DIAGNOSTIC REPORTS

INTERSHIP CLINICAL PSYCHOLOGY

T07617

Submitted by

Shakir Iqbal Khan

MS 3RD SEMESTER

9-FSS/MSPSY/F08

Submitted to

Dr. Asghar Ali Shah

DEPARTMENT OF PSYCHOLOGY
FACULITY OF SOCIAL SCIENCES
INTERNATIONAL ISLAMIC UNIVERSITY
ISLAMABAD

Accession No TH 7617

MS
155.282
KHD

1- Diagnostic graphology
2- Handwriting analysis

CERTIFICATE

It is certified that MS internship title Diagnostic Reports prepared by Shakir Iqbal Khan has been approved for submission to Psychology Department of International Islamic University Islamabad.

Dr. Asghar Ali Shah
(Supervisor)

CASE 1

(Substance Induced Psychosis)

BIO-DATA

Name	M. Latif
Age	25 years
Sex	Male
Education	Primary
Occupation	-
Marital Status	Married
Birth order	2nd born
Religion	Islam
Sibling	Five brothers Three Sisters
Parents	Both alive
Education of Father	Illiterate
Education of Mother	Illiterate
Residence	Attock
Past Psychiatric history in Family	Yes
Past medical history of patient	Yes

BEHAVIORAL OBSERVATION

Mr. M. Latif was young man of 25 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 deined to cooperiate during tests. Overall his behavior was uncooperative.

Presenting Complains

Persecution dellusion

Hallucination

Disturb Sleep

Isolation

Smoking

Irritable mood

Sense of Deprivation

Selef 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 schizophernic patient.

He was 2nd 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. Latif was a young man of 25 years and was the 2nd born child of his family. His borth 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 15 years. He also started illegal sexual relations with some prostitue. He often stole the things to buy the drugs.

HISTORY OF PRESENT ILLNESS

He had been admitted to IZ Psyschiateric center by his mother two years ago due to addiction. During the treatment his prognosis was satisfactory. But due to bad company and unsupportive family environment he started this habbit 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 to complete 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. Latif was a young man of 25 years from a poor class family of Attock. He was married. He was the 2nd born child in the family of 5 brothers and 3 sisters. His education was primary. It was patient 2nd admission to IZ Psychiateric Center for treatment of drug addiction.

He had severe symptoms as grandiosity delusion, persecutory delusion, suicidal ideation, abusive, hostility, smoking, disturbs sleep, irritable mood, cannabis dependence, cocaine and isolation.

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

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

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

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

TENTATIVE DIAGNOSIS

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

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to Latif

1. Supportive therapy
2. Relaxation training
3. Cognitive Behavioral therapy
4. Pharmachotherapy
5. Antipsychotic drugs

   (Olanzapine, Clozapine)

CASE 2

(Sehizoaffective Disorder)

BIO-DATA

Name	W.A.
Age	25 years
Sex	Male
Education	Matric
Marital Status	Unmarried
Birth order	2nd born
Religion	Islam
Sibling	Three brothers one sister
Parents	Alive
Education of Father	Matric
Education of Mother	Primary
Residence	Burhan
Referral	CI (crisis intervention)
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. W.A. was a young man of 25 years old. His complexion was fair and his dressing was appropriate. There were signs of trembling in his hands and his voice tone was not appropriate as well as his affect. He was well combed and his teeth were also brushed. He had poor eye contact and sometime started self talking.

Presenting Complains

Depressed mood

Loose association

Trembling

Abusive

Guilt feeling

Inappropriate affect

Refusal to eat

Aggression

Disturb sleep

Self talking

Obstinate

Irritable mood

FAMILY HISTORY

He belonged to Burhan from a middle class family of three brothers and one sister. His father education was just matric. His parents were alive. His father is security guard. 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 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. W.A. was a young man of 25 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 father depressed him more.

HISTORY OF PRESENT ILLNESS

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

Dr Jamil took him to IZ Psychiateric Center. He was in habit of self talking and liked to eat spicy foods and to drink hot tea.

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. W.A. was a young man of 25 years. He belonged to middle class family. He was the 2nd born child in the family of three 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. W.A. was a young man of 25 years from a middle class family of Burhan. He was unmarried. He was the 2nd born child in the family of 3 brothers and 1 sister. His education was matric 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	Interpersonal relationship problem

Axis V GAF = 21-30

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to W.A.

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

   (Respredon, Clozapine)

CASE 3

(Conversion Disorder)

BIO-DATA

Name	S.A.Q
Age	27 years
Sex	Male
Education	Matric
Marital Status	Unmarried
Birth order	1st born
Religion	Islam
Siblings	One step brother and sister
Parents	Both alive, Step mother deceased
Education of father	Primary
Education of mother	Illiterate
Residence	Kamra Kalan
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 marriges. 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 naib qasid in Govt college Attock. Also his father supported him economically.

PAST PERSONAL HISTORY

Mr. S.A.Q. was a young man of 27 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 naib qasid in Govt College Attock. He had good realtion 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 proporsal to her parents but they rejected the proporsal. He was very upset. His father tried to but faild to convience the girl's parents.

After one year the girl was married in a neighbour village and after one year she was died durig 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. S.A.Q. was a young man of 27 years. He belonged to middle class family. He was the 1st 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. S.A.Q was a young man of 27 years from a middle class family of Kamra. He was unmarried. He was the first born child in the family. His education was matric and naib qasid by occupation. It was patient 1st time in hospital for treatment of conversion diorder.

