ADULT CLINICAL PLACEMENT REPORT

SUBMITTED TO

MS. Asima Munawar

SUBMITTED BY

Sidra Taj

CMS# 28545

SESSION

2019 - 2020

DEPARTMENT OF APPLIED PSYCHOLGY

RIPHAH INTERNATIONAL UNIVERSITY ISLAMABAD

CASE REPORT COMPLETION CERTIFICATE

Certified that these case reports have been carried out and completed by **Sidra Taj** CMS NO. **28545** under our supervision.

External Examiner

Supervisor

Head of the department

Department of Applied Psychology

RIPHAH International University, Islamabad campus

ACKNOWLEDGEMENT

All glory and praises to Almighty Allah Who is most Merciful and Beneficent. I am so much indebted to Allah (S.W.T) for all His bounties He bestowed on me and enabled me to complete this report. I am very grateful to Almighty Allah (S.W.T) for He gave me courage and passion to finish this report successfully.

I would also like to express my eternal gratitude to my report supervisor Ma'am Asima Munawar for her guidance, motivation, unconditional support, patience, feedback and encouragement. She always guided me through whole process of report writing.

And last, but not the least, I am much beholden to my family members especially my dearest parents and sisters. Without their assistance and cooperation I may have not been able to complete this report. Their faith and confidence in me, continuous and persistent help resulted in completion of my report. I am much obliged to them for their love, care and concern for me.

(Sidra Taj)

CASE REPORT # 1

Case summary ……. 10

Bio data …… 11

Reason and source of referral …… 11

Presenting complaints…….. 12

History of present illness …….. 13

Preliminary investigation ……. 19

Informal assessment **…….. 19**

Formal assessment **…….. 21**

Diagnosis ……..... 26

Case formulation …….. 28

Management plan ……. 33

References ……... 37

APPENDIX-A

CASE REPORT # 2

Case summary …….. 59

Bio data …….. 60

Reason and source of referral …….. 60

Presenting complaints …… 61

History of present illness …… 62

Preliminary investigation …… 66

Informal assessment **…… 66**

Formal assessment **…… 69**

Diagnosis …….. 72

Case formulation ……. 73

Management plan …… 76

References …… 80

APPENDIX-B

CASE REPORT # 3

Case summary ……. 104

Bio data ……... 105

Reason and source of referral …… 105

Presenting complaints …… 106

History of present illness……. 107

Preliminary investigation …….. 115

Informal assessment **…….. 115**

Formal assessment **……..... 118**

Diagnosis ……. 120

Case formulation …… 123

Management plan …….. 126

References …….. 130

APPENDIX-C

CASE REPORT # 4

Case summary …….. 147

Bio data ……. 148

Reason and source of referral ……. 148

Presenting complaints …….. 148

History of present illness …….. 150

Preliminary investigation …….. 158

Informal assessment ……... 158

Formal assessment …… 161

Diagnosis ……. 165

Case formulation …… 166

Management plan ……... 170

References …… 176

APPENDIX-D

PORTFOLIO ……... 190

Preliminary report 1 ……..... 191

Preliminary Report 2 ……... 197

Assignment …… 204

Presentation …… 209

CASE I

Summary

Mr. I.U was 31 years old married man, educated till matriculation, currently unemployed and previously working in a hotel and resident of Attock. He had 2 children including 1 son and 1 daughter. His birth order was 2nd and he had nine siblings including 6 brothers and 3 sisters. He lived in a joint family system and belonged to middle socio-economic class. The patient was referred to PAC Hospital, Kamra with the complaints appetite loss, weight loss, restlessness, loss on interest in daily activities and headache and low mood for last two months. He even used to be easily irritated and showed verbal and physical aggression towards his family and colleagues. After formal and informal assessment using Beck Depression Inventory, Beck Anxiety Inventory, RISB and DSM 5 checklist his tentative diagnosis was Major Depressive Disorder, recurrent episode, with anxious distress 296.22 (F33.1). The prognosis of client seemed favorable as he had insight of his illness and he was willing for proper treatment to get rid from his problem. The management was done through Cognitive Behavioral Therapy, Daily Thought Record, Deep Breathing, Psycho-education; Progressive Muscle Relaxation etc were used within 10 sessions

Indentifying Information

Name	:	I.U
Age	:	31 years
Gender	:	Male
Education	:	Matriculation
Occupation	:	Hotel Waiter
Marital Status	:	Married
Children	:	2 (1 son, 1 daughter)
Siblings	:	9 (6 brothers, 3 sisters)
Birth Order	:	2nd
Mother Alive/Dead	:	Alive
Father Alive/Dead	:	Alive
Religion	:	Islam
Informant	:	Friend

Reason and Source of Referral

The client's friend brought him to hospital with complaints of appetite loss, weight loss, restlessness, and headache. The client was taken from PAC, Kamra and was referred for psychological assessment.

Presenting Complaints

Table 1.1

Shows presenting complaints as reported by client

دورانیہ	موجودہ مسائل
1مہینہ	چیزیں رکھ کر بھول جاتا ہوں
2مہینے	سر میں درد رہتا ہے
2مہینے	ہر وقت پریشان رہتا ہوں
2مہینے	بچوں کے مستقبل کا خوف رہتا ہے
1ہفتے	چکر آتے ہیں
1مہینہ	ہر وقت اداسی چھائی رہتی ہے
2مہینے	بھوک بہت کم لگتی ہے
2مہینے	کسی کام میں دل نہیں لگتا نیند خراب ہے بہت دیر تک نہیں آتی

Symptoms According to DSM-5

- Low mood
- Anhendonia
- Loss of appetite
- Future threat
- Headache
- Dizziness
- Insomnia

History of Present Illness

The client was brought to the hospital due to the symptoms of appetite loss, weight loss, restlessness, loss on interest in daily activities and headache. The client was analyzed by the physicians and it was found that the symptoms were not due to any physiological reasons.

He was working in Peshawar when the symptoms commenced. One day he came back from his work and found that his family members were arguing to distribute their property. All the brothers had their own residence but the client was staying at his parent's house which was going to be divided among all the members of the family. The client was supporting his parents, his wife and children. The client got married when he was 26 years old. It was purely an arrange marriage. The client had to think about a lot of issues particularly his job. Moreover, he didn't have his own house for his family to settle down. After that day, he couldn't sleep properly, thinking about his current problems and how to solve them. He was also becoming irritating and got easily annoyed over small issues. He started rebuking his children. Moreover he also started

having arguments with his wife over small issues. He kept thinking about his problems and gradually his appetite vanished and he started losing weight. He couldn't work properly and handle the service. Headache had become a part of his daily routine. Most of the times, he was lost in his own train of thoughts and couldn't respond to what his friends were saying. He also had a fight with one of his fellows which was settled down by the rest his friends.

The client never had experienced psychological symptoms ever in his life. Except the Appendicitis in 2002 from which he recovered health, he didn't have any other physical ailment. He also didn't have history of substance abuse. He used to smoke but he had quit smoking since he got married.

When he went to the doctors to seek treatment for his growing problems, they prescribed the medicines for his headache and appetite but to no avail. After taking a number of doses of medicines, he didn't recover at which the doctors referred him to the Psychiatry Ward for therapeutic intervention.

Personal History

Birth and Early Development

According to the client, he was born in 1988 and the delivery was done by a mid-wife. It was a normal delivery and he was a healthy baby; almost of seven pounds. There were no complications in his birth and his mother had no history of substance abuse. The client said that his mother didn't face any prenatal or postnatal problems.

The client achieved all his development milestones at the appropriated age during his childhood. His mother fed him for a year, started sitting approximately at the age of 8 months,

crawling 10 months, standing at almost year and a month and running at 20-21 months. The client started dressing himself completely when he was 5-6 years old. He had experienced no problem related to toilet training and he had normal sleep patterns in childhood. The client also had no behavioral problems like excessive fears, tantrums fits, stammering, sleep walking, nail biting, bed-wetting, thumb sucking etc.

He didn't suffer from any major injury, physiological illness or other psychological problem apart from Appendicitis in 2002.

Marital History

The client got married at the age of 26 years; his spouse's age was 18 years at the time of marriage. It was an arrange marriage. The client's was his paternal uncle's daughter and her age was 23 years currently. She was uneducated and a house wife. She competently managed all her responsibilities regarding the house.

Client reported that he had once loved someone in his life. It was when he was in Matriculation. But there were certain reasons which abstain the client from expressing his feelings in front of that girl. The girl got married and so the client didn't tell anyone. Although he had loved someone else but since the client's wife had entered in his life, he had forgotten about everything about that girl. Client reported that his wife had proven herself to be a faithful life partner. She was very understanding and compromising. She had never complained to the client about anything. Client's wife not only loved the client but also paid respect to all of his family members. None of the family members ever had any complaint related to the client's wife. The client expressed that he was proud to have such a heartfelt life partner.

The client had two offspring; a boy and a girl. The boy was four years old and the girl was two years old. The client said that offspring were the best gift his wife could have ever given him. His children were healthy and the client loved them though since the client's disorder, he had started remaining at distance from everyone. Once or twice he also beat his children because sometimes they were pesky. According to the client, his wife held all the credit for bringing up his children nicely.

Academic History

The client was admitted in school when he was five years old in 1993. It was a local school situated where teacher came from the nearby city to teach the students. He wasn't a bright student but he had somehow managed to pass exams of every standard without failing in any class. The client reported that sometimes their teacher helped them to solve the question paper, which although at that time had been very enjoying but now the client felt that their teacher was ruining the possibilities of the students to learn and acquire knowledge. Client went to school regularly. He was very punctual student, doing his homework daily. His favorite games were hockey and cricket and he used to participate in them whenever their matches held in the client's town. He had been an active player and also had won a fair number of trophies for his team. His favorite subject in school was Urdu but he hated English because he never grasped its grammar or the structure of its sentences. It was because of English that he was punished a lot by his teacher.

The client did Matriculation when he was seventeen years old. He took admission in F.A. part one but could never pursue his studies because of financial problems in the house. He had never felt sorry for quitting education because never had been a very ambitious person in his life

and instead started thinking about other opportunities he could avail to get a decent job with a handsome salary.

It was the client's mother who used to teach the client and the rest of the siblings Holy Quran. He had been a religious person throughout his life, offering prayers regularly. In fact his whole family was religion oriented. There was no compromise over religion and every one was bound to offer prayers and was monitored by the elder brother of the client. The client also sometimes used to read the Urdu translation of Holy Quran.

Social History

The client had genial relations with his parents and siblings. Although he had never been very frank with his siblings yet he loved all of them equally. He was never talkative and didn't indulge in other's affairs. He had few friends and all of them were employed in different stations. Client was the captain of his hockey team. Recreational activities were rare in client's remote area so the client and his friends never missed any chance to participate in sports and enjoy. Client never had any problems in initiating conversation with the strangers. He felt at ease whenever he came face to face with some stranger. He never had any problems being in crowded places or alone because in cricket and hockey matches, crow was must. He was an impressive captain and his team had won a considerable number of matches. He knew how to take the whole team with him and how to gain the beat optimum output from his teammates. Moreover, he disliked TV as now-a-days the TV channels were propagating values which were against Islam. According to him, he also didn't watch he Islamic channels as they were also not an authentic source of information, each channel disseminating its own ideology and criticizing and denying what other channels said.

Psycho-sexual History

The client reached the age of puberty when he was in about 8th class. According to the client, he had already known everything from his friends and his surroundings.

The client stated that he wasn't shocked to hear about sexual relations. He said that if God had meant the things that way, there must be a logical reason behind it and that the client was not going to deny it. He said that if God had chosen the continuation of life to be done in this way, then there was no point of hating it.

The client never had any homosexual or heterosexual experiences in his life. Homosexuality, according to client, was strictly against the limits laid down by Islam. According to the client, all the disasters and calamities on the Muslims were due to the reason that they were forgetting how to live by following the life of Holy Prophet (S.A.W.) and following the footprints of western countries.

Forensic history

No forensic history was reported by the client.

Family History

The client's father was 61 years old. He was illiterate. He had done single marriage. He had carpet business; he also had a dry fruits shop. His father had always managed to provide bread and butter to the client's family. Client's father was a simple, humble and honest man. Client's father had always inspired him and he wanted to be like the same father for his own children as the client's father was for the client and the rest of the siblings. The client reported that despite of having to support such a larger family, his father had never felt any burden or tension of any sort.

Client’s father had never ever spoken to his family harshly. Although the client was not very close and frank with his father, yet he could share considerable amount of things with him.

Client’s father was comparatively closer to the client’s sisters. Especially the youngest sister was quite guileless and she used to go, with the father, to the shops and to pay visits to relatives. The client’s father had exquisite and deferential relationship with client’s mother. He had always treated the client's mother with love, warmth and fondness. He had never experienced any psychological or physical illness in his life.

The client’s mother was 52 years old. She was Hafiz-e-Quran. She also had done single marriage. When she was young and healthy and had intact eye-sight, she used to do embroidery on clothes and sell them in market to earn money and to share her husband’s burden. Her monthly income was hardly three to four thousands at that time. She was a strong and courageous woman, who, despite of hardships had stood with the client’s father and earned money to fulfill the need of the family.

Client’s mother loved and took care of all the siblings equally. Although, she had grown old and weak yet she used to help her daughter-in-laws in kitchen chores. Client’s mother and father were his ideal personalities. Client’s mother had never fought with his father or demanded anything from him rather she was contended with what she had.

Client’s mother had never suffered from any psychological problems. She had asthma due to cooking on coal for a long time but every member of the family tried its level best to refrain her from going near the smoke of coal. It was the client whose responsibility was to buy medicines for his mother and father.

The client belonged to a joint family system. There were total twelve members in the client's family at that time. All the financial needs were fulfilled by the client's father; who had carpet business and dry-fruits shop, client himself; who was hotel waiter, and the client's sister who used to embroider clothes and sell them.

All the decisions were taken by the client's mother and father, who were the authoritative members of the family. Every member of the family used to go to the client's mother and father to have any piece of advice from them. Client's parents had tried their best to fulfill all the basic needs of the family. Client's house had three bedrooms; one for the client's mother and father, one for the client's family, and one for the rest of the siblings. The atmosphere of the house was serene and reassuring. Every member of the family understood the problems of one another and tried to help. Every one's ideas were welcomed and appreciated with open arms and a climate of spirituality prevailed the house.

Premorbid history

According to the client, he led a prosperous and soothing life. Although there were some minor issues in his house but such problems were a part of every family so client had never been bothered by them. Instead he dealt with them adequately. The client's friend reported that the client had never ever been such a quite person instead he used to be the ice-breaker and the life of the whole group of friends. The client's friend reported that the client had never fought with his friends despite of losing any match. The client used to play games especially hockey and cricket, in leisure time, with his friends. He didn't have any premarital or extramarital affairs in his life and considered them against Islam. The client used to be happy most of the time. He was truly a leader; whenever his team fell short of player, it was the client who went for searching out

new talent and made it a part of his team. Every teammate was inspired by the way the client ran things. He had never used drugs or alcohol in his life. As the client belonged to a religious family, so he was also inclined towards religion to a large extent; praying five times a day, reciting Holy Quran and sometimes also saying additional prayers. Overall the client had a happy, serene and tranquil life.

Psychiatric history in family

No significant psychiatric history was reported in the family.

Preliminary Investigation

- Clinical interview
- Behavioral observation
- Mental Status Examination
- Visual Analog Scale

Informal Assessment

The informal assessment comprised of detailed interview, behavioral information, and symptoms ratings.

Clinical Interview

Clinical interview was conducted to have an in-depth knowledge of the client's history of present illness as well as his personal history. It gave a lot of knowledge regarding his predisposing factors, precipitating factors and maintaining factors of the illness. Functioning of the client at different levels and the atmosphere of his home was discussed deeply.

Behavioral observation

Behavioral observation is the recording of the observable reponses of individuals by human observer (Hartmann & Wood, 1992). Behavioral observations are flexible and applicable means of observing behavior and it also provides a comprehensive description and evaluation of behavior. Moreover, it also provides information about the severity and frequency of any behavior (Nock & Kurtz, 2005)

The client was a man who was 31 years old. He was about 6 feet and a few more inches tall. He was sturdy and muscular looking. He was dressed weather appropriately. His hairs were unkempt. Client never maintained an ample eye contact; starring at the floor most of the time. His speech was reluctant initially but became sufficient afterwards. He was looking sad; corners of the mouth turned down and crease on the forehead. He once or twice rubbed his forehead as if trying to concentrate. He talked in low tone; though his speed was average during the interview but his tone had remained slow as ever. He was displaying constricted affect. He didn't display any disorganized speech. Client was conscious about proximity and was maintaining personal space between himself and trainee clinical psychologist

Mental Status Examination

Mental status examination is a method of organizing and evaluating clinical observation pertaining to mental status or mental condition. The primary purpose of the mental status exam is to evaluate current cognitive process (Strub &Black, 1985). Mental status examination contributes a set of interview questions and observations designed to reveal the degree and nature of a client's abnormal functioning (Corner, 2015). Mental status examination obtains evidence of symptoms and signs of mental disorders based on the information about different elements such as appearance, motor activity, speech, mood and affect etc.

Client was wearing neat and clean dress and overall hygienic condition was satisfactory. Attitude of the client towards therapist was uncooperative. Client's rate of speech was average but volume was low. Mood of the client was depressed with constricted affect. No signs of delusions or hallucinations were present. Depersonalization and Derealization was not reported. . His memory was affected. He was not oriented to time, place and person. He wasn't able to tell the time regardless of being asked in a number of ways. Attention span of the client was short and insight was present.

Visual Analog Scale

Visual analog scale scale is a subjective way of measuring the severity of any subjective construct which exists along a continuum. It could further be explained as an instrument which tends to measure any characteristic or attitude that have different values along an array (Gould, 2001)

Visual analog scale was used for subjective rating of client's problems. In visual analog scale, rating of the presenting problems was done on a 10-point rating scale with 1 indicaing the least significant problem and 10 indicating the most significant problem. (see Appendix A)

Table 1.2

Visual analog scale rating of problem at pre- intervention level

Presenting complaints	Pre-intervention rating
Low mood	9
Lack of interest and pleasure	10
Loss of appetite	9

Future threat	10
Headache	7
Irritibility	8
Insomnia	9

Formal Assessment

- Beck Depression Inventory (BDI)
- Beck Anxiety Inventory (BAI)
- Rotter Incomplete Sentence Blank (RISB)

Interpretation of Assessments

Beck Depression Inventory

The Beck Depression Inventory (BDI) was developed by Beck et al. in 1961. It is a 21-item multiple choice, self-reporting questionnaire for evaluating the severity of depression in normal and psychiatric populations.

Rationale

The test was used with the client to measure the symptoms severity of depression.

Procedure

The client was seated in a comfortable environment. Test with pencil was provided. Proper instructions about the test were given to him.”This test consists of 21 groups of statements, please read each carefully, pick out the one option that best describes the way you have been

feeling during past 2 weeks including today. If several statements in the group seem to apply equally well, circle the highest number. Be sure not to choose more than one statement."Test was completed by client in 15 minutes (see appendix A)

Quantitative Analysis

Table 1.3

The client's total raw score range and remarks on BDI are:

Total Raw Score	Range	Remarks
25	17-29	Moderate

Qualitative Analysis

The Client's score on the BDI was 25, the score falls in the moderate range. The client's score on item 11 was maximum which is about getting irritated by the things. According to the test, the client felt indecisive due to his problems. He had low self-esteem and considered himself unappealing. His appetite and weight had decreased to a considerable extent. He said that he always keep on thinking about his problems because he is the one who has to come up with some alternative solution. Other factors like sadness, fear of punishment, disappointment about himself, being critical about mistakes and weaknesses, crying, lack of sleep, lack of interest in other people, and lethargy were also reported by the client on other items of Beck Depression Inventory.

Beck Anxiety Inventory

The Beck Anxiety Inventory (BAI), created by Aaron T. Beck, MD, and colleagues, is a 21-item multiple-choice self-report inventory that measures the severity of an anxiety in Children and adults. Because the items in the BAI describe the emotional, physiological, and cognitive symptoms of anxiety but not depression, it can discriminate anxiety from depression.

Rationale

It was used with the client to assess the intensity of physical and cognitive anxiety symptoms during the past week.

Procedure

The client was seated in a comfortable environment. Test with pencil was provided. Proper instructions about the test were given to him." Below is a list of common symptoms of anxiety. Please carefully read each item in the list, indicate how much you have been bother by each symptoms during the past week including today, by placing an (X) in corresponding space in the column next to each symptom. Test was completed by client in 10 minutes (see appendix A)

Quantitative Analysis

Table 1.4

The client's total raw score, range and remarks on BAI are:

Total Raw Score	***Range***	***Remarks***
17	8-21	Mild

Qualitative Analysis

Beck Anxiety Inventory is used to measure the severity of anxiety. The questions used to measure about common symptoms of anxiety that the subject has had during the past week. Beck Anxiety Inventory was administered to assess if client had any symptom related to anxious distress. In Beck Anxiety Inventory, the symptoms of anxiety related to past week were noted-down and client scored 17, which indicated Mild level of anxiety due to depressive symptoms as the range 8-21 indicates Mild level of anxious distress. His anxious symptoms indicated that light-headed, pounding heart, she had fatigue i-e; he was unable to feel relax and feeling of worst happening as reported by him in his presenting complaints.

Rotter Incomplete Sentence Blank (RISB)

The Rotter Incomplete Sentences Blank (**RISB**) was developed by Julia B. Rotter and Janey E. Rfferty in 1950 at Ohio State University. It comprise of 40 statements. It can be used with adolescents and adults. It is the most frequently used sentence completion **test** of personality and socioemotional functioning. A performance-based **test**, the **RISB** is used to screen for adjustment problems, to facilitate case conceptualization and diagnosis, and to monitor treatment

Rational

To identify patterns of personality in form of adjusted and maladjusted using projective technique or stimuli.

Procedure

Client was seated in a comfortable environment. He was given the test and pencil. Proper instructions were given to him" Complete these sentences to express your feelings. Try to answer every word with a statement. Be sure to make a complete sentence." No further instructions were

given except to repeat the printed instructions if necessary and to urge subjects to complete all the items.

Quantitative Analysis

Table 1.5

The client's total raw score, range and remarks on RISB are:

Obtained score	Cut-off score	Category
141	135	Maladjusted

Qualitative Analysis

Rotter Incomplete Sentence Blank was administered to assess the form/pattern of personality in form of adjusted or maladjusted in presence of subjective stimuli. Then client scored 141, which indicated that he had maladjusted pattern of personality as he fell above 135. It measured four domains of client personality.

Familial Attitude: In indication of client's familial attitude her responses on some items showed that he had positive attitude toward her family i-e; Item no. 02, 08, 11, 7, 35.

Social and Sexual Attitude: In speaking of client relations with others, the client experience good interaction with others. According to him other people are good as in Item no. 10 and 40.

His views about both genders (males and females) were good and interacting i-e; Item no. 7, 40. Those responses of client showed that he had positive attitude toward both males and females. Those statements might indicate that he had satisfied sexual life.

General Attitude: On Item no. 14, 22 client showed that he had positive attitude toward world and other people as well as toward education.

Character Traits: On Item no. 18, 23 client showed negative attitude toward self.

Overall, he indicated maladjusted pattern of personality.

DSM -5 criteria

Client was assessed through formal and informal assessment means nd then after that diagnostic criteria was checked from DSM-5. As formal and informal assessment proposed that client meet diagnostic criteria for depressive disorder so for this reason criteria of depression was checked.

Diagnostic criteria	Symptoms present in client	Status of symptoms
Depressed mood most of the day, nearly everyday	Client used to be depressed most of the time with low mood	✓
Markedly diminished interest or pleasure	Client did not want to participate in any activity	✓
Significant weight loss	Client's appetite was decreased noticeably and he used to skip meals often	✓
Insomnia or hypersomnia	Client had poor sleep	✓

	quality	
Fatigue or loss of energy	Client reported fatigue most of the day.	✓
Feelings of worthlessness or excessive or inappropriate guilt	Client reported guilt due to his present condition	✓
Diminised ability to think or concentrate or indecisiveness	Client's concentration was not intact	✓
Recurrent thoughts of death	No suicidal ideations	×
Feeling restlessness	Client was experiencing unusal restless	✓
Difficulty concentrating	Client's could not concentrate on his work	✓

Tentative Diagnosis

296.22 (F33.1) Major Depressive Disorder, recurrent episode, with anxious distress

Prognosis

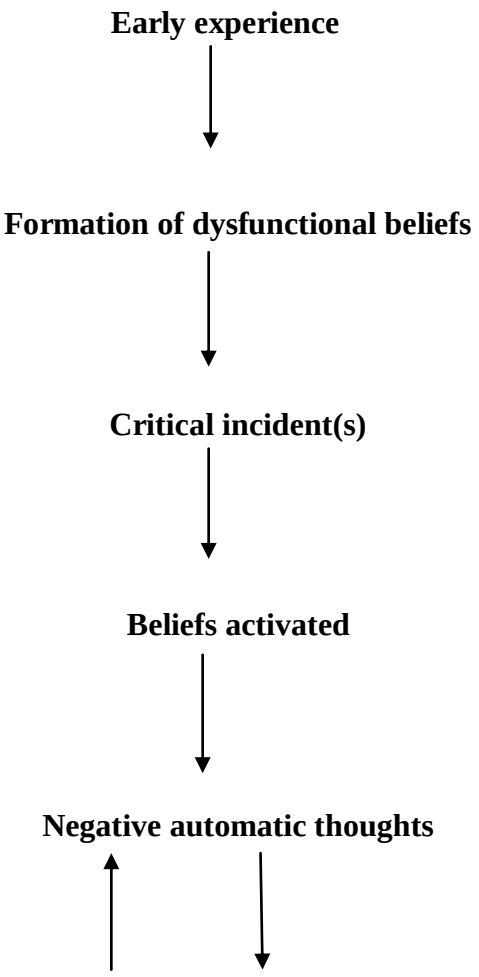
Prognosis is a prediction about how a particular patient is likely to fare over time

In the current case, the client had favorble prognosis due to the presence of good insight, presence of adequate facilities, and absence of premorbid disturbance.

Good outcome is associated with adequate treatment, mild to moderate initial symptoms, and late age of onset. Depressed people suffer an average of five or six episodes during a 20-year period, with an increased risk for recurrence in men. Given the average duration of an episode, chronic depression can consume one-quarter of a person's lifetime (Pelletier, & Kenneth, 2002).

Case Conceptualization

Below mentioned is a cognitive model of depression which was given by beck.



Symptoms of depression

Behavioral **Motivational** **Affective** **Cognitive** **Somatic**

Application of cognitive model of depression for current case involving symptoms of client

Early experience

(Constant comparison with other siblings)

Predisposing factors

↓

Formation of dysfunctional beliefs

(I am inferior to others)

↓

Critical incident(s)

(Being accused by parents, fight with siblings)

Precipitating factors

↓

Beliefs/ Assumptions activated

(I have sacrificed a lot but nothing gets back)

↓

Negative automatic thoughts

(No one likes me

I am useless)

Maintaining factors

↓

Symptoms of depression

Somatic	Motivational	Affective	Cognitive	Behavioral
Loss of sleep	Loss of interest	Sadness	Poor concentration	Missing work
Restlessness	Procrastination	Anxiety	Guilt	Decreased interaction,
Tiredness		Irritability	Indecisiveness	Become angry, weeping

Case formulation

Mr. I. U. was 31 years old and a married man who didn't seem in best of his health. The reasons for admission in hospital were appetite loss, weight loss, and restlessness, loss on interest in daily activities, lethargy, irritability, difficulty in concentration insomnia, and headache since approximately two months. He was working as hotel waiter. He belonged to a lower middle class family. He had nine siblings (6 brothers and 3 sisters). He got married at the age of 26 years. He has two offspring; a son and a daughter. It was the disturbing atmosphere of the house that played a vital role in the onset of symptoms of depression in the client. The client's brothers had a major argument to distribute all the property including the house where the client lived with his parents and wife. The elder brother had his own residence and so the younger brother. The house, in which the client lived, belonged to the client's father. The client didn't have the resources to seek some other place for his family and parents to stay. The client became increasingly worried about how to solve the problems and how to gather some finance to support his family. His brothers were continuously bashing him as he wasn't saying anything on the matter of distribution of property. The client's brothers were blaming him for the sole cause of hindrance in their way to solve their own problems. The client couldn't think of any escape and it was when his appetite decreased and he couldn't sleep well. Client had never beaten his children

but after the argument with his brothers, he also beat his children. Initially, the client considered his behavior normal but his irritability started increasing. He also had a row with his wife over minor issue. He thought of the atmosphere of the house to be responsible for his odd behavior. But he realized the intensity of his problem when he was back on work, his lethargy increased, he couldn't concentrate anything and started arguing with his fellow workers on almost every topic they were talking about. His weight was falling. He went to the hospital for treatment of his headache which had been constant. It was when he realized that his problems were very serious and the doctor admitted him in PAC kamra. He had been under treatment of a clinical psychologist and a psychiatrist.

Clinical interview, behavioral observation, baseline rating and formal assessment comprising of Beck Depression Inventory, Beck Anxiety Inventory, Rotter Incomplete Sentence Blank was administered to the client to find out any underlying factor that the client was not reporting directly. Beck Inventory revealed that the client was moderately depressed about his life.

The test results and case history interview suggested his diagnosis as Major Depressive Disorder. It had also been confirmed by clinical interview. Generally major depressive disorder refers to a condition characterized by a long-lasting depressed mood or marked loss of interest or pleasure (anhedonia) in all or nearly all activities.

Men are likely to be very tired, irritable, lose interest in once-pleasurable activities, and have difficulty sleeping when they experience depression (Poaalck, 1998; Cochran & Rabinowitz, 2000). The symptoms of depression aroused in the client after an exposure to stressful life event in his home environment. Depressive episodes are strongly correlated with

adverse events (Sadock, 2002). Disturbances in family functioning, such as parental (particularly maternal) depression, severe marital conflict or divorce, death of a parent, or other disturbances in parenting are additional risk factors (Raphael, 2000). In adulthood, stressful life events are strongly associated with the onset of major depressive episodes (Kessler, 1997). In this context, life events connected to social rejection appear to be particularly related to depression (Kessler, 1997; Kendler, 2003). Evidence that a first episode of depression is more likely to be immediately preceded by stressful life events than are recurrent ones is consistent with the hypothesis that people may become increasingly sensitized to life stress over successive recurrences of depression (Monroe, Slavich, Torres, & Gotlib, 2007; Sadock, 2000). Stressors may play a more significant role in the precipitation of the first or second episode of this disorder and play less of a role in the onset of subsequent episodes.

Environmental theories of the etiology (causation) of Major Depressive disorder emphasize the role of external events in triggering depression. According to this perspective, people become depressed primarily due to unfortunate circumstances that are difficult to change. In some cases, these misfortunes may include environmental disasters or personal losses; but such other factors as low socioeconomic status, oppression associated with one's sex or race, or unpleasant or frustrating relationships are also thought to contribute to depression.

Low socioeconomic status (SES) is generally associated with high psychiatric morbidity, more disability, and poorer access to health care (Lorant, Deliège, Eaton, Robert, Philippo, & Anssea, 2003).

Many studies have documented an association between low socioeconomic status (SES) and depression, but it has been difficult to determine whether the relation is causal. Lorant

(2007) surveyed 11,909 individuals yearly regarding depressive symptoms and SES (mean, 4.6 annual assessments). It was founded that low socioeconomic status as a risk factor for depression. Longitudinal models focusing on change over a year's time within individuals showed that increases in financial strain, deprivation, and poverty, and the end of cohabitation were associated with increases in depressive symptoms, depression cases, or both (Lorant, 2007). Lorant, Croux, Weich, Deliège, Mackenbach and Ansseau (2007) showed a clear relationship between worsening socio-economic circumstances and depression.

Client experienced depressive symptoms at the age of 31 years. The median age of onset is 32 (although adults age 49 -54 years are the age group with the highest rates of depression) (Cheung, Zuckerbrot, Jensen, Ghalib, Laraque, & Stein, 2007).

Client was a male and it has been proven by research that depression is not rare in men. In fact, white men over age 85 have the highest rates of suicide of any group. Some evidence suggests that men are more apt than women to mask their depression by using alcohol, which may result in a lower reported (but not actual) incidence of depression in men. Depression is less reported in the male population, but this may be caused by male tendency to mask emotional disorders with behavior such as alcohol abuse (Frederikse, Petrides, & Kellner, 2006). Although depression can occur at any age, its onset is typically between the ages 24 and 44. Later onset may correlate with the absence of a family history of depression. Fifty percent of people with major depressive disorder experience their first episode of depression at about age 40, but this may be shifting to the 30s. Studies find that the rate of incidence is higher among middle-aged people (Gross, Nakamura, Pascual-Leone, & Fregni, 2007). Major depressive disorder affects 10% of men and 20% of women (Golden, Lazo, Carnethon, Bertoni, Schreiner, & Roux, 2008).

Client was not adequately educated, he had done Matriculation and Francis, Weiss, Senf, Heist, and Hargraves, (2007) reported that lower levels of education linked to depression.

Client had low self-esteem. Raphael (2000) found that low self-esteem and self-defeating or distorted thinking were related to depression. Smits et al. (2008) found that anxiety symptoms, functional impairment, chronic illness, low mastery, low education and having no partner were the risk factors that best predicted depression risk.

Depression is associated with substantial and persistent impairments in psychosocial functioning (Hirschfeld, Montgomery, Keller, et al., 1989). The functional impairment experienced by patients with MDD is often comparable and, in some instances, more profound than that which has been reported among patients suffering from other chronic medical conditions (Wells, Stewart, Hays, et al., 2008**)**. In the present case, the functionality level declined in the client and he wasn't able to carry out the duties of his job.

Cognitive behavioral theorists suggest that depression results from maladaptive, faulty, or irrational cognitions taking the form of distorted thoughts and judgments. According to cognitive behavioral theory, depressed people think differently than non-depressed people, and it is this difference in thinking that causes them to become depressed. In the present case, the client tended to view himself, his environment, and the future in a negative, pessimistic light. As a result, he began to misinterpret facts in negative ways and blame himself for any misfortune that occurred (Linden, 2006).

There are following other theories that can be applicable:

Aron Beck's Cognitive Theory of Depression

According to Cognitive Behavioral Theory, depressed people think differently than non-depressed people and it is the unique difference in thinking that causes them to become depressed. The inner directed anger reduces the individual's self-esteem, and makes him/her vulnerable to experiencing depression in the future. Beck asserts three main dysfunctional belief themes that dominate depressed people's thinking. 1. I'm defective 2. All of my experience resulted in failure 3. The future is hopeless. Together, these three themes are described as Negative Cognitive Triad. When these beliefs are presented in someone's cognition, depression is very likely to occur.

Freud's Psychodynamic Theory

According to Freud's Psychodynamic Theory, depression could be linked to loss or rejection by a parent. Depression is like grief, in that it occurs as a reaction to the loss of an important relationship.

The clinical picture of client depicts that she had depressive symptoms as related to these theories.

Hopelessness Theory

According to hopelessness theory, the most important trigger of depression is hopelessness, which is defined as an expectation that desirable outcomes will not occur and that the person has no responses available to change the situation. It is defined by the symptoms of decreased energy, psychomotor retardation, sleep disturbances, poor concentration and negative cognitions.

Hopelessness is believed to be triggered by life events that have important consequences for a person and/or a person's self-evaluations. The model places emphasis on two key dimensions of attributions i-e; Stable verses Unstable causes and Global verses Specific causes.

In the current case, different factors are contributing towards the client's illness. He was facing stressful environment continuously. He belonged to a low socioeconomic status and lack of financial resources is making him prone to face the adverse effects of depression.

Management Plan

The management plan was based on eclectic approach. Different techniques were used to deal with the situation of client.

Short Term Goals

- The client was educated about his problem, possible outcomes and the process of therapy.
- Tentative numbers of sessions were told to his friend and moral support was provided to his and client to establish a therapist-client alliance.
- Rapport establishment was an important task which was achieved.
- He was taught forgiveness therapy to forgive himself and others.
- Behavioral experiments and techniques were used to treat his condition.
- Homework assignment was given to his to increase the effect of therapy.
- Elements of Cognitive behavioral therapy will be used to change his disruptive thoughts and beliefs.

