Indira Gandhi National Open University
National Centre for Disability Studies

MCFTP-001
Internship

Internship Manual

National Centre for Disability Studies
Indira Gandhi National Open University
Maidan Garhi, New Delhi – 110 068

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MCFTP-001
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Internship Manual

Page No.

Section 1 Introduction 9

Section 2 Counselling and Family Therapy Internship: An Overview 11

Section 3 Procedural Guidelines 18

Section 4 Broad Guidelines for Doing and Recording Case Work 23

Section 5 Report Writing and Evaluation 33

Section 6 Tools 39

- Tool 1 : Case History Taking of an Adult
- Tool 2 : Case History Taking of a Child/Adolescent
- Tool 3 : Mental Status Examination Inventory
- Tool 4 : Family Interview Schedule

Appendices

Annexure A : Certificate of Assigning an Approved Guide for Internship .... (i)

Annexure B : Evaluation Sheet (Sections 1, 2 & 3) .... (ii)

Annexure C : Certificate of Completion of Internship .... (vi)

Annexure D : Certificate of Authenticity .... (vii)

Supervisor's Comment Form .... (viii)

Sample of Permission Letter .... (ix)

Remuneration Bill Form for Guidance of Internship Work .... (x)

Dear Learner,

Welcome to the Course 'MCFTP-001: Internship'. The course 'Internship' is of 6 Credits. It is designed to give you hands on experience in counselling and family therapy. The Internship is planned for a period of 180 hours or 6 credits. In this Manual, guidelines for undertaking the Internship have been outlined. Internship is one of the compulsory components of M.Sc. (CFT) programme.

Remember, every entry in the Internship Report should be dated, and should include your own experiences and observations in the context of counselling and family therapy sessions, including comments such as the difficulties you encountered in certain situations, or ideas that occured to you, recommendations etc. Recognize that your Internship Report is the true record of what you did and observed at the time. The Internship Supervisor will certify that you undertook the Internship and the Report is the bonafide work done by you.

Here, we would like you to understand that in Internship, you have to work under the overall supervision of the Academic Counsellor, generally called Counsellor / Guide / Supervisor in this Block. Further, before starting the Internship, it is very important for you to be thorough with your knowledge about the other theory and practical courses of this programme of study. Go through the Manual in order to understand what has to be done.

With best wishes,

Programme Coordinators
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SECTION - 1

INTRODUCTION

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SECTION 1
INTRODUCTION

This Course MCFTP-001 'Internship' involves *original, rigorous* counselling and family therapy work carried out with substantial *independence* by each M. Sc. student of the Counselling and Family Therapy Programme launched by IGNOU. It is worth 6 credits (180 study hours).

To complete this Course, the pre-requisite is to have a good understanding of all the courses (both theory and practical components), so that you are well-versed with the various aspects of counselling and family therapy. Further, in the various theory papers as well as the supervised practicum courses of this Master's Degree Programme, we have tried to provide you adequate knowledge and information about the what, why, and how of counselling and family therapy; including a wide array of areas and issues. Clarity of theoretical aspects is vital for doing justice to the applied aspects, as well as for being able to do counselling and family therapy in real life situations in the field.

The M.Sc. (CFT) internship is intended to be the demonstration of your expertise and the mastery of knowledge of current practices and theoretical frameworks of counselling and family therapy. It is intended to prepare the student to conduct counselling and family therapy.

This Internship Manual provides the basic objectives, concepts, outcomes and the guidelines for undertaking the Internship. It is pertinent that you read and understand the objectives and motive of the Internship presented herewith carefully, since this is the course that will help you achieve knowledge and skills, as well as develop competencies for entry-level practice in various specialization areas of the counselling and family therapy profession. The Internship course aims at providing practical training in the field of child and adolescent counselling and family therapy; marital and family therapy and counselling; substance abuse counselling and family therapy; geriatric counselling and family therapy; crisis and trauma counselling and family therapy; gender and sexual abuse counselling and family therapy; HIV/AIDS counselling and family therapy; counselling and family therapy in chronic physical illness; etc.

