in the client.

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

Projective techniques HFD, was applied for personality assessment, on HFD test, shows emotional indicators that are over emphasis on hair over shading poor integration, improper place of organ showing of joint of the body petals type fingers of foot and over extended hand open mouth reveals immaturity oral eroticism body narcissism shyness helplessness poor inner self control, insecurity

anxiety, inadequacy of feeling, socially withdrawn and sexual conflicts.

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

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

FAMILY HISTORY

The client family history indicates that he belongs to a middle class family, he lives with his parents. He has six sibling consisted on two sisters and four brothers. His birth order is third among brothers and sisters. He is having good relations with his brothers and sisters. His father is having an authoritative attitude and style of life in family but he is cooperative also. He runs a cosmetic shop and client assist his father in this business. His mother is nice lady. She takes full care of him. His elder two brothers are married and led separate life. Some time when his younger brothers do not obey the client he shows aggression with them. Some time he quarrels with them. He does not like to go the relative homes because he feels shyness and hesitations with the relatives especial with girl of their families. He dislikes female sex. He thinks that person should be alone.

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

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

Tentative diagnosis

AXIS 1 300.23 Social phobia

AXIS 11 301.6 Dependent personality disorder

AXIS 111 None

AXIS 1V Problem related to social environment

AXIS V GAF current 71

Prognosis

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

Recommendations

On the bases of neuro psychological assessment and clinical intake interview following facilities are needed for the treatment of the problem

1. Behavior therapy
2. Cognitive Behavior therapy
3. RET
4. Family therapy
5. Interpersonal psychodynamic therapy

Case 12

Conversion Disorder

BIO-DATA

Name	XYZ
Age	22 years
Sex	Male
Education	FA
Marital Status	Unmarried
Birth order	last born
Religion	Islam
Siblings	One step brother and sister
Parents	Both alive, Step mother deceased
Education of father	Middle
Education of mother	Primary
Past Psychiatric history in family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. S.A.Q. was a young man of 27 years of age. He was unmarried. He was not in a satisfactory condition during the interview. He was very thin with poor hygienical condition. His mood was very low with low tone of voice. In the first ten minutes of the

interview he avoided to response on my questions. After building the rapport he was looking cooperative.

PRESENTING COMPLAINTS

Lack of appetite

Headache

Hypesthesia (Loss of sensation in body)

Vertigo

Aggression

Fits

Weakness

Fatigue

FAMILY HISTORY

He belong to a middle class family. His father had two marriages. His step mother was died. He had one step brother and sister. He was living with his mother in a separate home. His father was living with his step siblings. He had good relations with his father and his step siblings. After completion his matriculation he was working as a Clerk. Also his father supported him economically.

PAST PERSONAL HISTORY

Mr. XYZ was a young man of 22 years and he said that his birth was normal. He was sparkling and healthy in childhood. He was an average student in his class. After completion of matriculation he started worked as a Clerk. He had good relations with his father and his step siblings. According to him he liked a girl living near to his home and wanted to marry her. She was also studying and liked him. He told her mother about his relation. His mother was agreed and gave proposal to her parents but they rejected the proposal. He was very upset. His father tried to but failed to convince the girl's parents.

After one year the girl was married in a neighbor village and after one year she was died during her first delivery. Within month after her death his complaints became severe.

HISTORY OF PRESENT ILLNESS

He was admitted to mental hospital for 1st time. Now he had been in hospital since last 9 days. The cause of his admission was intense headache, fits, weakness and fatigue.

Doctor reported that he came hospital for first time. The cause may be the death of his beloved or the environment of his family. Because of these two reasons, he may shows conversion features.

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.F.D

4. R.I.S.B

INTELLECTUAL FUNCTIONING

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

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

PERSONALITY FUNCTIONING

Mr. XYZ. Was a young man of 22 years. He belonged to middle class family. He was the last born child in the family. This was patient's 1st psychiatric admission to hospital.

RISB, HFD, was administered to check the personality functioning of patient.

Patient score on RISB is 140 with a cut score of 135. It indicates that he is maladjusted person (Rotter, 1932).

Drawing indicates the inferiority complex, difficulty interpersonal relation and lack of impulsive control.

CASE FORMULATION

Mr. XYZ was a young man of 22 years from a middle class family. He was unmarried. He was the last born child in the family. His education was FA and Clerkby occupation. It was patient 1st time in hospital for treatment of conversion disorder.

He had severe symptoms as lack of appetite, headache, fits, vertigo and hypoesthesia.

From the drawing of HFD, score on RISB, it is clear that person has inferiority complex, lack of impulsive control and difficulty interpersonal relations.

Presenting complains and the results of the test support our diagnosis that the patient tends to have Conversion DisordeR

TENTATIVE DIAGNOSIS

Axis I	300.11 Conversion Disorder
Axis II	Nil
Axis III	Nil
Axis IV	poor Interpersonal relationships
Axis V	GAF = 55 (current)

PROGNOSIS

His symptoms were severe but have short history so prognosis was possible.