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

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	Interpersonal relationship problem
Axis V	GAF = (55) Modrate

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to S.A.Q

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

Antianxietic drugs

(Benzodiazapine, Xonax, Alprazolan)

CASE 4

(Manic-Depressive Disorder)

BIO-DATA

Name	A.M.
Age	38 years
Sex	Male
Education	B.A.
Occupation	Land lord
Marital Status	Married
Birth order	1st 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. A.M. was a young boy of 38 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 1st 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 childern. His marrital relations were not healthy. For two years his wife been living with her mother after his father's death.

PAST PERSONAL HISTORY

Mr. A.M. 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, homeopathaic course after his graduation. He was appointed as FM in POF Wah Cantt. After four years of his appointement, he been transferred to POF Sanjwal Cantt. He was living in a joint family system. According to him, he was sincer to his profession. He always made, his office happy, by his hardworking and sincerity. This made, his coleague 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 IZ Psychiateric Center for 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. A.M. 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. A.M. was a young man of 38 years from a middle class family of Attock. He was married. He was the 1st born child in the family of 4 brothers and 1 sister. His education was B.A and F.M (POF) by occupation. It was patient 1st time in hospital for treatment of aggression, irretiable mode.

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

From the drawing of HFD. score on RISB, it is clear that person has withdrawl tendency. inadequacy. severe depression, poor interpersonal relations. aggression, hyperpsychomoter 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 Order
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 A.M

1. Supportive therapy (Family Therapy)
2. Relaxation training
3. Cognitive Behavioral therapy
4. ECT

5. Pharmachotherapy

   (i) Tricyclics (ToFranil, Elavil)

   (ii) Selective Serotonin (Lithium, Prozac)

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CASE 5

(Schizopherenia Disorder)

BIO-DATA

Name	M.A.
Age	38 years
Sex	Male
Education	Middle
Occupation	Security Guard
Marital Status	Married
Birth order	5th born
Religion	Islam
Sibling	Three brothers Three sisters
Parents	Alive
Education of Father	Illiterate
Education of Mother	Illiterate
Residence	Village Chhab. Dhoke Shadi Khan
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. M.A was middle young man of 38 years .His dress was neat and clean. He answered in appropriate way and had maintained good eye contact during session. He completed tests with great interest but his tone was inappropriate. He had less vocabulary of words therefore repeat many sentences again and again. Overall his behavior was cooperative.

Presenting Complains

Audiotery hallucination

Insomnia

Delusions (Thoughts Insertion, Grandiosty)

Suspicious

Distrub Sleep

Disorganized Speech

FAMILY HISTORY

He belonged to middle class family of three brothers and three sisters of Chhab. His both parents were alive and they are in good terms with him.

He was 5th born child in his family. The attitude of his siblings was good and he told that he had joint family system and home environment was good, peaceful. He was married and had a male child of six years. His wife was 35 years with good health.

PAST PERSONAL HISTORY

Mr. M.A. was a young man of 38 years and was the 5th born child of his family. He told that he spent his childhood happily and according to him his birth was normal. He was not more intelligent student therefore could not carry on his studies. He had good terms with his friends and often he used some drugs with his friends specially cannabis. His younger brother had been killed four years ago.

HISTORY OF PRESENT ILLNESS

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

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

EVALUATION TECHNIQUES

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

Following techniques were used

1. 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 not much good as he could not recall most of the past and present events easily.

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

PERSONALITY FUNCTIONING

Mr. M.A. was a young man of 38 years. He belonged to middle class family. He was the 5th born child in the family of Three brothers and Three sisters. This was patient's 1st psychiatric admission to hospital.

HFD was administered to check the personality functioning of patient.

Drawing of HFD shows that he has schizophrenic tendency indicated by confusion full face, ear emphasis, emphasis on joints, giraffe neck and very faint lines, ommition of hands and feet.

CASE FORMULATION

Mr. M.A was a young man of 38 years from a middle class family of Chhab. He was married. He was the 5th born child in the family of 3 brothers and 3 sisters. His education was middle and he was security guard by occupation. It was patient 1st time in hospital for treatment of schizophrenia.

He had severe symptoms as Audiotery hallucination, delusions, insomnia.

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

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

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

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

TENTATIVE DIAGNOSIS

Axis I	292 Schizophrenia
Axis II	Nil
Axis III	Nil
Axis IV	Interpersonal Relation problem

Axis V GAF = 41-50

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to M.A.

1. Relaxation training
2. Cognitive Behavioral therapy
3. Pharmachotherapy
    (i) Anipsychotic drugs (Clozapine. Olanzapine. Quetiapine)

CASE 6

(Obsessive Compulsive Disorder)

Bio Data

Name:	N.B
Sex:	Female
Education:	B.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
Residence:	Narah, Attock
Past psychiatric history:	Nil
Past medical history:	Nil

Behavioral Observation:

Mrs. N.B was a young lady of 25 years . She was a good lookng lady. Her appearace was satisfactory. Overall she was a gorgeous lady. The skin of her hand was very white and looking clean. She had proper orientation of time and place.

Presenting Complaints

Repeatative Behavior

Insomnia

Headache

Fears

Family History:

Mrs. N.B was born in a middle class family of 5 brothers. Her father was a army person and mother was a house wife. Her family enviroment 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.