However, before you embark on the Internship training/schedule, it is essential that you should have undertaken all the course work (theory and supervised practicum) related to the M.Sc. (CFT) programme and your theoretical knowledge and practical concepts of the different subject areas which lend themselves to the study and applied aspects of counselling and family therapy should be sound. If you are not clear with concepts, then you may not be able to achieve the results expected from this hands-on training exercise.

> It is essential that you should have undertaken all the course work (theory and supervised practicum) of the M. Sc. (CFT) programme, before you commence the Internship component of the programme of study.

We wish you all the best in your endeavours.

SECTION - 2

COUNSELLING AND FAMILY THERAPY INTERNSHIP: AN OVERVIEW

SECTION 2

COUNSELLING AND FAMILY THERAPY INTERNSHIP: AN OVERVIEW

The Internship in Counselling and Family Therapy is essential towards the partial fulfillment of requirement for the Masters of Science in Counselling and Family Therapy [M. Sc. (CFT)] programme launched by IGNOU. The Internship is worth 6 credits (i.e. 180 study hours). The course involves carrying out the Internship work for the required duration in a requisite setting to learn practical application of the theoretical knowledge.

As a counsellor and family therapist, you would be trying to help individuals in different stages of the human life span and family life cycle, each having a general problem with unique specifications to the self and the family. When you start the Internship, you would have already completed your supervised practicums of both first and second year of M. Sc. (CFT) and should have imbibed the skills to apply counselling and family therapy in the field situations.

You should be clear about the theories and practices of various counselling and family therapy approaches as well as mental health problems, that people in different human life span and/ or family life cycle stages may have.

The Internship seeks to enable Interns to integrate and apply counselling/family therapy knowledge and intervention to promote optimum health of individuals or groups. The programme also seeks to provide opportunities for developing competencies through practical training in the areas of child and adolescent counselling and family therapy; marital and family therapy and counselling; substance abuse counselling and family therapy; geriatric counselling and family therapy; crisis and trauma counselling and family therapy; gender and sexual abuse counselling and family therapy; HIV/AIDS counselling and family therapy; counselling and family therapy in chronic physical illness; etc.

As part of Internship, the Intern is required to get hands-on experience in the above areas. The aim of counselling and family therapy Internship is to provide the opportunity for well-grounded, supervised, field-based, hands-on practical experience, to prepare professionals with requisite competencies required for entry-level positions in a variety of counselling and family therapy settings.

Internship will enable you to actually put into practice the knowledge and skills acquired during the programme of study, which in turn would help you become capable of entry-level practice as a professional in work set-ups such as schools, rehabilitation centres, special schools, hospitals, NGOs, charitable trusts, child guidance centres, social welfare organizations, remand homes, prisons, courts, women/men cells, family guidance centres, half way homes, and other allied settings.

During the Internship, you are required to conduct the stipulated activities, under the close and continuous supervision and monitoring by an expert (Supervisor) throughout the Internship period. It is expected that by the end of the Internship, you will be able to handle needs and concerns related to counselling and family therapy in diverse situations arising at the work place.

Objectives

The salient objectives of Internship programme are given below. Internship will help the learner to:-

Acquire hands-on experience in personally conducting counselling and family therapy sessions in a range of situations;

Understand the practical aspects of conducting counselling and family therapy sessions;

Learn the application of theoretical concepts and approaches of counselling and family therapy in real life situations; and

Gain an enriching and comprehensive insight into the recent concepts, current knowledge regarding the management of diverse disorders, complex family situations and personalities, and problems encountered in effective counselling and family therapy.

Expected Outcomes and Competencies

Expected Outcomes:

Learners completing the Counselling and Family Therapy Internship will gain practical knowledge and application skills through interaction with clinical preceptors in a variety of settings.

Interns will imbibe confidence and foundational competencies; knowledge and skill-set necessary among professionals in the field.

Programme graduates will keep on upgrading their knowledge regarding latest developments which take place in the domain of counselling and family therapy.

The Counselling and Family Therapy Internship will provide hands-on experience to prepare learners for entry level work in the field after programme completion.