Long Term Goals

- Follow ups by continuing with the short term goals.
- Inter-personal therapy will be helpful to settle his conflicts with family.

Therapeutic Recommendation

- Cognitive Behavioral Therapy (CBT)
- Daily Thought Record (DTR)
- Deep Breathing
- Psycho-education
- Progressive Muscle Relaxation (PMR)

Summary of therapeutic intervention

Cognitive Behavioral Therapy (CBT)

CBT is a type of psychotherapy. As it is the evidence-based theory for depression i-e; it works best with depression. It will modify thought patterns in order to change mood and behavior. It is based on the idea that negative actions or feelings are the result of current distorted beliefs or thoughts, not unconscious forces from the past. It can be effective if depression is mild or moderate. It can also help with more severe cases of depression if therapist is highly skilled.

Daily Thought Record (DTR)

It can be recommended to client in order to get record of his automatic thoughts come in mind. The purpose of keeping this record is to help catch the automatic thoughts, recognize the feelings that go along with them, and work on balancing the client's thinking towards modifying mood.

Deep Breathing

Deep breathing involves slow and deep inhalation through nose. Deep breathing can release stress and provide other noticeable health benefits. Client will likely feel calmer after performing deep breathing exercises, and may trade feelings of anger or fear for a focused, relaxed state of mind.

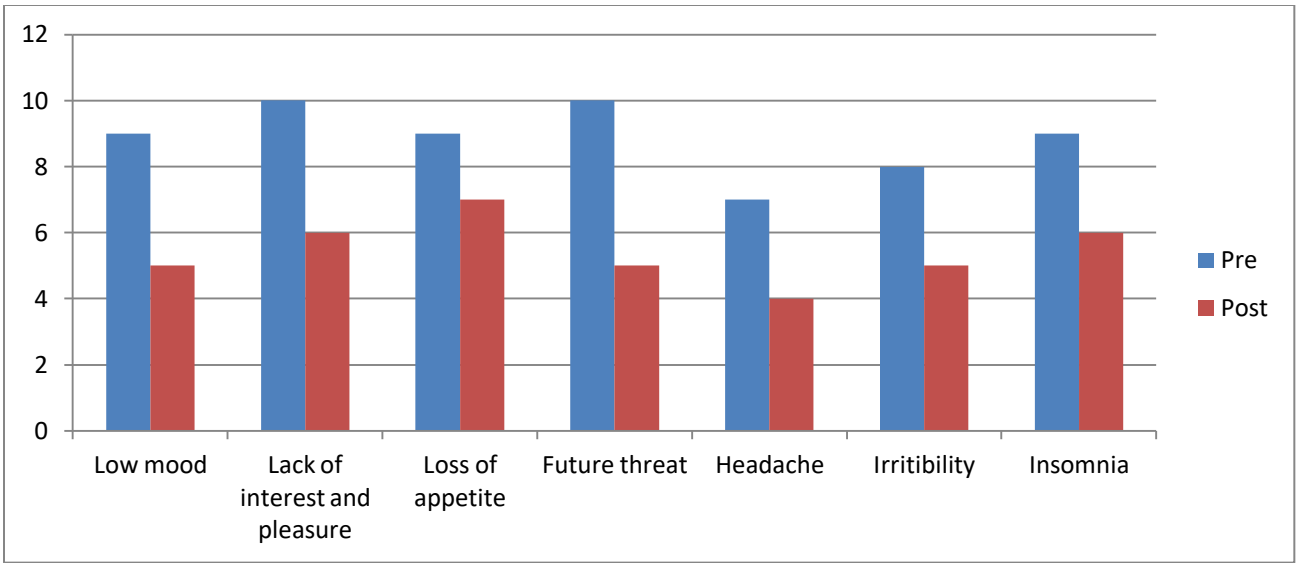
Psycho-education

Psycho-education will be given to the client in order to give him understanding about his illness. This purpose of psycho-education is to provide information to client about his illness and developed the insight about nature of problem, severity of problem, and management of problem.

Progressive Muscle Relaxation (PMR)

Depression sometimes causes physical symptoms such as tiredness and sleep problems. Progressive relaxation yields a variety of benefits, including the development of feeling of well-being, lowered blood pressure, decreased muscle tension, thereby, reducing the bodily need for oxygen and reducing fatigue and anxiety. It is also known as Deep Muscle Relaxation. The aim is to reach a deep state of relaxation and improve awareness of own body and tense areas.

Demographic presentation of pre- intervention and post- intervention rating of client's problem



Limitations

- There was no interaction with family of the client
- Extensive work could not be done due to brief therapeutic time period
- Extrinsic factors such as hospital environment hindered in proper management of client

Suggestions

- Proper individual sessions of client should be continued
- Long term goals should be continued
- Follow ups should be continued

References

World Health Organization (WHO). Global Programme on Evidence for Health Policy Discussion Paper 54. World Health Organization (WHO); 2007. Global Burden of Disease in 2002: data sources, methods and results.

Unutzer J, Patrick DL, Diehr P, Simon G, Grembowski D, Katon W. Quality adjusted life years in older adults with depressive symptoms and chronic medical disorders. Int Psychogeriatr. 2000;12:15–33.

Kessler RC, Berglund P, Demler O, et al. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA. 2003;289:3095–3105.

Simon GE. Social and economic burden of mood disorders. Biol Psychiatry. 2003;54:208–215.

Beck CT. Maternal depression and child behaviour problems: a meta-analysis. J Adv Nurs. 1999;29:623–629.

Downey G, Coyne JC. Children of depressed parents: an integrative review. Psychol Bull. 1990;108:50–76.

Kane P, Garber J. The relations among depression in fathers, children's psychopathology, and father-child conflict: a meta-analysis. Clin Psychol Rev. 2004;24:339–360.

Penninx BW, Leveille S, Ferrucci L, van Eijk JT, Guralnik JM. Exploring the effect of depression on physical disability: longitudinal evidence from the established populations for epidemiologic studies of the elderly. Am J Public Health. 1999;89:1346–1352.

Bruce ML, Seeman TE, Merrill SS, Blazer DG. The impact of depressive symptomatology on physical disability: MacArthur Studies of Successful Aging. Am J Public Health. 1994;84:1796–1799.

Ormel J, VonKorff M, Oldehinkel AJ, Simon G, Tiemens BG, Ustun TB. Onset of disability in depressed and non-depressed primary care patients. Psychol Med. 1999;29:847–853.

Katon W, Ciechanowski P. Impact of major depression on chronic medical illness. J Psychosom Res. 2002;53:859–863.

Sessions

Session No. 1

- Gathering history
- Rapport establishment
- Informational care

Presenting Complaints and History of Present Illness was obtained through Clinical Interview. Interview was conducted with client and informant. Information of this interview was used to start therapeutic process.

Counseling

Client was counseled about his present situation and he was assured complete support by using different counselling skills like empathy. Different counselling techniques were also use like rephrasing, summarizing and giving positive gestures of active listening.

Informal care

Informant was asked to be very vigilant in keeping an eye for anything that the client could use for deliberate self-harm or harm to any other person as well. He was also told to take care of his appetite and sleep as well.

He was also educated regarding therapy protocol and the importance of homework assignments. Estimated number of sessions were told to him to prepare him for this process and convenience. Further time of session was also decided to conduct an uninterrupted continuous sessions. Homework was explained as a necessary facilitator between sessions that would help

the client to be better explained and will be used in him further sessions for him betterment. He was also explained the importance of sessions and how it will be beneficial for him.

SessionNo.2

- Obtaining detailed history
- Formal assessment
- Motivational interview
- Homework

Information regarding his present illness and premorbid personality was taken. Further past history and events were also explored. His friend was also aware of his home issues. His friend was very concerned about it.

Assessment

Formal assessment was done through Beck Depression Inventory, Beck Anxiety Inventory and Rotter Incomplete Sentence Blank..Informal assessment was done through clinical interview, observing his behavior, and rating his behavior.

Motivational Interview

Client was motivated for the therapy, forgetting his problems and leading his life in proper direction by adopting correct path instead of the wrong one and by hoping for good things in the

future and welcoming them as well. He was motivated to focus on his future rather than living in his past.

Homework

Homework was assigned to him to take care of his physical health first as he had complaint of headache. He was asked to increase his water intake and take care of his diet as well. He was also asked to focus on his hygiene as well.

Session No. 3

- Feedback of Previous session was asked from him. He had made a schedule of him water intake and followed it. This can also be seen from his appearance as his eyes were not that pale.

- Relaxation exercises

Relaxation technique

Relaxation technique of deep breathing was taught to the client by first showing him how it was to be done then he was given instructions regarding it. The client was asked to sit comfortably in a chair during session and to close his eyes while letting loose his muscles. He was asked to take a deep breath from his nose and hold it in his stomach for 3-5 seconds and slowly releasing it through his mouth and repeating it, the client felt calm after it. After it he was asked to imagine his most preferable scenario where he wants to go and he was asked to imagine being there while deep breathing for optimal results.

He was asked to incorporate it in his routine and use it when he wakes up, when he is stressed out, when he is getting aggressive, when he is feeling the need for self-harm and also before sleeping.

Session No. 4

- Catharsis was also applied to eradicate feelings of guilt.
- Catharsis was used for feeling of guilt.

Forgiveness therapy (forgiving self)

Forgiveness therapy was applied to him. Client was asked to forget himself first. Following steps were followed.

Client was asked to think about his mistakes that he had made in past. After that he was asked to consider his guilty self as a small child who has done a mistake unconsciously.

After that client was asked to repeat this sentence loud, “I know I have done this mistake, I am sorry, I forgive myself and I love myself”. Client was asked to repeat this sentence again and again until he actually felt it to be true.

After that he was asked to love himself and pat himself with affection.

Next, client was asked to introduce himself with his new self that had made a mistake and now had forgiven himself.

He was asked to repeat this process a few times during the session and also at times when those feelings come up.

Catharsis

Catharsis was also used with him to facilitate the process of forgiveness therapy. During this process he cried multiple time and was console. Further he was asked to speak whatever he wanted to so that he can forgive himself completely.

After completing session client was relaxed through relaxation via deep breathing. He also felt better by forgiving himself. His homework assignment was repeating same process several times.

Session No. 5

- Feedback of previous session was taken and homework was checked. He was relaxed and he was able to maintain eye contact.
- Forgiveness therapy was continued.
- Anger management

Forgiveness Therapy (forgiving others)

Forgiveness therapy was continued with his and he was asked if he had forgiven himself. He had accepted himself and also forgiven himself to a great extent. After that he was asked to forgive others and society using same method. Forgiving his brothers was a difficult task for him but he was asked to do so for his own betterment.

In this he was asked to repeat verbally “I have forgiven my brothers for what they did”. This was done repeatedly to condition his mind in thinking the same as well.

Anger Management

Anger management techniques were told to him to control his aggression. Client had developed some anger issues due to his home problems, he used to be verbally abusive but he also showed physical aggression on his children on occasions. So a few techniques were taught which included:

- Acknowledge your own anger and stay "stop" to yourself.
- Count till 20 before responding as this will help to delay the response and interrupt the cycle.
- Deep breathing, as it will help to control physical state of body.
- Changing posture or starting a physical activity will help to redirect energy.
- De-tracking thoughts, as it will help to minimize the effect of anger stimulus. For de-tracking mind he was asked to recite few verses from Holy Quran.

Session No. 5

- Feedback of Previous Session was taken from the client.
- Verbal challenging.
- Stress coping techniques were told to his to cope with stress.

Feedback

Feedback was taken from the client regarding forgiveness therapy he said that he had forgiven his brothers but he was guiltier about himself that he couldn't do anything to stop them.

Verbal challenging

The client was low in self-esteem and being a rejected person. For this he was counseled a lot saying that not all people are doing to be same in his like. People are all internally different as they are externally different so if someone had fought him then it does not mean that all are.

For boosting his self-esteem he was asked why he felt so low, he said that he has had this feeling since childhood and that has persisted. He was disputed against it by using logic and reasoning.

Stress Coping

The client was told following things:

- Take care of your health, diet and sleep.
- Share your problems and talk to others as people might give you great advice.
- Don’t be afraid to take a break to relax.

The attendant was told following points:

- Help himself maintain a normal routine.
- Make an on-going effort to talk to others about ways to help yourself cope.

Session No. 7

- Sleep hygiene
- Activity scheduling was done for him
- Journaling was applied

Activity Scheduling

Activity schedule was made for him. He was asked about his routine and was asked to form a time table during the sessions. Then different suggestions were given to him and with his consent changes were made to it. Specific times were set for each thing like his eating patterns as well as fixing a time table.

Journaling

Client was asked to write his feelings on diary and he was asked to write all his emotions in this diary. Journaling helped the client to understand his emotions and mood changes. He was also asked to write 3 good things that happened today and that he is grateful for and also to write 3 things he learned today no matter how big or small or to just 3 inspirational or uplifting things.

Session No. 8

- Emotional freedom tapping
- Counseling

Feedback of previous session was taken from his. He was feeling better than before.

Emotional Freedom Technique

Emotional Freedom Technique was explained to the client. He was told about the basic tapping points like on the top of his head, on side of eye, below the eye, below the nose, on his chin, collarbone and below his arm. All taping points were taught to him with sentence "even though I have had a difficult and heart breaking life but now everything will be good". He was asked to repeat this sentence with all taping points and exercise was given to his as homework.

Counseling

He was counseled regarding his family and career. He was motivated to start a job again slowly so that he could support his parents and family. He was also told about the impact of a goal-directed life and how he should try to focus on his strong points and use them in his favor.

Session No. 9

- Feedback of previous session was asked from him. He was relaxed than before and he was accepting himself.
- Cognitive restructuring regarding his future was done.
- Circle of Excellence was also applied on his.

Cognitive Restructuring

Cognitive restructuring was done for him by using Socratic questioning so that he does not feel attacked. He was questioned regarding his future plans in which still some depressed cognitions were present. He was again questioned why only his future will not be good and is there any specific reason for it.

Circle of Excellence

An imaginary circle was drawn on floor in front of client and he was asked to imagine a person whom he considered an ideal personality and the person whose qualities he wants in himself. He was asked to imagine the positive energy of that person which he wanted in himself in the circle and then he was asked to step in. He was asked to feel that energy and transfer it in him. This process was repeated several times with him to make him feel better.

Session No. 10

- Homework was checked and discussed. He was also asked about his condition.
- Terminating session was conducted.

Termination

Session was terminated after his post-therapy assessment. He was asked to take his pharmacological treatment and seek psychological help as soon as he needs it.

Outcome

Client was able to control his symptoms to great extent after 10 sessions. A considerable shift in his cognitive sets was seen after therapy. His misinterpretations about himself were greatly reduced. The most effective technique for him was forgiving himself and others and emotional freedom technique that helped him to accept himself.

Appendix-A

SCORING OF ROTTER'S INCOMPLETE BLANK SENTENCES

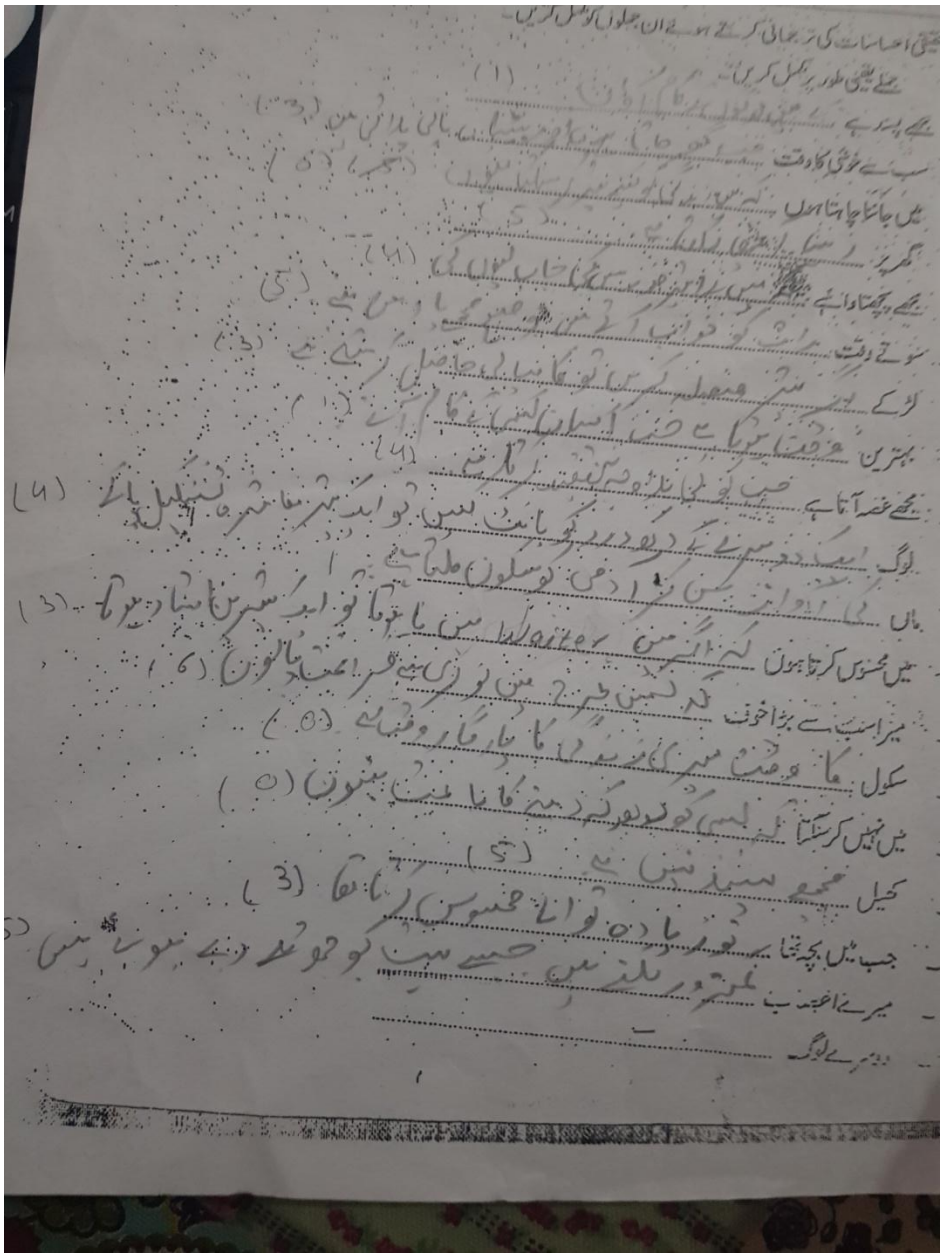
FAMILY		PERSONAL		GENERAL		OPPOSITE G	
Item No.	Score	Item No.	Score	Item No.	Score	Item No.	Score
4	5	1		2	3	7	
6	5	3	6	8	2		
11	1	5	4	10	4		
17	3	9	4	14	0		
26	4	12	3	16	5		
35	2	13	6	19	–		
		15	0	22	1		
		18	5	24	6		
		20	4	28	5		
		21	5	29	4		
		23	6	31	2		
		25	5	33	6		
		27	3	38	5		
		30	5	40	1		
		32	4				
		34	6				
		36	—				
		37	2				
		39	6				
Total	20	Total	75	Total	43	Total	3

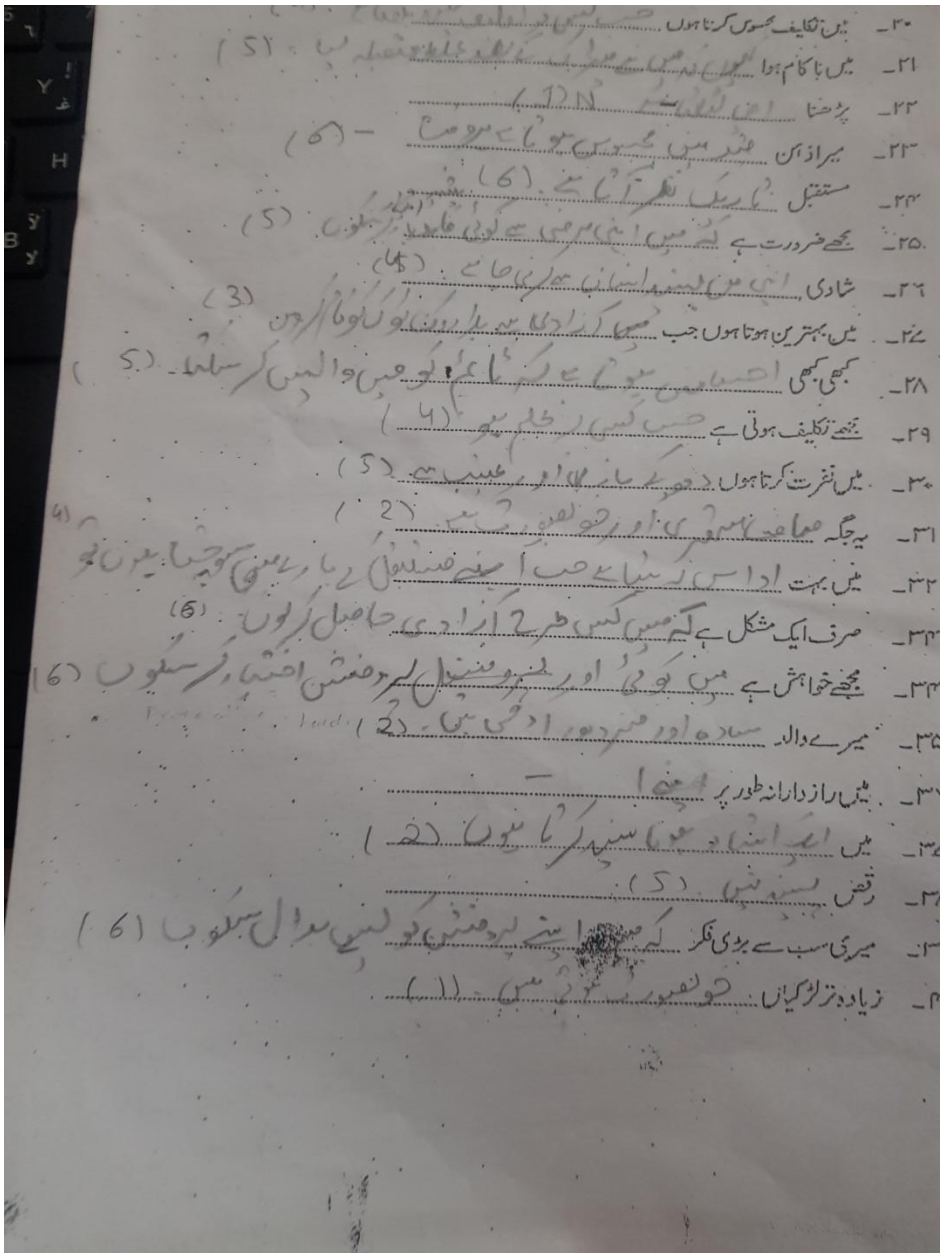
The results have shown that the problem is in Job and Family Dissatisfaction domain.

Total Score: 141

Socially Adjusted:

Socially Maladjusted: ✓





۲۰۔ میں تکلیف محسوس کرتا ہوں .....

۲۱۔ میں ناکام ہوا .....

۲۲۔ پڑھنا .....

۲۳۔ میرا ذہن .....

۲۴۔ مستقبل .....

۲۵۔ مجھے ضرورت ہے .....

۲۶۔ شادی .....

۲۷۔ میں بہترین ہوتا ہوں جب .....

۲۸۔ کبھی کبھی .....

۲۹۔ مجھے تکلیف ہوتی ہے .....

۳۰۔ میں نفرت کرتا ہوں .....

۳۱۔ یہ جگہ .....

۳۲۔ میں بہت اداس رہتا ہے جب .....

۳۳۔ صرف ایک مشکل ہے کہ .....

۳۴۔ مجھے خواہش ہے .....

۳۵۔ میرے والد .....

۳۶۔ میں رازدارانہ طور پر .....

۳۷۔ میں .....

۳۸۔ رقص .....

۳۹۔ میری سب سے بڑی فکر .....

۴۰۔ زیادہ تر لڑکیاں .....

BECK ANXIETY INVENTORY

اپنی کیفیت کے مطابق چارٹ میں درست آپشن پر نشان لگائیں

بیانات	بالکل نہیں (0)	معمولی (1)	قابل برداشت (2)	نا قابل برداشت (3)
جسم میں سوئیاں چبھنا (جسم کا سو جانا				
جسم میں آگ کا نکلنا (گرمی لگنا				
ٹانگوں میں جان نہ رہنا (کپکپاہٹ طاری ہونا			✓	
سکون نہ آنا				✓
بد ترین حالات کا خوف رہنا			✓	
چکر آنا (سر بھاری ہونا				
دل کی دھڑکن تیز ہونا				✓
غیر یقینی کی کیفیت رہنا				
گھبراہٹ رہنا				
خوف زدہ رہنا				
گھٹن محسوس ہونا				
ہاتھوں کا کانپنا				
خود اعتمادی میں کمی			✓	
غصہ آنا ، چڑچڑا ہونا				✓
سانس میں دشواری				
موت کا خوف				
مستقل ڈر رہنا			✓	
بدہضمی یا پیٹ میں تکلیف				
بے ہوشی طاری ہونا				
چہرے سے گرمی نکلنا ، یا چہرہ کالا پڑ جانا				
بغیر گرمی کے پسینہ آنا				

ABC Model

Activiting event	Belief	Consequences
My brother insulted me	I'm failure	Anger, Anxiety, Hopeless

(D)

Appendix G: Thought Record Form

Cognitive Therapy Thought Record www.CognitiveTherapyGuide.org				
Situation	Initial Thought	Negative Thinking	Evidence for this Thinking	Alternative Thinking
My brother said something disrespectful about my Progession in a family gathering	My brother hate me because I'm a failure. I started feeling myself inferior	Negative Self-labelling focusing on the negatives only	I can still hear my Parents voice that I'm a failure & that I will never amount to anything	I feel better when I am kind of myself because every Profession in this world is respectful.
Describe the situation that led to your unpleasant feelings	What thought first entered your mind?	Identify the negative thinking behind your initial thought.	Look at the evidence for and against this thinking. Have you been in a similar situation before? What strengths do you bring to this situation? Look at the whole picture.	Once you've considered the facts, write down a healthier way of thinking.

* This thought record template can be copied without restrictions for personal use.

28

بیک انونٹری

درج ذیل میں 21 طرح کے بیانات ہیں جو لوگوں کے احساسات اور اعتقادات سے متعلق ہیں۔ جو بیان آپ کے گذشتہ ہفتے
احوال کو صحیح بیاں کرتا ہے اس پر دائرہ ڈال دیں۔

0۔ مجھے افسردگی محسوس نہیں ہوتی۔
1۔ مجھے اداسی محسوس ہوتی ہے۔
2۔ میں ہر وقت افسردہ رہتا ہوں اور اس کیفیت سے نکل نہیں سکتا۔
3۔ میں اتنا افسردہ، یا اتنا خوش ہوں کہ مجھ سے اپنی کیفیت برداشت بھی نہیں ہوتی۔

0۔ میں خاص طور پر مستقبل کے بارے میں مایوس نہیں۔
1۔ میں اپنے مستقبل کے بارے میں مایوس ہوں۔
2 میں محسوس کرتا ہوں کہ مستقبل میں میرے لئے کچھ بھی نہیں ہے۔
3۔ میں محسوس کرتا ہوں کہ مستقبل بھی مایوس کن ہے اور یہ صورتحال بہتر نہیں ہو سکتی۔

---

0 میں ناکام محسوس نہیں کرتا۔
1۔ مجھے احساس ہے کہ میں ایک عام اوسط انسان کی نسبت زیادہ کام ہوں۔
2۔ جب میں اپنی گزشتہ زندگی پر نظر ڈالتا ہوں تو مجھے بہت سی ناکامیاں دکھائی دیتی ہیں۔
3۔ یوں محسوس ہوتا ہے کہ میں بالکل ناکام شخص ہوں۔

0۔ مجھے چیزوں میں اتنی ہی تسکین / تسلی ملتی ہے جتنی پہلے ملا کرتی تھی۔
1۔ مجھے جس طرح پہلے مختلف چیزوں سے مسرت حاصل ہوتی تھی اب نہیں ہوتی۔
2۔ اب مجھے کسی چیز سے حقیقی تسکین نہیں ملتی۔
3۔ میں ہر شے سے غیر مطمئن اور بے زار ہوں۔

0- میں معمول سے زیادہ نہیں روتا / روتی۔

1- میں پہلے کی نسبت اب زیادہ روتا / روتی ہوں۔

2- اب میں ہر وقت روتا / روتی ہوں۔

3- مجھ میں پہلے رونے کی ہمت ہوتی تھی۔ اب میں رونا چاہوں بھی تو بھی نہیں رو سکتا۔

0- میں معمول سے زیادہ چڑچڑا / جھنجلایا ہوا نہیں ہوں۔

1- اب میں پہلے کی نسبت زیادہ جلدی جھنجلا جاتا ہوں یا خفا ہو جاتا ہوں۔

2- میں اب ہر وقت چڑچڑا رہتا ہوں۔

3- میں اب ان چیزوں سے تنگ نہیں آتا جن سے پہلے میں تنگ آیا کرتا تھا۔

0- دوسرے لوگوں میں میری دلچسپی ختم نہیں ہوئی۔

1- دوسرے لوگوں میری دلچسپی اب پہلے کی نسبت کم ہو گئی ہے۔

2- میں نے اب لوگوں میں دلچسپی لینا چھوڑ دی ہے۔

3- مجھے اب لوگوں میں بالکل کوئی دلچسپی نہیں رہی۔

0- میں اب بھی پہلے کی طرح فیصلے کرنے کی اہلیت رکھتا ہوں۔

1- میں اب فیصلہ کرنے کے مرحلے کو پہلے کی نسبت زیادہ بار ملتوی کرتا ہوں۔

2- پہلے کی نسبت اب فیصلے کرنے میں مجھے زیادہ دشواری پیش آتی ہیں۔

3- اب میں مزید بالکل کوئی فیصلے نہیں کر سکتا۔

0- مجھے نہیں لگتا کہ میں پہلے سے بدتر دکھائی دیتا ہوں۔

1- مجھے پریشانی ہے کہ میں اب بوڑھا اور بدشکل دکھائی دیتا ہوں۔

2- میرے خیال میں میری ظاہری شکل و صورت میں مستقل تبدیلی آ چکی ہے۔ جو مجھے بدشکل اور بدنما بنا رہی ہے۔

3- مجھے یقین ہے کہ میں بدشکل دکھائی دیتا ہوں۔

میں پہلے کی طرح خوش اسلوبی سے کام کر سکتا ہوں

(-1) کوئی کام شروع کرنے کے لئے مجھے اب زیادہ کوشش کرنا پڑتی ہے۔

-2 مجھے کوئی کام کرنے کے لئے اپنے آپ کو بہت کوشش سے مائل و مجبور کرنا پڑتا ہے۔

3 میں بالکل کام نہیں کر سکتا۔

-0 میں حسب معمول اچھی نیند سو سکتا ہوں۔

(-1) میری نیند اب پہلے کی طرح اچھی نہیں۔

-2 میں معمول سے 1-2 گھنٹے قبل اٹھ جاتا ہوں اور پھر دوبارہ سونے میں بہت مشکل پیش آتی ہے۔

3 میں پہلے کے معمول سے کئی گھنٹے پہلے جاگ جاتا ہوں اور پھر دوبارہ نہیں سو سکتا۔

(-0) میں معمول سے زیادہ نہیں تھکتا۔

-1 میں پہلے کی نسبت بہت تھک جاتا ہوں۔

-2 میں تقریباً ہر کام کرنے سے تھک جاتا ہوں۔

(3) میں اتنا تھکا ہوا ہوں کہ کوئی کام نہیں کر سکتا۔

-0 میری بھوک معمول سے خراب نہیں۔

(-1) میری بھوک اب اتنی اچھی نہیں رہی جتنی ہوا کرتی تھی۔

-2 مجھے اب بہت ہی کم بھوک لگتی ہے۔

(3) مجھے اب بالکل بھوک نہیں لگتی۔

0- میں خود کو خاص طور پر قصوروار نہیں سمجھتا۔

1- میں خاصا وقت خود کو قصوروار سمجھتا ہوں۔

2- میں بیشتر وقت احساس جرم کا شکار رہتا ہوں۔

3- میں ہر وقت احساس جرم کا شکار رہتا ہوں۔

0- میں یہ محسوس نہیں کرتا / کرتی کہ مجھے سزا مل رہی ہے۔

1- میں یہ محسوس کرتا / کرتی ہوں کہ شائد مجھے سزا مل رہی ہے۔

2- میں سزا دیئے جانے کی توقع کرتا ہوں۔

3- یوں لگتا ہے کہ مجھے سزا مل رہی ہے۔

0- میں اپنے آپ سے مایوس نہیں ہوں۔

1- میں اپنے آپ سے مایوس ہوں۔

2- میں اپنے آپ سے بیزار ہوں۔

3- مجھے اپنے آپ سے نفرت ہے۔

0- میں محسوس نہیں کرتا کہ میں کسی بھی دوسرے فرد سے بدتر ہوں۔

1- میں اپنی کمزوریوں اور غلطیوں پر خود تنقید کرتا ہوں۔

2- میں ہر وقت اپنی غلطیوں کیلئے خود کو الزام دیتا ہوں اور قصوروار ٹھہراتا ہوں۔

3- میں اپنے ساتھ ہونے والی ہر بری بات کا خود کو ذمہ دار اور قصوروار ٹھہراتا ہوں۔

0- مجھے اپنے آپ کو ختم کرنے کے کوئی خیال نہیں آتے۔

1- مجھے اپنے آپ کو ختم کرنے کا خیال تو آتا ہے لیکن میں اس پر عمل نہیں کروں گا۔

2- میں خود کو ختم کر دینا چاہتا / چاہتی ہوں۔

3- اگر مجھے موقع ملا تو میں اپنے آپ کو ختم کر ڈالتا۔

0. حال ہی میں میرا وزن کوئی زیادہ متاثر نہیں ہوا۔
1. میرا وزن پانچ پونڈ سے زیادہ کم ہوا ہے۔
2. میرا وزن دس پونڈ سے زیادہ کم ہوا ہے۔
3. میرا وزن پندرہ پونڈ سے زیادہ کم ہوا ہے۔
4. میں جان بوجھ کر وزن کم کرنے کے لئے کم کھا رہا ہوں۔

---

0. میں معمول سے زیادہ اپنی صحت کے بارے میں فکر مند نہیں۔
1. میں جسمانی تکالیف مثلاً بدن میں درد یں، بدہضمی یا قبض وغیرہ کے بارے میں فکر مند ہوں۔
2. میں جسمانی تکالیف کے بارے میں بہت زیادہ فکر مند ہوں اور مجھے زیادہ کسی اور چیز کے بارے میں سوچنے کی مہلت نہیں ملتی۔
3. میں اپنی جسمانی صحت کے بارے میں اتنا فکر مند ہوں کہ کچھ اور سوجھتا ہی نہیں۔

---

0. میں نے حال ہی میں جنس میں اپنی دلچسپی میں کوئی تبدیلی محسوس نہیں کی۔
1. پہلے کی نسبت اب مجھے جنس میں کم دلچسپی ہے۔
2. مجھے اب جنس میں بہت کم دلچسپی ہے۔
3. جنس میں میری دلچسپی بالکل ختم ہو گئی ہے۔

Case II

Summary

A.B was a 20 years old unmarried boy currently doing BS (Hons.). He came himself with the complaints of preoccupied thoughts and repetitive acts like over thinking about mathematical concepts, arranging cupboard, pocket checking, shoes checking and arranging the shelves of the kitchen since 5 years. He was tentatively diagnosed with the 300.3 (F42) Obsessive Compulsive Disorder, on the basis of formal assessment which included Yales-Brown Obsessive Compulsive Scale (Y-BOCS), HTP and DSM 5 checklist to assess his symptoms, and informal assessment which included clinical interview, behavioral observation, MMSE. The prognosis of client seemed favorable as he was motivated to change, educated, self-referred, and he had proper insight of his illness. Management was based on CBT (thought suppression (pink bear technique), coping statements, , detached mindfulness, exposure and response prevention, relaxation exercise, evidence for and against, cost benefit analysis, attention training technique) within 13 sessions, which resulted in 80 percent improvement as indicated by post assessment.