Acording 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:

Mrs. N.B was a young lady of 25 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. Acording 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 examinaton
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:

Mrs. N.B was a young lady of 25 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 indicats 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

Mrs. N.B was a young lady of 25 years. This is patient's 1st psychiatric admission to the hospital. She came to the hospital for the treatment of her repetative 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	
Axis III	
Axis IV	Primary support problem
Axis V	GAF (50) Severe obsession rituals.

Prognosis

Symptoms will be recovered and prognosis seemed to be favorable.

TREATMENT

1. Family therapy
2. Psychoanalysis
3. Behavioral therapy
4. Pharmachotherapy

Antianxiety Drugs

(i) Alprazolam

(ii) Xonax

(iii) Librium

CASE 7

(Catatonic Schizopherenia)

Bio Data

Name	N.A
Age	28
Sex	Male
Marital Status	Unmarried
Religion	Islam
Siblings	5 brothers and 2 sisters
Birth order	6th born
Qualification	Illiterate
Parents	Mother alive and father deceased
Education of father	Metric
Education of Mother	Illiterate
Residence	Vero, Kamra
Psychiatric admission	2nd
Past psychiatric history	Yes
Past medical history	Yes

Behavioral Observation:

Mr. N.A was a young man of 28 years with poor complexion. His appearance matched with his chronological age. He was neatly dressed but his hair was not properly done. He din't maintain an appropriate eye contact during the session. His concrete thinking was shattered. His speech was derailed. During the session he was repeatedly standing up and shaking his hand with laughing. He was repeating the last word of the question. History was taken in the presence of younger brother.

Presenting Complaints:

Motric immobility

Excessive motor activity

Negativism

Peculirities of voluntary movements

Odd posture

Undue compliance

Catatonic stupers

Family History:

Mr. N.A was young man of 28 years. He was residence of Kamra. He belonged to middle class family. His father was deceased and mother is alive. He had 5 brothers and 2 sisters. He was the 6th one among siblings.

He spent his childhood in Karachi with his family as his father had been running his bussiness for ten years. After his father death his family been shifted to Vero Kamra. His three brothers and both sisters were married. One of his brothers was running his business in Dubai. He was living in a joint family system. Socio-economically his family was well set.

Past Personal History:

Mr. N.A was a young man of 28 years. According to his brother, his childhood was very normal but he never been a good student. That's why in the 2nd class he ran away from the school. At the age of 12 years he started work at an auto workshop. He been working there for four years before the first onset of his mental disorders.

History of Present Illness:

This is patient 2nd psychiatric admission to IZ Psychiatric Center. First time he been admitted to IZ Psychiatric Center since 10 years ago. After than he been taken to Charsada for the treatment. There his treatement been continued for 8 years. Because of the regular treatment his prognosis was gradually improved. But than he stopped to take the medicine. Nearly two years he was reamained without any treatment. For second time he was admitted to the hospital for serveral reasons.

He was very aggressive to his sisters-in-Law. He often abused them and putoff his paint. Often he was laughing repeatedly with shaking his hands. Sometime he was talking meaningless and the next time he remained very quiet for many hours.

Evaluating Technique:

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

Mental Status Examination

Case history interview

HFD

Intellectual Functioning:

On the basis of his Mental Status Examination it is clear that his recent memory was not good but remote memory was good, as she could remember many of his pleasant and sad events. He had poor orientation of time and place as he didn't know about day, date and place.

Personality Functioning:

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

In the drawing of human figure large size of head indicate his psychotic features. Ommition of central body indicates his schattered concrete thoughts.

Case Formulation:

Mr. N.A was a young man of 28 years. He was the 6th born child in the family of 5 brothers and 2 sisters. He was illetriate. This was patient 2nd psychiatric admission to IZ Psychiatric Center.

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

Patient N.A. doesn't meet the criteria of disorganized type because he doesn't have disorganized speech, behavior and effect.

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

Patient N.A fulfill the criteria of catatonic type so that's why he is diagnose as Catatonic Schizophrenia patient.

From the drawing of HFD, it is clear that patient had Catatonic tendency, aggressive and negative frame of mind.

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

Diagnosis:

Axis I	(293.30) Catatonic Schizophrenia
Axis II	V71.90
Axis III	V71.90

Axis IV Problem related to the social environment

Axis V GAF (21-30)

Prognosis:

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

Treatment:

1. ECT
2. Family therapy
3. Behavioural Therapy
4. Pharmachotherapy

Antipsychotic drugs

(i) Clozapine
(ii) Risperidone
(iii) Olanzapine

CASE 8

(Generalized Anxiety Disorder)

Bio Data:

Name:	K.K
Age:	21
Sex:	Male
Marital Status:	Unmarried
Religion:	Islam
Siblings:	4 Brothers & 2 Sisters
Birth Order.	2nd One
Qualification:	Metric
Parents:	Both are Alive
Education of Father:	Uneducated
Education of Mother:	Uneducated
Residence:	Jabbi Attock
Psychiatric Admission:	1st
Past Psychiatric History:	Nil
Past Medical History:	Nil

Behavioral Observation:

Mr. K.K was a young boy of 21 years old. He had fair complexion and his appearance matched with his chronological age. His hygienic condition was inappropriate. His hair were not properly done and had put dirty dress. He had poor eye contact during the session. He looked worry during interview.