Competencies:

After completion of Internship, the following competencies are expected to be highlighted in the learner:

- Ability to establish and maintain productive Client-Counsellor/Family Therapist relations.
- Ability to interpret facts and information about clients in the context of their background.
- Ability to understand complex family situations and perspectives of all family members.
- Ability to identify and use correct counselling and family therapy theories, strategies, and models.
- Ability to establish rapport, do intake, intensive therapy/counselling and termination of family therapy/counselling efficiently.
- Ability to maintain cooperation, coordination and consultation in the work setting and with the community.

Venue of Internship

The internship work may be undertaken in settings such as an approved Government or private hospital, institute, school, rehabilitation centre, health centre, remand home, family guidance centre, child guidance centre or any such allied settings, including community and neighbourhood. Thus, you may carry out Internship at centres where relevant work in the

field is going on, such as the following: Counselling centres (government or private) in community settings like approved hospitals, juvenile and remedial/ remand homes, women cell, family courts; child guidance centres/ counselling and family therapy set-ups in universities/ colleges /institutions/schools/special schools, Human Development and Family Studies/Child Development/Human Development/ Psychiatry/ Mental Health and Social Psychology/ Clinical Psychology/allied departments in universities/colleges, mental health care institutions, centres for children/elderly/women (the vulnerable sections of the population) at treatment, recovery and rehabilitation levels, as well as those working for promotion of positive mental health; and governmental/non-governmental and private sector organisations of repute working in this field. The Intern may also visit street children's home, mobile creches, night shelters, migration homes, adoption centres etc.; including the local community and neighbourhood, under the guidance and supervision of the Supervisor, and carry out the requisite internship activities for 180 hours equivalent to 6 credits.

Internship Supervisor

Each intern is required to undergo training under the guidance of a Supervisor (a counsellor or a family therapist with requisite qualification and at least 5 years of relevant work experience), who has to be duly approved by the Programme Coordinators, IGNOU, HQ, Delhi.

Essential Qualifications

The internship supervisor must have a Master's degree in any of these disciplines: Human Development and Family Studies/Child Development/Human Development/ Psychiatry/ Mental Health and Social Psychology/Psychiatric Social Work/Clinical Psychology/allied fields, with at least five years of relevant experience in the field.

Commencement of Internship

The students should start their internship only after successfully completing all the courses of the first year, as well as after having submitted the assignments of second year theory courses and having submitted the Supervised Practicum Files of the 3 theory courses of the second year. *Before allotment of Supervisor/Guide for the internship, the Programme Study Centre Incharge or the Study Centre Coordinator should verify that the student has cleared the first year courses and submitted the second year assignments and Supervised Practicum Files.*

The students are permitted to identify the Supervisor/Guide under whom they wish to do their internship, as well as the internship centre(s) where they would like to do their internship work. In such a case, the student must provide the biodata of the proposed Supervisor/Guide for Internship, to the Programme Incharge at the PSC or the Study Centre Coordinator. Whether identified by the student or the PSC/SC, the biodatas of the proposed Supervisors/Guides for Internship must be forwarded by the PSC/SC to the Programme Coordinators at the IGNOU headquarters for approval, keeping the Regional Centre in the loop. Only after this approval is granted, should the Programme Incharge at the PSC/SC permit students to do Internship under the particular Supervisor. Once approved, the Supervisor/Guide may form a part of the panel available to future students at the PSC/SC.

> Internship has to be done only under a Supervisor who is approved by the Programme Coordinators at the IGNOU headquarters.

Content of Internship

Counselling/Family Therapy Case Records

Internship would comprise supervised experiential learning. **During internship, the learner would be required to make at least four case records, from at least three of the following areas:**

- Couples/Marital therapy
- Emotional/Behavioural proplems among child/adolescent in the family
- Chronic illness in the family
- Dealing with substance abuse
- Dysfunctional family
- Sexual abuse
- HIV/AIDS person
- Dealing with old age problems in the family
- Suicidal ideation
- Street children
- Destitute children/Children of prostitutes
- Children/adolescents in institutions – such as orphanages, juvenile homes
- Jail inmates
- Elderly in old age homes
- Peer interactions and related problems
- Intergenerational problems
- Adjustment problems at work place
- Emotional/Behavioural problems in an adult.

Of the four essential case records, two case records have to be of individual counselling involving 8-10 counselling sessions and two case records have to be of family therapy involving 13-15 family therapy sessions.