Identifying Information

Name	:	A.Y
Age	:	20 years
Gender	:	Male
Education	:	BS (Hons.)
Occupation	:	Unemployed
Marital Status	:	Unmarried
Children	:	NIL
Siblings	:	3 (1 brother, 2 sisters)
Birth Order	:	Last
Mother Alive/Dead	:	Alive
Father Alive/Dead	:	Alive
Religion	:	Islam
Referral Source	:	Father

Reason for referral

Client was seen in psychiatry OPD in PAC Hospital, Kamra. He came himself with the complaints of preoccupied thoughts and repetitive acts like over thinking about mathematical concepts, arranging cupboard, pocket checking, shoes checking and arranging the shelves of the kitchen since 5 years. He was referred to trainee psychologist for management of his problems.

Presenting Complaints

Table 2

Shows Presenting complaints as reported by client

موجودہ مسائل	دورانیہ
ایک سوچ ذہن میں آجائے تو وہی سوچتا رہتا ہوں .	**8 سال**
بار بار الماری سیٹ کرتا ہوں	**5سال**
پلف صاف کرتا ہوںبار بار کچن کے ش	**5سال**
ایک راستے سے بار بار گزرنے کا دل کرتا ہے	**5سال**
بار بار جیب چیک کرتا ہوں	**5سال**
بیڈ کے پاس پڑے ہوئے جوتے کی بار بار تسلی کرتا ہوں	**5سال**

Symptoms by DSM-5

- Obsessions
  - Recurrent thoughts of pocket checking
  - Repetitive thoughts of cupboard setting
- Compulsions
  - Repetitive acts of pocket checking
  - Repetitive acts of shoes checking
- Guilt, distress and anxiety provoked by thoughts
- Over-thinking
- Irritable mood
- Anger outbursts

History of Present Illness

Client's history of present illness dates back to 2013 when he was in 9th standard. After preparing his last exam, his mind suddenly focused on the concept and formula of area and he started thinking about it. Client reported that he tried to restrain his thoughts and told himself that these concepts are clear in his mind but still his mind was pre occupied with such thoughts.

ذہن میں ایسے سوال آتے تھے جن کے جواب معلوم تھے لیکن اس باوجود ذہن سے ےریم"

نہیں نکلتے تھے جس کی وجہ سے میرا بہت وقت ضائع ہوتا تھا ان سوچوں میں

This event led towards over thinking about similar concepts like usage of symbols in mathematics. According to him, he knew these concepts but his mind was not satisfied and he continued thinking about them.

"میرے ذہن میں اسی سے متآ لاوس سے جیسے ھت سے (=) اک اس نئی کو کو لگتے ہیں، ہی کو کو

یں. پ لس ک ا سائ ن ک یوں ہوت ا ہے حالان کہ مجھے پ تا ب ھی ہوت ا ت ھا." ب ناہے گ ئے ہ

This over thinking caused him big deal of stress. He reported that he spent a lot of time thinking about such useless things and could not focus on studies. It affected his studies and resulted as poor performance in exams. It caused him much stress and he started over thinking about his poor performance. He tried to control these thoughts but had not control over them.

After passing final exams, he started focusing on his studies. He used to repeat sentences in order to learn and understand more clearly. Because of this habit, he started over thinking and repeated thinking about some concepts like run rate, velocity, and calculations. He spent a lot of time thinking about these concepts while doing other chores as well. In fact, sometimes he forgot to do the actual work while over thinking. It was making it hard for him to keep his attention on other tasks like attending lectures. He reported that he tried to distract himself from these thoughts by doing some work but it couldn’t control the thoughts and causes dissatisfaction and mental stress. He reported that he faced absence of mind while thinking about his thoughts. He could not pay attention when he was addressed.

It was strange situation for him as he had no idea and awareness of these symptoms. He reported that he thought he would get mad because of these thoughts. He tried to ignore and suppress these thoughts but he could not control them. He discussed this situation with his family

but they did not considered it as a problem as they have no awareness about it. He did not go for any help as he reported that he didn't know if it was really a problem or not.

After completing matriculation, he got admission in a renowned college for doing F.Sc. Pre Engineering. The change in environment, course pattern, method of teaching and curriculum was another stressor for him. He reported that his mind remained pre-occupied with thoughts like he cannot survive there.

When he was doing F.Sc., other symptoms like arranging cupboard and shelves started occurring along with pocket checking, opening and closing of doors and watching his shoes again and again. He reported that he had urge of doing these acts because his mind could not be satisfied unless these acts were performed. He reported that he was afraid that if he didn't check his pocket, he will miss something important. He told that these acts were increasing day by day and those were time taking to the extent that he sometimes forgot the actual work to be done in that time. He told that his attention, focus and concentration were also affected. He could not attend lectures attentively or maintain his concentration. The symptoms continued which affected his studies and daily life matters. His result of Intermediate was not satisfactory, he got 62%. It was a shock for his family as he was an efficient and extra ordinary good student in studies. It was another stressor for him. He kept worrying about his problem and future.

After completing Intermediate studies, He got admission in BS (hons.) Accounting. During this time, his father met a road accident. He was severely injured. It added to his turmoil because they suffered from a financial crisis as well in the same time. All the responsibility of their business was resting on his shoulders because his elder brother was not interested in business and wanted to continue his job. During this time, he started having mood disturbance

like being argumentative, irritated and anger out bursts. He started having arguments with his parents.

Meanwhile he was going to University. There he studied a course of Psychology as a minor subject. He discussed his problem with his Psychology teacher who told him to consult a psychiatric or a Psychologist. She told him that he had symptoms of Obsessive Compulsive Disorder. He was very glad to know his problem because before this he had no idea that this situation and problem even exist in people. He told his family members. His mother agreed to consult a psychiatrist but his father was against it as he did not consider it a problem. The client searched and read about Obsessive Compulsive Disorder on Internet. He looked for some private practitioners but their session dues were unaffordable for him.

The client consulted a psychologist in PAC Hospital on the suggestion of a relative. He was referred to trainee psychologist for his management.

Personal History

Early childhood

The client was born through normal delivery, had first cry at time of birth and his mother did not suffered through any pre and post natal complications. All the developmental milestones were achieved at age appropriate levels. The client reported that he had habit of leg shaking since childhood. He told that he had active imagination. He used to live in fantasies where he was the hero and went on many adventures. He was naughty and confident. He was friendly and lively child who liked to spend time with friends and family. He reported no history of any physical illness or head injury.

Psychosexual History

The client achieved puberty at the age of 13 years. He had prior information regarding this matter from his friends so he reacted normally. He adjusted with this change easily as he was aware that its part of life that happens to every boy. The client reported no emotional or physical attachment with same or opposite gender.

Academic History

The client got admitted in the school at the age of 4 years. He was obedient and compliant student. He was hard working since childhood. He was high achiever and participated in all extra-curricular activities. According to the client, he did very poor in mid-term exams of 9th standard because he was over confident about his studies. The result was not satisfactory and he felt hurt and ashamed. So he tried to compensate in final exams by studying hard.

After the on-set of symptoms, his education was severely affected. He could not pay attention and concentration on his studies due to overthinking and performing compulsive acts.

Social History

The client was social before the onset of his problem. He liked to watch English movies and series. He was fond of watching football matches on T.V and playing video games with friends. He also reported that he was an ambitious, goal oriented and determined person. With increased severity of his problems his social life changed. The client reported that he is left with few friends only. His relationship with them was healthy and satisfactory. Sometimes they come over or we talk on phone. The client reported that although he goes out for education but he does not like to mix-up with new people. He did not like to meet new people. He came home after

university and did not go out. The client reported that he did not take part in family functions. He had limited relationship with his family members after the onset of problem. He felt difficulty to meet the people and maintain his relationship with them.

Forensic History

No forensic history of the client was present.

Family History

The client belonged to upper middle class family. He lives in a nuclear family with his parents and siblings.

His father is 65 years old, literate businessman. As reported by the client, he has a rigid and stubborn personality. He is the authoritative person of the family and did not like when someone argue with him. The client had few conflicts with his father as both are argumentative. His father met a road accident in 2017 which made him bed ridden for some time. During the same period, they suffer through financial crisis that affected his father's mood. He started having mood swings and used abusive language. He wanted the client to carry on his business but due to client's problems he could not concentrate and did not want to do business.

Client's mother is 60 years old housewife. She has friendly nature. Client reported to be more attached to his mother. He shared problems with her and has satisfactory relationship with his mother. He used to help his mother in household chores but after worsening of his condition he became aggressive towards his mother and elder siblings as well.

Premorbid Personality

Mr. A.Y reported himself as an active and extrovert person. He was naughty child since childhood. He was outgoing, confident and friendly by nature. He enjoyed the company of friends and family. He was not shy or timid but he became sensitive when it comes to family issues. Since he has brilliant student, he had a bossy nature when it comes to work. He liked to lead when working in group. He had active imagination. He reported that he used to live in his fantasies where he was the hero. He liked to watch English movies and series. He was fond of watching football matches on T.V and playing video games. Before the illness hit him, he reported that he was an ambitious, goal oriented and determined person. When asked about religious inclination, he reported that he was regular in prayers, 5 times a day. But after his illness, whenever he missed a prayer, he became sad and felt huge guilt.

Psychiatric history in family

No significant psychiatric history is present in client's family.

Preliminary Investigation

Informal Assessment

Informal assessment was carried out to assess the client's problem and planning therapeutic intervention based on his problems. The following measures were used for this purpose:

- Clinical interview
- Behavioral Observation
- Subjective symptom rating

Clinical Interview

Clinical interview was conducted with the client to get information about client's problematic behaviors and complaints and to find out possible causes underlying these problems. It is used as a way to gather information to help determine the appropriate course of treatment. It is aimed at determining diagnosis, history, causes of problems and possible treatment options (Davison & Neale, 1966).

A detailed clinical interview was conducted with the client and his mother who told about the presenting complaints, history of the client's illness, information about the family background and client's personal history.

Behavioral observation

Behavioral observation is the recording of the observable reponses of individuals by human observer (Hartmann & Wood, 1992). Behavioral observations are flexible and applicable means of observing behavior and it also provides a comprehensive description and evaluation of behavior. Moreover, it also provides information about the severity and frequency of any behavior (Nock & Kurtz, 2005)

The client was young boy who was 20 years old. He was of average height and weight. His dress was tidy and hair was combed. His gait was normal and he maintained proper eye contact. His tone of voice fluctuated between normal and low tone. He became sad while talking about his life events and his sufferings when he was not aware of his problem and how he struggled alone along with family issues. His speech was elaborative. He provided complete history in sequences but sometimes he used pressured speech. The mood and affect of the client were according to his emotions and situation as he was looking worried and tensed while talking

about his problem. He was comfortable to disclose his information even he was happy to know the fact that his problem was not alien and it really exist. Client reported his mind became preoccupied with thoughts that came in his mind and he felt tensed and worried because of these thoughts as they were making him dysfunctional in daily life.

Mental Status Examination

Mental status examination is a method of organizing and evaluating clinical observation pertaining to mental status or mental condition. The primary purpose of the mental status exam is to evaluate current cognitive process (Strub &Black, 1985). Mental status examination contributes a set of interview questions and observations designed to reveal the degree and nature of a client's abnormal functioning (Corner, 2015). Mental status examination obtains evidence of symptoms and signs of mental disorders based on the information about different elements such as appearance, motor activity, speech, mood and affect etc.

Client was wearing neat and clean dress and overall hygienic condition was satisfactory. Attitude of the client towards therapist was cooperative, as he was ready to share about his life experiences. Client's rate of speech was normal but at times he used pressured speech. Volume was between normal to low. The mood and affect of the client were according to his emotions and situation. . He reported obsessive thoughts with ordering and checking theme along with compulsive acts. The client denied any kind of delusions, hallucinations or mood disturbance. Depersonalization and Derealization was not reported. The abstract reasoning and judgment was intact. He was well oriented with the time, place and person. Attention span of the client was short and insight was present.

Visual Analog Scale

Visual analog scale is a subjective way of measuring the severity of any subjective construct which exists along a continuum. It could further be explained as an instrument which tends to measure any characteristic or attitude that have different values along an array (Gould, 2001)

Visual analog scale was used for subjective rating of client's problems. In visual analog scale, rating of the presenting problems was done on a 10-point rating scale with 1 indicaing the least significant problem and 10 indicating the most significant problem. (see Appendix)

Table 2.2

Visual analog scale rating of problem at pre- intervention level

Symptoms	**Pre treatment ratings**
Recurrent thoughts of pocket checking	9
Repetitive thoughts of cupboard setting	9
Repetitive acts of pocket checking	8
Repetitive acts of shoes checking	9
Guilt, distress and anxiety provoked by thoughts	10

Formal Assessment

Yale's-Brown Obsessive Compulsive Scale (Y-BOCS)

The scale, which was designed by Wayne K. Goodman and his colleagues, is used to rate the severity of obsessive–compulsive disorder (OCD) symptoms for patients with age range vary from 18- 85 and to monitor improvement during treatment.

Rationale

This test was devised to assess symptoms of Obsessive Compulsive Disorder in client.

Procedure

The client was seated in a comfortable environment. Test with pencil was provided. Proper instructions about the test were given to him "Check the appropriate score below. Choose only one item per question. The first 5 questions relate to obsessive thoughts, the last 5 questions relate to compulsive behaviours. Scores should reflect the composite effect of all obsessive compulsive symptoms. Rate the average occurrence of each item during the prior week up to and including now. Test was completed by client in 15 minutes (see appendix B)

Quantitative interpretation

Raw score	Range	Severity
27	24-31	Severe

Qualitative interpretation

Score of client on Yales-Brown Obsessive Compulsive Scale (Y-BOCS) was 27 that shows extreme OCD symptoms.The client scores on the test reflected that he had high score on obsessing, checking and ordering. The client total score had exceeded the cutoff score which indicate the presence of Obsessive Compulsive Disorder.

House, Tree, Person (HTP)

House tree person test was developed by John Buck(1948) and is an extension of good enough scale i.e. Draw a person Test used to asses intellectual functioning.It is a projective test which let people respond to ambiguous stimuli, presumably revealing hidden emotions and internal conflicts.

Rationale

The House Tree Person is a projective test designed to measure aspects of personality. The test can also be used to asses brain damage and general mental functioning.

Procedure

The client was seated in a comfortable environment. He was given 3 A4 plain sheets one by one and a pencil. Instructions were given to him. “Here I want you to draw as good a house, tree and a person as you can”. After that questions were asked related to the drawings. Test was completed by client within 30 minutes.

Qualitative Interpretation

House Interpretation

In case of house normal size represents that the house is nurturing place for client, close door indicates not very social, locked door shows defensive, door and windows indicate willingness to interact with others, weak lines showed weak ego boundaries, extra attention on roof shows fantasy and ideation and absence of pathways shows that client was not very social and never show feeling with others.

Tree Interpretation

Client draw fruit tree which shows dependency and immaturity, tree look was cloud like shows fantasy, absence roots indicates instable personality and sense of insecurity and the tree which client draw was apple tree indicates high need of nurturance and dependency.

Person Interpretation

In person client draw same sex which indicates restlessness, finger depicted in motion indicates fantasy, facial features were lights shows withdrawal, side pose shows that he don't want to expose his personality. Chopped feet showed helplessness, small feet indicate insecurity. Finger were petal like shows immaturity, open arms indicates aggressiveness, difference in arm's length indicates conflicts in inhibiting some abilities, weak arms shows dependency and nurturance, thin legs insecurity and dependency, eye pupil indicates communication difficulties, open mouth indicates neediness, absence of facial expression indicates poor interpersonal relations and absence of ear indicates criticism.

DSM -5 criteria

Client was assessed through formal and informal assessment means nd then after those diagnostic criteria was checked from DSM-5. As formal and informal assessment proposed that

client meet diagnostic criteria for depressive disorder so for this reason criteria of Obsessive compulsive disorder was checked.

Diagnostic Criteria	Symptoms present in client	Status of symptoms
Presence of obsessions and compulsions	Client reported obsessive thoughts with ordering and checking theme along with compulsive acts.	✓
Time consumption more than 1 hr	Client spent a lot of his time thinking and doing repetitive checking	✓
Clinically significant distress and anxiety	Client felt tensed and worried because of these thoughts	✓
Interfere with daily life activities	Client's education was severely effected	✓

Tentative Diagnosis

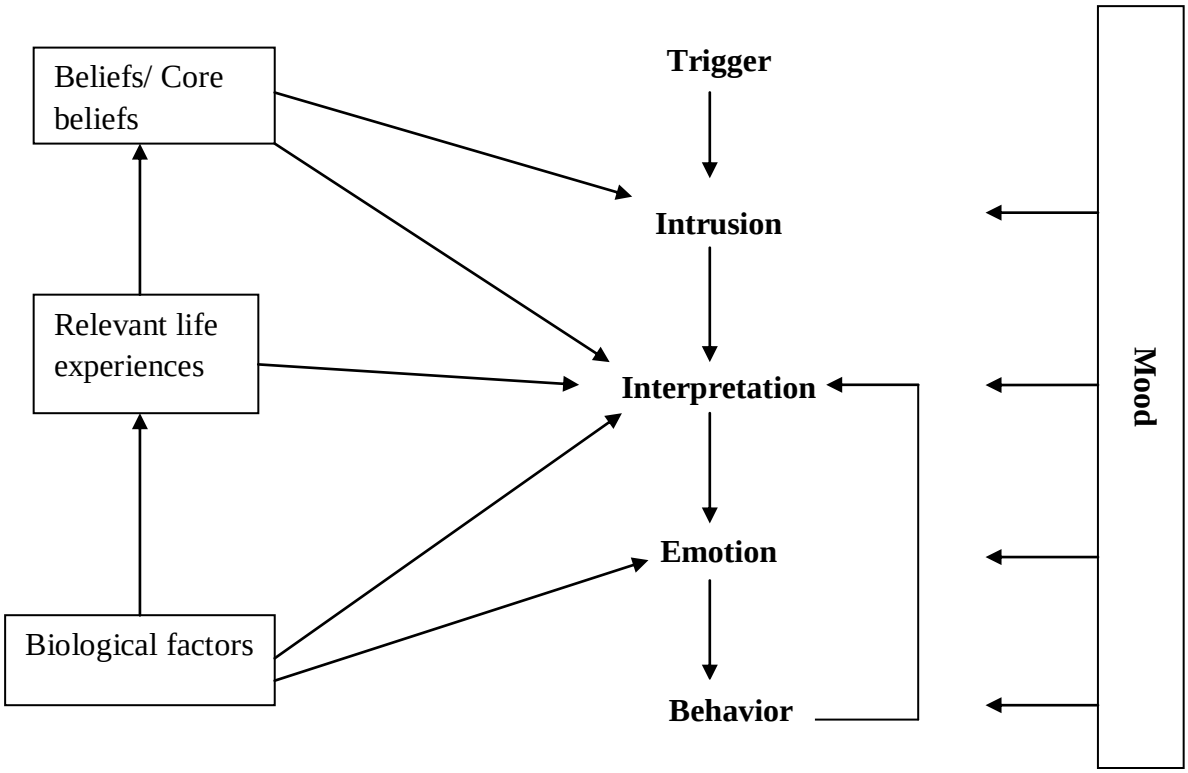
300.3(F42) Obsessive Compulsive Disorder, with fair insight

Prognosis

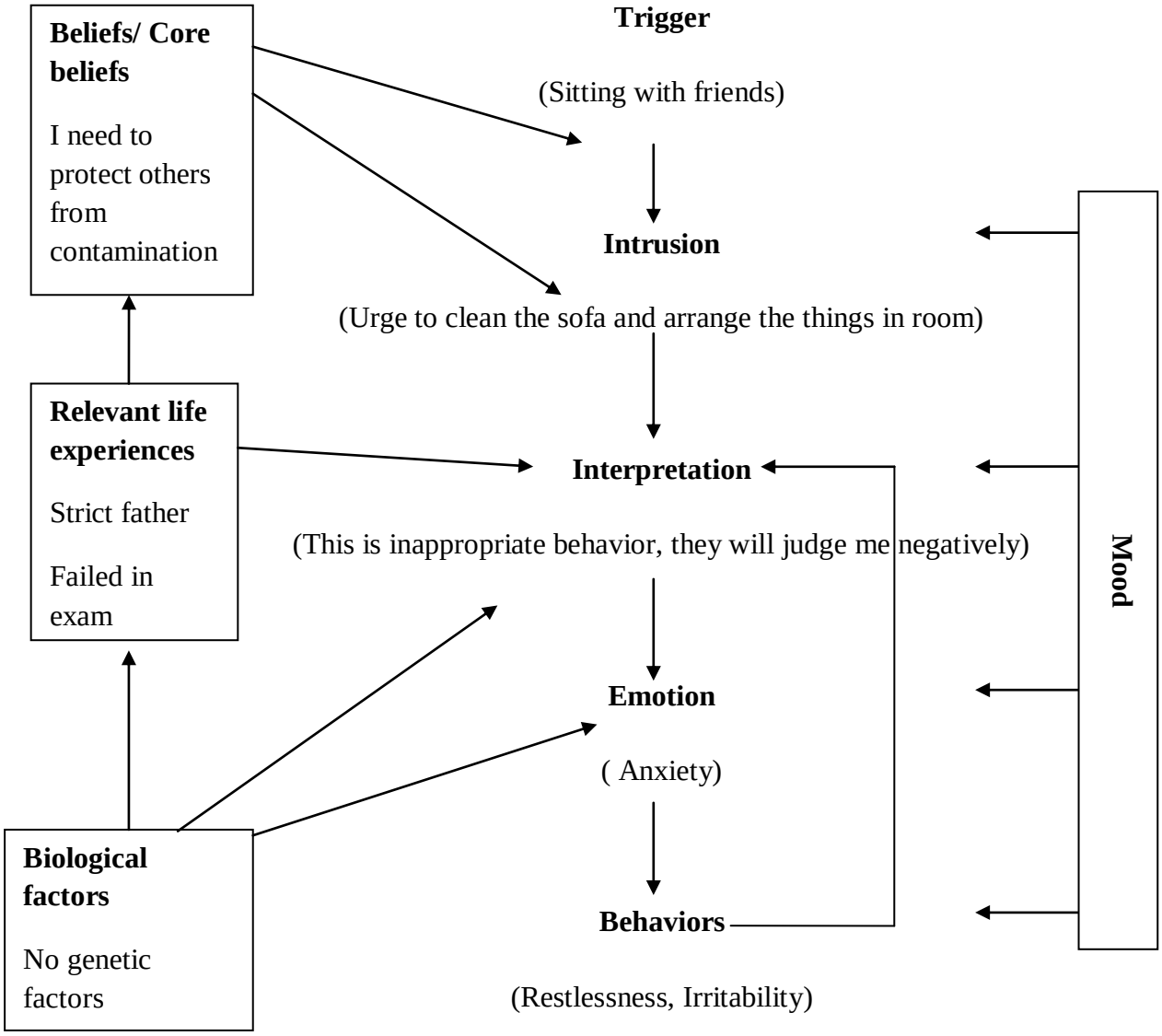
Prognosis is a prediction about how a particular patient is likely to fare over time.The prognosis of client seemed favorable as he was motivated to change, educated, self-referred, and he had proper insight of his illness.

Case Conceptualization

Case formulation is done on the bases of Cognitive Model given by Beck.



Implementation of cognitive model of obsessive compulsive disorder



Case Formulation

A.B was a 20 year's old unmarried boy currently doing BS (Hons.). He came himself with the complaints of preoccupied thoughts and repetitive acts like over thinking about mathematical concepts, arranging cupboard, pocket checking, shoes checking and arranging the shelves of the

kitchen since 5 years. He was tentatively diagnosed with the 300.3 (F42) Obsessive Compulsive Disorder, on the basis of formal assessment which included Yales-Brown Obsessive Compulsive Scale (Y-BOCS), HTP and DSM 5 checklist to assess his symptoms, and informal assessment which included clinical interview, behavioral observation, MMSE.

Man is free and responsible for his will and action and at least for his attitude towards life. This former statement is the concept of man in logotherapy. The external and internal forces or events cannot affect the man while the attitude of accepting that force or event is the primary reason for the effected state of man. The absence of meaning in the particular situation and time is the actual cause for any psychological disorder. Meaning is the primary motivational force in the life if the meaning is not present then the life will be hacked by other forces and disturbed the condition of man but it cannot snatch the freedom of man because it lies in the Noetic dimension of man which cannot be affected in any case (Frankl, 2005).

One of the best explanation of obessesive compulsive behavior resides in Behavioral Explanations that is Operant Conditioning and Compulsions.Compulsive behavior can provide short-term relief from anxiety that is produced by an obsession. Operant conditioning occurs when the behavior is negatively reinforced, Because it (temporarily) relieves the anxiety, it is more likely to recur when the thoughts arise again. All of my client's various eccentric behaviors—his rechecking, his precautions against germs, temporarily relieved his anxiety. Other than behavioral explanation one of the contributing explanation is of Cognition. Obsessional Thinking If you've ever liked something or someone , you may have spent a lot of time thinking about the thing or person—it may have even felt like an obsession. Such obsessions arise surprisingly frequently (Weissman et al., 1994), but they don't usually develop into a disorder. One theory about how a normal obsession became part of OCD is that the person

decides that his or her thoughts refer to something unacceptable, such as killing someone or,catching someone else's illness (Salkovskis, 1985). These obsessive thoughts, which the individual believes imply some kind of danger, lead to very uncomfortable feelings.In case of my client he thought that if he did not clean the shelves something catastrophic will occur that will be difficult to manage and he will be responsible for that.

Mental or behavioral rituals arise in order to reduce these feelings. A related theory is that for some people who develop OCD, a disturbing thought is the moral equivalent of actually performing the act, which leads to greater distress in response to the initial obsession (Rachman, 1997; Shafran, Thordarson, & Rachman, 1996). Both theories contrast a normal response to "unacceptable" thoughts (an awareness that such thoughts don't need to be controlled and an ability to let them fade from consciousness) with the belief of OCD patients that such thoughts must be controlled—and trying to do so amplifi es the thoughts (Tolin, Worhunsky, & Maltby, 2006). Consistent with this theoretical approach, researchers have found that some mental processes function differently in people with OCD than in people without the disorder. In particular, such patients are more likely to pay attention to and remember threat-relevant stimuli, and their processing of complex visual stimuli (as, for example, is necessary to decide whether an object has been touched by a dirty or clean tissue among people with contamination fears) is impaired (Constans et al., 1995; Muller & Roberts, 2005; Radomsky, Rachman, & Hammond, 2001). Such processing may make threatening stimuli easier to remember and harder to ignore, which keeps them in the patients' awareness longer (Muller & Roberts, 2005). Studies of memory also find that those with the checking type of OCD had less confidence in the accuracy of their recognition memories (MacDonald et al., 1997; McNally & Kohlbeck 1993; Muller & Roberts, 2005). Thus, because they are more likely to doubt their memories, they are more likely

to want to go back and check. Same is the case with my client.Social Factors Two types of social factors can contribute to OCD. One is stress, which can influence the onset and course of the disorder; the other is culture, which can influence the particular content of symptoms.

Stress The onset of OCD often follows a stressor, and the severity of the symptoms is often proportional to the severity of the stressor (Turner & Beidel, 1988), which might range from taking a vacation at one end to the death of a family member at the other. However, such fi ndings are not always easy to interpret. For example, one study found that people with more severe OCD tend to have more kinds of family stress and are more likely to be rejected by their families (Calvocoressi et al., 1995). Note, however, that the direction of causation is not clear: Although stress in the family may cause the greater severity of symptoms, it is also possible that the more severe symptoms led the families to reject the patients. In fact, a more recent study found that the more severe the patient's OCD symptoms, the less hopeful and more depressed were family members (Geffken et al., 2006). In this case, Client's father is strict that controls clients behavior as well as they have many conflicts in family regarding financial status that puts fire in client's present condition.

People with OCD often impose various restrictions on the behavior of friends and family members to ensure that it conforms to the patient's "rules," as my client did. For instance, my client who compulsively checks his shoes and pockets may demand that family members similarly—and repeatedly—check their shoes and pockets throughout the day. Stress greatly affected the course of client's symptoms. For much of his teen years, he was able to function relatively well. Although he was often preoccupied with work—staying up for 20 hours at a time to prepare himself for exams he was able to keep his obsessions and compulsions at bay well enough to do his work. However, there were occasional periods of time when the external

demands of his life became intense—deadlines, high expectation of family members ,his symptoms worsened. During one particularly stressful period when My client had repetitive thoughts about formulas that he kept repeating himself at home and in casual conversations with friends and family. As by passing time the stressors increased and his functioning diminished. There were periods when he was so preoccupied with his germ phobia that he couldn't pay attention to anything else. At other times, his symptoms ebbed enough that he was able to focus somewhat on running the universe. But he couldn't reliably attend to the day-to-day demands of his work

Management Plan

Short Term Goals

- For starting treatment and developing trustworthy therapeutic relationship, rapport building was done by giving unconditional positive regard and empathy to the client.
- Psycho-education was provided about the symptoms, nature of illness, etiology, diagnosis and rationale of therapeutic techniques. So that he could develop awareness about his illness.
- Detach mindfulness / letting go technique was used to help client in order to reduce his habit of suppressing thoughts regarding obsessions.
- Coping statements were given to the client to control his compulsive behaviors.
- Relaxation techniques like deep breathing and progressive muscle relaxation (Jacobson, 1938) were used for stress and anger management.
- Cognitive restructuring was done to change negative beliefs.

- Exposure and response prevention was used to reduce the rituals.
- Attention training technique was used to enhance and improve his attention and concentration.
- Relapse Prevention was done in terminal sessions.

Long Term Goals

- Continuation of the short term goals.
- Continuing follow up session was conducted to monitor the changes brought by therapy and to keep check and balance.

Summary of therapeutic intervention

Cognitive Behavioral Therapy (CBT)

CBT is a type of psychotherapy. As it is the evidence-based theory for depression i-e; it works best with depression. It will modify thought patterns in order to change mood and behavior. It is based on the idea that negative actions or feelings are the result of current distorted beliefs or thoughts, not unconscious forces from the past.

Daily Thought Record (DTR)

It can be recommended to client in order to get record of his automatic thoughts come in mind. The purpose of keeping this record is to help catch the automatic thoughts, recognize the feelings that go along with them, and work on balancing the client's thinking towards modifying mood.

Deep Breathing

Deep breathing involves slow and deep inhalation through nose. Deep breathing can release stress and provide other noticeable health benefits. Client will likely feel calmer after performing deep breathing exercises, and may trade feelings of anger or fear for a focused, relaxed state of mind.

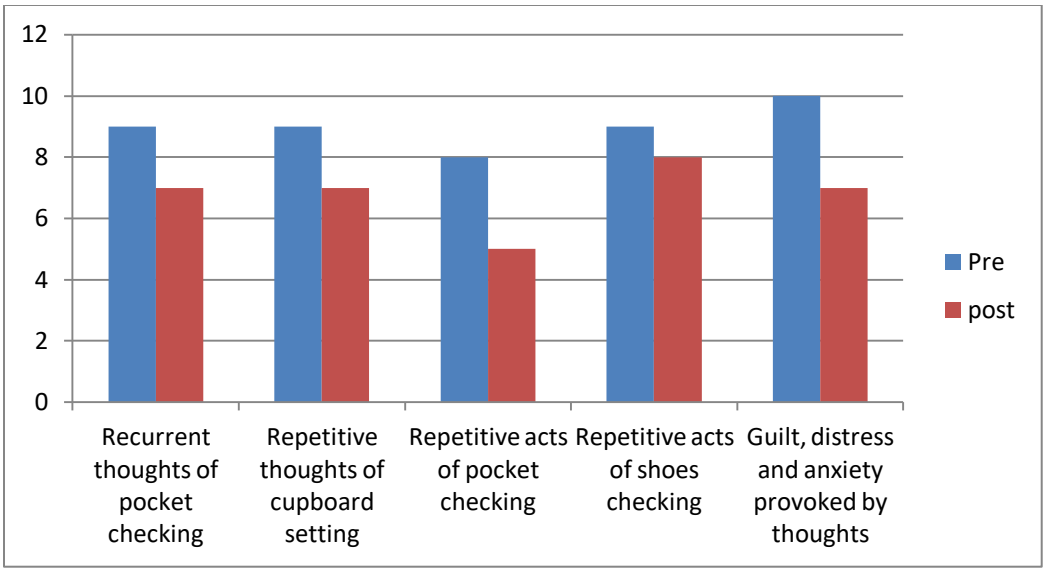
Psycho-education

Psycho-education will be given to the client in order to give him understanding about his illness. This purpose of psycho-education is to provide information to client about his illness and developed the insight about nature of problem, severity of problem, and management of problem.

Progressive Muscle Relaxation (PMR)

Depression sometimes causes physical symptoms such as tiredness and sleep problems. Progressive relaxation yields a variety of benefits, including the development of feeling of well-being, lowered blood pressure, decreased muscle tension, thereby, reducing the bodily need for oxygen and reducing fatigue and anxiety. It is also known as Deep Muscle Relaxation. The aim is to reach a deep state of relaxation and improve awareness of own body and tense areas.

Demographic presentation of pre- intervention and post- intervention rating of client's problem



Limitations

- Distraction free environment wasn't available that created disturbance in taking session with the client.
- Family of the client wasn't available that's why most of the information couldn't cross checked.
- Extensive work could be carried out due to brief therapeutic period

Suggestions

- Proper follow-ups should be taken
- New techniques should be applied with the rehearsal of the old ones.
- Family therapy should be provided to the client's family.

References

Greenberg BD, et al. "Deep Brain Stimulation of the Ventral Internal Capsule/Ventral Striatum for Obsessive-Compulsive Disorder: Worldwide Experience," *Molecular Psychiatry* (May 20, 2008): Electronic publication ahead of print. www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=18490925

Jenike MA. "Clinical Practice. Obsessive-Compulsive Disorder," *New England Journal of Medicine* (Jan. 15, 2004): Vol. 350, No. 3, pp. 259–65. www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=14724305

Kopell BH, et al. "Anatomy and Physiology of the Basal Ganglia: Implications for DBS in Psychiatry," *Neuroscience and Biobehavioral Reviews* (2008): Vol. 32, No. 3, pp. 408–22. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=17854894

Koran LM, et al. "Practice Guideline for the Treatment of Patients with Obsessive-Compulsive Disorder," *American Journal of Psychiatry* (July 2007): Vol. 164, No. 7 Suppl., pp. 5–53. www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=17849776

Lipsman N, et al. "Deep Brain Stimulation for Treatment-Refractory Obsessive-Compulsive Disorder: The Search for a Valid Target," *Neurosurgery* (July 2007): Vol. 61, No. 1, pp. 1–

11. www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=17621014

Martin JL, et al. "Transcranial Magnetic Stimulation for the Treatment of Obsessive-Compulsive Disorder," *Cochrane Database of Systematic Reviews* (2003): Publication No. CD003387. www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=12917964

Sachdev PS, et al. "Repetitive Transcranial Magnetic Stimulation for the Treatment of Obsessive Compulsive Disorder: A Double-Blind Controlled Investigation," *Psychological Medicine* (Nov. 2007): Vol. 37, No. 11, pp. 1645–49. www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=17655805

Session report

Session 1

- Rapport building
- Identifying presenting complaints
- To take personal history
- To explain therapeutic procedure

Techniques

- Clinical Interview
- Active listening
- Unconditional positive regard

Procedure

In order to develop compatible therapeutic relationship of trust with the client, the client was actively listened. He was allowed to discuss his problems with details. The client was given empathetic response towards his problems. A detailed clinical interview was conducted with the client to know the presenting complaints, history of the client's illness, information about the family background, client's personal history and pre-morbid personality. It was done to gather information that could help to determine the appropriate course of treatment. The client was given unconditional positive regard and he was actively listened in non-judgmental way.

The client was guided about the therapeutic treatment and procedure. He was informed about the time and number of sessions that would be required.

Response

Rapport was easily built with the client as he was motivated to know about and deal with his problems. He openly discussed and provided details of his problems.

Feedback

The client told that he was hopeful about his treatment and management.

Session 2

Session goals

- To complete the history
- To observe client's current functioning status
- To identify precipitating and maintaining factors

Techniques

- Clinical Interview
- Behavioral Observation
- Unconditional positive regard
- Active listening

Procedure

Family and personal history was completed in order to know the precipitating and maintain factors. The client was empathetically listened and given unconditional positive regard so that the client could comfortably discuss his problems. For assessing the current functioning of the client, clinical interview and behavioral observation was done.