Presenting Complaints

Worries about future

Irritabilty

Muscle tension

Feeling Keyedup

Family History:

Mr. K.K was borne in a middle class family of 4 brothers and 2 sisters. His father and mother both were alive. His father and mother both were uneducated. He was the 2nd borne child in the family. His attitude towards his sibling was not good.

His brothers often used to beat him because of his uncooperative attitude.

Past Personal History

Mr. K.K was a young boy of 21 years old. He was healthy in his childhood. He was not a good student in his childhood. He was metric but he passed metric with very low grade.

After the metric he had worked as a moter mechanic for 3 years. He felt in love with a girl who lived near the workshop. He said that he wanted to marry her but she did not like him.

He was depressed due to the failure of love .

History of Present Illness:

This is patient's 1st psychiatric admission to the hospital. Now he had been in the hospital since last 10 days. The cause of admission was his worry about his work. He thought that he couldn't do any thing. He had poor relations with his family.

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

According to him the attitude of his brothers made him depressed therefore his parents admitted him to the hospital.

Evaluating Techniques

Case History Interview

HFD

Mental Status Examination

RISB

Intellectual Functioning

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

Personality Functioning

RISB. HFD were administered to check the personality functioning of the patient.

Patient score on RISB is 140 with a cut off score 135. It indicates that patient is maladjusted. C responses in the RISB are more than Positive and neutral responses. Conflict responses are indication of unhealthily hostility reaction, anxiety, pessimisms, hopelessness and negativism (Rotter 1932).

Feet omitted in male drawing are a sign of withdrawl dependency and discouragement.

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

Case Formulation

Mr. K.K was a young boy of 21 years. This is patient's 1st psychiatric admission to the hospital. He had the symptoms like excessive anxiety and worry, irritability; sleep disturbance, muscle tension, restlessness and lack of concentration.

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

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

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

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

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

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

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

Diagnosis

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

Prognosis:

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

Treatment:

1. Behavioural Therapy
2. Psychoanalytic Therapy
3. Pharmachotherapy

Antianxiety Drugs

(i) Benzodiazpine (Alprazolam, Xonax)

CASE 9

(Posttraumatic Stress Disorder)

Bio Data

Name:	S.B
Age:	31 Years
Sex:	Female
Education:	F.Sc
Marital Status:	Married
Religion:	Islam
Sibling:	4 Brothers 2 Sisters
Parents:	Both are alive
Birth Order:	4th Order
Education of Father:	Matric
Education of Mother:	Middle
Residence:	PAF Kamra
Children:	2 Sons
Referral:	Husband
Past Psychiatric History:	Nil
Past Medical History:	Nil

Behavioral Observation

Mrs S.B was a young lady of 31 years. She was in viel. Her hygienic condition was not appropriate. She had good health. Her tone was slow during the interview. Her mood was appropriate. Her affect was congruent with her mood. Her eye contact was also appropriate. She was cooperative and provided detailed information about her life.

Family History:

Mrs. S.B was a young lady of 31 years. She was 4th borne child of the middle class family of 4 brothers and 2 sisters. She said that her parent's lover her and attitude of her sibling was also good.

She said that she was healthy in her childhood. She was F.Sc. Her father and mother both were alive. Her siblings were very careful and in good terms with her. She had very healthy relations within her family.

Past Personal History

Mrs. S.B was a young lady of 31 years. She belonged to a middle class family of 4 brothers and 2 sisters. She was 4th borne child in her family. At the age of 25 she was married with her first cousin. Her husband was working as Chief Tech in PAC Kamra. He was very carefull and loving. She had two sons. For the both time her delivery was normal. Last year she gave birth her third child but that time unfortunatly the child was physically abnormal. He was physically immature. His uper lip was cut in the middle with the absence of lower lip. The child was alive for a week and died. This made her very shocked.

History of present illness:

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

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

Evaluative Techniques:

Case History Interview

Mental Status Examination

RISB

HFD

Intellectual Functioning:

She couldn't recall past and present events easily. She couldn't recall the name of doctor and patient easily. So her remote and recent memory was poor. She felt difficulty to recall date of events.

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

Personality Functioning:

Mrs. S.B. was a young lady of 31 years old. She belonged to a middle class family. She was the 4th born child in the family of 4 brothers and 2 sisters. This is the patient's first psychiatric admission to the hospital. RISB and HFD were administered to check the personality functioning of patient. Patient's score on RISB was 137 with a cut score of 135. it indicates that patient is highly defensive. C responses are more than P responses and it is the indication of hopelessness, unhealthy state of mind and hostility.

Large nose is the indication of melancholia, sexual impotency (Hammer, Leavey). Arms away from the body are the indication of externalized aggression. Neck omitted is the indication of immaturity, lack of impulse control and regression (Machover). Top and centre drawing showed that patient is emotional and self-centered.

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

Case Formulation

Mrs. S.B. was a young lady of 31 years. She was married and had 2 children. This is patient first psychiatric admission to the hospital. Her husband was loving and caring. He took her to the IZ Psychiateric Center. She had two sons. Her delivery was normal for the both time. Last year she gave birth a physically immature child. His upper lip was cut in the middle while lower lip was totally absent. He died in a week. So this treumatic experience lead her toward mental problem.