Preparing the case record would include case history taking, mental status examination, administering the family interview schedule, conducting/participating in counselling/family therapy sessions, preparation of transcript, discussion with supervisor and documentation of case records.

It is essential to carry out the stipulated number of sessions for preparation of the case record.

Each session would need to be of around one hour duration. The time taken for case history taking, mental status examination and administering the family interview schedule would be

included in these sessions. However, you would recollect that you have had sufficient practice in case history taking and mental status examination when you did the supervised Practicum (MCFTL-002) of Course 2 in the first year. Thus, this component should not take you much time now.

"Family" may have to be defined in terms of the primary caregiver in certain cases; for instance, in the case of adoption centres or orphanages.

The ultimate purpose of these case records is to enable you to undertake the journey from intake to planned termination, in a variety of cases requiring counselling/family therapy intervention. A range of areas have been given for you to choose from. You would benefit from exploring diverse set-ups and addressing the needs of individuals and families at different stages of the life span, through counselling/family theapy interventions. Your Guide/Supervisor would oversee your induction into the process, deciding on how much your direct participation would be in each counselling/ family therapy session; don't worry, your effectiveness in conducting counselling as well as family therapy sessions would increase as sessions go by. In any case, while some of the sessions may entail physical presence of your Guide/Supervisor, on other occassions, your Supervisor may monitor and evaluate the counselling/family therapy session through one-way mirror, audio tape, video tape, or the transcript of the session. Pay heed to your Supervisor's advice in each case!

In this Manual for Internship, we have provided some guidelines which will enable you to do Internship and prepare the duly completed Internship Report/File. Your Supervisor will provide you further necessary guidance.

Acclimatisation sessions

Before conducting the counselling/family therapy sessions yourself, it would be a good idea for you to observe how your Guide/Supervisor engages in counselling and family therapy, as well as carry out some mock sessions or role play in the presence of the Supervisor. At least 4-5 such sessions would be very useful. Include a detailed report on these acclimatisation sessions in your Internship Report.

Internship Report

Interns will be expected to submit an Internship Report, duly signed and evaluated by the Supervisor at the end of 180 hours of Internship duration.

The details of writing the Internship Report are given in Section 5.

Duration of Internship

You have to complete your Internship work in a total of 180 hours consisting of 45 working days which include 4 hours of work per day.

If the Internship takes more time than this scheduled duration, then you can rearrange your work accordingly, but only after discussing it with the Supervisor you have been attached with by the Programme Incharge.

The maximum duration to complete Internship is four months.

Duration with the Supervisor

The Intership Supervisor at any given time shall have a maximum of only 6 learners/Interns attached to him/her. Once the Supervisor has been allotted, the Supervisor would be

committed to the learner for Internship work from a minimum 45 working days to a maximum of 4 months.

If for any reason a student is not able to complete the work in a maximum duration of 4 months, the student has to start afresh, and would be treated as new student to the Supervisor.

Student is NOT permitted to hop between different Supervisors.

If the student has to change the Supervisor, then it should be done in the beginning itself; once the work assigned starts no changes are permissible.

Role of the Supervisor in Internship

- The Internship Supervisor is a qualified professional in the field, allotted by the Programme Study Centre/Study Centre to which you are attached. The Supervisor will supervise and guide you for Internship.
- You have to spend at least 1 hour during each of your 45 working days of Internship with the Supervisor, in which she/he will guide you on any issues or situations to be dealt with and help in your Internship. Besides this, you can seek the help of the Supervisor at any time during the sessions.
- The Supervisor may or may not be associated with the individuals or families you identify for case work but, she or he can help you in identifying the same.
- The Supervior may actually see you conduct a session in person or analyse your recorded session or scrutinise its transcript. All your Internship activities have to be under the guidance and supervision of the Supervisor.
- To conduct case work, you have to meet the Supervisor first, discuss how and what you are going to do; which theory you would apply, and why; the tool (e.g., interview schedule) that you are going to use for the purpose, etc. You would take her or his advice, and then visit your case (a person and/or family whom you have identified for counselling/family therapy). Here, in this programme of study, respondent is also called 'participant' and at times 'subject' or 'client' or 'patient'. In this Course, it has been called 'case'. It is advisable to report to your Supervisor after you complete each session, and discuss what had transpired in the course of conducting the counselling/family therapy session. Of course, you could also be conducting or participating in some sessions in the presence of your Supervisor.
- Apart from guiding and supervising, the Supervisor will also evaluate your work. Thus, the Supervisor will evaluate and mark each component of your Internship work. The evaluation sheet to be used is given at the end of this Manual.