Response

The client actively participated in the session and gave all required information without any hesitation.

Session 3

Session goals

- To complete assessment
- To rule out other problems
- To inform the client about his problems

Techniques

- Y-BOCS
- Normalization
- Psycho-education

Procedure

Questions related to other disorders were asked in order to rule out other problems for differential diagnosis. Y-BOCS was administered to find out the severity of client's symptoms. It

was verbally administered as client was more comfortable for it. The client rated each statement according to him. He was provided information related to the symptoms. To remove the alien feelings associated with symptoms experience, normalization was done by providing prevalence rate of the problem.

Response

The client actively participated in assessment and he was confident about the success of his treatment.

Session 4

Session goals

- To educate the client about OCD
- To teach relaxation techniques

Techniques

- Psycho-education
- ABC model CBT
- Deep breathing
- Progressive Muscle Relaxation (PMR)

Procedure

ABC model of CBT was explained. He was told how the thoughts were responsible for the emotions. In order to deal with his frustration because of his problems, he was taught relaxation

exercises. In order to teach deep breathing, he was asked to inhale the air through nose and count up to 3 in mind. While inhaling he was asked to put a hand on his diaphragm to feel the contraction and relaxation. While exhaling, he was told to exhale the air through mouth and count up to 6 in mind. He was told to repeat this exercise daily and specifically when he felt stressed.

PMR was also taught to the client. He was explained the rationale for these exercises. The client was instructed that this exercise can be practiced lying down or in a chair with your head supported. Each muscle or muscle group is tensed for 5 seconds and then relaxed for 10 seconds. The therapist also demonstrated the exercise to the client. He was asked to practice the exercise twice a day.

Response

The client felt relaxed after performing the exercises.

Session 5

Session goals

- To deal with the obsessions.

Techniques

- Suppression experiment
- Detached mindfulness
- Cloud metaphor

Procedure

Thought suppression (pink bear technique) was carried out. Thought suppression experiment like the pink elephant technique helps to understand the behavioral responses exacerbates intrusion and maintain the monitoring of thoughts (Wells, 1997). The client was asked to think of pink bear for 1-2 minutes then he was asked not think about it at all and if still the image comes in mind, he needs to raise index finger every time when it happens. Feedback was taken from him. Then he was educated that when he tried to suppress the thought of thinking about the bear it came more and more into his mind. After explaining the concept of pink bear the client was introduced to the concept of detach mindfulness. The rationale provided for it was that the more the individual tries to suppress the thought the more it will occur (Wells, 1997). Trying to stop thoughts is a form of active engagement with them since you are trying to push them out of your mind. Pushing something is hardly leaving something alone and so this effort backfires and you remain in contact with your thoughts (Wells, 2008). He was instructed not to engage with the intrusion on behavioral and mental level and let them go. He was also told to practice it by imagining the thoughts printed on clouds and allowed to drift across the sky.

Response

The client understood the concepts and was confident about controlling his thoughts.

Session 6

Session goals

- To deal with obsessions and compulsions
- To alleviate his symptoms

Technique

- Exposure and response prevention
- Detached mindfulness
- Imagery

Procedure

Detached mindfulness technique learned in the previous session was repeated and it was practiced in the subsequent sessions. The curve of the anxiety was explained to the client. The client was explained that anxiety is an emotion and it lowers down by itself after reaching to a certain level and he needs no compulsive act to decrease it. A list was generated that caused distress for him and rating was taken of the avoidance item. Lowest rating items exposure was started initially. The exposure of the anxiety provoking situation was done at imaginary level and response was prevented. This technique was repeated in the subsequent sessions for all compulsions at imaginary as well as actual level the decrease the distress associated with the problem.

Response

The client responded to the technique and followed the instruction.

Session 7

Session goals

- To deal with obsessions and compulsions

- To identify clients core IBs
- To explore maladaptive coping strategies

Technique

- ERP
- Detached mindfulness
- Socialization with OCD model
- Explanation of cognitive distortions

Procedure

The client was explained the OCD model and connection of beliefs to the consequences. His cognitive distortions were identified through downward arrow technique. He was also explained about the cognitive distortions that a person might have and what distortion he is having and its consequences. The general and idiosyncratic model was explained to the client. The therapist made him realize through the model about the roots of problems and from where intervention is needed. He was told about the theme of most of the compulsions was intolerance of uncertainty and inflated responsibility. The idiosyncratic model was used to help the client understand the development of his illness.

Response

The client himself identified many cognitive distortions which include mind reading, jumping to conclusion, labelling, fallacy of change.

Session 8

Session goals

- To challenge and replace client Irrational beliefs

Technique

- Cognitive restructuring
- Triple column technique
- Evidence for and against

Procedure

Cognitive restructuring of the client was done in terms of the appraisal he has given to the obsession. For this purpose Evidence for and against was carried out to examine the evidence as it is a powerful method for helping clients to modify automatic thoughts. This technique involves listing evidences for and against the validity of an automatic thought or other cognition, evaluating this evidence, and then working on changing the thought to be consistent with the newfound evidence (Wright, Basco&Thase, 2006). He first practiced this exercise in session and then assigned as homework where he was asked to list his thoughts that distressed him. He was asked to practice it regarding his belief of washing and also his belief regarding checking otrainf the things.

Response

He reported this exercise to be extremely helpful.

Session 9-10

Session goals

- To challenge and replace client Irrational beliefs

Technique

- ERP
- Detached mindfulness
- Cognitive restructuring
- Cost benefit analysis
- Evidence for and against

Procedure

The technique was implemented to make the client realize the advantages and disadvantages he was gaining by holding on to her negative schemas. The client filled both the columns and gave percentages to each statement depending upon the level of importance given to each factor. The therapist then quantitatively analyzed each column and a conclusion was drawn that there were most disadvantages as compared to benefits of the thought. An alternative thought was, thus, generated and the client was then asked to write the advantages and disadvantages of that thought. The benefits of the thought were more in contrast to its costs so the client realized that he can’t control the situation and holding a negative schema in lore distressing and harmful. He has the capacity to deal with the situations effectively. This realization increased his faith in himself and he became more confident of being self-worthy. The client was asked to list

evidences for and against the validity of an automatic thought or other cognition, evaluating this evidence, and then working on changing the thought to be consistent with the newfound evidence (Wright, Basco&Thase, 2006). He first practiced this exercise in session and then assigned as homework where he was asked to list his thoughts that distressed him. He was asked to practice it regarding his belief of washing and also his belief regarding acquiring the personalities of other if he touched other things. He reported this exercise to be extremely helpful.

Response

The client was confident about changing his perspective.

Feedback

The client rated his satisfaction on 8 out of 10 on 0-10 scale.

Session 11

Session goals

- Anger Management

Technique

- Hot/Cool thoughts
- Distraction techniques

Procedure

The client was taught distraction technique for managing anger such as drinking water, leaving the place and counting backward. He was also given the concept of hot and cool thoughts. This technique was employed to restructure the client's thoughts about daily life interactions. Her angry thoughts were identified from the dysfunctional thought record according to each interaction and then reshaped into cooler thoughts. These cooler thoughts were then practiced numerously by the client which in turn decreased the severity of her anger. The client was able to handle her anger to a great degree as she started to take time before responding, thinking clearly and positively and then responding with the appropriate behavior.

Response

The client felt motivated to see the situations from differing perspectives.

Feedback

The client rated his satisfaction on 10 out of 10 on 0-10 scale.

Session 12

Session goals

- To improve attention

Technique

- Attention training techniques

Procedure

The client was asked to watch a black dot marked on the wall. Client was asked to try to keep his eyes fixed on the dot. He was told that he would be asked to focus on some different sounds inside from this room and outside of this room. First he was asked to focus on the therapist sound, then on sounds like the tapping on desk, ticking of pen, sound of fan, sounds from outside the room. Then he was asked to quickly shift his attention as the therapist mentioned the sounds. Then he was asked to expand his attention and absorb all of the sounds and all of the locations that could be identified at the same time. Then the client was asked to count all the sounds.

Response

The client actively participated in the activity.

Feedback

The client rated his satisfaction on 9 out of 10 on 0-10 scale.

Session 13

Goals

- Relapse prevention

Technique

Procedure

Therapy blue print was carryout where the client was revised all the technique used to deal with his problem and he was told to continue using them to prevent her symptoms from exacerbating.

Response

The client felt satisfied with the therapy.

Feedback

The client rated his satisfaction on 9 out of 10 on 0-10 scale.

Therapeutic Outcome

Client was informally post assessed to check the effects of therapeutic intervention to analyze the progress of the client. It indicated that there was an overall improvement of 80% in client's complaints.

Appendix-B

YALES BROWN OBSESSIVE COMPULSIVE SCALE

Name: A-4 Age: 20 Sex: M
Marital status Single Qualification: BS(Hons) Registration number:
—

OBSESSIONS:

1. Time occupied by obsessive thoughts

Q. How much of your time is occupied by obsessive thoughts?

0= None
1= Less then 1 hr/day or occasional occurrence.
2= 1 to 3 hr/day frequent
3= Greater then 3 and up to 8hrs/day or very frequent occurrence
4= Greater then 8hrs/day or nearly constant occurrence

2. Interference Due to obsessive thoughts

Q. How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of them?

0= None
1= slight interference with social or other activities, but over all performance not impaired
2= Definite interference with social or occupational performance, but still manageable
3= cause substantial impairment in social or occupational performance.
4= incapacitating

3. Distress Association with obsessive thoughts.

Q. How much distress do your obsessive thoughts cause you?

0= None
1= Not too disturbing
2= Disturbing but still manageable
3= very disturbing
4= near constant and disabling distress.

4. Resistance against Obsessions

Q. How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?

0= Try to resist all the time

Psychology Department

Fauji Foundation Hospital Rawalpindi

8. Distress association with compulsive behavior

Q. How would you feel if prevented form performing your compulsions? How anxious would you become?

0= None
1= only slightly anxious if compulsions prevented
2= Anxiety would mount but remain manageable if compulsions prevented.
3= prominent and very disturbing increase in anxiety if compulsions interrupted.
4= Incapacitating anxiety from any intervention aimed at modifying activity.

9. Resistance against compulsions

Q. How much of an effort do you make to resist the compulsions?

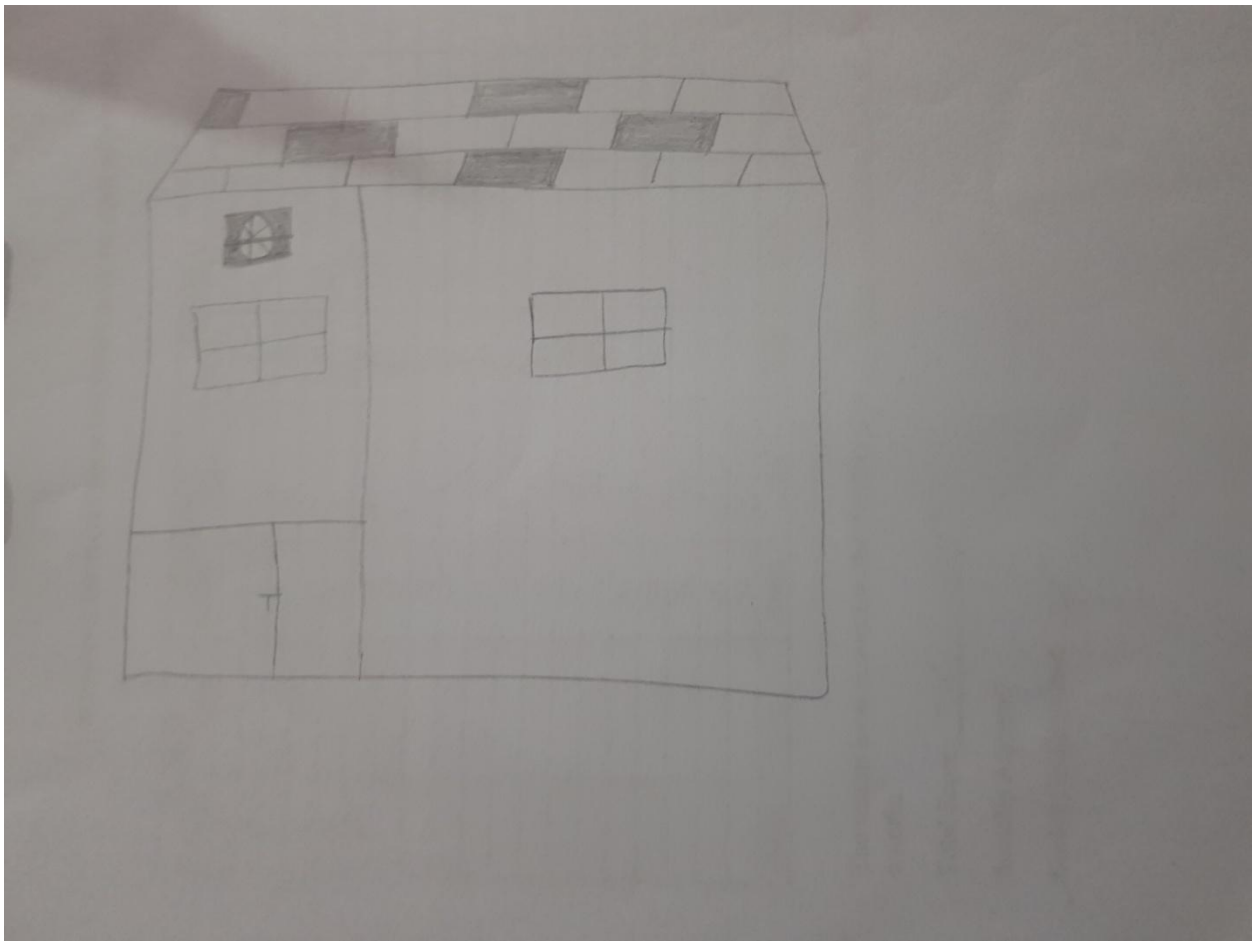
0= Always try to resist
1= Try to resist most of the time
2= Make some effort to resist
3= Yield to almost all compulsions without attempting to control them but with some reluctance
4= completely and willingly yield to all compulsions

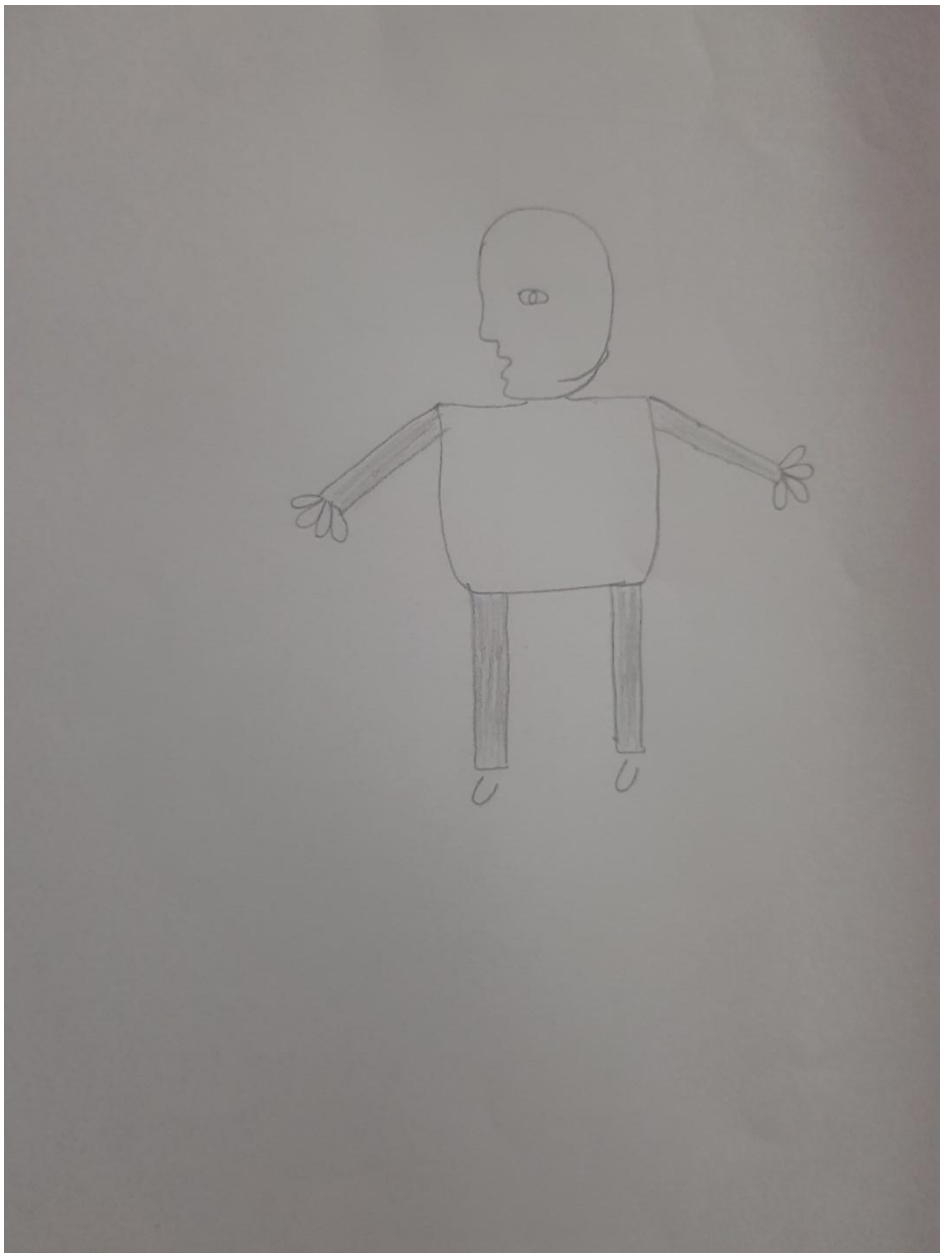
10. Degree of control over compulsions

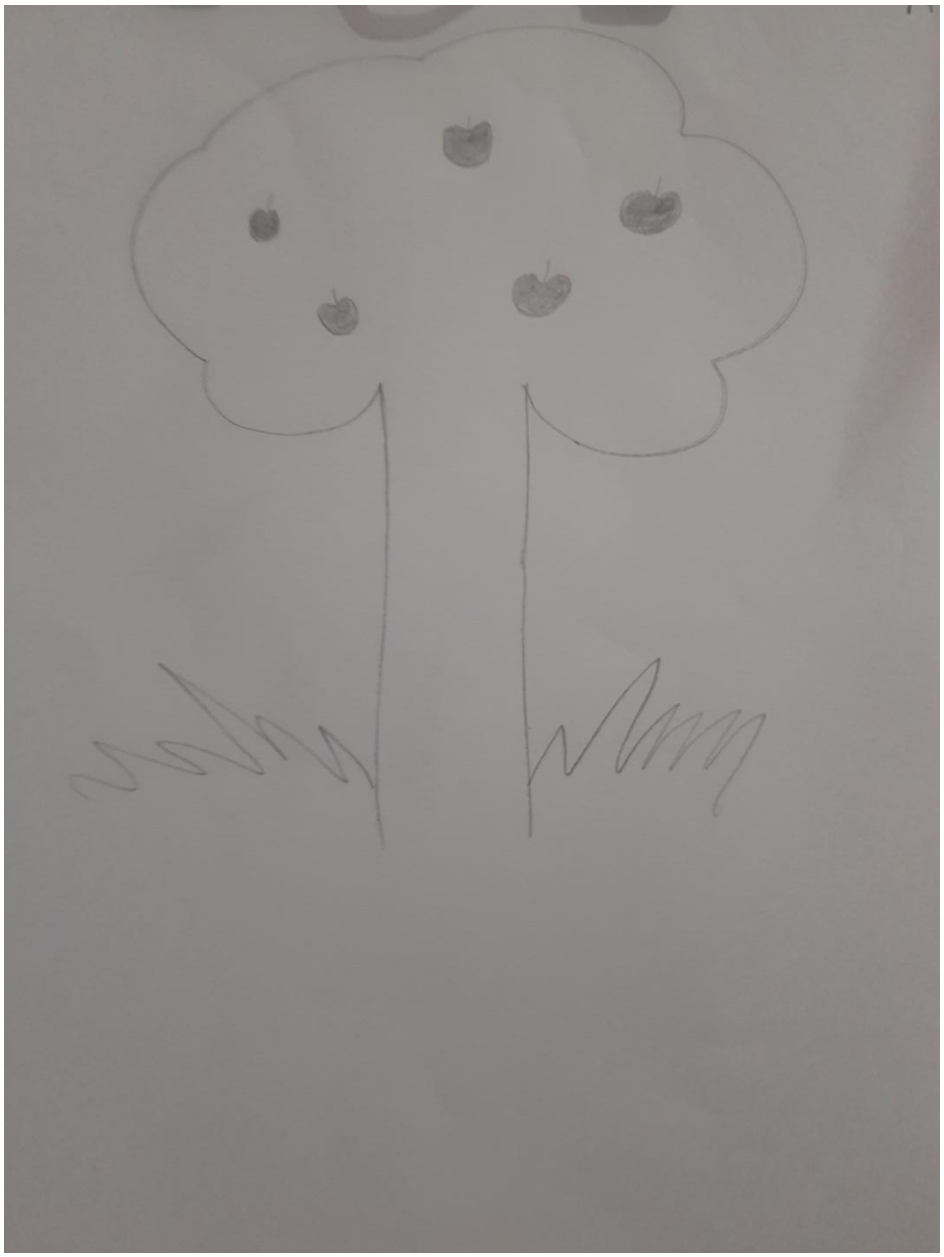
Q. How strong is the drive to perform the compulsive behavior? How much control do you have over the compulsions?

0= Complete control
1= pressure to perform the behavior but usually able to exercise voluntary control over it
2= Strong pressure to perform behavior, can control it only with difficulty
3= very strong drive to perform behavior must be carried to completion can only delay with difficulty.
4= Drive to perform behavior experienced as completely involuntary and overpowering rarely able to even momentarily delay activity...

Psychology Department







ABC Model

Activiting Event	Belief	Consequence
As I was going out for work with my father, He asked me to check your ID card	Over-Importance of thought	Repitative Pocket checking

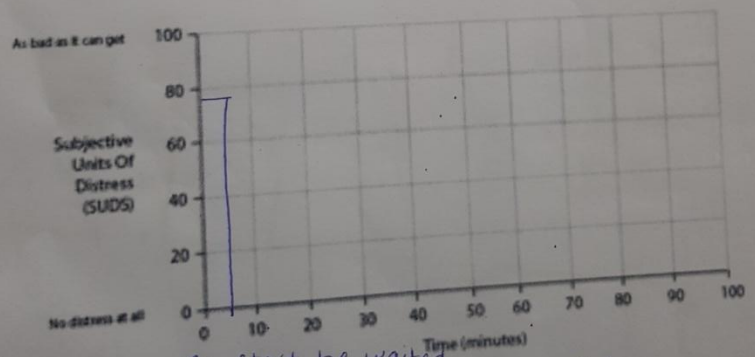
Exposure and Response Prevention

Exposure and Response Prevention is about exposing yourself to a situation that triggers your obsessions or compulsions (exposure), and then deliberately resisting the urge to carry out the compulsion that would normally relieve your anxiety (response prevention).

Situation / Trigger What situations trigger my obsession?	Obsession What is the thought, image, urge or impulse that bothers me?	Compulsion What do I do to make myself feel better when I get the obsession?
Saw dust on the table	Recurrent thought of cleaning it with tissue	I tried to overcome my obsession without acting on it but failed

EX/RP Instructions

1. Expose yourself to the trigger
2. Resist performing the compulsion
3. Record how distressed you feel over time using the graph below
4. If you do perform the compulsion, expose yourself to the trigger again



At start he waited but as soon as distress increase, he acted.

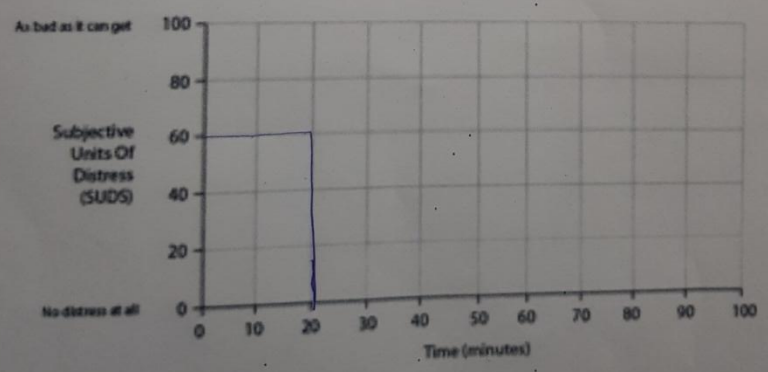
Exposure And Response Prevention

Exposure and Response Prevention is about exposing yourself to a situation that triggers your obsessions or compulsions (exposure), and then deliberately resisting the urge to carry out the compulsion that would normally relieve your anxiety (response prevention).

Situation / Trigger What situations trigger my obsession?	Obsession What is the thought, image, urge or impulse that bothers me?	Compulsion What do I do to make myself feel better when I get the obsession?
Saw dust on the table	Recurrent thought of cleaning it	Waited a little longer than before but again acted on Obsession.

EX/RP Instructions

1. Expose yourself to the trigger
2. Resist performing the compulsion
3. Record how distressed you feel over time using the graph below
4. If you do perform the compulsion, expose yourself to the trigger again



Case III

Summary

Mr. M.R was a 30 year old man, uneducated, unmarried, currently unemployed and previously working in a flour mill and resident of village in Attock. His birth order was 6th and he had total 9 siblings; 6 sisters and 3 brothers. He belonged to middle socio-economic class. The patient was referred to PAC Hospital, Attock with the complaints restlessness, anger outbursts, frequent quarrels, anhedonia, self-taking, persecutory and grandiose delusions, visual and auditory hallucination, inability to sleep properly, reacting aggressively whenever someone objected or criticized him. He even used to be easily irritated and showed verbal and physical aggression. After formal and informal assessment using Positive and Negative Syndrome Scale, and DSM 5 checklist, he was tentatively diagnosed with Schizophrenia, with Persecutory Delusions 295.90 (F20.9). His prognosis was unfavorable because he had no insight. Management plan included Cognitive Behavioral Theory and therapy i.e. psycho education, Deep breathing, Progressive muscle relaxation, daily record of dysfunctional thoughts, activity rescheduling etc were used within 13 sessions.

Identifying information

Name	:	M.R
Age	:	30 years old
Gender	:	Male
Education	:	Uneducated
Occupation	:	Unemployed
Marital Status	:	Unmarried
Siblings	:	9 (6 sisters, 3 brothers)
Birth Order	:	6th
Mother Alive/Dead	:	Dead
Father Alive/Dead	:	Alive
Religion	:	Christianity
Socio-economic Status:		Lower Class
Informant	:	Brother

Reason for Referral

The client was taken from PAC Hospital, Kamra and was referred for the purpose of psychological assessment and therapeutic intervention.

Presenting Complaints

Table 3

Shows presenting complaints by client

موجودہ مسائل	دورانیہ
مجھے نیند نہیں آتی جس کی وجہ سے میں چکر کاٹتا رہتا ہوں	تقریبا 1سال
میرے کمرے میں سانپ ہیں جو مجھے ماریں گے	تقریبا 1سال
آوازیں تو آتی ہیں	تقریبا 1سال
گھر والے مجھے سے جھگڑا کرتے ہیں	تقریبا 1سال
مجھے ان سے بات کرنا نہیں پسند	تقریبا 1سال
مجھے ان کی ضرورت نہیں	تقریبا 1سال

Complaints according to the informant (Brother)

Table 3.1

The informant reported that following symptoms

موجودہ مسائل	دورانیہ
ٹھیک سے نہیں سوتا	1 سال سے زیادہ
سب پہ غصہ کرتا ہے	11 مہینےتقریبا
خود پہ دھیان نہیں دیتا	9 مہینے
اندھیرے میں ڈرتا ہے اور چیخ پڑتا ہے	1 سال
گھر والوں کو پریشان کرتا ہے	1 سال
کسی کو پاس نہیں آنے دیتا کہ تم لوگ مجھے مار دو گے	
خود سے باتیں کرتا رہتا ہے	1 سال

Symptoms According to DSM-5

- Anger outburst
- Hallucinations
- Delusions
    - Persecutory type
- Restlessness
- Anhedonia

- Insomnia

History of Present Illness

Client was admitted in PAC Hospital, Kamra. The client was brought to the hospital due to the symptoms of restlessness, anger outbursts, frequent quarrels, disinterest in all the activities and aloofness from others, talking to himself all the time, talking about self importance all the time, strong belief that he had special powers to control the spirits and get things done from them, strong belief that others were jealous from him and wanted to inflict harm on him, inability to sleep properly, reacting aggressively whenever someone objected or criticized him, and seeing spirits as well as talking to them and also hearing the hissing sounds of snakes.

The client's history of present illness started almost 11 months back. One day client was coming back from a neighboring city to his village. He used to work in a flour mill. On the way, his van met with an accident. The driver of the van ran away and some of the passengers quickly left the spot due to the fear of police investigation. Client and two other passengers, who were injured, were left there. Client had a fracture in his left leg and he couldn't walk. After some couple of minutes, the remaining two passengers also left the spot as they were not seriously injured. The client was left alone. When the passersby came to the spot, the client was unconscious. They quickly recognized him and called his family. His brothers came and took him to the nearby doctor. The doctor cleaned his wounds and plastered his leg. The client couldn't move at all at that time and he used to remain on his bed. After three and a half months, when the plaster was removed, client and all the family members came to know that his bones had joined in wrong way. He had another operation but even then he couldn't walk well. He was fired from the job at flour mill. So he started working in his own village. He was very slow in his

work because he couldn't walk properly moreover, he couldn't lift any weight. As a result he earned lesser wages than his own brothers and his co-workers. He started becoming worried about his life and about his future. One day he also had a fight with his co-worker as they were smoking cigarettes and when the client asked them to give him one cigarette, they made fun of him as he couldn't buy his own cigarette. From that time onwards, the client started avoiding going to work and used to confine himself in his room. At night, he used to walk in the streets for hours without going to sleep. He started quarrelling with his siblings often. His elder brother became worried about his condition and went to talk to him about his job. The client said that he was weighing his options and hadn't considered doing something yet. His brother came back. But the client didn't take any step to show that he was actually searching for a job. After a few days client's elder brother went to the client's room again (as the client had now started confining himself in his room) and when he started talking to the client about his job, the client started laughing. His brother became angry at the client, he didn't know that why was the client laughing. He went near to the client and touched his shoulders at which the client instantly became violent, he started abusing his brother, his father and his sisters. He started beating his elder brother.

All of the family members became worried about his condition. Meanwhile the client was seen talking to himself about how superior he was to others. He was seen praising himself. He said that he was very strong and his broken leg was a mark of his strength as nobody had such a leg. Whenever anybody went near him, he used to abuse them, became angry and started beating them. He used to stay in his room for hours except when going to washroom. Food was placed at his doorstep, which he ate sometimes, and sometimes he left it. He didn't care about personal hygiene. Whenever anyone turned off the light of the client's room, he would start screaming

that there were snakes in his room which would bite his right leg and would kill him. He was often seen sticking fingers in his ears as if to stop some sounds entering his ears.

As reported by the client, that one day he was wandering in the streets at night and saw a group of "*sisters*" in corner of street, they were smiling at the client and when the client went near them, they disappeared. The client realized that they were spirits. He started seeing them often. After that, the client was sure of himself that as he had some special powers that is why those spirits of "*sisters*" came to him. The client was sure of himself that he was superior to others and had powers to control supernatural beings. According to the client, afterwards he tried to talk to the spirits because he had powers to control them. The spirits responded him and were happy to serve him. The client used to talk to them often and the spirits in turn talked to him, they praised the client. The client used to stand on his doorstep and tell his family members that he had spirits who had told him that somebody was on the mission of killing him that is why he had met with an accident, had a dislocated leg and couldn't work. Even when he used to go to washroom, he didn't close the door because he said that someone had ordered a pair of snakes to kill him and if he would close the door of the washroom, the snakes would bite him. Sometimes he used to point in one corner of his room and said that the snakes were lying there, sleeping, waiting for the light to be turned off so that they could come out and kill the client. Sometimes he was also heard, as if talking to someone, planning how to kill the snakes. Whenever his father went to talk to him, the client said that his co-workers in the flour mill were after him, they wanted to kill him and that is why there were snakes in his room (although there were not any). His father had also searched the whole room to ensure the client that there weren't any snakes, the client would say that the snakes hid themselves whenever anyone went near them. He used to tell his father that the spirits had told the client that his co-workers were jealous of his superior

abilities and potentials and they wanted to harm him. The client said that as long as he had the spirits with him, nobody could harm him.

The client's functioning had totally declined, he didn't participate in any affair of the house. When his elder sister went to him and cried, the client kept quite all the time and stared his sister. Even when the client's father fell ill, he didn't come out of the room and kept standing at his doorstep, watching everyone silently.

All the family members tried their best to convince the client that there was no one who tried to kill him, there were no snakes in his room and that the client didn't have any spirits. The client always became angry and violent as a result of such talk. They took him to a Christian spiritual healer but it was of no use. At last, the client's elder sister proposed the idea of taking to client at the hospital for the betterment of the client as well as the rest of the family members.

Currently the client, aggressive and violent, experiences all the maladaptive behaviors with full intensity. His functionality had declined and he had not been able to perform his daily activities or took care of his hygiene properly. His social activities had decreased to zilch, he remained dejected, didn't talk to anyone and hardly paid attention to what was happening around him.

Personal History

Birth and early childhood

The client's birth was normal. He was born at the house and the delivery was handled by a mid-wife. The health of client's mother was good at the time of his birth. She had no prenatal and postnatal problems. The client's birth was normal at home. His birth weight was average and the

mother didn't suffer from any illness during pregnancy. He achieved all the milestones at the appropriate age. The client started talking at the age of 9 month and same like client started sitting, crawling, standing, walking and using toilet at appropriate age. No neurotic traits were reported in the client. His birth and early developmental history was quite satisfactory.

Psycho-sexual history

The client reported that he reached puberty at age of 16 years. He was exited at the developmental changes and he was not confused on these changes in body. He got information related to sexual information from coworkers at flour mill. He had great interest in opposite sex. But he hadn't loved anyone in his life.

Academic history

The client was illiterate. He was not educated due to his family's financial problems. No religious education was obtained by the client. The client didn't blame parents for the fact that he didn't get educated. He reported that other issues of the house were more important than the client's education.

Social history

The client wasn't a very social person before his illness. He hadn't many friends. There were two friends from his neighborhood who now worked in another city. The client was always excited to meet them. But since the client's problems, he has stopped meeting his old friends. According to the informant, he remained sad and quite all the time and lost interest in all the daily activities. He kept himself in a room and doesn't talk to his family members at all. Client reported that he didn't like talking to anyone and that he didn't want to waste time socializing.

He preferred spending every moment of his life thinking about his condition and talking to the spirits to solve his problems.

Forensic history

No forensic history was present

Family History

The client's father was 78 years old. He was an illiterate man. By occupation he was manual labor. His monthly income was 5,000 rupees per month. The client's father was very strict and aggressive person. He used to physically abuse his children even over minor mistakes. The client wasn't close with his father, instead his father wasn't very close with any of the client's siblings. The client's father used to work for the whole day and in the evening when he came back, he often had bad mood. He also verbally abused them. Client didn't like his father very much. Client had grown up in an atmosphere where quarrels and fights were regularly seen. Sometimes, the client's father beat the client's mother because of minor issues like not being given a glass of water on time.

The client's mother was 65 years old when she died from Hepatitis C. She was illiterate woman. She used to work in the fields of a landlord to contribute in the family earnings. She was a hardworking and understanding woman. She never blamed or complained her husband because she knew that such a temperament of her husband was due to financial problems. The client's mother had never been harsh with the client or with her husband. Despite of being beaten by her husband, she stood with him through thick and thin. She was a kind and affectionate mother. She tried her level best to be available for her children whenever they needed her. The client reported that she had good relation with all of her children. She never abused her children and never

spoke harshly to them. According to the client, when his mother was alive, she was always there to support and help her children.