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

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

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

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

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

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

Diagnosis

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

Prognosis

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

Treatment:

1. Behavioural Therapy
2. Relaxation Training
3. Family Therapy
4. Pharmachotherapy

Antianxiety Drugs

(Xonax, Valium, Tranqilizer)

CASE 10

(Acute Stress Disorder)

Bio Data:

Name:	M.N
Age:	17
Sex:	Male
Education:	Metric
Marital Status:	Unmarried
Religion:	Islam
Sibling:	2 brothers and 2 sisters
Parents:	Father deceased and mother alive
Birth Order:	2nd
Education of Father:	F.A
Education of Mother:	Uneducated
Residence:	Sagar. Attock
Past psychiatric history:	Nil
Past medical history:	Nil

Behavioral Observation:

Mr. M.N was a young boy of 17 years. Although he was a handsome boy but his appearance was not satisfactory. He had poor hygeinic condition. His Hb was low. He was talking with low tone of voice. He was looking gloom. He had proper orientation of time and place. Overall he was cooperative during the interview.

Presenting Complaints

Intense fear

Helplessness

Horror

Difficulty sleeping

Poor concentration

Fatigue

Sad mood

Family History:

Mr. M.N was born in a middle class family of 24 brothers and 2 sisters. His father was a school teacher and died three months ago.He was a heart patient. His mother was a house wife with good health. He was 2nd born child and had very good terms with his parents and siblings but he was very closed to his father. After his father death often he was weeping and remembering him. Before his father death he had never faced any incident in his life.

Past Personal History:

Mr. M.N was a young boy of 17 years. He was sparkling and healthy in his childhood. He was average student in school but had good relation with his class mates. He was spending a happy life. He was also interested in sports. He was religious and offered prayers regularly. After his father death he was remaining sad and his routine activities were disturbed. Often he was weeping to remember his father.

History of present illness:

This is patient's 1st psychiatric admission to IZ psychiatric hospital. Now he had been in the hospital since last 2 weeks. The cause of admission was severe headache, intense sad mood. This problem was started afer his father's sudden death.

Evaluative Techniques:

Mental status examination

Case history interview

HFD

RISB

Intellectual Functioning

On the basis of Mental Status Exam, it is clear that the patient has intact recent and remote memory as he was very well knew about his past event and he had good orientation of time and place, as he knew about day, date, year and place. **Personality Functioning:**

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

Patient score on RISB is 140 with a cut off score 135. it indicates that patient is maladjusted. C responses in the RISB are more than positive and neutral responses. Conflict responses are indication of unhealthy hostility reaction, pessimisms, hopelessness and negativism (Rotter 1932).

Case Formulation

Mr. M.N was a young boy of 17 years. This is patient's 1st psychiatric admission to the hospital. He had the symptoms like headache, fatigue, sad mood, sleep disturbance and appetite problem.

From the drawing of HFD, score on BAS person has feeling of helplessness, social withdraw and axiety.

Presenting complaints and result of the tests support our diagnosis that person tends to have Acute Stress Disorder.

Diagnosis

Axis I 308.3 Acute Stress Disorder

Axis II

Axis III

Axis IV

Axis V GAF 55 moderatre

Prognosis

Patient will be recovered prognosis seem to be favourable.

Treatment

Social skill therapy

Cognitive behavioural therapy

Phremacotherapy

Antiaxiety drugs

(Benzodizapine, Xonax)

CASE 11

(Neurotic Depression)

BIODATA

Name	M.H
Age	26 years
Sex	Male
Education	Matric
Marital Status	Unmarried
Birth order	5th born
Religion	Islam
Sibling	Three brothers Three sisters
Parents	Alive
Education of Father	Illiterate
Education of Mother	Illiterate
Residence	Sheen Bagh Attock
Referral	Brother
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. M.H. was a young man of 26 years. His complexion was fair and his dressing was appropriate. His voice tone was not appropriate. He was well combed with small beard and his teeth were also brushed. He had poor eye contact. For the most time he was looking down during the interview. He was thin person with some Cuberosus Sclerosis on his face near his nose. During the interview his speech and body movement were slow.

Presenting Complains

Depressed mood (Anhedonia)

Feeling of Hopelessness

Loss of interest

Guilt feeling

Hallucination

Refusal to eat

Aggression

Disturb sleep

Weeping

Irretiable

Retardation

Weight loss

FAMILY HISTORY

He belonged to Sheen Bagh Attock from a middle class family of three brothers and three sisters. His father was illiterate and was constructor by occupation. He did not like his father and often became aggressive towards his father.

He was 5th 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. According to the client he did not like his father as he always forced him to take his meal at the proper time.

PAST PERSONAL HISTORY

Mr. M.H. was a young man of 26 years and he reported that he born at home with normal delivery. Accordingly to client his childhood was good and he spent it happily.

According to the client he had never been a good student at any level. His class fellows always kept a distance because of his ---------- on the face. His teacher did not like him. Most of the time he was remaining alone in the class and school. He had only a single friend. At home he spent most of the time in his room playing games on computer. He was religious minded and offered prayers regularly.

HISTORY OF PRESENT ILLNESS

This was patient's 1st psychiatric admission to the IZ Psychiatric Center. The main reason behind his admission was his aggressive behaviour to his father, weeping and refusal to eat.

His brother took him to IZ Psychatric Center for his present condition.

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
5. B.D.I

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. M.H. was a young man of 26 years. He belonged to middle class family. He was the 5th born child in the family of three brothers and three sisters. This was patient's 1st psychiatric admission to hospital.

