Ms. Alana, a 24-year-old married female Muslim client was referred for psychological intervention in the Psychiatry Outpatient Department. She was assigned to the present therapist and was diagnosed as depression by the psychiatrist. She and her husband would like to build a new life not associated with her past. In the assessment sessions she presented her problems along with history. Her problems are presented in the following summary in clustered fashion according to different areas of functioning.

The client believed that she was suffering from psychological illness. The client complained lack of concentration, lack of self-confidence, and indecisiveness. She also complained of depressed mood, feeling of guilt, lack of pleasure, anger and hopelessness. She felt irritability and fear. She avoids social gathering, friends and sometimes occasionally she used to cry. The client complained of headache, palpitation. She also complained that family members usually irritate her especially eldest brother. Her dress up, appearance and behavior appeared to be culturally appropriate. At the initial interview she spoke willingly about her problems. She was well motivated and interested to work collaboratively with therapist.

Exploration of history revealed that the client was in a middle-class family of a rural area with three brothers and three sisters. Her father is 57 year old and he was a small business man. Her mother is a 45 year old house wife. From her childhood she experienced that the relationship between her parents was not good. The eldest son of their family maintains everything of the whole family. Her eldest brother was very dominating. She had to lead her life as to his liking. She was the last issue of her parents. Though she was meritorious student from childhood she was always underestimated instead of being encouraged. The senior most brothers always used to apply pressure on her for studies. They were not happy with the results she obtained. During any bad occurrence in her family if she protested, she had been termed as “disobedient”. She likes reading story, listening to music and reciting poetry which are not supported by her elder brother. Her brother doesn’t even like her writing skills. She was physically tortured several times for doing these. She was sexually abused for several times. At the age of five or six years old, some of her playmates abused her. When she was in class seven her cousin tried the same way. During college life one of her uncles tried to abuse her also. She couldn’t tell these to her family with a fear of receiving disbelief of the family. When she was 15years, she had an affair with a boy. Then due to misunderstanding that broke up. When she was in college she again got involved with a boy only to pass time with that boy. Now she is having third affair. She is a graduate student. Since having all these she thinks that if she had got family support enough, there wouldn’t be so many problems. There was no history of psychiatric problem in her childhood and adolescence.

She is recently married and expecting her first child. She reports her husband is patient and caring and understands her past as a block in their relationship. She reports being hopeful for the future since she has been in America for 5 years now and wants a better life for her children. She currently works as an assistant advocate at the local college in the cultural and community center helping minority women navigate the college experience.

In clinical interview the client was asked the reason for referral, why she sought for help and how long the main complaint had persisted, when did the problem first occur, what was the subsequent development in her life (occupation, living with parents, at school), what were the impairments that have been produced by the her difficulties, how have she and others coped with the problem, what her belief about the problem, what was the attitude to her difficulties, what was her cognitive functioning, what was her prevailing mood, what was her background history, early development history, occupational and educational history, sexual history and what previous psychiatric, psychological or medical help she had taken. The client asked to find out and list up her main problems. Thought diary was applied to assess situation specific negative automatic thoughts (NATs) and corresponding emotion, physiological changes and behavior for the client. It was administered to identify the NATs about the social situation and the relation to changes in emotion, physical reaction, and behavior

Therapist conducted both type of measurement, subjective & objective measurement. In assessment session client mentioned her overall problems severity at ‘100’ point on (0-100) rating scale. For objective measure Depression scale was used to assess the severity of depression. The highest possible score of 30 items form of depression scale was 150 and the lowest possible score was 30. Higher score on the scale indicates high level of depression and lower score indicates low level of depression. Her anxiety was assessed on a scale of 0-10 through objective measurement questions as well. She scored an 8.

*Consider what psychotherapy plan you would develop for this client. Incorporate additional therapy modalities with CBT if you feel they are valid in this case.*

*The plan should follow the template supplied. Fill in as much information as you have, for any other not provided state “information not provided”.*