The client had 9 siblings, of them; there were 6 sisters and 4 3 were brothers. The client's eldest brother was 51 years old. He was uneducated. He used to work in a cloth mill. He had three children; two sons and one daughter. He lived in a separate house with his family. He was a loving and affectionate brother. He was always there to financially help the client as well as the rest of the family members. He was a thrifty person and used to save money for tough times. He also used to spend money in small businesses like purchasing an auto-rickshaw and giving it on rent, small share in the vegetables market, etc. the client's this sibling was very hard working, intelligent and foresighted person. In fact he was the one who was giving money for the client's medicines and treatment.

Second born was the client sister who was 49 years old and lived in another village with his own family. Her husband was a taxi driver in the neighboring city and she used to stitch clothes to support her family financially. They lived happily. Whenever she came to meet her family, she brought "gur" which had peanut, almonds and raisin in it, for the client as he loved it. She was tender for all the client's siblings. When she was unmarried, she used to go to the fields with her mother to work there and earn money for the rest of the family. She was gentle for everyone. The client loved his sister.

The third born was the client's sister who died when she was 43 years old when she was delivering her twin daughters. The delivery was done by a mid-wife and she couldn't control the complications as a result, the client's sister died. The twin babies also died inside the womb as there wasn't even time t o save them. According to the client she was a shy person, she never

talked too much. When asked something, she used to answer, but she never took the initiate of breaking the ice. There was always a smile on her face when she used to listen all of the siblings together. After marriage she settled in a city which was very far from the client's village that is why the client's family used to meet her once in a blue moon. Her death was shock for everyone.

The fourth born was the client's brother who was 40 years old. He was a factory worker and got separated after his marriage. He had 1 daughter and 1 son. The client reported that he was loving and caring towards his sibling's before his marriage but after his marriage his wife persuaded him to live separately so that his income would be consumed only by them. Client's brother listened to his wife a lot and so soon after his marriage he got distant from his family. The client missed him often.

The fifth born were the client's twin sister who were 37 years old. Both were married. One of them was a mid-wife. She was settled in another village with her husband and rendered her services there. She had only one son. She was a kind-hearted person and of happy-go-lucky nature. The client's this sibling had affable relations with all the family members. The other twin sister worked in a beauty parlor with her sister-in-law. She wasn't very talkative but she was more intelligent and wise than the client's other twin sister. She was also gentle towards others.

The sixth born was the client' himself. He was 30 years old and was unmarried. Since he was born, he saw his father struggling to earn money to meet the needs of the family and his mother striving to help the client's father in this regard. Client had seen poverty and knew what hunger actually meant. It was the poverty that had made his father so much distant that he couldn't think of anything else but to fulfill the needs of his huge family. It was the poverty due to which his mother had died because there wasn't enough money to get his mother treated from

a good doctor. It was the poverty as a result of which one of his sisters had died because there was not enough money to take her to some gynecologist when the complications had aroused. The client didn't want to be like his father because he was afraid that one day, like his father, he would have no one close to him in front of whom he could open his heart and share his worries. The client loved his siblings and his father too. But he hated them when they didn't understand his perspective that he had powers and that he could control the spirits. He hated them when they didn't approve the idea that someone wanted to kill the client and had set snakes to fulfill that purpose. He hated his siblings whenever they rejected the client's point that he could even listen to the hissing sound of the snakes.

The last born were the client's sisters. They were unmarried and lived in a hostel for the "*sisters*" (of the church). They used to pay visits once in a while and always assured the client that his faith on god was being tested. The client's sisters always advised all the siblings that their torments meant that they were on the higher ranks of the god at which all of them should be thankful to god and be pleased and contended with their life.

The client lived in nuclear family system and the earning members of the family were his father, elder brother and the client himself. Despite three working family members their family's needs were not fulfilled and they faced serious financial crisis. The authoritative figure in the home was client's father. Client's father was unable to provide adequate affection and love to his children. Her mother tried her best to fulfill the emotional needs of her children. But since she had died, the client missed her. The client belonged to low socio economic status. Client's parents could not satisfy their family's needs. They lived in a four room's house with poor living conditions. The general atmosphere of the house was not happy. They all seemed to be

dissatisfied with their lives. Their socioeconomic status influenced their lives a lot. No psychiatric illness was reported in any of the members of the client's family.

Occupational History

The client reported that he was unemployed from last year. He had worked at a flour mill in a neighboring city and then as a labor in his own village. He could not adjust himself in his work due to his illness. He could not focus his attention in his work. He reported that he knew that everyone was against him. His relationships with his siblings and father were not good anymore. The client reported that his elder brother took care of his needs. The client also reported that he did not do work and nor got any job.

Premorbid History

Before the onset of the illness the client's relationship with his family were almost satisfactory. He was not very close to his siblings. Client had never been a family person even before his illness. He wasn't socially an active person. He didn't have many friends. Whenever he had free time, he used to sleep. He was of the view that if he worked day and night, he would be able to save enough money so that he would be able to change their condition and lead a happy life. He didn't like to read newspapers, novels or books as he was illiterate. He also didn't watch movies or dramas. Sometimes he used to watch cricket matches on the T.V. sometimes he listened to radio for any news. The client never had any homosexual or heterosexual experiences in his life. He was of the view that if would indulge them from such activities they would detract him from his goal. He reported that he had never used drugs or alcohol in his life. Most of the times he was a calm person, who never annoyed anyone and never had problem with others. He liked to help

others and sympathize with them. He always believed in hard work, he tried his level best to lead a happy life.

Psychiatric history

No significant psychiatric history was present in client's family

Onset of Illness

The onset of illness went back to almost 11 months when client was travelling in a local van and that van met an accident. In result, the client got injured and his left leg was fractured. After treatment, they came to know that the bones of left leg of client were dislocated. After that incident, he lost his job and different complaints as mentioned above were started appearing in client.

Preliminary investigation

Psychological Assessment was done at formal and informal level to understand the client's problem and to monitor the progress of therapy.

Informal Assessment.

The informal assessment comprised of detailed interview, behavioral observation.

- Clinical Interview
- Behavioral Observation

Clinical Interview

Clinical interview was conducted to have an in-depth knowledge of the client's history of present illness as well as his personal history. It gave a lot of knowledge regarding his predisposing factors, precipitating factors and maintaining factors of the illness. Functioning of the client at different levels and the atmosphere of his home was discussed deeply.

Behavioral observation

Behavioral observation is the recording of the observable reponses of individuals by human observer (Hartmann & Wood, 1992). Behavioral observations are flexible and applicable means of observing behavior and it also provides a comprehensive description and evaluation of behavior. Moreover, it also provides information about the severity and frequency of any behavior (Nock & Kurtz, 2005)

The client was a man who was 30 years old. He was about 5 feet and 5 inches tall. He was dressed weather appropriately but not decently. He wore sky blue shalwar kameez with sandals. His hairs were also unkempt. Client never maintained an ample eye contact; starring at the floor and observing his surrounding most of the time. It was hard to establish rapport with him as he was not responding to whatever was inquired from him. The initiation of the interview was very difficult. Slowly, the client started responding and with the establishment of rapport, the interview paced smoothly.. The client had disorganized speech, he was not talkative and when he did he give short and sometimes disconnected replies to questions with average speed and tone. He was displaying flattening affect. Client was conscious about proximity and was maintaining personal space between himself and trainee clinical psychologist.

Mental Status Examination

Mental status examination is a method of organizing and evaluating clinical observation pertaining to mental status or mental condition. The primary purpose of the mental status exam is to evaluate current cognitive process (Strub &Black, 1985). Mental status examination contributes a set of interview questions and observations designed to reveal the degree and nature of a client's abnormal functioning (Corner, 2015). Mental status examination obtains evidence of symptoms and signs of mental disorders based on the information about different elements such as appearance, motor activity, speech, mood and affect etc.

Client was wearing clean dress and overall hygienic condition was not satisfactory. Attitude of the client towards therapist was uncooperative. Client's rate of speech and volume was average .Client displayed flattened affect. . His memory was uneffected but his concentration was effected. He was oriented to place but not to time and person. There was absence of suicidal ideations. The thought pattern was related to the client's delusions and hallucinations. He had auditory as well as visual hallucinations. He suffered from delusion of grandiosity and persecutory delusions. He kept talking about the power and control he had over spirits. He didn't have any obsessive or compulsive beliefs. Attention span was poor and his insight was not intact about the disorder.

Visual Analog Scale

Visual analog scale scale is a subjective way of measuring the severity of any subjective construct which exists along a continuum. It could further be explained as an instrument which tends to measure any characteristic or attitude that have different values along an array (Gould, 2001)

Visual analog scale was used for subjective rating of client's problems. In visual analog scale, rating of the presenting problems was done on a 10-point rating scale with 1 indicaing the least significant problem and 10 indicating the most significant problem. (see Appendix A-II)

Table 3.3

Visual analog scale rating of problem at pre- intervention level

Presenting complaints	Pre-intervention rating (Informant)
Anger outburst	9
Hallucinations	10
Persecutory and grandiose delusion	10
Restlessness	10
Anhedonia	9
Irritability	9
Insomnia	9

Formal Assessment

The formal assessment comprised of:

- Positive and Negative Syndrome Scale (PANSS)

Interpretation of test

Positive and Negative Syndrome Scale (PANSS)

It was published in 1987 by Stanley Kay, Lewis Opler, and Abraham Fiszbein.It is among the best-validated instruments for assessing positive, negative, and general psychopathology associated with schizophrenia. It is a standardized, clinical interview that rates the presence and severity of positive and negative symptoms, as well as general psychopathology for people with schizophrenia within the past week.

Rationale

It was used with the client to check the presence and severity of positive and negative symptoms as well as psychopathology within past week.

Procedure

PANSS was done on the base of client's interview and information taken from informant.

Quantitative Interpretation

Raw score	Range	Severity
106	95-116	Severe

Positive scale = 27

Negative scale = 30

General psychopathology = 49

Total composite = 106

Qualitative Interpretation

The client had total score 106 in result of administration of PANSS, which indicated that client fell between the range of 95-116 that indicated markedly illness and he had schizophrenia.

DSM -5 criteria

Client was assessed through formal and informal assessment means nd then after that diagnostic criteria was checked from DSM-5. As formal and informal assessment proposed that client meet diagnostic criteria for depressive disorder so for this reason criteria of schizophrenia with persecutory delusions was checked

Diagnostic criteria	Symptoms present in client	Status of symptoms
Delusions	He have strong belief that others were jealous from him and wanted to inflict harm on him	✓
Hallucinations	Client reported visual and auditory hallucinations that he see snakes and hear “hisses “around him	✓
Disorganized speech	Lose association was observed	✓
Disorganized behavior	Client and informant reported that he does not like to interact with people, does not take care	✓

	of himself	
Negative symptoms	Client displayed apathy, social withdrawal and anhedonia with lethargy	✓
Social/occupational dysfunction	Reported by informant that after the onset he does not take care of himself, left his work and doesnot like to be around people	✓
Signs of the disturbance persist for at least 6 months	Informant reported that he started displaying these signs from last 7 months	✓

Tentative Diagnosis

(295.90) Schizophrenia, with Persecutory Delusions

Prognosis

Prognosis is a prediction about how a particular patient is likely to fare over time.In the present case, the Prognosis seemed to be unfavorable due to multiple reasons. Client had no insight about his problem. He was completely unaware of the severity of his problems. Secondly he is

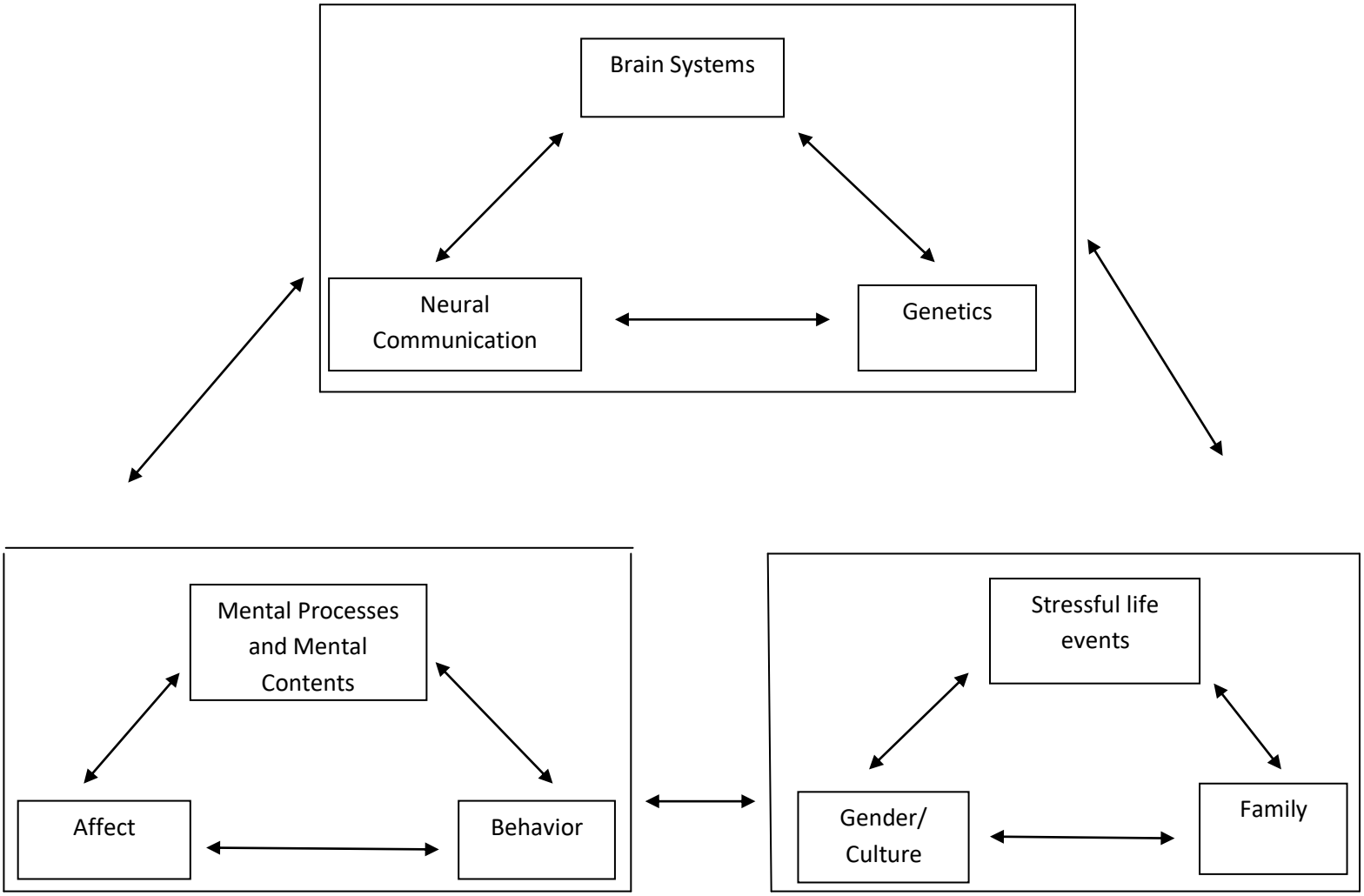
illiterate as well as belongs to a rural area where there are no facilities to provide on-spot interventions whenever the problem occurs. Through formal and informal assessment, it is revealed that the client's prognosis was unfavorable. Another important factor for poor prognostic criteria was social isolation and early age of onset and being male. However there was one factor which might contribute to a good prognosis and that was being an inhabitant of developing country.

According to Bustillo (2008) factors associated with a poor prognosis include young age at onset, poor premorbid functioning, family history of schizophrenia, disorganized or deficit subtype with many negative symptoms. Bustillo (2008) also showed that men had poorer outcomes than women; women respond better to treatment with antipsychotics.

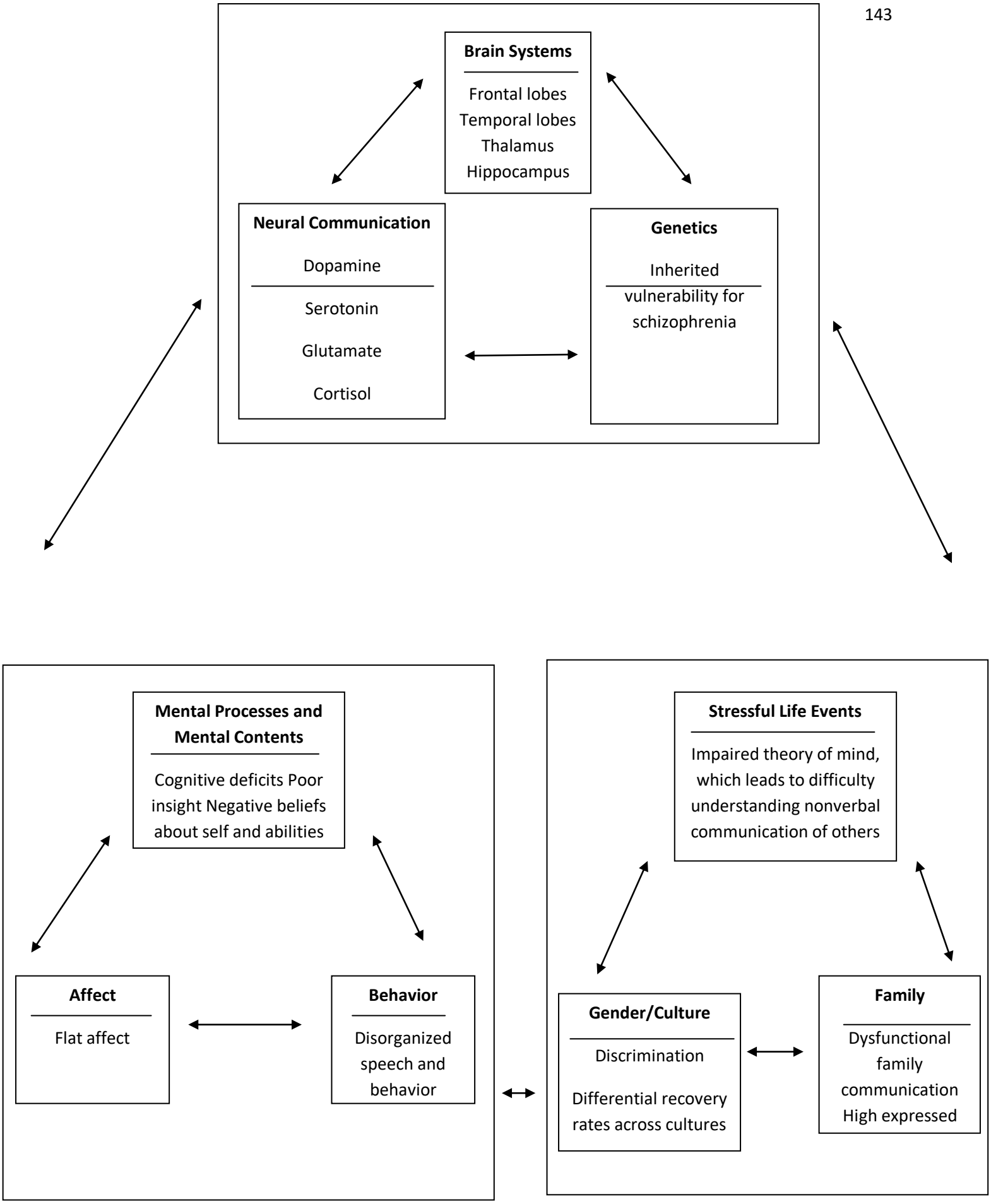
Torrey (1995) showed that males, on average, suffered from more severe schizophrenic symptoms and were more seriously disabled than females. Males, on average, also showed their first symptoms of schizophrenia at an earlier age than females. Men typically were affected by the disease starting in their late teens or early twenties, while women were more likely to first show signs of the disease 10 years later, in their late twenties or early thirties.

They had found that, in fact, severity of schizophrenia was related to the age at which symptoms first appeared, not specifically the gender of the patient. Both males and females with earlier onset of symptoms were more severely affected than either males or females with late onset of symptoms. Symptoms earlier in life disrupt education and development of social connections.

Case Conceptualization



Below is the implementation of Neuropsychosocial model


Brain Systems
Frontal lobes
Temporal lobes
Thalamus
Hippocampus
Neural Communication
Dopamine
Serotonin
Glutamate
Cortisol
Genetics
Inherited
vulnerability for
schizophrenia
Mental Processes and Mental Contents
Cognitive deficits Poor insight Negative beliefs about self and abilities
Affect
Flat affect
Behavior
Disorganized speech and behavior
Stressful Life Events
Impaired theory of mind, which leads to difficulty understanding nonverbal communication of others
Gender/Culture
Discrimination
Differential recovery rates across cultures
Family
Dysfunctional family communication High expressed

Case Formulation

Mr. M. R. was 30 years old unmarried man who didn't seem in best of his health. The client was brought to the hospital due to the symptoms of restlessness, anger outbursts, frequent quarrels, detachment from others, self-talk, talking about self importance all the time, delusion of grandiosity, delusion of persecution, insomnia, aggressive reaction to criticism, and visual as well as auditory hallucinations since approximately a year. Currently the client is unemployed. He belongs to a lower middle class family. He has nine siblings (6 sisters and 3 brothers) and the client's birth order is 6th. It was a van accident that the client faced leading to a dislocated leg and it played a vital role in the onset of symptoms of paranoid schizophrenia in the client. The client was fired from the job as he couldn't manage its tiring routine. He moved to his native village and tried to work there as a labor but the mocking behaviors of his coworker lead the client to quit that job too. The client started confining himself to his room. He never slept and whenever anyone went to talk to him to console him, he became angry, aggressive and violent. He started wandering in the streets late at night telling the family members that he could see the spirits of "*sisters*". Slowly he said that he had powers to control those spirits and that he could talk to them. He was often seen talking to the spirits of "*sisters*". He also said that his coworkers form the city had sent snakes to kill him as they were jealous of his potentials and his powers. He said that everyone wanted to pull his leg. It was when his family members realized that his problems were very serious and the doctor admitted him in District Headquarter Hospital, Lahore. He has been under treatment of a clinical psychologist and a psychiatrist.

The informal assessment had been administered on client by history-taking, clinical interview, and behavioral observation. The behavior of client during interview session was unusual. He was sitting in a restless manner. He had not intact eye-contact. He was inattentive

and the reality check of client was poor. In formal assessment, Positive and Negative Symptom Scale was administered on client and result of those tests indicated that client had persecutory beliefs, rigidity, psychotic tendencies, and suspiciousness.

Following theories can be applied.

Social Learning Theory of Schizophrenia

According to this theory, schizophrenics do not respond appropriately to the social environment like their counterpartners. Thus, deficit in attention to social environment leads to lack of proper association and disturbances in the thought processes of such individuals.

Socioeconomic Status and Schizophrenia

The relationship between socioeconomic status and schizophrenia is not such that the prevalence of schizophrenia goes up as socioeconomic status goes down. Rather, there is a sharp upturn in the prevalence of schizophrenia in people of the lowest socioeconomic status.

The correlation between socioeconomic status and schizophrenia is consistent but difficult to interpret in casual terms. Degrading treatment by others of higher status, daily-life stressors, and lack of awards and opportunities may taken together, make low socioeconomic status so stressful that people who are predisposed to develop schizophrenia readily develops the disorder.

It was shown in a study that people with schizophrenia were eight times more likely to be in the lowest socioeconomic groups (Schultz, North, & Shields, 2007). Low income and poverty increased the risk for delayed diagnosis and treatment, and such delays could lead to more severe disease in patients with fewer resources. Schizophrenia is inversely related with the social class;

the lower the social class, the higher the rate of schizophrenia (Seligman, Walker & Rosenhan, 2001). Client belonged to a lower middle class. His father was a manual labor who worked hard to support his family but his income was never enough to provide the luxuries and comforts of life to his wife and children. So keeping in view the sociogenic hypothesis, this deficit in the client's life can also be regarded as another predisposing cause of schizophrenia.

The researchers found that people whose fathers held more menial jobs, or were raised in poorer parts of Nottingham country, were twice as likely to develop schizophrenia in later life as those whose fathers held more professional positions, or were raised in more-affluent areas. The researchers suggested that perhaps poverty played a role in increasing a person's susceptibility to schizophrenia. Read (2010) conducted a study and the results showed that poverty is more strongly related to 'schizophrenia' than to other mental health problems. The New Haven study (Hollingshead & Redlich, 1958), which measured class directly on the basis of education and occupation rather than location, found that the poorest class (V: 'unskilled, manual') was three times more likely than the wealthiest two classes (I and II: 'business, professional and managerial') to be treated for psychiatric problems. The diagnosis having the strongest relationship with class was, again, 'schizophrenia'. The poorest people were eight times more likely to be diagnosed 'schizophrenic' than the wealthiest. Tennessee study of 10,000 first admissions again confirmed that the diagnosis most strongly related to low socio-economic status was 'schizophrenia' (Rushing & Ortega, 1979). The relationship between 'schizophrenia' and poverty was described as 'one of the most consistent findings in the field of psychiatric epidemiology' (Eaton, 1980). The Israel data revealed that being born in a poor neighborhood was itself a risk factor for 'schizophrenia' (Werner, et al., 2007). In South Auckland, one of the poorest areas of New Zealand, those living in the most deprived neighborhoods were, after

controlling for age and gender, 4.1 times more likely to be admitted than those living in the least deprived neighborhoods. The most common diagnostic category was ‘schizophrenia and schizoaffective disorder’ (Abas, et al., 2003). Psychiatric admission rates increase during economic declines. This relationship was, again, particularly strong for psychoses in general and 'schizophrenia' in particular. (Thompson et al., 2002; Warner, 1985). The client belonged to a rural area and had been seeing poverty since he was born. Poverty, rural area and low socio-economic status might have contributed to the development of schizophrenia in the client.

In 40% of men and 23% of women diagnosed with schizophrenia (Picchioni & Murray, 2007). Schizophrenia may be more common in men, and symptoms tend to be more severe. It occurs 1.4 times more frequently in males than females and typically appears earlier in men the peak ages of onset are 20–28 years for males and 26–32 years for females (Castle, Wessely, Der, & Murray, 1991). Xiang, et al., (2011) aimed to explore the socio-demographic and clinical characteristics of paranoid and non-paranoid subtypes of schizophrenia. The results showed that, male sex was independently associated with paranoid schizophrenia. The phenotypic expression of the subtypes of schizophrenic disorders was studied by Beratis, Gabriel, and Hoidas (1997) in relationship to their relative frequency and the gender composition within each subtype using 374 successive DSM-III-R diagnosed schizophrenic patients. The results showed that the frequency of men with schizophrenia was more than three times greater than that of women. David, Castle, McGrath, and Kukarni (2000) in their study suggested that schizophrenia was more prevalent in men than women-with women developing schizophrenia at a rate of approximately 50% to 75% that of men, overall. In the present case, the client was a male of 30 years whose symptoms of schizophrenia initiated almost when he was 28 years old.

A population based longitudinal study in Israel found that education level of father, education level of mother and occupational status of father (all at birth) were significant risk factors for being diagnosed with 'schizophrenia' (Werner, Malaspina, & Rabinowitz, 2007). The client's well as the rest of his family members were illiterate in the current case which might have played a significant role in on-setting the symptoms of schizophrenia in the client.

In the current case, different factors are contributing towards the client's illness. He is facing stressful environment continuously. He is an unmarried male, he belongs to a low socioeconomic status, poverty, unemployment, lack of education and lack of financial resources is making him prone to face the adverse effects of schizophrenia.

Management Plan

A variety of psychological and social (psychosocial) strategies for treating schizophrenia have been developed, each offering a different level and type of support to persons recovering from schizophrenia. Treatments are often mixed and matched to fit the individual, as resources (money and/or health insurance) permit.It consisted of the following therapeutic interventions:

- Rapport building
- Medications
- Psycho-education
- Cognitive Enhancement Therapy
- Social Skills Training

Short term goals

- To develop good therapeutic alliance for successful management

- To use psycho education with the client
- To teach relaxation exercises to client
- To change routine of client through daily activity chart
- To use examining evidence technique for challenging false beliefs of client
- To teach the client different sort of distraction techniques
- To use vocational training in order to built up interaction in client towards society

Long term goals

- To continue short term goals for enduring betterment of client
- To schedule proper follow up sessions
- To take proper steps for relapse prevention

Summary of therapeutic intervention

Therapeutic alliance

Therapeutic alliance is a collaborative relationship between therapist and this client relationship is affected by in- session responsiveness (Stiles, 2009).A good therapeutic alliance was established with client in the starting sessions. For this client was given unconditional positive regards, empathizing the client during sessions. The technique of sharing was used for developing a sense of trust and good rapport.

Medications

In case of schizophrenia, medication works 70% and psychological therapies work 30%.

Psycho-education

Psycho-education was given to the client in order to give him understanding about his illness. The purpose of psycho-education is to provide information to client about his illness and developed the insight about nature of problem, severity of problem and management of his problem.

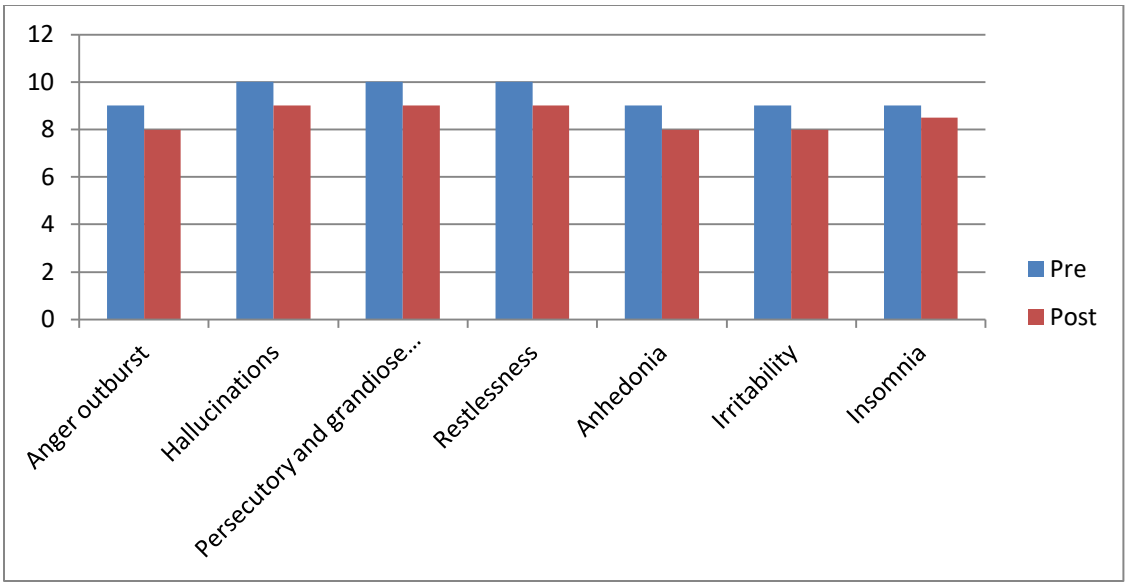
Cognitive Enhancement Therapy

Recently developed treatments that seek to enhance basic cognitive functions such as verbal learning ability are referred to as Cognitive Remediation Training or Cognitive Enhancement Therapy (CET). It is consisted of nearly 80 hours of computer-based training in attention, memory, and problem-solving, social cognitions and social adjustments. It is very effective at reducing symptoms and improving cognitive abilities, and it appears to be linked to good functional outcomes, such as employment and social functioning.

Social Skills Training

The purpose of this built up interaction in client towards society. After illness management, social skills training involves teaching clients way to handle social situations appropriately. It often involves the person scripting (thinking through or role-playing) situations that occur in social settings in order to prepare for those situations when they actually occur. This treatment has been found to help people with schizophrenia to improve their relationships with health-care professionals and with people at work.

Demographic presentation of pre- intervention and post- intervention rating of client's problem



Limitations

- No prior psychological treatment was given to the client.

- Formation of therapeutic alliance was necessary between the client and the trainee clinical psychologist as it is one of the essential part of successful therapy. It was difficult to build therapeutic alliance because client was non- complaint and there was lack of insight.

- Extensive work could be carried out due to brief therapeutic period

- Extrinsic factors such as hospital environment caused disturbance in taking sessions with client

Suggestions

- The focus of health services is still on the medical solutions to schizophrenia, along with this focus should be on psycho- social aspect of the life of affected individuals

- Medication and long term goals should be continued

- On daily basis, sessions should be conducted with the client

- Proper follow-ups should be taken

- Family therapy should be provided to the client's family.

References

Lodge, D.J. & Perez, S. M. New approaches to the management of schizophrenia: focus on the aberrant hippocampal drive of dopamine pathways. *Drug Design, Development and Therapy*. 8, 887-896 (2014).

Hashimoto, K. Targeting of NMDA receptors in new treatments for schizophrenia. *Expert Opin. Ther. Targets.* 18, 1049-1063 (2014)

Becker, T. The *DISC* locus and schizophrenia: evidence from an association study in a central European sample and from a meta-analysis across different European populations. *Human Molecular Genetics*. 18, 2719-2727 (2009).

Need, A. C. & Nutt, D. J. Where now for schizophrenia research? *European Neuropsychopharmacology*. 24, 1181-1187 (2014).

Chant. D. et. al. A systematic review of the prevalence of schizophrenia. *PLoS Med.* 2, 413-433 (2005).

Howard, R. et. al. Late-onset schizophrenia and very-late-onset schizophrenia-like psychosis: an international consensus. The International Late-Onset Schizophrenia Group**.** *Am J Psychiatry*. 157, 172-178 (2000).

Gottesman, I. I. & Gould, T. D. The endophenotype concept in psychiatry: etymology and strategic intentions**.** *Am J Psychiatry*. 160, 636-645 (2003).

Cuesta, M. J. & Peralta, V. How many and which are the psychopathological dimensions in schizophrenia? Issues influencing their ascertainment. *Schizophr Res*. 49, 269-285 (2001).

Thornton, A. E., Torres, I. J., & Van Snellenberg, J. X. Functional neuroimaging of working memory in schizophrenia: task performance as a moderating variable. *Neuropsychology*. 20, 497-510 (2006).

Hamer, R. M. et. al. Brain volume in first-episode schizophrenia: systematic review and meta-analysis of magnetic resonance imaging studies. *Br J Psychiatry*. 188, 510-518 (2006).

Kapur, S. & van Os, J. Schizophrenia. *The Lancet*. 374, 635-645 (2009).

Ballon, J.S. et. al. Signaling pathways in schizophrenia: emerging targets and therapeutic strategies. *Trends in Pharmacological Sciences.* 31, 381-390 (2010).

Kalkman, H. O. The role of the phosphatidylinositide 3-kinase-protein kinase B pathway in schizophrenia. *Pharmacology & Therapeutics*. 110, 117-134 (2006).

Sessions

Session No. 1

- Intake Interview
- History of present Illness
- Rapport building

Clinical interview was conducted to have an in-depth knowledge of the client's history of present illness as well as his personal history. It gave a lot of knowledge regarding his predisposing factors, precipitating factors and maintaining factors of the illness. Functioning of the client at different levels and the atmosphere of his home was discussed deeply. It was very hard to establish rapport with him as he was not making eye contact at all. He was also not responding to whatever was inquired from him. The initiation of the interview was very difficult. Slowly, the client started responding and with the establishment of rapport, the interview paced smoothly. He progressively became more open and supportive but didn't maintain eye-contact.

Session No. 2

- Rapport building
- Explored Further History
- Assessment

The therapist actively built level of trust with the client by explicitly acknowledging the client's difficulty, allowing him to led discussions and establishing role as the therapist, whose interest in the client was strictly professional. The therapist used good eye contact, active listening,

unconditional positive regard, and warm acceptance to help increase the client's ability to identify and express feelings, the therapist demonstrated a calm, tolerant demeanor in sessions to decrease the client's fears.

The therapist assessed the nature, extent, and severity of the client's beliefs, probing for delusional beliefs and conviction in them.

The interpretation of House Tree Person test indicated that client had psychotic tendencies, rejection, social withdrawal, anxiety, introversion, grandiosity, fantasy-based life, regression, rigid tendencies, indecisiveness, and suspiciousness. The client showed severe visuospatial disorganization of time such as he omitted number 11 on clock drawing test, he had poor spacing and he turned page while drawing clock which appeared clock upside-down. The client had total score 106 in result of administration of PANSS, which indicated that client fell between the range of 95-116 that indicated markedly illness and he had schizophrenia.

Session No. 3

- Tentative Diagnosis

The client and his family were psycho-educated about the nature, causes, and relapse chances of the illness. Psycho-education reduced anxiety, guilt, hopelessness, and blame, as well as, it made client feel free to develop and use their own coping resources in order to better negotiate stress, avoid a relapse, and resume functioning.