RISB, HFD, BDI and MSE, CHE 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. C responses in the RISB more than positive and neutral responses so conflict responses are indication of maladjusted from the mind.

On the basis of HFD, it shows that he has depressive feeling as indicated by omitted arms and legs,. He has also poor interpersonal relationships with his family.

High scores on BDI are indicator of severe depression which are 33 (Beck) and high constricted drawing indicates depression.

CASE FORMULATION

Mr. M.H. was a young man of 26 years from a middle class family of Sheek Bagh Attock. He was the 5th born child in the family of 3 brothers and 3 sisters. His education was matric. It was patient 1st time in hospital for treatment of neurotic depression.

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

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 appitite, social impairment, irritable mood, disturbance in mood. So he fall in the criteria of neurotic depression.

From the drawing of HFD, score on RISB, score on BDI, WAT, it is clear that person has neurotic depressive tendency.

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

TENTATIVE DIAGNOSIS

Axis I	294.70	Neurotic Depression
Axis II	Nil	
Axis III	Nil	
Axis IV	Problem related to social environme	
Axis V	GAF = 21-30	

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to M.H.

1. Relaxation training
2. Behavior therapy
3. Pharmachotherapy

Anti Depressant Drugs

(i) SSRIs Group (Paxil, Prozak)

CASE 12

(Schizoaffective Disorder)

BIODATA

Name	M.A
Age	22 years
Sex	Male
Education	Middle
Marital Status	Unmarried
Birth order	6th born
Religion	Islam
Siblings	Five sisters
Parents	Both alive
Education of father	Illiterate
Education of mother	Illiterate
Residence	Jhang Bahatar
Past Psychiatric history in family	YES
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. M.A was a young boy of 22 years of age. He had fair complexion. He maintained good eye contact during session. His speech was appropriate whereas his was mildly depressed. His hygenical condition was appropriate and his hair was properly done. His teeth were not brushed and he started gazing during all session.

PRESENTING COMPLAINTS

Auditory hallucination

Lack of appetite

Abusive

Hyperactive

Spontaneous speech

Sexuality

Dangerousness

Loss of energy

Loss of sleep

Suspicious thoughts

Nerve stretch

FAMILY HISTORY

Mr. M.A was born in middle class family of 5 sisters in Jhang Bahatar. His parents were alived. He was agriculturist and it was the source of their income. His two sisters were married and he lived in joint family system.

He was 6th born child in family. The attitude of his mother and sibling was good. He told that his home environment was good and peaceful. all members of family remain good for most of time and show no aggressive behaviour. But his father sometime used drugs and sometimes beats his mother and sisters.

PAST PERSONAL HISTORY

Mr. M.A was a young boy of 22 years and according to him, his birth was normal. He told about his childhood that he spent quite happily and he was average student and mostly ran away from school due to fear of his teacher. His father wanted him to become an officer. His mother loved him but his father did not love him more because he was dull students and his father think that he can not become an officer like him.

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

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

HISTORY OF PRESENT ILLNESS

He was admitted to mental hospital for 2nd time and it became the patient got relapse of diseased for two months and refused to take medicine. Now he had been in hospital for last 7 weeks. The main reason behind his admission was his aggressive and sexual behavior when his sister and father came with him and admitted him into the hospital.

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

EVALUATION TECHNIQUES

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

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

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 (see appendix, 2-A).

PERSONALITY FUNCTIONING

Mr. M.A. was a young boy of 22 years. He belonged to middle class family. He was the 6th born child in the family five sisters. This was patient's 2nd admission to IZ Psychiatric Center.

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

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

HFD shows that he has aggressive tendencies and schizophrenia as indicated by extended arm, strong hand and broad shoulder (Levy, Hammer). He has also sexual inadequacy as indicated by long nose and mutations (Machover). One dimension of tree shows sheltering experience in life (Machover).

CASE FORMULATION

Mr. M.A. was a young boy of 22 years from a middle class family of Jahang Bahatar. He was unmarried. He was the 6th born child in the family of 5 sisters. His education was Middle. It was patient 2nd time in hospital for treatment of schizoaffective and aggressive behavior.

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

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

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

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

C). The symptoms must not be due to the direct physiological effect of a substance or a general medical condition (Criteria D) (DSM IV-TM).

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

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

TENTATIVE DIAGNOSIS

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

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to M.A.

1. Relaxation training
2. Behavior therapy
3. Pharmachotherapy

Antipsychotic drugs

(i) A typical drug (Clozapine, Olanzapine, Quetiapine)

CASE 13

(Manic Mood Disorder)

BIODATA

Name	M.S.
Age	18 years
Sex	Male
Education	Matric
Marital Status	Unmarried
Birth order	5th born
Religion	Islam
Siblings	3 brothers, 3 sisters
Parents	Alive,
Education of father	Matric
Education of mother	Primary
Residence	Rangly, Jand
Past Psychiatric history in family	Yes
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr.M.S. was a young boy of 18 years . He was thin, with fair complexion and neat dress. During the interview his tone of voice was high with hypermoter activty. His eye contact was good. He was cooperative but sometime he aggitation during the session.