SECTION - 3

PROCEDURAL GUIDELINES

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SECTION 3

PROCEDURAL GUIDELINES

For all M. Sc. (CFT) learners, the Internship is absolutely compulsory. Candidates who are absent or do not present themselves on a regular basis for the Internship will NOT qualify for the degree of Masters of Science in Counselling and Family Therapy.

***Note* :** No request will be considered for waiver of Internship programme.

Pre-requisite for Internship

It is absolutely important that you commence the Internship only after having sucessfully completed the entire course work (theory and practical) of the first year and after having submitted the assignments of the second year theory courses as well as the supervised practicum files of the M. Sc. (CFT) programme. This is a pre-requisite for the Internship programme. The programme incharge/ study centre coordinator will consider this strictly before assigning you an Intership Supervisor and permitting you to start your Internship.

Procedural Checklist:

1) Consult the Programme Incharge for Allotment of Internship Guide/Counsellor/ Supervisor:

It is essential that you do your Internship under a Supervisor/Guide/Academic Counsellor, approved for the purpose by the Programme Coordinators at IGNOU Headquarters. Otherwise your Internship work/report will be considered null and void. Do not forget to enclose the duly filled in Certificate of Assigning an Approved Guide for Internship; given at Annexure A in this Manual for the purpose, in the Internship Report that you submit to the University for evaluation.

When you are ready for Internship work, the first thing you have to do is to contact the programme study centre incharge/study centre coordinator. The programme incharge/study centre coordinator may have got some Guides/Supervisors/Academic Counsellors and centres already approved from the Programme Coordinators at IGNOU Headquarters for M. Sc. (CFT) Internship work. In such a case, you may be assigned to an approved Supervisor right away. You may also identify the Internship Counsellor/Supervisor/Guide on your own from the programme study centre or an expert from outside (with relevant qualifications and subject background), whom you would want to have as a Supervisor for your Internship. The Expert must also consent to being the Internship Supervisor, and so should the Programme Incharge. The final approval is to be granted by the Programme Coordinators at IGNOU Headquarters.

Who can be the Supervisor

a) The Supervisor must have a Master's degree in any of these discipline: Human Development and Family Studies/Child Development/Psychiatry/Mental Health and Social Psychology/ Psychiatric Social Work/Clinical Psychology/allied fields, with at least five years of relevant experience in the field.

b) The name of the Supervisor has to be approved by the Programme Coordinators at IGNOU Headquarters by assessment of relevant documents submitted.

c) Mere possession of the degree and experience would not qualify a person to be the Supervisor.

d) The student should identify the Supervisor, take his/her detailed bio-data, consent letter for being the Internship Supervisor, details of organization attached to, and preferably, the details of centre(s) and locations as well where the student would go to do the case works, and submit the same to the Programme Study Centre Incharge/Study Centre Coordinator to be further sent to the Programme Coordinators at IGNOU HQ, keeping the Regional Centre, IGNOU in the loop. The student may identify 2-3 prospective Supervisors and submit the above.

   In some centres, there may be some specific permission modalities, and procedures that need to be followed through to function as an Intern. In such circumstances, you may obtain the necessary information from the hospital/organization/school, etc. also, and do the needful.

e) Once the Supervisor is approved by the Programme Coordinators, it would be intimated to the Programme Incharge keeping the Regional Centre in the loop.

f) Only after getting written clearance, the student should start the Internship work.

2) **You may begin your Internship work under the Supervisor/Guide proposed by you, only after the approval has been granted by the Programme Coordinators at IGNOU Headquarters.** You will be informed of the approval by the Programme Incharge, and are requested to stay in touch with the Programme Incharge for the purpose.

   Once approved, the Supervisor/Guide may form a part of the panel available to future students of M.Sc. (CFT) at the PSC/SC.