Session No. 4

- Feedback of previous session was taken.
- Cognitive Behavioral Therapy for delusions

- Examining the evidence

The process of examining the evidence is the core of the CBT approach to modify the delusions. In this case, client often found it easier to explore the evidence for the delusions, which he believed. Even when the client listed the key perceptions that appear to be very strong evidence, the effort to identify evidence for a delusion almost always exposed areas of illogical thinking and uncertainty. Thus listing evidence provided the therapist with a trove of information that can be used to plan the interventions.

Session No. 5

- Cognitive Behavioral Therapy for delusions
    - Reality testing
    - Peripheral Questioning

The tests of specific delusions need to be set up in a collaborative way. It should not be done in an abstract way, but with a firm record kept of findings. In analysis of this case, the finding of “guided discovery” mode was used and the client helped to generate possible explanations for the findings.

Peripheral questioning involved asking questions of fact of the delusional belief, for example: "how might something like that work?" Such questions did not threaten the core of the delusion and normally maintained collaboration without threatening self-esteem. As such, those questions were used most often in early sessions and led directly to reality-testing homework.

Session No. 6

- Cognitive Behavioral Therapy
  - Schema focused work

Clearly, the work at the schema level focused on issues of approval demands and underlying low self-esteem. Schemas included core maladaptive beliefs, for example: "I am unlovable" and compensatory beliefs such as: "I must be approved of at all costs". Those were strongly held beliefs about the self which were typically not challenged and often the client was not even aware of them. Schemas were detected from following the general themes in cognitions, from questioning the meaning of specific events and from inference chaining to detect hot cognitions. Techniques involved articulating the evidence, positive and negative logging of approvals, acting against the belief in imagery and in real-life situations, and direct disputation.

Session No. 7

- Cognitive Behavioral Therapy for Hallucinations
  - Developing Rational Explanations

Once a collaborative and functional relationship had been established and the client had begun to show interest in understanding more about those voices, he became more agreeable to the use of the CBT techniques. One of the most valuable interventions was to help the client in developing the more adaptive explanations for his hallucinations. Techniques such a Socratic questioning, examining the evidence, and checking out the beliefs with homework assignments were usually used in the process of modifying the explanations. Those methods proved very helpful in generating the alternative ideas.

Session No. 8

- Cognitive Behavioral Therapy
- Building coping strategies

Coping-strategy enhancement was another one of the most valuable CBT methods for helping client control hallucinations. In building coping strategies, the difficulties were explained to the client and also the point that what worked for client may not work for another client. Coping strategies grouped onto these general categories: Distraction, Focusing, and Schematic level.

Coping strategies were chosen collaboratively and were often demonstrated and practiced during the sessions especially when the client didn't clearly know about how to use the skill.

Session No. 9

- Distraction Technique
- Cognitive Restructuring (Triple-Column Technique)

The key of distraction techniques is to get patients change their focus of attention from internal (i.e., automatic thoughts, memories, physical sensations) to external. Although some of these techniques seem quite simple, they do help to overcome the hallucinations. In this case, flash cards were very useful mean to distract client with positive messages or memories of happy experiences such as holidays or personal achievements, reminding client that things will improve again.

The "triple-column technique" can be used to restructure the way one thinks about oneself when he/she has goofed up in some way. The aim is to substitute more objective rational thoughts for the illogical, harsh self-criticisms that automatically flood the mind when a negative event occurs (Hershman, 2007).

It was originally developed by Burns (1984) to use with the adults but it had been modified to use with adolescents and children. It is used to record dysfunctional thoughts but it does not contain more detail. The description of the three columns is as given below

- What was my negative thought?
- What thinking error did I make?
- What is the more realistic way to think about it?

This technique was very helpful in recording dysfunctional thoughts and replacing them with more rational cognitions.

Session No. 10

- Behavioral Therapy
    - Activity Scheduling
    - Relaxation Technique

Behavior Therapy

Any coping strategy in which patients are taught to monitor and evaluate their behavior and to modify their reactions to pain (Stanley, Winters, & Cox, 1973). Behavioral techniques for treating schizophrenia frequently have been paired with a variety of cognitive interventions (Beck, Rush, Shaw, & Emery, 1979; Lewinsohn, Munoz, Youngren, & Zeiss, 1986).

Activity Scheduling

This strategy was designed to make the patient more “cognitively aware” of potentially satisfying events and also to make him more conscious of feelings of pleasure. Because of his all-or-none thinking, the client considered totally unpleasurable in any activity that elicits less than this normal amount of satisfaction. Thus, he was asked to rate the degree of pleasure on 0-5 scale. The planning of specific activities in collaboration with the client was an important step in demonstrating to him that he was capable of controlling his time.

Relaxation Technique

Progressive muscle relaxation was a technique use to monitor and control the state of muscular tension of client. For each muscle group, following directions were given to client.

1. Sit in a comfortable position, with eyes closed. Take a few deep breaths, expanding your belly as you breathe air in and contracting it as you exhale.

2. Begin at the top of your body, and go down. Start with your head, tensing your facial muscles, squeezing your eyes shut, puckering your mouth and clenching your jaw. Hold, then release and breathe.

3. Tense as you lift your shoulders to your ears, hold, then release and breathe.

4. Make a fist with your right hand; tighten the muscles in your lower and upper arm, hold, then release. Breathe in and out. Repeat with left hand.

5. Concentrate on your back, squeezing shoulder blades together. Hold, then release. Breathe in and out.

6. Suck in your stomach, hold, and then release. Breathe in and out.

7. Clench your buttocks, hold, and then release. Breathe in and out.

8. Tighten your right hamstring, hold, and then release. Breathe in and out. Repeat with left hamstring.

9. Flex your right calf, hold, and then release. Breathe in and out. Repeat with left calf

10. Tighten toes on your right foot, hold, and then release. Breathe in and out. Repeat with left foot.

Session No. 11

- Feedback of previous session was taken and relaxation technique.
- Controlled breathing

Slowing down over breathing can help to control physical sensation quickly and therefore help us to feel more comfortable. Client practiced this exercise in the session for 5 or 10 minutes. Then the therapist asked for feedback from the client about how he found the experience and discusses any difficulties.

Session No. 12

- Supportive Therapy
- Relapse Prevention

Supportive therapy for schizophrenia clients is a critical part of the treatment for sufferers of this illness. Such supportive therapy was given to client involved helping the client learn life skills that will enable him to continue down the path of healing. Examples of such life skills – how to

manage medication, re-learning how to socialize, managing relationships with family members, loved ones and friends, dealing with finances, and re-entering the job market. It also helped the client to understand what resources are available in the community for him to take advantage of. The ultimate goal of such supportive therapy for client was to provide him with encouragement, practical advice. The aim was to cultivate a strong hope in the client that the situation can indeed get better, and that he can lead almost normal lives with family, loved ones and within his community.

Relapse Prevention

Early developments focused on establishing reliable methodologies for identifying early warning signs of relapse and translated them into practicable methodologies for working with individuals to construct a relapse signature, capturing the unique early signs and symptoms of relapse for a given individual and developing a set of coping strategies, often termed as a relapse drill to manage them. Relapse prevention work required client to a) accept that he has a relapsing condition that needs long term monitoring, b) recognize early wanting signs, c) change his behavior accordingly and/or initiate care and support from others. This model included psycho-education, self-monitoring and implicitly cognitive therapy to reduce hopelessness and perceptions of entrapment that aided recovery and preventeed often traumatic repeated admissions.

Session No. 13

- Feedback
- Social Skills Training

- Termination

Social Skills Training

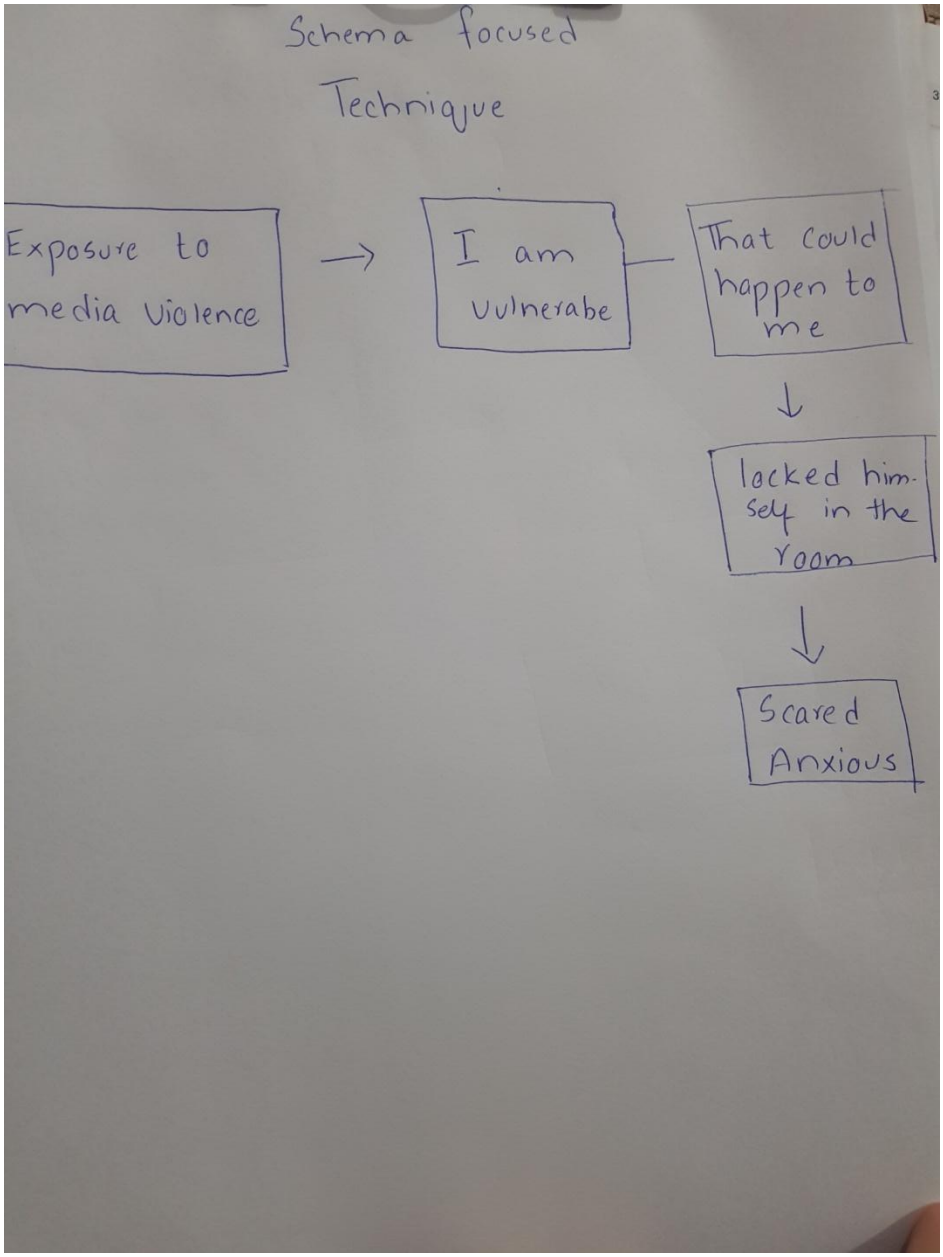
Social skill training was applied to teach client that how to successfully manage a wide variety of interpersonal situations like discussing medication with their psychiatrist, ordering meals in restaurants, filling out job applications, saying no to drug dealer on the street. There has been extensive research on the effective use of social skills training for the treatment of schizophrenia, in outpatient clinics as well as inpatient units. Social skill training was used to help client to make better eye contact with other people, increase assertiveness, and improve their general conversational skills. For the treatment of schizophrenia, social skill training was combined with pharmacotherapy, family therapy, and assertive case management.

.

Appendix-C

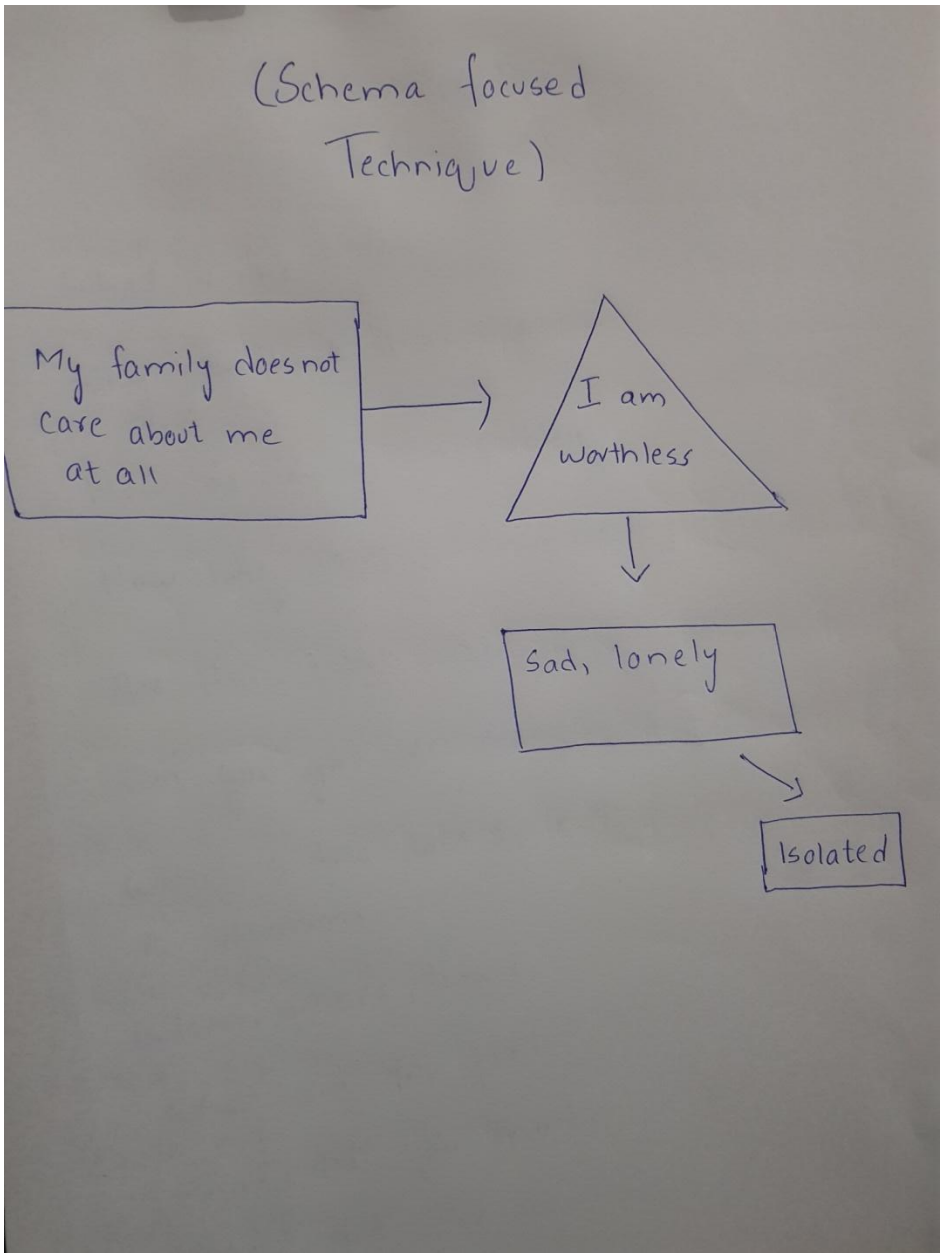
PANSS RATING FORM

		absent	minimal	mild	moderate	moderate severe	severe	extreme
P1	Delusions	1	2	3	4	5	6	7
P2	Conceptual disorganisation	1	2	3	4	5	6	7
P3	Hallucinatory behaviour	1	2	3	4	5	6	7
P4	Excitement	1	2	3	4	5	6	7
P5	Grandiosity	1	2	3	4	5	6	7
P6	Suspiciousness/persecution	1	2	3	4	5	6	7
P7	Hostility	1	2	3	4	5	6	7
N1	Blunted affect	1	2	3	4	5	6	7
N2	Emotional withdrawal	1	2	3	4	5	6	7
N3	Poor rapport	1	2	3	4	5	6	7
N4	Passive/apathetic social withdrawal	1	2	3	4	5	6	7
N5	Difficulty in abstract thinking	1	2	3	4	5	6	7
N6	Lack of spontaneity & flow of conversation	1	2	3	4	5	6	7
N7	Stereotyped thinking	1	2	3	4	5	6	7
G1	Somatic concern	1	2	3	4	5	6	7
G2	Anxiety	1	2	3	4	5	6	7
G3	Guilt feelings	1	2	3	4	5	6	7
G4	Tension	1	2	3	4	5	6	7
G5	Mannerisms & posturing	1	2	3	4	5	6	7
G6	Depression	1	2	3	4	5	6	7
G7	Motor retardation	1	2	3	4	5	6	7
G8	Uncooperativeness	1	2	3	4	5	6	7
G9	Unusual thought content	1	2	3	4	5	6	7
G10	Disorientation	1	2	3	4	5	6	7
G11	Poor attention	1	2	3	4	5	6	7
G12	Lack of judgement & insight	1	2	3	4	5	6	7
G13	Disturbance of volition	1	2	3	4	5	6	7
G14	Poor impulse control	1	2	3	4	5	6	7
G15	Preoccupation	1	2	3	4	5	6	7
G16	Active social avoidance	1	2	3	4	5	6	7


Schema focused
Technique
Exposure to media violence
I am vulnerabe
That could happen to me
locked himsely in the room
Scared Anxious

ABC Model

Activating Event	Belief	Consequence
My family hates me and soon they will kill me	Jumping to conclusions	Aggression Verbal abuse Fighting with others for self-defence


(Schema focused
Technique)
My family does not care about me at all
I am worthless
Sad, lonely
Isolated

(Guided Discovery Questions)

What is the Problem?

Why you think it as a problem?

How Severe is this problem?

How long have you been having this problem?

Are there times when it gets totally better?

Can you give an example of that situation?

When is the last time that you lived such a situation?

When, where, how?

What did you feel?

What did you think?

What did you do?

Case IV

Summary

Mr. J.A was a 28 year old man, his birth order was fifth. He had six siblings, including three brothers and three sisters. All of his siblings were settled in their lives. His qualification was B.A, and he was divorced. He lived in a nuclear family system and belonged to middle socio-economic class. He was employed as a manager of CNG stations. The client was referred to PAC Hospital, Attock with the complaints of opioid withdrawal symptoms use on and off for the past 2 years. He even used to be easily irritated and showed aggression when told to quit drugs. Formal assessment DAST (The drug abuse screening test),HTP and DSM 5 checklist was used to assess him. The prognosis of client seemed good because he was motivated to quit drug use. Management plan was based on Motivational Enhancement Therapy, Community Reinforcement Approach and Interpersonal therapy. More techniques of motivation, ensuring commitment, behavioral techniques and interpersonal therapy to mend their relations etc were used within 10 sessions.

Identifying Information

Name	:	J.A
Age	:	28 years
Gender	:	Male
Education	:	B.A
Occupation	:	Manager of CNG station
Marital Status	:	Divorced
Children	:	NIL
Siblings	:	6 (3 brothers, 3 sisters)
Birth Order	:	Fifth
Mother Alive/Dead	:	Alive
Father Alive/Dead	:	Dead
Religion	:	Islam
Informant	:	Sister

Reason for Referral

The client was taken with complaints of disrupted heart rate, constipation, constantly irritable mood, decreased appetite, sweating, agitation, nausea, vomiting, insomnia and weakness in limbs and was referred for the purpose of psychological assessment.

Presenting Complaints

Table 4

Shows presenting complaints by client

موجودہ مسائل	دورانیہ
آنکھیں جلتی ہیں	1مہینہ
ہاتھ سن ہو جاتا ہے	1مہینہ
سر میں درد رہتا ہے	9 مہینےتقریبا
ہر وقت الجھن سی رہتی ہے	1مہینہ
سکون کی نیند آتی ہی نہیں	1مہینہ
سر میں درد ہوتا ہے تو چکر بھی آتے ہیں	1مہینہ
ٹھیک سے بھوک نہیں لگتی	1مہینہ
بخار ہوتا ہے	1مہینہ

پسینہ آتا ہے	1مہینہ

Table 4.1

Shows presenting complaints according to his sister

موجودہ مسائل	دورانیہ
یہ سوتا نہیں ہے رات کو چکر لگاتا ہے	پیچلےمہینےسے

Symptoms by DSM-5

- Disrupted heart rate
- Constipation
- Constantly irritable mood
- Decreased appetite
- Sweating
- Agitation
- Nausea
- Vomiting
- Insomnia
- Weakness in limbs

History of Present Illness

The client was brought to the PAC Hospital, Kamra due to the symptoms of disrupted heart rate, constipation, constantly irritable mood, decreased appetite, sweating, agitation, nausea, vomiting, insomnia and weakness in limbs.

The client started taking drugs in November 2017, about two years ago. Client was divorced in March 2017 which proved to be a major blow in taking the client on the verge of taking drugs so he started using them. According to the client, he did court marriage three years ago in September 2016 as all the members of the family were against his decision. Client and his wife had lived happily for eight months. One day client heard his wife talking to someone on the phone and when the client inquired about it, she said that it was no one. From that time, the client frequently noticed his wife talking to someone on the phone and whenever the client went near her, she cut the call. Client reported that he had also seen his wife meeting two or three guys frequently and when client finally inquired his wife about them, she started quarrelling with client. From that time onwards, there were frequent fights in the client's house. The client came to know that his wife was pregnant. He was very happy to hear that he was becoming father of a girl. But two days after client got news of about fathering a child, his wife had an abortion. The client had a major fight with his wife and then she went to her parent's home and asked for a divorce.

According to the client, on the day of divorce client cried a lot in his room. He hadn't told his family members about that problem. He was worried about his life and about what had happened to him.

During the same days client made new friends who used to visit his CNG station very often. Client reported that, previously, he had ignored them because he didn't like them. But

after his divorce, the client wanted to escape from all the worries so he started responding to those guys. They used to visit his house and brought cigarettes which the client also smoked. One day they brought beer to the client's room at which the client had an argument with them. They left the client's house without saying anything. They had also left the beer at the client's house. During the same night, the client had a dream about his wife having intimate relations with another guy. He went to his T. V. room and started drinking beer. The client didn't like it but gradually soothing feelings took control over him. After a week the client called his friends and asked for an apology and invited them to his house. Client had already arranged beer for them as a surprise. When they came all of them had a party. All of them moved to wine afterwards. It became usual for them to drink wine and then sleep for the whole day. The client's assistant used to do the client's work at CNG station.

Client's friends also started bringing girls with them. Client had sexual relations with lots of them and he enjoyed his new life.

Client reported that, meanwhile, his friends started bringing heroine cigarettes. The client totally refused to smoke them at which his friends made fun of him that he was weak and couldn't even smoke a cigarette. The client became angry at this and smoked three cigarettes consecutively. He woke up two days later and didn't remember what he did during those two days. It was the client who arranged wine and heroine cigarettes for all of them as according to client, his friends brought substandard heroine and wine with them. The client loved his new life. He reported that his new life was tension free.

The client had a call from one of his sisters about her marital problem. When the client went home, all of his family members were perplexed to see his condition. All of them started

crying. Client didn't know what to do with them so he quarreled with them. The client went to his own room and lied down for sleep. The client knew that he couldn't drink alcohol or smoke heroine here so he had planned that his stay at home would consist of only two days. The client's sister came to his room and talked to him. The client started feeling irritable and violent again but his sister calmed him down. They talked for the whole night and the client told her about all his marital problems. His sister was bothered about her brother's condition. Next day, all of the family members stressed that the client should stay there for a week. The client didn't agreed first but later on he agreed. They started spending lot of time with the client. Client's sisters cooked all the client's favorite foods and in the evening they daily went for outing somewhere.

The client hadn't entered his father's room during his visit. His father had died three years ago and the client loved him and respected him very much. One day the client entered his father's room and started crying on thinking about his father. At that time, he promised to himself that he will not go back and he will quit drug abuse. Although he used to leave house for a few hours to smoke heroine cigarettes but he promised to Allah this time that he will quit using such things.

Initially the client didn't feel any problem related to it but as the days passed he started feeling weakness in his limbs. His heart beat had started to increase and the decrease without any reason. Sometimes he turned pale. He couldn't sleep properly and had constipation. The client went to a number of doctors but to no avail. He had ECG and hormone test but none of the medicines were effective.

The client never had experienced psychological symptoms ever in his life. When he was 8 years old, he had swelling in his genital areas due to some infection. But the client had

recovered from it. He had never ever smoked a cigarette in his life before it. The client started becoming worried about his problems and talked to his brother-in-law. He took the client to hospital. The client was referred to the Psychiatry ward and then to the drug addicts ward for therapeutic intervention.

Personal History

Birth and Early Development

According to the client, he was born in February 1991 in Government hospital. It was a normal delivery and he was a healthy baby; almost of eight pounds. There were no complications in his birth and his mother had no history of substance abuse. His mother didn't face any prenatal or postnatal problems.

The client achieved all his development milestones at the appropriated age during his childhood. The client was breast-fed by his mother for one and a half year (till he was almost one year and few months old), started sitting approximately at the age of 8 months, crawling 10 months, standing at almost year and a month and running at 20-21 months. The client started dressing himself completely when he was in 5-6 years old. He had experienced no problem related to toilet training and he had normal sleep patterns in childhood. The client did nail biting but he quitted this habit when he was about nine years old. It was his mother who used to tie green chilies on his fingers so that he would stop nail biting.

He didn't suffer from any major injury, physiological illness or other psychological problem apart from swelling and infection in his genital areas when he was eight years old. He was treated by a doctor from nearby clinic.

Psychosexual History

The client reached the age of puberty when he was in about 9th class. According to the client, he had already known everything from his cousin. Client wasn't shocked or depressed to hear about it.

He considered it normal. His cousin (who told him about it) had sexual relations with a number of females. Client himself had sexual relations with a number of girls for the whole year. His friends used to bring girls with them and when all of them were drunk, they used to have sexual relations with them. At that time the client considered it normal. But now, according to the client, he was guilty for those acts.

Marital History

The client got married when he was twenty-five years old. His spouse was twenty-years old at that time. It was a love marriage. His spouse had done Matriculation. She was client's neighbor and client saw her daily but never felt anything special for her. Then the client moved to Faisalabad for the job. When he came back, he was thrilled to see the same girl as she was very beautiful now. The client had promised to himself that he will marry that girl.

He talked to his family members but they rejected the client's proposal. When the client went to talk to the girl's family on his own they became very angry and shouted at the client and asked him to get out of the house. The girl's family members had forbidden her from talking to the client so they started meeting in parks. The client planned for the court marriage at that time. One day, both of them ran away and did court marriage.

Client was exhilarated to have his dream girl in his life. Client reported that he gave her everything he could, best clothes, best jewelry, best food, and everything else. Client had never spoken harshly with his wife. He had never ever asked her to do anything. Client did all of his tasks by himself. Client had arranged two house-maids for his wife. The house-maids did the cleaning, washing, cooking, laundry, pressing clothes, etc.

The client daily took his wife out for dinner. His wife had been a good partner during the initial months and client was happy to have such a sincere life partner but gradually their relationship worsened and ended with a divorce. The client had tried his level best to ask his wife about everything but she never talked about anything and bet about the bush. The client never knew why his wife did this to him.

Academic History

The client was admitted in school when he was five years old. It was an English medium local school situated near the house. He wasn't a bright student but he had somehow managed to pass exams of every standard. Client reported that he failed in mathematics when he was in fifth class but later on he passed it. He knew that mathematics was his weak subject so he had a tutor for mathematics. Client went to school regularly. The client sometimes didn't do his homework due to which he was punished. He also used to make noise in the class and he was also punished because of that. He was a naughty kid.

The client did Matriculation when he was seventeen years. He took admission in F.A. and failed in first attempt. He tried again, he wasn't sure of himself that whether he would be able to clear F.A. but he did that and he was very proud of himself for passing and after that he did B.A. and after B.A. he didn't continue his studies.

The client had number of friends and he was always the one behind making plan to do something mischievous. Client and his friends were known as the trouble makers in the school.

Client had received religious education from a nearby Madrassah. In fact, it was the Madrassah where all the siblings had gone one by one regularly to receive all the religious education. Client was never a religious person and didn't pray or recited Holy Quran.

Social History

The client had genial relations with his father and siblings. He had been very frank with his siblings and he loved all of them equally. He was talkative and indulged in other's affairs when others were in trouble only. He had a number of friends and all of them were employed. Client didn't like to play games or read anything; instead he used to watch movies whenever he was free. Client never had any problems in initiating conversation with the strangers. He felt at ease whenever he came face to face with some stranger. He never had any problems being in crowded places or alone. Moreover, he liked to watch TV especially the Hollywood movie channels and fictional movies were the movies that he watched most of all. The client used to watch English movies too. He also liked to watch national TV channels for dramas as all the family members had one or two favorite dramas which they mostly watched together.

Forensic history

No forensic history was present

Family History

The client's father was 73 years old when he died due to Hepatitis C. He was illiterate. Client's father was a simple, humble and honest man. He had leather business. He had done three

marriages. The client's mother was his father's first wife. The client's father had given him divorce when the client was twelve years old. It was due to family fights and the client's paternal uncles had some issues with the client's maternal relatives. Those issues couldn't be resolved except the client's father giving divorce to his mother. So his father gave divorce to the client's mother. His father's second wife (client's step-mother) had died due to kidney failure ten years ago and she had two daughters.

Client's father had always inspired him and he wanted to be like his father for his own children as the client's father was for the client and the rest of the siblings. The client reported that despite of having to support family, his father had never felt any burden or tension of any sort. Client's father had never ever spoken to his family harshly. Client's father had equally loved all the siblings as well as the client's step-sisters.

The client's father also used to drink alcohol when he was young but at the birth of his first daughter, he had quit it. The client's father had led a happy and healthy life and didn't suffer from any psychological illness.

According to the client, his own mother was approximately 52 years old and lived in Quetta. He had vague memories of his mother. She was also a very caring woman. Client's father was thirty-five years old and his mother was seventeen years old when they were married.

Client had a one photo of his mother. He missed his mother and wanted her to be with him right now. When his mother left the house, the client didn't show any reaction.

His elder sister took client's mother place and used to take care of the whole family. Client had total six siblings; 3 sisters and 3 brothers. All the sisters were married and happily

settled in their homes. One of his brothers was married and settled in Rahim Yar Khan with his wife and two children.

Client had affable relations with all of his sisters especially the elder sister who was like a mother to him. She was the first born and had three sons. She was educated till fifth class.

Second born was the client's sister. She had a beauty parlor and had two daughter and two sons. She was very talkative and used to annoy the client but the client also paid her respect. Client's this sister was educated till matriculation and had done a couple of diplomas related to beauty parlor management.

Third born was the client sister who was settled in Saudi Arabia. She had a son and a daughter. She was innocent and simple. Client loved her. She was very courteous. She was also educated till matriculation. Her sister's face resembled client's mother and sometimes the client used to stare his sister unconsciously because his sister remind the client about his mother.

The client had estranged relations with his brother who was the fourth born. Client was not very fond of him as he used to advise client a lot and interfered in client's life. But the client had never said anything to his brother to infuriate him. Clients this sibling was educated till B.A. Client also respected his brother as he was older than client. Fifth born was the client himself who had tried his level best to lead a happy life.

Sixth born was the client's youngest brother. He was in F.Sc. and played basketball for the school. Recently he had won a national competition of basketball. Client's this sibling was of jovial nature and was very humorous. Client was concerned about his brother's future as he wanted to excel in basket ball but didn't take interest in studies.

Client also had lovely relations with his step sisters and step-mother. His step sisters were married and happily settled with their own husbands. None of client's siblings had any psychological illness. All of them had suffered from chicken pox almost eighteen years ago, one after the other.

All the siblings loved and took care of each other. They were always ready to help one another in the dilemma. They used to spend time together and gave gifts (such as suits, wrist watches, jewelry, etc) to one another frequently.

The client belonged to a middle class, nuclear family system. His sisters lived in their own houses. Eldest sister used to come to the client's house daily. Client was the one who used to financially support his younger brother and gave money to his sisters on occasions such as eids, birthdays, etc.

Client's father used to be authoritative figure of the family and since he died, all the family members cooperated and discussed before making any decisions. There wasn't any authoritative figure in the family.

Client's house had three floors. Except the ground floor, rests of the floors were on rent and the families living there were also nice. General atmosphere of the house was tranquil. When the client used to take drugs, there had been a couple of fights in his house, except that, there was no problem in the house. Every family member was available to help others all the time.

Psychiatric history in family

No significant psychiatric history was present in client's family

Occupational History

Client was manager in a CNG station. Before it, he had done job as cable operator but the pay wasn't enough so he quitted that job and went to another city and started working at CNG station. Because of his hard work, he was given the post of manager. His colleagues were fond of him because of his witty nature. His supervisors adored him because he was very hardworking and talented. Client was satisfied with his job salary as he was able to fulfill the needs of his family comfortably.

Initially client had faced difficulty in doing the job as it was new for client, but he overcame the difficulty and efficiently managed everything. Client was happy with his job as he had his own apartment and a cubicle for doing office work. He had also been given a computer.

Pre-morbid Personality

According to the client, he led a prosperous and soothing life. Although there were some minor issues in his house but such problems were a part of every family so client had never been bothered by them. Instead he dealt with them adequately. The client's sister reported that the client had never ever been such an irritable person instead he used to be the life of the house. The client's sister reported that the client had never fought with his siblings. The client used to help his sister in the kitchen whenever he was free or played basketball with his brother. The client was happy most of the time. He used to be satisfied with his life. Before drug addiction, the client didn't have any premarital/extramarital affairs. He didn't have any homosexual experiences in his life and considered them against Islam. He said that God had set boundaries for all of us so all human beings shall lead their life within those boundaries.

Preliminary investigation

Informal Assessment.

The informal assessment comprised of detailed interview, behavioral observation.

Clinical Interview

Clinical interview was conducted to have an in-depth knowledge of the client's history of present illness as well as his personal history. It gave a lot of knowledge regarding his predisposing factors, precipitating factors and maintaining factors of the illness. Functioning of the client at different levels and the atmosphere of his home was discussed deeply.

Behavioral observation

Behavioral observation is the recording of the observable reponses of individuals by human observer (Hartmann & Wood, 1992). Behavioral observations are flexible and applicable means of observing behavior and it also provides a comprehensive description and evaluation of behavior. Moreover, it also provides information about the severity and frequency of any behavior (Nock & Kurtz, 2005)

The client was a man who was 28 years old.He was dressed weather appropriately. His hairs were unkempt.Client maintained an ample eye contact all the time.Client was cooperative and It was easy to establish rapport with him as he was very confident of himself that he will recover soon due to this the interview paced smoothly. The speed and tone of his speech was average.He didn't display any disorganized speech. Client was conscious about proximity and was maintaining personal space between himself and trainee clinical psychologist.

Mental Status Examination

Mental status examination is a method of organizing and evaluating clinical observation pertaining to mental status or mental condition. The primary purpose of the mental status exam is

to evaluate current cognitive process (Strub &Black, 1985). Mental status examination contributes a set of interview questions and observations designed to reveal the degree and nature of a client's abnormal functioning (Corner, 2015). Mental status examination obtains evidence of symptoms and signs of mental disorders based on the information about different elements such as appearance, motor activity, speech, mood and affect etc.

Client was wearing neat and clean dress and overall hygienic condition was satisfactory. Attitude of the client towards therapist was cooperative and attentive. Client's rate of speech was normal but tone was soft. Mood of the client was appropriate with his affect. He was happy and energetic His memory was unaffected and his concentration was also intact. He was properly oriented to time, place and person. His general knowledge was adequate so were his judgmental abilities. There was absence of suicidal ideations. Hallucinations and delusional beliefs were absent. Furthermore, he didn't have any obsessive or compulsive beliefs. His insight was intact about the disorder. He accepted that he was suffering from withdrawal symptoms, and needed psychological as well as psychiatric help and that he would strictly adhere to the treatment regimen advised for him by the professionals.