PRESENTING COMPLAINTS

Lack of appetite

Aggressiveness

Excesive energy

Decreasd sleep

Smoking

Fail in love

Talkative

Hyperpsychomoter Activities

Suspicious

Lack of concentration

FAMILY HISTORY

He belonged to middle class family of 3 brothers and 3 sisters of Jand. His parents were alived. His father's education was metric and his mother was primary passed. His was landlord. His father also been suffered from manic-depressive disorder.

He was 4th born in the family. He told that his home environment was good and peaceful, all members of family loved each other but his father had been suffering from manic-depressive disorder since 5 years,which made him very frusraed.

PAST PERSONAL HISTORY

Mr. M.S was o young boy of 18 years and according to him, his birth was normal and he born at home. He told about his childhood that he spent quite happily. He was average student but takes interest in studies and respected his teacher. Now hehad been working at he tailer shop for two years.

He told that he had loved a girl who lived in the neighbour village. She loved him too. But once. someone saw hm when he was kissing her near the shop. Acording to him , the people of village tried to harm his dignity. They were talking everywhere about his affair. Acording to him he knew. What they were plaing against him. But he did no expose his feelings to them. Acording to him many other girls of his native village were iterested in him, therefore the people of village. even his relatives were against him. Acording to he had power to take revang and would do everything against them.

HISTORY OF PRESENT ILLNESS

He was admitted to mental hospital for 1st time due to talkativeness, hyperpsychomoter activiies and aggression. Now he was in hospital since last 2 weeks.

Doctor reported that he came hospital foe 1st time. The cause may be genitic, his failur in love or the environment of family.

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. HFD
4. R.I.S.B
5. B.D.I

INTELLECTUAL FUNCTIONING

.His recent and remote memory seemed to be average as he recalled most of the past and present events in split form.

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. M.S. was a young boy of 18 years. He belonged to middle class family. He was the 5th born child in the family of thee brothers and three sisters. This was patient's 1st psychiatric admission to hospital.

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

Patient score on RISB is 132 with a cut score of 135. It indicates that he is not well adjusted person because his scores lie on borderline. C responses in the RISB are high than positive and neutral responses so responses are indication of unhealthy adjusted from the mind. These indicate hostility reactions, pessimisms, hopelessness and negativism (Rotter, 1932).

On the basis of HFD, it shows that he is hyperactive, inadequate and aggressive.

CASE FORMULATION

Mr. M.S was a young boy of 18 years, from a middle class family of Jand. He was unmarried. He was the 5th born child in the family of three brothers and three sisters. His education was Metric and was tailor by occupation. It was patient 1st time in hospital for treatment of his manic and aggressive behavior.

He had severe symptoms as lack of appetite, irritable mood, excesive energy, decreased sleep and aggression.

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 have irritable mood, unlimited energy, decreased sleep so Patient does not meet the criteria of major depressive disorder because patient also use drugs. So we can't diagnose it, patient with major depressive disorder.

From the drawing of HFD, score on RISB, BDI, it is clear that person has hyperactive tendency, inadequacy, agitation, aggression, expensive selfestem and poor interpersonal relations tendency.

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

TENTATIVE DIAGNOSIS

Axis I	299.84 Manic Mood Disorder
Axis II	Nil
Axis III	Nil
Axis IV	Interpersonal relationship problem
Axis V	GAF = 61-70

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to M.S

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

Antidepressant Drugs(SSRIs Group)

CASE 14

(Disorganized Schizopherenia)

BIODATA

Name	M.N
Age	28 years
Sex	Male
Education	Middel
Marital Status	Married
Birth order	1st born
Religion	Islam
Siblings	No
Parents	father deceased, mother alive
Education of father	illiterate
Education of mother	illiterate
Residence	Sanjwal
Past Psychiatric history in family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. M.M. was a young man of 28 years of age. He was married. He was failed to make rapport. So case history was taken from his first cousin in his presence. He had poor hygeinic condition. He had long hair and unshaved beard. His teeth were not burshed. Durig the session. he was repeatedly weeping and laughing. For sometime he became silent and ruminate. but then he started weeping a laughing again.

PRESENTING COMPLAINTS

Disorganize behavior

Flat effect

Anhedonia

Avotiion

Asociality

FAMILY HISTORY

He belonged to a lower class family. He had no siblings. His father was a worker in POF Sanjwal. He was quite healthy, but unfortunatly was killed. when he was only 8 years of his age. His mother was a house wife. She took care of him well. She wanted him to get education , but he was not a good student at school. He hardly complete the middle and left the study. His family had poor socio-economic status. He only source of income was the pension of his father.

PAST PERSONAL HISTORY

Mr. M.M was a young man of 28 years and he his birth was normal. He was sparkling and healthy in childhood but he had not all pleasures of life.

He was weak student therefore could not carry his studies. He was totally disoriented to time and place. His memory was disassociative. Once, at he age of 9 years, he had broken his righ hand and gotten serious head injury. At the age of 20 years , he was married to his cousin. He had three children. For wo years, he been working in Margala compny as a worker.

HITORY OF PRESENT ILLNESS

He was admitted to mental hopital for 1st time. Now he had been in the hosptal since last 2 weeks. The cause of his admission was his repeated weaping .laughig and blunt behavior.

Doctor reported that he had come hospital for 1st time. The cause may be the head injury and stresseull family environent.

EVALUATION TECHNIQUES

1 Mental status examination

2 Case History examination

3 HFD

4 R.I.S.B

5 B.D.I

CASE FORMULATION

Mr. M.M was a young man of 28 years from a lower class family of Sanjwal. He was married. He was the only born child in the family . His education was middle . It was patient 1st time in hospital for treatment of psychotic symptoms.