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to XYZ

1. Supportive therapy
2. Relaxation training
3. Cognitive behavioral therapy
4. Pharmachotherapy

CASE 13

Manic Depressive Disorder

BIO-DATA

Name	MA.
Age	32 years
Sex	Male
Education	BSc
Occupation	Govt Employ
Marital Status	Married
Birth order	2nd born
Religion	Islam
Sibling	Four brothers one sister
Parents	father deceased, mother alive
Education of Father	Matric
Education of Mother	Illetrate
Residence	Sadar, Attock

Past Psychiatric history in Family Nil

Past medical history of patient Nil

BEHAVIORAL OBSERVATION

Mr. MA. was a young boy of 32 years .His dress was tidy with tidy hair. He answered in appropriate way and had maintained good eye contact during session. He completed tests with great interest and his tone was appropriate. He was showing so much etiquette. Overall his behavior was cooperative.

Presenting Complains

Aggression

Hyperactive

Decreased Sleep

Perfectism

Flight of ideas

Dangerousness

Irritable mood

Suspicious thoughts

Lack of concentration

FAMILY HISTORY

He belonged to middle class family of four brothers and one sister of Attock. His father was deceased few years ago due to accident. He was a retired POF officer. He felt sorrow to think about his father.

He was 2nd born child in his family. The attitude of his siblings was good and he told that he had joint family system and home environment was good, peaceful but sometimes they started to fight due to me.

He was married and had two male children. His marital relations were not healthy. For two years his wife was living with her mother after his father's death.

PAST PERSONAL HISTORY

Mr. MA. was a young man of 38 years and was the 1st born child of his family. He told that he spent his childhood happily and according to him his birth was normal.

He was an intelligent student and completed his Graduation with great interest. He also completed, homeopathic course after his graduation. He was appointed as FM in POF Wah Cantt. After four years of his appointment, he was transferred to POF Sanjwal Cantt. He was living in a joint family system. According to him, he was since to his profession. He always made, his office happy, by his hardworking and sincerity. This made his colleague against him. They gave application to the director, against him. As a result he lost his present rank. According to him, this incident made him more energetic. He started overtime duty in his department. Now most of his time he spent in overtime duty. He was working in night shift and coming home late at night. He did not give proper time to his wife and children.

HISTORY OF PRESENT ILLNESS

He was admitted to the hospital 1st time for the treatment of aggression, irritable mode and decreased sleep. His younger brother took him to the hospital. He had very poor interpersonal and social relationship with others. He became violent. He had suspicious thoughts about his job.

Doctor reported that he came to hospital for 1st time. The cause may be the seasonal effect, tense job routine or the environment of the family or the department.

EVALUATION TECHNIQUES

He was cooperative and took great interest in completing the tests. Following techniques were used

1. Mental status examination
2. Case History examination
3. H.F.D
4. R.I.S.B
5. B.D.I

INTELLECTUAL FUNCTIONING

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

He had good orientation of time, place and person. He know about his name, name of patients, day, time and the name of place where he lived as he matched with the information given by the staff of hospital.

PERSONALITY FUNCTIONING

Mr. MA. was a young man of 38 years. He belonged to middle class family. He was the 1st born child in the family of 4 brothers and 1 sister. This was patient's 1st psychiatric admission to hospital.

RISB, HFD, BDI was administered to check the personality functioning of patient.

Patient score on RISB is 139 with a cut score of 135. It indicates that he is maladjusted person (Rotter, 1932).

Drawing of HFD shows that he has depression, withdrawal tendency, inadequacy indicated by feet omitted, narrow neck. Symptom of infantile aggression as indicated by fingers without hands, fingers like stick, hair emphasis, armed extended from body, many sharp edges, straight lines, heavy thick lines and saw like features (Machover, Hammer, levy). Detail of internal organ indicate anxiety, drawing of breast and penis indicate intense sexual urges.

CASE FORMULATION

Mr. MA. was a young man of 32 years from a middle class family He was married. He was the 2nd born child in the family of 4 brothers and 1 sister. His education was BSc and F.M (POF) by occupation. It was patient 1st time in hospital for treatment of aggression, irritable mode.

He had severe symptoms as perfection, decreased sleep, aggression, dangerousness, and hyperactive, irritable mood suspicious thoughts.

From the drawing of HFD, score on RISB, it is clear that person has withdrawal tendency, inadequacy, severe depression, poor interpersonal relations, aggression, hyper psychomoter activity.

Presenting complains and the results of the test support our diagnosis that the patient tends to have Manic-Depressive Disorder.

TENTATIVE DIAGNOSIS

Axis I	302.11 Manic-Depressive disorder
Axis II	Nil
Axis III	Nil
Axis IV	Interpersonal Relation problem
Axis V	GAF = 55

PROGNOSIS

His symptoms were not severe and have short history, so prognosis was possible.