Visual Analog Scale

Visual analog scale scale is a subjective way of measuring the severity of any subjective construct which exists along a continuum. It could further be explained as an instrument which tends to measure any characteristic or attitude that have different values along an array (Gould, 2001)

Visual analog scale was used for subjective rating of client's problems. In visual analog scale, rating of the presenting problems was done on a 10-point rating scale with 1 indicaing the least significant problem and 10 indicating the most significant problem. (see Appendix A-II)

Table 4.3

Visual analog scale rating of problem at pre- intervention level

Presenting complaints	**Pre-intervention rating**
Disrupted heart rate	8
Constipation	7
Constantly irritable mood	7
Decreased appetite	9
Sweating	6
Agitation	7
Nausea	7
Vomiting	7

Insomnia	9
Weakness in limbs	8

Formal Assessment

Following scales were used as formal assessment.

- The Drug Abuse Screening Test (DAST)

The Drug Abuse Screening Test (DAST).

DAST consists of 28 questions such as whether or not the client has used any drug other than prescribed by the doctor, or had any problem at his work place or family because of drug abuse. It can be very helpful in assessing the severity of the problem.

Rationale

DAST was administered to assess the client either he was screened to abuse or not and severity level of drug/substance abuse.

Procedure

Client was seated on a comfortable chair with comfortable environment. Proper instructions were provided to him before the test was started. The test questions were asked in the form of interview from the client. It took 15-20 to administer the test. The client seems motivated for the test.

Quantitative interpretation

Table 3

Table Showing Scores, Range and Severity of Client on Drug Abuse Screening Test (

Raw score	Range	Severity
22	16 and above	Severe

Qualitative interpretation

The total score obtained by client was 22, which was substantial than normal score. This score indicated that subject was drug addicted and showed severity of drug abuse and withdrawal symptoms.

House Tree Person (HTP)

House tree person test was developed by John Buck(1948) and is an extension of good enough scale i.e. Draw a person Test used to asses intellectual functioning.It is a projective test which let people respond to ambiguous stimuli, presumably revealing hidden emotions and internal conflicts.

Rationale

The House Tree Person is a projective test designed to measure aspects of personality. The test can also be used to asses brain damage and general mental functioning.

Procedure

The client was seated in a comfortable environment. He was given 3 A4 plain sheets one by one and a pencil. Instructions were given to him. “Here I want you to draw as good a house, tree and a person as you can”. After that questions were asked related to the drawings. Test was completed by client within 30 minutes.

Qualitative Interpretation

House Interpretation

He preferred left placement which indicated the impulsivity in client. He drew a small door which indicated the indecisive nature of client and he omitted windows, which indicated social withdrawal. Light line quality indicated insecurity and shading indicated anxiety.

Tree Interpretation

Left placement of tree indicated withdrawal and insecurity. Base drawn by client was narrow which indicated the loss of control and shading indicated anxiety.

Person Interpretation

The left placement of person indicated the impulsivity, insecurity and social withdrawal. Arms drawn by client indicated guilt, rejection, and social ambivalence. Client omitted feet of person, which indicated helplessness, loss of autonomy and omitted neck indicated impulsive nature of client.

The overall interpretation indicated that client was insecure, withdrawal socially, indecisive in nature and had distractive personality.

DSM -5 criteria

Client was assessed through formal and informal assessment means and then after those diagnostic criteria was checked from DSM-5. As formal and informal assessment proposed that client meet diagnostic criteria for depressive disorder so for this reason criteria of opioid withdrawal was checked.

Diagnostic criteria	**Symptoms present in client**	**Status of symptoms**
Cessation of (or reduction in) opioid use that has been heavy and prolonged	Client reported that he was on drugs for last 2 years	✓
Administration of an opiod antagonist after a period of opioid use	Not reported	×
Dysphoric mood	Client narrated that someday he feels numbness and on others irritability	✓
Nausea or vomiting	Experienced by client at start of treatment for few days, due to this he was afraid to intake anything	✓
Muscle aches	Client report that his hands and legs feels stingy and feels pain on right side of the body	✓

Sweating	Client reported he sweat a lot when fever occur	✓
Insomnia	He could not make himself sleep easily	✓
Yawning	During sessions yawning was observed	✓
Diarrhea	Experienced by client after his sudden withdrawal from drugs	✓
Fever	Client reported that he feel fever most of the days after withdrawal	✓
Social/occupational disturbance	Narrated by client his condition was having adverse effects on his work	✓

Tentative Diagnosis

(292.0) Opioid Withdrawal, Severe (Heroin)

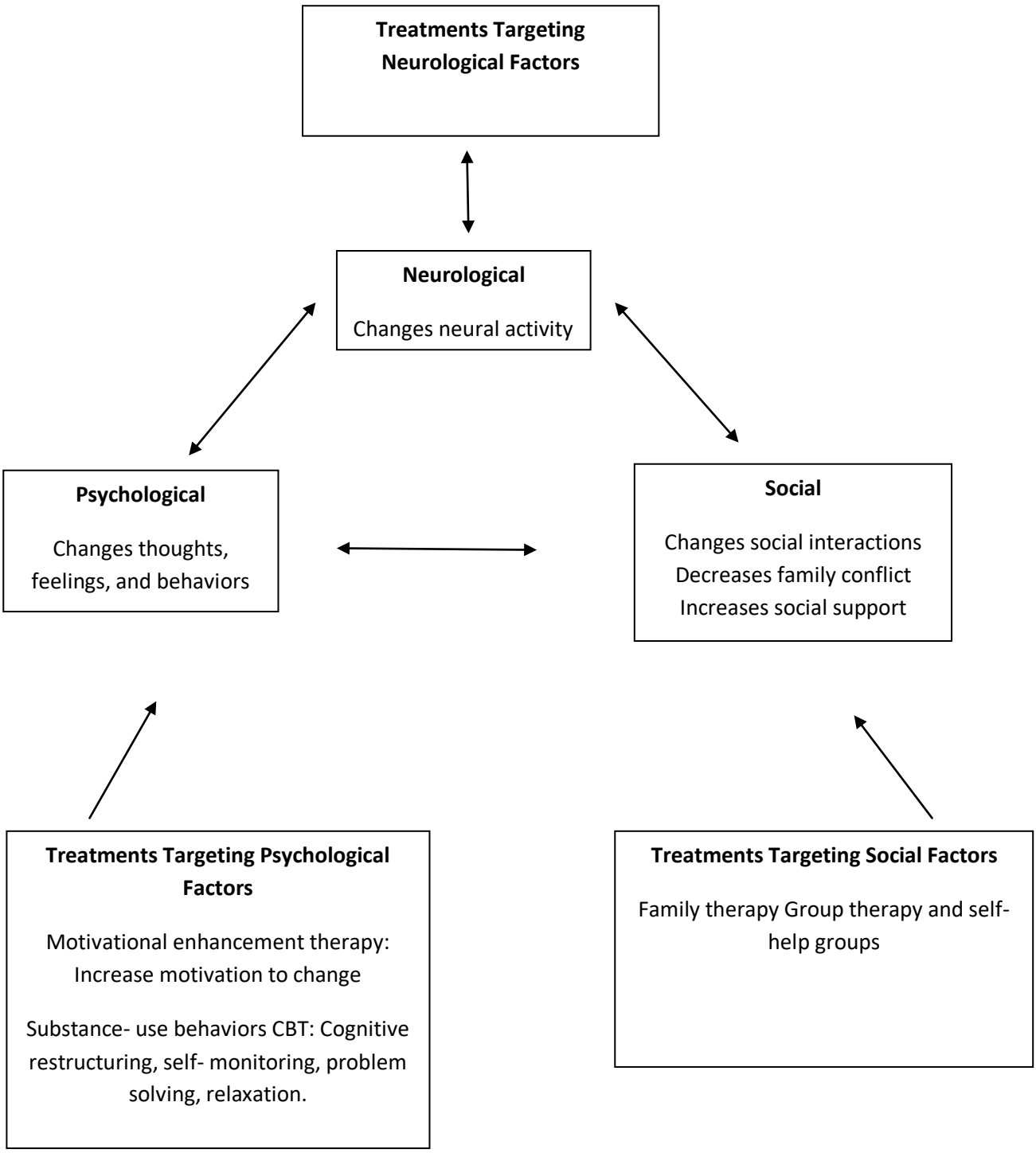
Prognosis

Prognosis is a prediction about how a particular patient is likely to fare over time.The client was highly motivated to become healthy again and to get rid of substance dependence and withdrawal symptoms leading to a favorable prognosis. Absence of peri-natal pathology, no personality

deviation in the pre-morbid personality, and lack of hereditary mental illness are contributing towards a good prognosis (Talimbekova, 2011).

Case Conceptualization

Neuropsychosocial model was used to conceptualize case



Case Formulation

Mr. M.R is a 28 years old male who was decently dressed. He was admitted to the hospital due to the symptoms of disrupted heart rate, constipation, constantly irritable mood, decreased appetite, sweating, agitation, nausea, vomiting, insomnia and weakness in limbs. Currently he was employed as a manager of CNG station in Faisalabad. He belongs to a middle class family and has seven siblings (four sisters and three brothers). He got married at the age of twenty-five. It was a court marriage. Both the partners had lived together happily during the initial months. The event that led the client to use drugs was abortion by his wife and later on his own divorce. According to the client, his wife had affairs with two other guys and she quarreled with the client whenever he talked about them with his wife. The client was very happy to hear that he was becoming father of a girl but he was devastated to hear that his wife had aborted the baby. They had a major argument on it and his wife asked for divorce. The client felt that his life had ruined. He then started having friendship with few guys who used to take drugs and ultimately the client also started taking them. He wanted to escape and forget about his miserable life condition. He didn't go to the CNG station for his job as his assistant managed the client's work on client's behalf. The client left rest of his friends because they tried to talk to him so he started fighting with them. One day he went home and on seeing his condition, his sisters started crying. During his stay there, he realized how wrong he had been and what he had done. At that point, he promised to himself that he will quit using drugs. He got admitted in PAC Hospital, Kamra. He has been under treatment of a clinical psychologist.

Clinical interview, behavioral observation, and formal assessment comprising of Belief About Substance Abuse was administered to the client to find out any underlying factor that the client was not reporting directly and to assess the functioning and personality of client.

The test results and case history interview suggested his diagnosis as Alcohol withdrawal that is one of the categories of substance withdrawal. It has also been confirmed by clinical interview. Generally substance withdrawal refers to discontinuation of drugs or alcohol, even when significant problems related to their use have developed. Signs include an increased tolerance or need for increased amounts of substance to attain the desired effect, withdrawal symptoms with decreased use, unsuccessful efforts to decrease use, increased time spent in activities to obtain substances, withdrawal from social and recreational activities, and continued use of substance even with awareness of physical or psychological problems encountered by the extent of substance use (Madoz-Gúrpide, Barbudo del Cura & Sanmartín, 2004).

A substantially higher number of men than women abuse alcohol; some estimate the ratio to be as high as 5:1(Remedy Health Media, 2012). Dielman, Campanelli, Shope and Butchart (1987) conducted research to determine levels of use of alcohol, marijuana, and cigarettes, intentions to use these substances, and problems resulting from alcohol misuse. The questionnaire also included 45 items concerning susceptibility to peer pressure, self-esteem, and health locus of control. The "Susceptibility to Peer Pressure" index correlated more highly with the adolescent substance use, misuse, and intention items than the self-esteem or the health locus of control indices. Two leading data sources on substance use-National Household Survey on Drug Abuse (NHSDA) and the Monitoring the Future (MTF) study-report a greater occurrence of illicit substance use among males than among females. Both surveys have consistently documented this pattern over the years. According to the 1997 NHSDA survey, men reported a higher rate of illicit substance use (any illicit drug) than women, 8.5 percent to 4.5 percent, nearly double. Men report higher rates of cocaine use .9 percent versus .5 percent. Alcohol use (58 percent versus 45 percent), binge drinking (23 percent versus 8 percent), and heavy drinking

(8.7 percent versus 2.1 percent). The same pattern was observed in marijuana use (Office of Applied Studies [OAS] 1997). Thirty-eight percent of males report heavy drinking, while only 2 percent of females do (Johnston et al. 1997). In the present case the client was a male of 32 years who had been abusing the drugs since almost two years.

Peer influences have been found to be among the strongest predictors of drug use during adolescence. It has been argued that peers initiate youth into drugs, provide drugs, model drug-using behaviors, and shape attitudes about drugs (Borsari & Carey, 2001). Drawing on differential association theory (Sutherland, 1947), risks of substance use among adolescents may be influenced by their level of association with deviant peers. A mediating effect of peer networks also is suggested by the work of Steinberg (1987), who reported greater susceptibility to peer pressure among adolescents from step- and single-parent families, compared with mother–father families. Client was also forced into the habit of taking drugs by his friends.

Parental substance abuse has been identified to be a risk factor in leading to offspring towards it (Galanter & Kleber, 2008). Studies indicate that up to 25% of sons of alcoholic fathers will develop alcohol abuse or dependence (Remedy Health Media, 2012). Social learning theory argues that individuals acquire social behavior by modeling or imitating others' behavior (Bandura, 1977). Family members are central in shaping behavior, including deviant behavior. As illustrations, parental use of substances is associated consistently with greater use by their offspring (Stephenson, Henry & Robinson, 1996; Friedman, Terras & Glassman, 2000). In the current case, the client's father had also abused drugs which might have proven to be a predisposing factor in the client's drug abuse.

According to Fu and Goldman (2000) and Wishman (1999) (as cited in Galanter & Kleber, 2008) Individuals who are divorced, single or experience marital dissatisfaction are more likely to develop substance dependence. Stress reduction hypothesis posits that drug/substance abuse is a maladaptive form of coping associated with stressful environment and negative life events (Sinha, 2001 as cited in Galanter & Kleber, 2008). Barrett and Turner (2005) found that respondents from single-parent families report a significantly higher level of problematic substance use than those from mother–father families. The researchers found strongest evidence for differential association with deviant peers and exposure to stress. The client also started abusing the drugs after he was divorced and couldn't handle the stress.

An explanation for family structure differences in substance use focuses on differential exposure to social stress. Research finds consistently that greater stress is associated with worse health (Pearlin, 1989; Aneshensel, 1992; Turner & Lloyd, 1995); including greater risk of problematic substance use (Turner & Lloyd, 2003). Several human studies have reported a positive association between adverse life events, chronic distress and increased drug abuse. Preclinical research has shown that stress, in addition to drug itself, plays a key role in perpetuating drug abuse and relapse. Most major theories of addiction postulate that acute and chronic stress plays an important role in the motivation to abuse addictive substances (Tomkins 1966; Russell and Mehrabian, 1975; Leventhal & Cleary, 1980; Shiffman, 1982; Marlatt & Gordon, 1985; Wills & Shiffman, 1985; Koob & Le Moal, 1997). For example, the stress-coping model of addiction proposes that use of addictive substances serves to both reduce negative affect and increase positive effect, thereby reinforcing drug taking as an effective, albeit maladaptive, coping strategy (Shiffman, 1982; Wills & Shiffman, 1985). The popular tension reduction (Conger, 1956; Sher & Levenson, 1982) and self-medication hypotheses (Khantzian,

1985) have proposed that people use drugs to enhance mood and alleviate emotional distress. Alcohol consumption is positively associated with stress levels, lack of social support and avoidance coping (Aro, 1981; Cronkite & Moos, 1984; DeFrank et al. 1987; Chassin et al. 1988; Pohorecky, 1991). The client started abusing the drugs after a stressful life event of being divorced.

Mathew, Fetzner, Hon, Katherine, McMillan, Jitendar, Sareen, Gordon and Asmundson (2011) indicated significant positive relationships between traumatic events and drug dependence, particularly among individuals without PTSD.

In the current case, different factors are contributing towards the client's illness. He is continuously feeling stress because of thinking about his life partner who deceived him.

Environmental Influences

As the initiation of opioid abuse, was related to environmental influences such as peer-pressure, disrupted family dynamics and history of availability of drugs in environment. There was no direct evidence supporting cause to explain any specific substance abuse disorder. However, research has supported links between certain factors and the subsequent development of substance related problems. By this past history, it had been identified that due to his divorce he got upset and became more engaged in substance abuse.

Opioid Addiction and Opioid Dependence sometimes, classified together as an opioid use disorder, medical condition that categorize the compulsive use of opioids (For Example; Morphine, Codeine, Oxycodene, Heroine, Hydrocene etc). Inspite of, consequences of continued use and the withdrawal syndrome that occurs when opioid abuse stops, respectively. The opioid-

dependant withdrawal symptoms involve both physical dependence and psychological dependence upon opioid compounds.

Personality Factors for Opioid Abuse

According to another model. Environmental influences for Opioid Addiction, it appears that some potential causes may function through genetic influences For Example; temperamental qualities, such as, novelty-seeking and impulsivity believed o be inborn, have been linked to an increased risk of opioid addiction. Additionally, out nature influences what type of people we choose to be around. Thus, while peers can influence our choices as far as beginning and continuing to use a substance, we decide which peer group to which we want to belong. Factors such as these are thought to result from an interaction between heredity and environment.

Pleasure Experienced in Brain

Everyone enjoys the experience of pleasure. It is important enough to our well-being that there is a pleasure and reward center located in our brains and specific chemicals responsible for neural communication are strongly related to our ability to experience pleasure, happiness, joy, and excitement. When we take opioids, the resulting sudden rush of pleasure we experience is stronger than what we may normally experience on a daily basis.

Management Plan

The purpose of the management plan was to aid the client in better adapting to the environment, overcoming the negative views regarding it and to deal with the current symptoms to improve the level of functionality.

Short Term Goals

- Client and his family members were psycho-educated about the nature of the problems, goals of the therapy and prognosis of the problems to make them have insight about the client's problems.

- Using activity scheduling of the behavior therapy, the client was taught to initiate enjoyable/recreational activities that can be done alone.
- Through the triple column technique of cognitive behavior therapy the negative, distorted cognitions that mediate intense negative emotions in the client was identified.

- The client was also trained in revising the core schemas using cognitive restructuring techniques.

- The client was reinforced in positive, realistic cognitive self talk that mediates a sense of peace.

- Through distraction the client was helped to think about something pleasing whenever he has urge to use drugs.

- Using techniques such as deep breathing, progressive relaxation, and the client was taught how to relax completely and he was encouraged to relax whenever he felt uncomfortable.

- Pointed out to the client the destructive effects of over-control of others and angry resentment when others pulled back from relationships. Encourage separation of helpless, desperate feelings of the past from current relationships.

- Through REBT, the client was identified, challenge and dispute his dysfunctional thought patterns.

- Motivational interviewing was used designed to strengthen the client's motivation for and movement toward a specific goal by eliciting and exploring the his own arguments for change.

Long Term Goals

- Follow up sessions was conducted in order to see the effectiveness of the therapeutic techniques and helping the client regarding any problem he faced while implementing the techniques out of therapeutic session.
- Continuation of short term goals.
- Developed and demonstrated anger management skills.
- Gained control over life.
- Developed social skills.
- Active participation in the recovery program.
- Acquired the necessary skills to maintain long-term sobriety from all mood altering substances.
- Improved the quality of life by maintaining an ongoing distance from all mood-altering substances.

Summary of therapeutic intervention

A variety of psychological and social (psychosocial) strategies for treating drug and alcohol dependence have been developed, each offering a different level and type of support to persons recovering from drug or alcohol dependence. Treatments are often mixed and matched to fit the

individual, as resources (money and/or health insurance) permit. It consisted of the following therapeutic interventions:

- Rehabilitation
- Aversion Therapy
- Motivational Enhancement Therapy
- Group Therapy
- Religious Counseling
- Cognitive Behavioral Therapy (ABC model)
- Family-focused Therapy
- Drug Therapy
- Psycho-education

Aversion Therapy

It is a technique of Behavioral therapy, in which an aversive (causing a strong feeling of dislike or disgust) stimulus is paired with an undesirable behavior in order to reduce or eliminate that behavior under the right circumstances. Depending upon the objectives established in the beginning of treatment, client successfully completing the course of an aversive therapy, will expect to see the reduction/cessation of an undesirable behavior. By adding relapse prevention technique with it, client can expect to maintain the behavior.

Motivational Enhancement Therapy

It will be conducted over a short period of time to build and strengthen motivation to change behavior of substance abuse. This therapy will focus on identifying the pros and cons of seeking

treatment, forming a plan for making changes in client's behavior of substance abuse, building confidence, and developing the skills needed to stick to the plan.

Group Therapy

A group will be formed where everyone will experience the same problem. In group therapy, therapist will lead and conclude the discussion i-e; if someone will suggest that not to take drugs for the minor issues therapist will give encourager for that.

Religious Counseling

This therapy will be recommended to the client with substance abuse and withdrawal symptoms. Individuals who're involved in some type of spiritual practice may find it easier to maintain recovery from addiction. For many people, gaining greater insight into their spiritual side is key element in recovery say offering prayers.

Cognitive-Behavioral Therapy (CBT)

In CBT, patient learns to examine how his thoughts affect the emotions. He also learn how to change negative thinking patterns, and behaviors into more positive ways of responding.

ABC Model. ABC model could be described as "As I think, so I feel (and do)

A – Activating Event: The actual event of the clients, as if he wants to quit substance abuse and go back to take his responsibilities.

B – Beliefs about the Event: This evaluation can be irrational and his belief about the event is that "I don't got my job again".

C – Consequences: Feels worthless, rejected.

Family-focused Therapy

Family-focused therapy addresses issues to family and works to restore a healthy and supportive home environment. Educating family members about the disease/illness of client and how to cope with its symptoms is the major component of treatment. Working through problems in the home and improving communication is also a focus of treatment.

Drug Therapy

Drug therapy is used to cope up with the dependency of drug. The client is kept away from drug for some days.

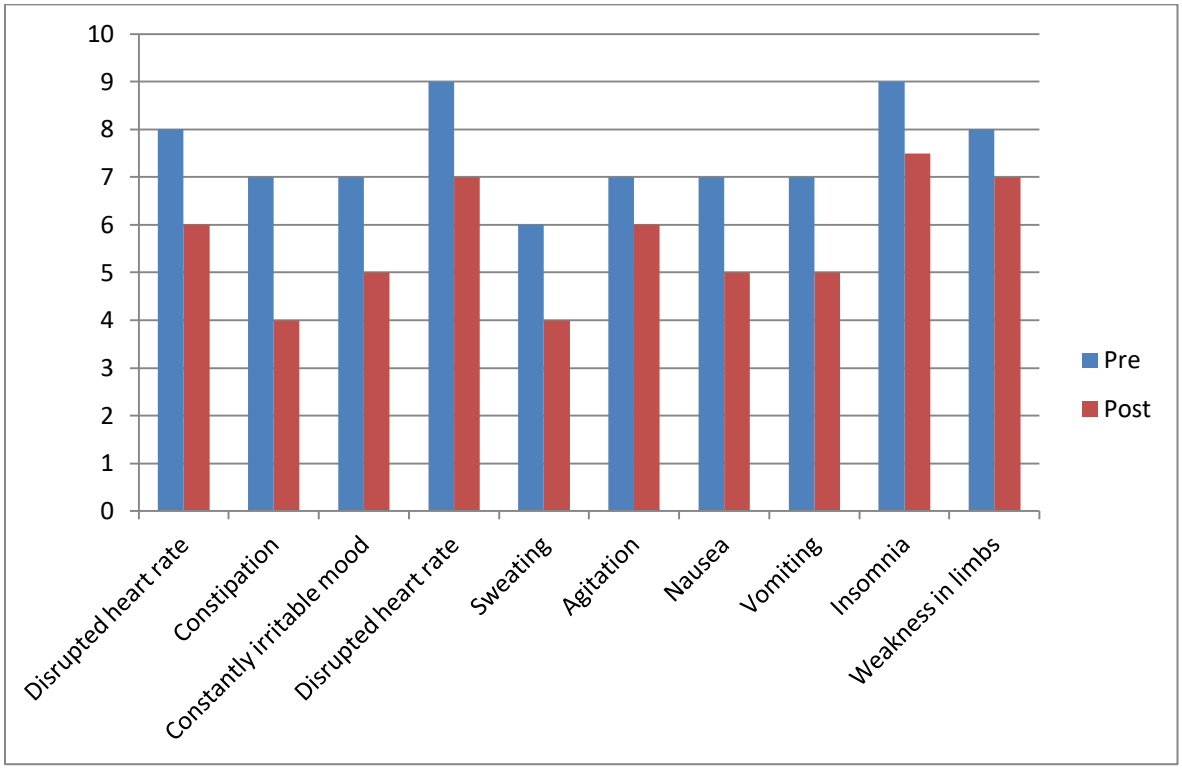
Psycho-education

Psycho-education is a way to educate individuals and their families about mental health or substance abuse issues. Psycho-education usually focuses on helping people to better understand the issues for which they are getting help. For instance, psycho-education for a person who is in treatment for substance abuse problems focuses on the process of addiction and recovery, the biological aspects of addiction and ways to prevent relapse (Glidden-Tracey, 2006).

Behavioral Therapies

Behavioral treatments help engage people in drug abuse treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to drug abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive abuse.

Demographic presentation of pre- intervention and post- intervention rating of client's problem



Limitations

- Extensive work could be carried out due to brief therapeutic period
- Distraction free environment wasn't available that created disturbance in taking session with the client.
- Family of the client wasn't available after first session that's why most of the information couldn't cross checked

Suggestions

- Proper follow-ups should be taken

- new techniques should be applied with the rehearsal of the old ones.
- Proper individual sessions should be continued
- Family therapy should be provided to the client's family.
- Long term goals should be continued

References

Stewart, Dorothy (1998) Gower handbook of management skills. Gower Publishing, UK, pp. 1-430.

Walters ST, Rotgers F (2013) Treating Substance Abuse: Theory and Technique. Guilford Press, USA. pp. 1-436.

Jack Hafner (2002) REBT Anger Workbook. Hazelden, p. 1-9.

Andrews G, Jenkins (1999) Management of mental disorders. London: World Health Organization Collaborating Centers for Mental health and Substance Abuse, UK.

Jeanne (2002) Client's Handbook: Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders. U.S. Department of Health and Human Services, USA, pp. 1-168.

American psychiatric association (2000) Diagnostic and statistical manual of mental disorders. (4th edn), American Psychiatric Association, DSM Library, USA.

David SL (2000) National conference on drug abuse prevention research. USA.

Beck AT, Wright FD, Newman CF, Liesev BS (1993) Cognitive therapy of substance abuse. Guilford Publication Inc., USA, pp. 1-354.

Benton AL (1974) Revised Visual Retention Test. Clinical and Experimental Application. (4th edn), The Psychological Corporation, USA.

Carlson L (1959) Depression and relapses in treated drug addicts. International Journal of Addicts 30: 329-333.

Colzato LS (2009) Psychopharmacology. Journal of Psychopharmacology 10: 225-234.

Session Report

Management Plan

Session No. 1

- History taking
- Developing rapport
- Informational care

- Presenting Complaints and History of Present Illness was obtained through Clinical Interview. Interview was conducted with patient and informant, but since the patient was very restless, agitated and over-talkative most information was gathered from the informant. Information of this interview was used to start therapeutic process.

- Initial mental state examination was also conducted at this stage but due to lack of cooperation and client's compliance it could not be completed. The client was allowed to freely talk to note down the content of the speech to find out any perceptual or cognitive disturbance which was observed and noted. Then techniques of empathy and listening were used to build rapport with the patient which was very crucial for any further psychological work.

- **Informational care.** In this, the attendant of the client was asked to keep a close eye on him and to keep any drug or substance for from his reach as well. He was also asked to look out for any other signs as well. He was asked to take care of appetite of the patient as well. The attendant was also instructed to keep any sharp or dangerous object away from patient as well to avoid any harm to him or others.

Session No. 2

- Further history was explored
- Assessment was conducted in this session.
- Family was psycho-educated about the illness, causes and treatment.

History

In this session only the client was asked to come and a detailed account was taken from him regarding the reason he started using cannabis and what was the reason behind relapse. A detailed account was obtained about his personality, his friend circle and also his relationships in which he mentioned about his marital life. Then history was taken about his source of getting opioid and he told that he got it from his friend.

Assessment

Formal assessment was done in this scale using The Drug Abuse Screening Test which indicated severe psychological dependence on opioid, House Tree Person Test was used to assess his personality, and Beck Anxiety Inventory which indicated that he had anxious symptoms due to withdrawal of drug use.

Psycho-education

The client's family was also in quite stress because of the state of the client especially because the client had aggression and other behavioral disturbances as well. They were told that the client was suffering from a mental disorder called Opioid Withdrawal disorder and it is generally called as addiction. The rate of relapse is 90% in those who had once stopped it and that it can be treated

via psychotherapy and help from medications as well. This all needs great motivation and strength of the client and support ad care of the attendant.

Homework

The client was assigned task to properly take medication and take care of his hygiene.

Session No. 3

- Relaxation exercises
- Starting MET by building motivation to change

Relaxation exercise

Relaxation technique was taught for the symptoms of body aches and headaches in client due to staying away from the drugs. Relaxation technique of deep breathing was taught to the client by first showing him how it was to be done then he was given instructions regarding it. The client was asked to sit comfortably in a chair during session and to close his eyes while letting loose his muscles. He was asked to take a deep breath from his nose and hold it in his stomach for 5 seconds and slowly releasing it through his mouth and repeating it, the client felt calm after it. After it he was asked to imagine his most preferable scenario where he wants to go and he was asked to imagine being there while deep breathing for optimal results.

Motivation to change

Firstly the client was motivated by using positive statements like:

- Being open to input about drug abuse.

- Acknowledging real and potential problems related to drug abuse.
- Expressing a need, desire or willingness to change.

Then all the views of the client about his reason, his worries about abuse were heard with empathy to avoid evoking client's resistance and to encourage the client to keep talking. While doing so whenever he expressed idea about quitting it was highly motivated.

Then the client was reaffirmed by appreciating him for hanging in the therapy and also acknowledging his ideas for change.

Towards the end of a session summarized the client's self-motivational statements. This functioned in allowing clients to hear their own self motivational statement and therapist reflection on it.

Session No. 4

- Working on commitment to change using elements of MET
- Anger management

Feedback

Feedback of previous session was taken. He was relaxed and there was reduction in behavioral disturbances and he was willing to bring a change in him.

Working on commitment

Second major process in MET is to consolidate client's commitment to change, once sufficient motivation is present. This is determination stage, where the balance of contemplation has tipped in favor of change and client is ready for action.

Recognizing change readiness

A shift towards making a plan was taken and he was asked questions like I wonder what you are thinking about your smoking at this point? And what do you make from all of this? What are you thinking you will do about it? And his answers were more motivated and positive now. He had been dealing with his withdrawal as well so he was motivated about that too. The overall message conveyed was that you can change your drinking behavior and its up-to you and only you can change it.

Then some information is taken about drug abuse running in family and he was told about the changes that it brings to the brain. Brief and specific information was provided of all the client's questions

Session was ended by answering his questions as also motivating again.

Homework

The client was then asked to take care of his hygiene now and care for himself.

Session No. 5

- Feedback of previous session was taken.
- Sleep hygiene was taught

- Functional analysis was conducted

Feedback

Feedback was taken regarding the previous session. The client said that he felt more at ease now knowing that he was understood and he said that relaxation helped him but his sleep was a concern for him.

Sleep hygiene

Instructions about sleep hygiene were necessary for the client. He was asked to stay away from caffeine and drugs and was also asked to not drink tea or coffee before sleeping. He was asked to make his bed before sleeping and fixing a sleep time to regulate his sleep. The client was also asked to lie down comfortably and practice deep breathing before sleeping. And he was said that if he still fails to sleep then instead of lying down for hours he should get up from bed and sit on side to avoid over-thinking and again lay down after 20 minutes.

Functional analysis

It is done by taking a close look at the functions served by the use of substance and functional analysis of pro-social behavior i.e. sober activities.

A structured interview outlines both the antecedents (triggers) for the drug abuse behavior and the consequences were taken:

Antecedents are broken down first into:

- External triggers: peers and friends, he went to
- Internal triggers: physical sensation of being strong, feeling of euphoria

- Next a description of the type and amount of cannabis and regular cigarettes was outlined so that progress can be monitored.
- Finally, the consequences for an individual's use were examined. The highly reinforcing but short-lived immediate consequences were identified first, such as the reported ability to relax. Eventually he was assisted in finding non-using ways for the individual to obtain these same feelings.

Session No. 6

- Counseling
- Communication skills training.
- Engaging in O.T

Counseling

In this the negative, long-term consequences of the using behavior were highlighted, including problems in interpersonal relationships, health, job, legal issues, and finances. He was told that he lost his job because he could not work properly and his relations with his family and his mother also went downhill because of substance use and he was also told that all this has done more damage to him and his family.

He was also counseled regarding his girl-friend that he should not ruin his life over someone who got away and left him. He was told to be more optimistic about his future.

Communication skills training Communication skills training focused on three components of a good conversation:

- Giving an understanding statement,
- Accepting partial responsibility for problems,
- Offering to help.

For this the client was given a situation to talk about and the role of therapist was the second person. This resulted in increased level of confidence of the patient and by the end of the session he was more relaxed and maintained eye-contact.

Engaging in O.T

The client was engaged in occupational therapy room so that he would learn a new skill set of it will result in behavioral activation of the client. He was also sent there so that it would distract him and he would get bored sitting in his room all day.

Session No. 7

- Problem solving training
- Activity scheduling

Problem-solving training

It is a step-by-step procedure for addressing specific problems, such as combating urges to drink, developing non-drinking friendships, or developing new ways to relax. It included

- Listening problems.
- Choose a problem like peer pressure.

- Define the problem like feeling the need to smoke because all his friends who used to smoke.
- Brainstorm like never go to there, go for some time, and refuse to smoke.
- Decided that he would limit his visits only when needed and that too with any of his family member and he would decline smoking.
- Action plan: he said that he would work on it.
- Review by seeing if it succeeds or not as a plan.

Activity Scheduling

Activity schedule was made for him. He was asked about his routine and was asked to form a time table during the sessions. Then different suggestions were given to him and with his consent changes were made to it. Specific times were set for each thing like is eating patterns and also his studies as well as fixing a time table.

Session No. 8

- Occupational counseling
- Social and recreational counseling

Social and Recreational Counseling

Social-skill training was provided to clients, who report or demonstrate difficulties in recreation so, he was asked to

- Meet non-drug using peers.

- Interact with coworkers or roommates.
- Attend social activities where he feels comfortable and slowly interacting with more people.
- Express his feelings or asserting themselves in an appropriate way like being assertive in refusing drugs.

Occupational counseling

Since the client had left his job so he was asked to

- Develop a resume.
- Send out 4 resumes with a cover in at least a week.
- Enroll in a job training program.
- Enroll in a vocational exploration program.
- Take a job-skills-related class.
- Collect and consider information on educational possibilities.

And he was also counseled to first contact his previous job and if that does not work out he should apply for more and should start with something he is more passionate about and he wanted to go abroad and work with his cousin so he was asked to apply for visa work further.

Mobilizing social support

Since the patient felt that he did not have much social support in his family now so his social support was mobilized by asking his brother to appreciate him whenever he does something good, making most of their resources.

Session No. 9

- Interpersonal therapy
- Stress coping skills to avoid relapses

Interpersonal therapy

It was used to work on the relation of the patient with his brother. He said that his brother does not respect him despite being young and he also bosses the patient around. While his brother said that is condition in embarrassing for us so we don't know what to do with him. So the both were brought to a consensus that all they will do in future will be for each other's benefit and good.

Stress coping

Since there is a major future probability of relapse in patients again as well so it was very necessary to teach him stress coping skills to reduce these chances altogether. The patient was told that he should have a positive outlook of things and that every issue or problem has a solution. He was also asked to identify his stressors so that whenever they arise he copes with them immediately and smoothly. So when there is stressful situation, do not let the stress stimuli over-power you instead try to find its solution.

He was told that whenever he faces a stressful stimuli he should remain calm and relax and should try relaxation technique and after that he should try to come up with possible solutions

and while doing so he should look at it as if it is someone else's problem or look at it from a general perspective. Client was briefed that it is not possible that all things will work out the way we want them to, so instead we should look for other alternatives too. He was asked to have a proper diet and proper sleep schedule which will reduce the effects of stress.

Session No. 10

- Therapy was formally terminated

Termination of session

Session was terminated. He was asked to take his pharmacological treatment and seek psychological help as soon as he needs it.