He had severe symptoms as disorganized behavior. anheadonia. avolition and flat effect.

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).

As he patient has clear symptoms of disorganized behavior. flat effect. anhedonia so he tends to have Disorganized Schezopherenia.

TENTATIVE DIAGNOSIS

Axis I	294.89 Disorganized Schizopherenia.
Axis II	Nil
Axis III	Nil
Axis IV	Interpersonal relationship problem
Axis V	GAF = 61-70

PROGNOSIS

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

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to M.M

1. Relaxation training
2. Cognitive behavioral therapy
3. Family therapy Pharmchotherpy

Antipsychotc drugs(clozapine,olanzapine, quetiapine)

CASE 15

(Major Depressive Disorder)

BIODATA

Name	M.I
Age	40 years
Sex	Male
Education	M.A Economics
Occupation	Teacher(SST)
Marital Status	Married
Birth order	3rd born
Religion	Islam
Sibling	Three brothers two sisters
Parents	Father deceased
Education of Father	Matric
Education of Mother	Primary
Residence	Attock
Past Psychiatric history in Family	Nil
Past medical history of patient	Nil

BEHAVIORAL OBSERVATION

Mr. M. I was tall, serious stature middle aged man of 40 years .His dress was untidy with untidy hair and long beard but he wanted to look neat and clean as he reported. He answered in low tone of voice but maintained good eye contact during session. He completed tests with great interest. . Overall his behavior was cooperative.

Presenting Complains

Depressed mood

Suicidal ideation

Feeling of Hopelessness

Rumination about past

Lost of interest

Insomnia

Moter retardation

Weight loss

Agitation

Decreased concentration

Fatigue

Irritable mood

FAMILY HISTORY

He belonged to middle class family of three brothers and one two sisters of Attock.

He was 3rd born child in his family. The attitude of his siblings was good and he told that he had independent family system and home environment was good, peaceful but sometimes he became harsh and also came late at home because he wanted to spent time with his friends.

He was married at the age of 32 years. His wife was out of his family, therefore his father never liked her. He had three children.

PAST PERSONAL HISTORY

Mr. M.I. was a middle aged man of 40 years and was the 3rd child of his family. He told that he spent his childhood happily and according to him his birth was normal.

He was an intelligent and position holder student. After compeletion of his education. he was oppointed as a teacher a Govt high school Haddowali. He spent most of the time out of his family because of his job. Afer 5 years ,he been transferred to Hazro high school. He also cotinued his study. Here he fall in love with the daughter of his house's owner. She wa also higher educated and was oppointed as lecturer in a college. After three years. he married her, but his father had never appriciated him. He did not like his wife. After wo years of his marriage his father was died.

HISTORY OF PRESENT ILLNESS

He was admitted to hospital for 1st time for the treatment of Depression. His wife took him in mental hospital. due to his depressed mood, lost of interest in routine activities.weigt loss and headace. After his father's death.he started feeling that his been disliking him. He was blaming himself for this , he married, without his father's will. He also felt that his wife was more educated than him and earnd more. So she tried to force him n every matter. Therefore he became isolate. He also had suicidal ideation.

Doctor reported that he came to hospital for 1st time. The cause may be the death of his father and his family set up. Because of these two reasons ,he might show signs of depressive mood.

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. HFD

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 village where he lived as he matched with the information given by the staff of hospital.

PERSONALITY FUNCTIONING

Mr. M.I was a middle aged man of 40 years. He belonged to middle class family. He was the 3rd born child in the family three brothers and two sisters. This was patient's 1st psychiatric admission to hospital.

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

Patient score on RISB is 136 with a cut score of 135. It indicates that he is not well adjusted person because his scores lie on borderline. C responses in the RISB are high than positive and neutral responses so responses are indication of unhealthy adjusted from the mind.

Drawing of HFD shows that he has depression, withdrawal tendency, inadequacy indicated by legs omitted, very faint area, narrow neck, small same sex figure, tiny drawing and excessive symmetry (Machover, Levy, Hammer). break lines indicates his conflict to that area.

Scores on BDI are indicator of sever depression as the scores are 34 (Beck).

CASE FORMULATION

Mr. M.I was a middle aged man of 40 years from a middle class family of Attock. He was married. He was the 3rd born child in the family of three brothers and two sisters. His education was M.A and a teacher by occupation. It was patient 1st time in hospital for treatment of Depression.

He had severe symptoms as depressive mood, suicidal ideation. feeling of hopelessness. guilt. distub sleep, irritable mood.

From the drawing of HFD, score on RISB, BDI, it is clear that person has withdrawl tendency, inadequacy, severe depression.and poor interpersonal relations.

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

TENTATIVE DIAGNOSIS

Axis I	296.2 Major Depressive Disorder
Axis II	Nil
Axis III	Nil
Axis IV	Interpersonal Relation problem
Axis V	GAF = 55

PROGNOSIS

His symptoms were severe but have no long history, so prognosis was possible.

TREATMENT RECOMMENDATION

Following treatment interrelation we applied to M.I.

1. Relaxation training

2. Behavior therapy

3. Cognitive behavioral therapy

4. Family therapy

5 .Pharmachotherapy

Antidepressant Drugs

(SSRIs Group .paxil. prozak. zoloft)