Important

On being assigned an approved Guide/Supervisor by the Programme Incharge, the student is allowed a maximum time period of four months to complete the Internship work and submit the Internship Report. Failure to do so would require fresh approvals, and the student may then be assigned the same or a different Guide by the Programme Incharge through mutual consent. The student would need to start afresh.

3) Consult the Supervisor: Once the centre and Supervisor for Internship has been identified and assigned, the student should present herself or himself at the centre and in consultation with the Supervisor shall decide on the appropriate schedule for the Internship activities.

4) **Plan the schedule with the Supervisor under whose guidance the Internship is being undertaken:** A detailed schedule has to be planned with the Supervisor in accordance with the list of activities, aspects/points of interest to be addressed, and the prescribed tasks to be accomplished as part of the Internship programme stated in this Manual. It is to be strictly adhered to.

5) **Review and study the functioning of the centre:** The student should review the functioning of the Centre with respect to administration, therapeutic services, research and training and record the same. This would help the student to learn more about the field level reality and delivery of services, and enable the External Evaluator of the student's Internship Report to understand the context of the student's work better.

6) **Record the Activities:** The student should record the activities undertaken and their experience in a file.

7) **Communicate regularly with your Internship Supervisor:** Learn through observation of your Supervisor. Carry out the tasks assigned, share your experiences, report on the activities undertaken, discuss the problem points, report the difficulties/problems encountered to the Supervisor, and seek advice on a regular basis. You should explain the therapeutic process adopted to the Supervisor and seek approval for the same. Consultation regarding counselling/therapy process with the Supervisor is a must.

8) **Submit the Internship Report for Evaluation:** Submit the Internship Report including administrative information of the Centre, different therapeutic interventions made, sessions observed and conducted, report of each case work and related activities undertaken as part of the internship programme, duly evaluated and authenticated by the Supervisor and the Programme Incharge (refer to Annexures A, B, C & D included at the end of the Manual). The Internship Report must be submitted at the following address for evaluation:-

   M.Sc. (CFT) Internship Report
   Student Evaluation Division
   Indira Gandhi National Open University
   Maidan Garhi,
   New Delhi-110068

> *Submit the original document for evaluation at the above address. Keep a photocopy of the Report including the Annexures for your reference, so that in case of loss in transit or misplacement, you would be able to submit the copy of that file. The file submitted will not be returned to you.*

9) ***Evaluation:*** Internships Reports will be evaluated in the order received. The final evaluation of the Internship Report would comprise 50% weightage of scores obtained from both internal evaluator and external evaluation.

Points to Remember

Remember not to copy case records of other students of M.Sc. (CFT) known to you. The University will reject the Internship Report, if it is found to be copied, repeated or translated from another similar case presentation on internet, books etc. One can be debarred from continuing the programme of study for a couple of years or even for lifetime.

The name and particulars of the Internship Supervisor that the student has been assigned to, and submission deadline has to be mandatorily sent by the Programme Incharge at the PSC or the Study Centre Coordinator to the Programme Coordinators at IGNOU HQ.

If you want the Programme Coordinators at the IGNOU Headquarters to be your Supervisor, only then you may contact them for approval of the same. This would mean that you have to be located in the NCR Region.

Students are advised not to pay any fees/remuneration to the Internship Guide/ Supervisor, as the University has the provision for paying remuneration to the Internship Supervisor (the requisite proforma is attached at the end of this Manual).

Violation of the internship guidelines will lead to the rejection of the Internship at any stage.

The University will require about 2-3 months to complete the evaluation process before your grades/ results are declared. The evaluation is done by a pool of experts identified by IGNOU from across the country. Therefore, the evaluation process requires sufficient time.

The Internship Report submitted to IGNOU will not be returned to you.

- Do remember to keep a photocopy of your Internship Report.

Last Date for Submission of the Internship Report

- If you wish the marks of the Internship to be included in the June term-end Examination marksheet, then your Internship Report must reach SED, IGNOU, Maidan Garhi, New Delhi latest by 30th April. The Report should be duly verified and evaluated by your Supervisor, and should be complete in all respects, before submission for external evaluation.

- In case the Internship Report is submitted after 30th April, and before 31st October, marks would be included in December term-end examination marksheet.