Outcome

Client was able to control his symptoms to great extent after 10 sessions. A considerable decrease was seen in his aggression with a marked increase in his adaptive functioning. He realized that all problems can be solved and most importantly his family life came back to the baseline. For his motivational enhancement therapy and interpersonal social rhythm therapy was seen as the most affective.

Appendix-D

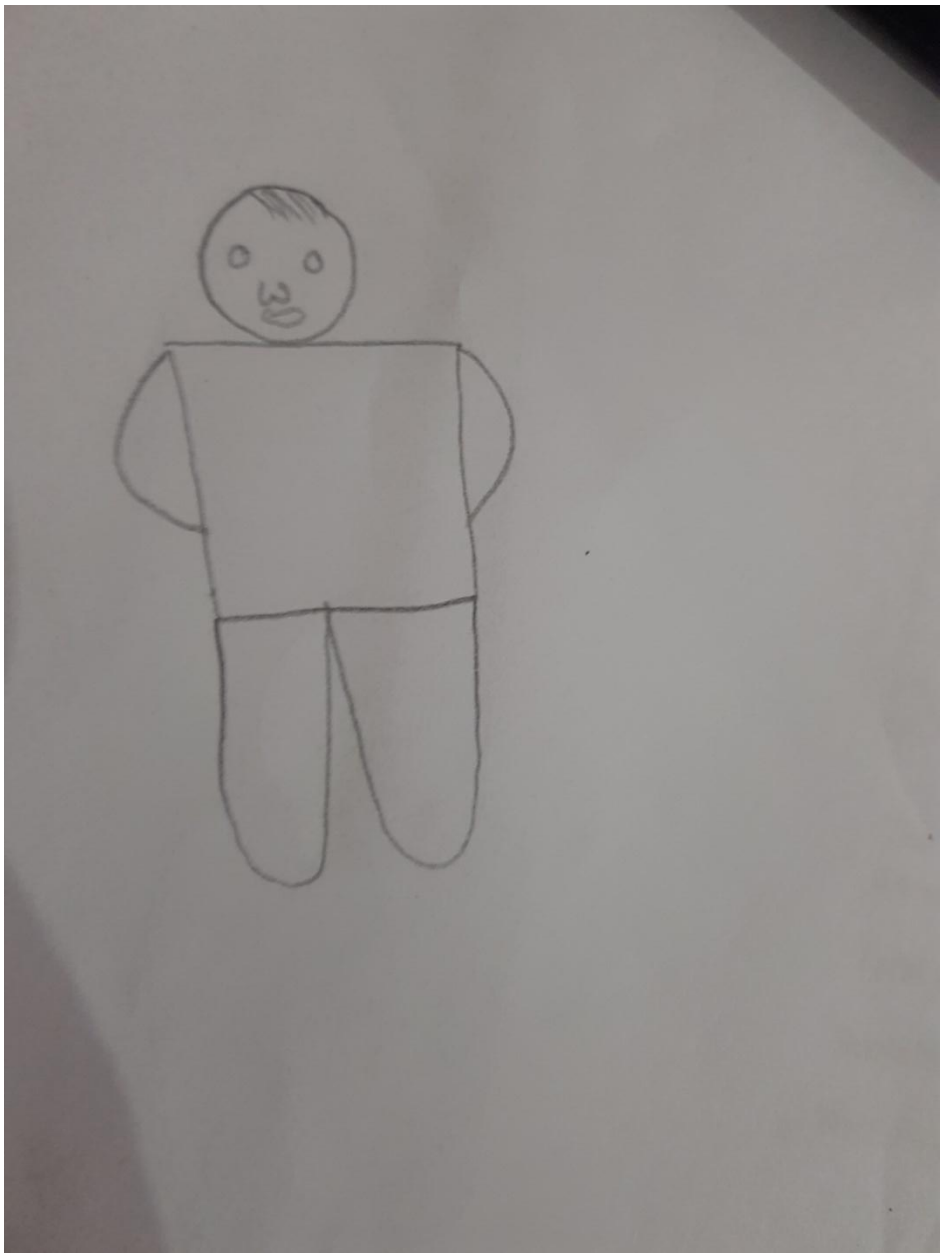
...metric properties" ... that parallel those of the Michigan Alcoholism Screening Test (MAST). The DAST has "exhibited valid ... and has been found to be "a sensitive screening instrument for the abuse of drugs other than alcohol. ... and is still an excellent screening tool. It is a 28-item self-report

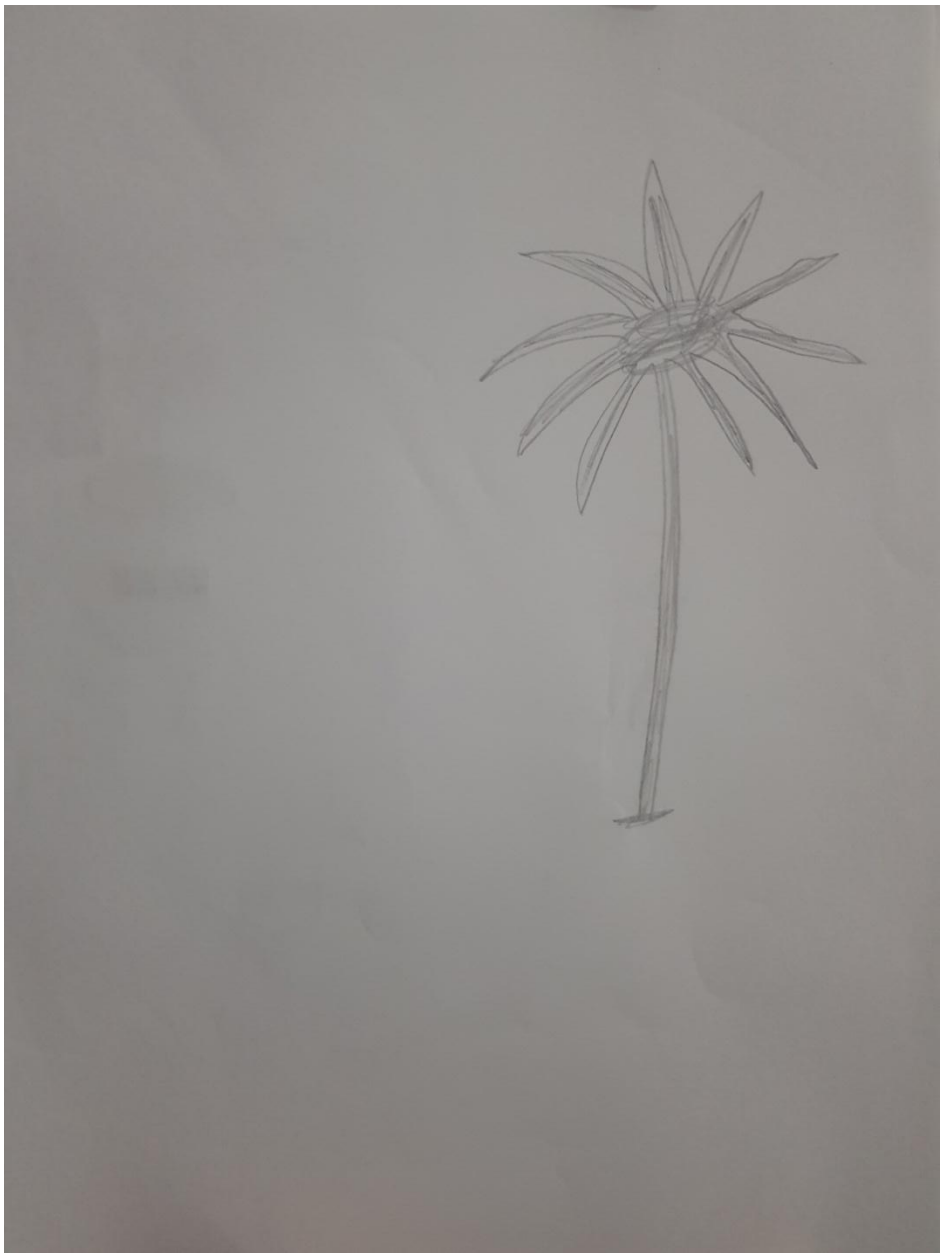
The Drug Abuse Screening Test (DAST)

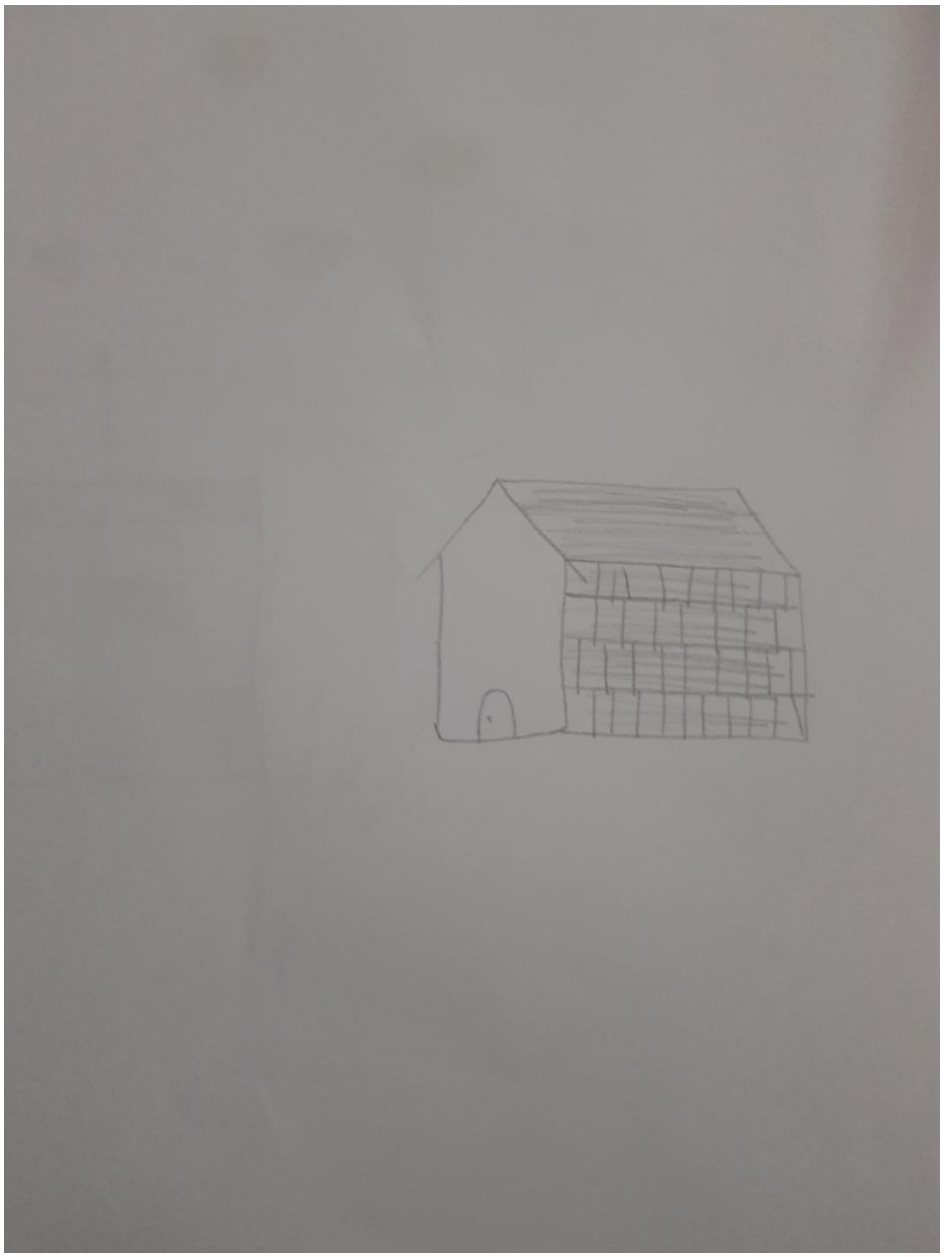
Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

		YES	NO
1.	Have you used drugs other than those required for medical reasons?	✓	
2.	Have you abused prescription drugs?		✓
3.	Do you abuse more than one drug at a time?	✓	
4.	Can you get through the week without using drugs (other than those required for medical reasons)?		✓
5.	Are you always able to stop using drugs when you want to?		✓
6.	Do you abuse drugs on a continuous basis?		✓
7.	Do you try to limit your drug use to certain situations?	✓	
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?		✓
9.	Do you ever feel bad about your drug abuse?	✓	
10.	Does your spouse (or parents) ever complain about your involvement with drugs?		✓
11.	Do your friends or relatives know or suspect you abuse drugs?	✓	
12.	Has drug abuse ever created problems between you and your spouse?		✓
13.	Has any family member ever sought help for problems related to your drug use?	✓	
14.	Have you ever lost friends because of your use of drugs?	✓	
15.	Have you ever neglected your family or missed work because of your use of drugs?	✓	
16.	Have you ever been in trouble at work because of drug abuse?	✓	
17.	Have you ever lost a job because of drug abuse?	✓	
18.	Have you gotten into fights when under the influence of drugs?	✓	
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?		✓
20.	Have you ever been arrested for driving while under the influence of drugs?		✓
21.	Have you engaged in illegal activities in order to obtain drug?	✓	
22.	Have you ever been arrested for possession of illegal drugs?		✓
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	✓	
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	✓	
25.	Have you ever gone to anyone for help for a drug problem?	✓	
26.	Have you ever been in a hospital for medical problems related to your drug use?	✓	
27.	Have you ever been involved in a treatment program specifically related to drug use?	✓	
28.	Have you been treated as an outpatient for problems related to drug abuse?	✓	

Scoring and interpretation: A score of "1" is given for each YES response, except for items 4,5, and 7, for which a NO response is given a score of "1." Based on data from a heterogeneous psychiatric patient population, cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have substance use disorders). Using a cutoff score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4,7,16,20, and 22.







Portfolio

Preliminary Report 1

Summary

The client was 45 year, married male. He came with the complaints of excessive worry, fatigue, difficulty in concentration, muscle tension, nervousness, insomnia, dizziness, irritable mood, anhedonia, loss of appetite, and restlessness. These complaints became more sever from last few months. The client reported that his mother's dead was a trauma for him and now his brother fought with him over property. Due to his brother's attitude, he was facing such complaints.Only 1 session was taken in which identifying data, presenting complaints and history of present illness was noted down.

Identifying Information

Name	:	M.A
Age	:	45 years
Gender	:	Male
Education	:	Primary
Occupation	:	Carpenter
Marital Status	:	Married
Children	:	2 (1 son, 1 daughter)
Siblings	:	5 (1 brother, 4 sisters)
Birth Order	:	Second
Mother Alive/Dead	:	Dead
Father Alive/Dead	:	Alive
Religion	:	Islam
Informant	:	Wife

Reason for Referral

The client was taken from the PAC, Hospital Kamra and referred for the purpose of psychological assessments and management.

Presenting Complaints

According to the Client

مجھے چکر آتے ہیں اور جب سے گھر میں یہ بات ہوئ ہے عجیب سی پریشانی لگی رہتی ہے۔تھکن جلد ہو جاتی ہے پٹھوں میں درد رہتا ہے۔ اور جسم میں نیند کم ہو گئ ہے۔

According to the Informant

ہہں ہیں۔غسہ کرتے ہیں اور اب کام میں دلچسپی بھی نہیں لیتے۔ انکی بھوک پیاس کم ہو گی ہے اور سوتے بھی ٹھیک نہ جلدی تھک جاتے ہیں۔

Symptoms by DSM-5

- Excessive worry
- Fatigue
- Difficulty in concentration
- Muscle tension
- Nervousness
- Insomnia
- Dizziness
- Irritable mood
- Anhedonia
- Loss of appetite
- Restlessness

History of Present Illness

The client reported that he came with complaints of excessive worries about everything and many times a day. He reported that he keyed up at normal matters of daily life. He got fatigued without any hard work. He had difficulty to concentrate his attention to the work. He felt anxious all the time. He also reported that he felt muscle tension and nervousness. The client reported that he felt dizziness but had difficulty in falling sleep. The client reported that it was irritating and he was too tense.

The client was 45 year old, married male. He brought to hospital by his wife. He stated that he had facing many problems. His routine life had become anxious due to his problems. He felt pressure and apprehensions all the time. The client reported he was tense and become twitchy on little things. He was unable to do his work. He had lost his interest in all activities of life. He reported that he could not stop himself from worrying about all things and future. He was irritated and unsteady.

The client's problems started with the death of his mother. He was 7 years old when his mother died. The death of his mother was a traumatic event of his life. He felt lonely without mother's affection. The client reported that he was a sensitive person and become easily anxious on little things. When he reached to adulthood he started to remain depressed. He took part little interest in other doings than work. The client reported that he felt pressure on doing work. He also reported that he had difficulty to mange his work. His sleep and appetite was almost ended. It was troubling for him. His wife asked him for his medical checkup. She brought him to the hospital in 2018. The doctors prescribed tranquilizers and sleeping pills to him. He had been taking medicine for 6 months but could not recover. During his treatment, one day his younger brother quarreled with him on the partition of property. The client was upset at the younger brother's behavior. This incidence was painful and troubling. He started to feel worries and fears

about the future of his children. He reported that it was cruel moment in his life. He did not imagine it ever. His most of the time spent in worrying about future. He was terrified. He left to go on work. He spent all the time at home. He started to feel agitation and fears on little things. His wife was too upset on his awful condition. She again brought him to the psychiatrist at the PAC Hospital, Kamra. There he was admitted. The client reported that it was shocking for him when his younger brother separated his work with him. He had never thought for such thing. The client reported that it was unacceptable for him. The client reported that his father also favored his brother. His father gave all the property to his brother. He told that all things gone against his expectation. It seemed that no one want to support him. He felt lonely.

These family matters made him fearful and anxious. He remained thinking all the time to get rid of his problems. He felt headache and pains in shoulders. He was quite worried and anxious. He remained worried most of the time. He started to feel constant worry on every little thing. This made him restless. He felt nervousness on his work. He was totally unable to do work. The client also reported he could not sleep in night.

The client reported that his wife was a brave lady. She had encouraged him on every problem. The client reported that his wife brought him to hospital for his treatment. She was living with client at hospital. She took care of all the needs of client.

Preliminary Investigation

Informal Assessment

- Clinical Interview
- Behavioral Observation

Behavioral Observation

The client was tall and fair, wearing shalwar qameez. His dress was not cleaned. When he came in room he seemed as appropriate. His speech form and content was inappropriate and irrelevant. The tone of his voice was high. His attitude toward examiner was cooperative. His behavior was normal and he seated in a normal way. He was confident and openly answered each question. Rapport was built immediately. The client was well oriented with time, place and person. His recent memory, and short term memory was good. His abstract thinking was average and his attention and concentration was also averaged.

Sessions

Session No. 1

- History taking
- Developing rapport
- Deep breathing

Presenting Complaints and History of Present Illness was obtained through Clinical Interview. Interview was conducted with patient and informant. Information of this interview was used to start therapeutic process.

Counseling

Client was counseled about his present situation and he was assured complete support by using different counseling skills like empathy. Different counseling techniques were also use like rephrasing, summarizing and giving positive gestures of active listening.

Relaxation technique of deep breathing was taught to the client by first showing him how it was to be done then he was given instructions regarding it. The client was asked to sit comfortably in a chair during session and to close his eyes while letting loose his muscles. He was asked to take a deep breath from his nose and hold it in his stomach for 5 seconds and slowly releasing it through his mouth and repeating it, the client felt calm after it. After it he was asked to imagine his most preferable scenario where he wants to go and he was asked to imagine being there while deep breathing for optimal results.

Therapy Termination

After first session therapy was terminated because of closure of hospital due to recent pandemic.

Preliminary case 2

Summary

Mr. A.A was a 19 year old, educated till 10th grade and resident of Attock. He lived in a nuclear family with his parents and his siblings. His father was very abusive and physically, verbally and emotionally abuses his mother and even him when he tried to take his mother's side or tried to protect her. He was eldest in the kinship of 3. He was presented with the complaints of fluctuating mood, low at the time of referral, impulsively reacting to things, verbal as well as some physical aggression, difficulty in maintaining relations with others, smoking cigarettes since age 8, displeased with other people and had started self-harm for the past 2 years. Client's problem had been going on since his childhood but they had worsened since 2 years. His biological functioning was also disturbed. After formal and informal assessment and score 9 on Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) client was obtained which helped in diagnosing as Borderline Personality Disorder. His management plan will be based on freedom therapy and few elements of Dialectical Behavior Therapy by tailoring the therapy according to the client.

Identifying Information

Name	:	A.A
Age	:	19 years
Gender	:	Male
Education	:	Matriculation
Marital Status	:	Unmarried
Siblings	:	3 (1 brother, 2 sisters)
Birth Order	:	First
Mother Alive/Dead	:	Alive
Father Alive/Dead	:	Alive
Religion	:	Islam
Informant	:	Mother

Reason and Source of Referral

Client was presented in OPD for assessment. He was presented with the complaints of fluctuating mood; low at the time of referral, impulsively reacting to things, verbal as well as some physical aggression, difficulty in maintaining relations with others, smoking cigarettes since age 10, displeased with other people and self-harm for the past 2.5 years.

Presenting Complaints

As reported by the mother

ہر کسی سے تنگ رہتا ہے۔

غصہ پر قابو نہیں کرتا۔

اپنے فیصلوں میں جلد بازی کر رہا ہی

اپنے اپ کو نقصان پہنچاتا ہے

As reported by the client

زندگی میں سکون نہیں ہے۔

کوءی میرا ساتھ نہیں دیتا۔

اپنے اپ کو کاٹ لگا کر سکون ملتا ہے۔

Symptoms by DSM-5

- Impulsivity
- Anger outbursts
- Difficulty in maintaining relationships
- Self-harm
- Loneliness

History of Present Illness

The illness of the client was insidious in nature but progressive in course. Since his childhood, the client had shown impulsivity in reacting to things. He used to get angry at small situations very quickly and he also had difficulty in maintaining friends since childhood. He had several

friends but his friends used to change rapidly and he did not keep the same friends for a longer time. He also felt that he was not loved much by his parents and they had too much expectation from him and that he had no-one to share his feelings with. He felt like he was alone. And he later liked being alone and disconnected with his family.

As reported by the mother of the client, symptoms had started off at age 10 when he used to be very stubborn and was very unpleased by everything. He used to also manipulate by either crying or being very aggressive to get what he wants and needs.

He had a very impulsive response to things. He started participating in dangerous activities like rough bike riding. He also had difficulty in maintaining relationships because he was either too clingy or he didn't care at all. In his childhood, he was very clingy to his mother because his father was very abusive and used to physically abuse his mother in front of him and if he stopped him then even he was beaten by his father but now he thinks that his mother does not understand him and his worries.

He had a very difficult childhood because his father was a laborer and also a smoker so whenever his father had difficulty in managing house expenditures he used to take it all out on his mother and also him for supporting his mother. He started self-harming him by making cuts on his fore-arms 2.5 years back. He used a blade of a pencil sharpener to make these cuts and making these cuts according to him relaxed him. And he also reported that before coming to the hospital he threw the blade away because he wanted to get a bigger and sharper blade. At the time of his visit, he had several cut marks on the back of his hand as well as below his wrists and on his forearms.

In his past psychiatric history, he was not previously admitted in any psychiatric facility.History of childhood physical abuse was present. No history of fits, shocks, head injury or trauma present.

Onset of Illness

As reported by the mother of the client, symptoms had started off at age 10 when he used to be very stubborn and was very unpleased by everything. He used to also manipulate by either crying or being very aggressive to get what he wants and needs.

Preliminary Investigation

Psychological assessment was done at formal and informal level to understand the client's problem and to monitor the progress of therapy.

Informal Assessment

Following measures were used as informal assessment.

- Clinical Interview
- Behavioral Observation

Clinical Interview

Semi-Structured Clinical Interview was conducted to get description about his Bio Data, Presenting Problems, History of Illness, Family History, and Background Information. It helped in devising a distinctive case formulation and management plan that was tailored to the needs of the client.

Behavioral Observation

Client was a young adolescent of stated age, lean built and short height. He was dressed in pants and a shirt. His appearance showed signs of self-neglect like really dehydrated and was quite unkempt. He entered room confidently and sat on chair comfortably but looked around to see who else was in the room. He had proper eye-contact with therapist. Rapport was established easily. His mood was subjectively euthymic but objectively was low. He was oriented in time, place and person. His speech was normal in tone, speed and volume and it was mostly relevant. Slight depressed cognitions were present like feeling of emptiness and loneliness. No formal thought disorder was found. His thinking was abstract. His short term memory and long term memory was intact. His judgment was intact. He also had insight about his illness and that he had a mental illness but he was quite stubborn regarding relationship problems with people.

Sessions

Session No. 1

- History taking
- Developing rapport
- Psycho education
- Presenting Complaints and History of Present Illness was obtained through Clinical Interview. Interview was conducted with patient and informant. Information of this interview was used to start therapeutic process.

Counseling

Client was counseled about his present situation and he was assured complete support by using different counseling skills like empathy. Different counseling techniques were also use like rephrasing, summarizing and giving positive gestures of active listening.

Informal care

Informant was asked to be very vigilant in keeping an eye for anything that the client could use for deliberate self-harm or harm to any other person as well. He was also told to take care of his appetite and sleep as well.

He was also educated regarding therapy protocol and the importance of homework assignments. Estimated number of sessions was told to him to prepare him for this process and convenience. Further time of session was also decided to conduct an uninterrupted continuous sessions. Homework was explained as a necessary facilitator between sessions that would help the client to be better explained and will be used in him further sessions for him betterment. He was also explained the importance of sessions and how it will be beneficial for him.-

Therapy Termination

After first session therapy was terminated because recent pandemic.

Assignments

Generalized Anxiety Disorder

Diagnostic Criteria **300.02(F41.1)**

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months);

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.

2. Being easily fatigued.

3. Difficulty concentrating or mind going blank.

4. Irritability.

5. Muscle tension.

6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Understanding Generalized Anxiety Disorder

Neurological factors

- More gray and white matter in the areas of the brain related to hearing and language comprehension—the superior temporal gyrus—particularly in the right hemisphere. Moreover, unlike most other anxiety disorders, GAD is associated with decreased arousal because the parasympathetic nervous system is extremely responsive.
- Unusually strong activation in the right front lobe when viewing angry faces, which may be related to the operation of coping mechanisms;
- Abnormal activity of serotonin, dopamine, and other neurotransmitters, which in turn influences motivation, response to reward, and attention;
- A genetic predisposition to become anxious and/or depressed. This predisposition, however, is not specific to GAD.

Psychological factors

Psychological factors contributing to GAD include being hyper vigilant for possible threats, a sense that the worrying is out of control, and the reinforcing experience that worrying prevents panic.

Social factors

Social factors that contribute to GAD include stressful life events, which can trigger the disorder.

Treatments for GAD

- medication (which targets neurological factors), such as buspirone or an SNRI or SSRI when depression is present as a co morbid disorder; and
- CBT (which targets psychological factors), which may include breathing retraining, muscle relaxation training, worry exposure, cognitive restructuring, self-monitoring, problem solving, psycho education, and/or meditation. CBT may be employed in a group format.

Assignment 2

Introduction to Obsessive Compulsive Disorder

Obsessive compulsive and related disorders include obsessive-compulsive disorder (OCD), body dysmorphic disorder, hoarding disorder, trichotillomania (hairpulling disorder), excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related disorder, obsessive-compulsive and related disorder due to another medical condition, and other specified obsessive-compulsive and related disorder and unspecified obsessive-compulsive and related disorder (e.g., body-focused repetitive behavior disorder, obsessional jealousy).

OCD is characterized by the presence of obsessions and/or compulsions. Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. Some other obsessive-compulsive and related disorders are also characterized by preoccupations and by repetitive behaviors or mental acts in response to the preoccupations. Other obsessive-compulsive and related disorders are characterized primarily by recurrent body-focused repetitive behaviors (e.g., hair pulling, skin picking) and repeated attempts to decrease or stop the behaviors.

The inclusion of a chapter on obsessive-compulsive and related disorders in DSM-5 reflects the increasing evidence of these disorders' relatedness to one another in terms of a range of diagnostic validators as well as the clinical utility of grouping these disorders in the same chapter. Clinicians are encouraged to screen for these conditions in individuals who present with one of them and be aware of overlaps between these conditions. At the same time, there are

important differences in diagnostic validators and treatment approaches across these disorders. Moreover, there are close relationships between the anxiety disorders and some of the obsessive-compulsive and related disorders (e.g., OCD), which is reflected in the sequence of DSM-5 chapters, with obsessive-compulsive and related disorders following anxiety disorders. The obsessive-compulsive and related disorders differ from developmentally normative preoccupations and rituals by being excessive or persisting beyond developmentally appropriate periods. The distinction between the presence of subclinical symptoms and a clinical disorder requires assessment of a number of factors, including the individual's level of distress and impairment in functioning.

Presentation

Rotter Incomplete Sentence Blank (RISB)

Projective Techniques
By Sidra Taj

Introduction

- It was developed by Julia B. Rotter and Janey E. Rafferty (1950) at the Ohio State University
- Comprise of 40 incomplete sentences
- Age Range: High School to Adult
- Rationale: To identify patterns of personality in form of adjusted and maladjusted using projective technique or stimuli

SENTENCE COMPLETION METHOD

- The sentence completion method of studying personality is a semi structured projective technique in which the subject is asked to finish a sentence for which the first word or words are supplied. As in other projective devices, it is assumed that the subject reflects his own wishes, desires, fears and attitudes in the sentences he makes. Historically, the incomplete sentence method is related most closely to the word association test.

THE SENTENCE COMPLETION METHOD

- In some test incomplete sentences tests only a single word or brief response is called for; the major differences appears to be in the length of the stimulus. In the sentence completion tests, tendencies to block and to twist the meaning of the stimulus words appear and the responses may be categorized in a somewhat similar fashion to the word association method.

PURPOSE OF RISB

- The Rotter's incomplete sentence blank is an attempt to standardize the sentence completion method for the use at college level.
- Forty stems are completed by the subject. These completions are then scored by comparing them against typical items in empirically derived scoring manuals for men and women and by assigning to each response a scale value from 0 to 6. The total score is an index of maladjustment

DEVELOPMENT OF ISB

Development of ISB

- The Incomplete Sentence Blank consists of forty items revised from a form used by Rotter and Willermann in the army. This form was, in turn, a revision of blanks used by Shor (15), Hutt (5), and Holzberg (4) at the Mason General Hospital. In the development of the ISB, two objectives were kept in mind.

1. One aim was to provide a technique which could be used objectively for screening and experimental purposes. It was felt that this technique should have at least some of the advantages of projective methods, and also be economical from the point of view of administration and scoring.
2. A second goal was to obtain information of rather specific diagnostic value for treatment purposes.

Development of ISB

- The Incomplete Sentence Blank consists of forty items revised from a form used by Rotter and Willermann in the army. This form was, in turn, a revision of blanks used by Shor (15), Hutt (5), and Holzberg (4) at the Mason General Hospital. In the development of the ISB, two objectives were kept in mind.

1. One aim was to provide a technique which could be used objectively for screening and experimental purposes. It was felt that this technique should have at least some of the advantages of projective methods, and also be economical from the point of view of administration and scoring.
2. A second goal was to obtain information of rather specific diagnostic value for treatment purposes.

Administration

- The printed instructions are given on the page which state

"Complete these sentences to express your real feelings.
Try to do every one.
Be sure to make a complete sentence. "

- No further instructions are given except to repeat the printed instructions if necessary and to urge subjects to complete all the items. Administration to a group of any number of subjects is possible. The approximate average time for administration is twenty minutes.

SCORING: 1. OMISSION RESPONSE

- Omission responses are designated as those for which no answer is given or for which the thought is incomplete. Omissions and fragments are not scored.
- Theses responses are recognized as provocative stimuli since they may point to areas which the individual does not recognize or cannot bring himself to express.
- For all responses which are subsumed under the heading of incomplete thoughts or omissions, no scoring is made. After the remainder of responses is prorated by the formula {40 / (40-omissions)} times the total score. However, if there are more than 20 omissions, the paper is considered un-scorable for all practical purposes.
- For example, " I hate . . . the thought of going home since"

2. CONFLICT RESPONSES

- "C" or conflict, responses are those indicating an <u>un healthy or maladjusted frame of mind.</u> These include hostility reactions, pessimism, symptom elicitation, hopelessness and suicidal wishes, statements of unhappy experiences, and indications of past maladjustment.
- Responses range from C1 to C3 according to the severity of the conflict or maladjusted expressed. The numerical weights for the conflict responses are
  - C1=4 C2=5 C3=6
- Typical of the C1 category are responses in which concern is expressed regarding such things as the world state of affairs, financial problems, specific school difficulties, physical complaints, identification with minority groups, and so on.

- More serious indications of maladjustments are found in the category C2. They represent broader or more generalized difficulties than found in C1.

- C2 includes expressions of inferiority feelings, psychosomatic complaints, concern over possible failure, generalized school problems, lack of goal, feelings of inadequacy, concern over vocational choice and difficulty in interpersonal relationships (romantic relationships)

- Expression of Severe conflicts or indications of maladjustments are rated at C3.

- Among the difficulties found in this area are suicidal wishes, sexual conflicts, severe family problems, fear of insanity, strong negative attitude towards people in general, feeling of confusion, expression of rather bizzare attitude

For example
"I wish….I were dead". This type of response will lie in C3 category."

"Other people…don't seem to be impressed with me" and this type of response will lie in C2 category. "

"The only trouble…is financial", this type of response will lie in C1 category

3. POSITIVE RESPONSES

- "P" or positive responses are those indicating a healthy or hopeful frame of mind. These are evidence by humorous or flippant remarks, optimistic responses, and acceptance reactions. Responses range from P1 to P3 depending on the degree of good adjustment expressed in the statement. The numerical weights for the positive responses are
- P1= 2 P2=1 P3=0

- In the P1 class common responses are those which deal with positive attitudes toward school, hobbies, sports, expression interest in people, expression of warm feeling toward some individual and so on.

- Generally found under the heading of P2 are those replies which indicate a generalized positive feeling toward people, good social adjustment, healthy family life, optimism and humor.

- Clear cut good natured humor, real optimism, and warm acceptance are types of responses which are subsumed under the P3 group.

- For example,
- "I like. . . to have good time", this type of response will lie in P1 category. "

- "The happiest time . . . is yet to come", this type of response will lie in P2 category. "

- "Back home . . .are many friends", this type of response will lie in P3 category.

4. NEUTRAL RESPONSES

- "N" or neutral responses are those not falling clearly into either of the above categories. They are generally on a simple descriptive level.
- Two general types of responses which account for a large share of those that fall in the neutral category.

1. One group includes those lacking emotional tone or personal reference.
2. The other group is composed of many responses which are found as often among maladjusted as among adjusted individual and through clinical judgment could not be legitimately place in either C or P group. All the N responses are scored 3.

For example,

- " Most girls . . . are females" or
- "When I was child . . . I spoke as a child".

These types of responses will lie in neutral responses.

Quantitative Analysis

Obtained Score	Cut-off Score	Category

Qualitative Analysis

- The qualitative analysis can be made in terms of four categories:

1. Familial: The items on which participant's attitude towards family appears, reveal the environment and happy feelings to be home and with family.
2. Social and Sexual: They are related to the social and sexual orientation of the participants

- 3. General Attitude: These types of responses shows general feelings of participants towards life.

- 4. Character Traits: Highlights the personal traits, characteristic's, features, emotions and feelings of the participant.

ADVANTAGES OF RISB

- The general advantages of the sentence completion method can be summarized as follows

1. There is freedom of response. That is, the subject is not forced to answer yes or no or? To the examiner question. He may instead, in any way he desires.
2. Some disguise in the purpose of the test is present. Although the subject may de aware of general intend, what constitutes a good or bad answer is not readily apparent to most subjects.
3. Group administration is relatively efficient.

4. No special training is necessary for administration. Interpretation depends on the examiner's general clinical experience, although the examiner does not need specific training in the use of this method.

5. RISB lends itself to objective scoring

6. The time duration for administration of test is shorter than most of the other projective tests.

DISADVANTAGES OF RISB

1. There is not as much disguise of purpose as in other projective methods. Consequently, a sophisticated subject may be able to keep the examiner from knowing what he does not wish to reveal.
2. Insufficient material is obtained in some cases, particularly from illiterate, disturbed or uncooperative subjects.
3. Application of the method as a group test also requires writing and language skills and has not yet been adequately evaluated for potential clinical usefulness for younger children