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to MA

1. Supportive therapy (Family Therapy)

2. Relaxation training

3. Cognitive Behavioral therapy

4. ECT

5. Pharmachotherapy

    Tricyclics (ToFranil, Elavil)

    Selective Serotonin (Lithium, Prozac)

Case 14

Obsessive compulsive disorder

Bio Data

Name:	BB
Sex:	Female
Age:	27 years
Education:	M.A
Marital Status:	Unmarried
Religion:	Islam
Sibling:	5 brothers
Parents:	Both are alive
Birth Order:	4th one
Education of Father:	Middle
Education of Mother:	Uneducated
Past psychiatric history:	Nil
Past medical history:	Nil

Behavioral Observation:

Ms BB was a young lady of 27 years. She was a good looking lady. Her appearance was satisfactory. The skin of her hand was very white and looking clean. She had proper orientation of time and place.

Presenting Complaints

Repetitive Behavior (compulsions) of hand washing

Ordering

Insomnia

Headache

Fears

Distress

Family History:

Ms. B.B was born in a middle class family of 5 brothers. Her father was an army person and mother was a house wife. Her family environment was very restricted. Her father wanted her to be a doctor, but she could not and became a teacher. Her father did not like her as teacher. She had five brothers, two of them were married and living independently.

According to her, her father had hardly given his love to her. Her mother also was blaming her. She thought that she been a neglected child since her childhood.

Past Personal History:

Ms. B.B was a young lady of 27 years. She was an average student at school and college level. She was a teacher by occupation. Her father did not like her profession as he had wanted her to be a doctor. According to her, because of her restricted family environment she came very o her cousin. And soon she had developed sexual relation with him.

Now she was often feeling guilt, and had gradually developed these symptoms.

History of present illness:

This is patient's 1st psychiatric admission to the hospital. Now she had been in the hospital since last 22days. The cause of admission was her repeatedly hands washing.

Evaluative Techniques:

Mental Status examination
Case history interview
HFD
RISB
BAS

Intellectual Functioning:

Her recent and remote memory seemed to be intact as she could recall most of the past and present events. She completed RISB, and HFD with full interest and concentration. She had good orientation of places and persons. She knew about her name, name of other patients and name of city where she lived.

Personality Functioning:

Ms B.B was a young lady of 27 years. She belonged to a middle class family. She was the 4th born child in the family of 5 brothers. This is patient's 1st psychiatric admission to the hospital.

RISB, HFD, MSE, RPM and were administered to check the personality functioning of the patients. Patient score on RISB is 137 with a cut off score 135. It indicates this patient is highly maladjusted. C responses in RISB are very high than positive and neutral responses are indication of maladjusted frame of mind. Score on BAS indicates high anxiety level of the patient.

The interpretation of HFD also indicated the main features of her personality.

In human drawing eyes without pupil showed that patient has guilt feeling .

Overall, we can say that patient has adjustment problem, guilt feeling, sexual tendency and negative frame of mind.

Case Formulation

Ms. B.B was a young lady of 27 years. This is patient's 1st psychiatric admission to the hospital. She came to the hospital for the treatment of her repetitive behavior.

Presenting complaints and result of the test support our diagnosis that patient has Obsessive Compulsive Disorder.

Diagnosis

Axis I	300.3 Obsessive Compulsive Disorder.
Axis II	no diagnosis
Axis III	no diagnosis

Axis IV	problem with the Primary support group
Axis V	GAF 50 (current).

Prognosis

Symptoms will be recovered and prognosis seemed to be favorable.

TREATMENT

Psychoanalysis

Behavioral therapy

Pharmachotherapy

Antianxiety Drugs

Alprazolam

Xonax

Librium

CASE 15

Anti Social Personality Disorder

Bio Data

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

Behavioral Observation:

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

Presenting Complaints

Aggressive, repeatedly violated the laws, quarreled with others, hostile. Irritable personality. Irresponsible behavior. Thefts.

Family History:

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

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

Past Personal History:

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

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

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

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

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

History of present illness:

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

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

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

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

Evaluative Techniques:

MSE

Case history interview

HTP

RISB

RPM

Intellectual Functioning

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

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

Personality Functioning:

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

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

The interpretation of HTP also indicated the main features of his personality. Closed door of house shows that he had weak social relations. Compartmentalization

showed that Mr. A.B has poor interpersonal relationships. (Buck, 1966).

In the drawing of tree, the sword like branches and leaves showed that patient is aggressive. The strong trunk emphasize in the drawing of tree is the feeling of the basic strength of her ego but dim line show lack of emotion and depression. (Buck, 1966).

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

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

Case Formulation

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

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

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

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

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

Individual with antisocial personality disorder may not be needy of admiration of

others and person with narcissistic personality usually lacks the history of conduct disorder in childhood or criminal behavior in adulthood.

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

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

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

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

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

Diagnosis

Axis I	V 71.09
Axis II	301.7 (Antisocial Personality Disorder)
Axis III	V 71.09
Axis IV	Social and occupational problem
Axis V	GAF (21 – 30) CURRENT

Prognosis

Patient prognosis seemed to be favorable.