  Thus, if your Internship Report reaches IGNOU between 1st November and 30th April, it will be accounted for in the marksheet for the June examination, and if the Internship Report reaches IGNOU between 1st May and 31st October, it will be accounted for in the marksheet for the December examination.

SECTION - 4

BROAD GUIDELINES FOR DOING AND RECORDING CASE WORK

SECTION 4

BROAD GUIDELINES FOR DOING AND RECORDING CASE WORK

Important guidelines for working with cases

For working with a case you have to first identify the case — an individual or a family, who is willing to take counselling/family therapy sessions with you to resolve their problems. Confidentiality, trust buiding, rapport formation, sensitivity and neutrality are among the key points which need to be remembered while handling a case.

- Seek the consent from the case — individual/family before conducting counselling/ family therapy. For each case, separate consent needs to be taken. The consent form is enclosed at the end of this Manual.
- The time schedule for conducting the counselling/family therapy sessions should be planned according to the convenience of the family or the individual with whom the sessions have to be carried out.
- Be punctual for your appointment; and if there is any change in time or day inform the concerned family or individual and also expect the same from them.
- Before conducting any session, you should have thorough knowledge of the theoretical components as well as thorough understanding of the procedures.
- Respect the views of the individual(s) involved, and do not interrupt or show your own attitude, opinion or prejudice regarding what they are saying or doing. The process should not be biased by your view points. Keep the information confidential, and do not discuss it with any other person including your friend, spouse, parents and other family members. You have to discuss the case with you Supervisor though.
- In a case where the family or the individual refuses to cooperate with you, or you feel that therapy/counselling is not successful or making a desired impact, or if the individual/family stops coming for counselling/family therapy and you are forced towards unplanned termination, you would have to accept the case work as incomplete, and a learning exercise rather than a case you may submit for evaluation in your Internship Report. You would then need to identify another case to carry out your work.
- Your Internship File must have at least two case works involving individual counselling (minimum 8-10 sessions each) and two involving family therapy (minimum 13-15 sessions each).

Important points to keep in mind while carrying out the case work:

Intake of the client(s) should be recorded. If it was through any referral, their comments/suggestions should also be recorded.

Give due emphasis to rapport formation, senstivity, objectivity and neutrality.

Your report for each case work should include the case history and mental status examination of your respondents.

Make an assessment through genogram and family line. Carry out genogram analysis and find out whether the problem occurred in any previous generation(s). At least 2-3 stage genogram analysis has to be done. Identification of repeat of any problem seen in the client with the family members from past generations should be probed further and noted.

Family history taking interview should begin from the client's present family life cycle stage and proceed backwards.

Understand power, hierarchy, subsystems in the family from therapeutic viewpoint.

Identify of stressors in your client. Help your client in coping with stress.

Understand manifestations of the problem in the family.

Note down hypothesization formulated by you in each case.

Understand handling resistance to change in the client.

Note: The tools for case history taking and mental status examination are given at the end of this Manual for your reference and ease. Use the ones relevant for the individual whom you have identified for the specific case. For adults you will use Tool 1 (Case History Taking of an Adult) and Tool 3 (Mental Status Examination Inventory). For children/adolescents you would use Tool 2 (Case History Taking of Child/Adolescent) and Tool 3 (Mental Status Examination Inventory).

Semi-structured Family Interview Schedule has been given as Tool 4. Use the areas/ topics relevant for the individual / family whom you have identified for the specific case work.

Listing of what has to be done with the client(s):

- List all the characters in the case record including your client.
- List all the worries, problems, ailments, feelings or disorders which your client has reported.
- List all the worries, problems, ailments, feelings or disorders which you feel are likely to exist and the client is unaware of.
- Give reasons as to why do you think the client must be experiencing both — something in particular which client(s) is unaware of and something which client(s) is aware of.
- Find out your client's purpose in coming to you.
- Summarise and interpret what the client has reported to you.
- Transform the problem statements made by your client into goal statements.
- Set realistic goals mutually with your client and describe the same.

- Explore the possibilities to reach the goal(s) and list them. Plan both long term and short term goals. Long term goal is the outcome expected after completion of the counselling/therapy. Short term goal is for one or two/three therapy/counselling session(s).
- Develop a plan to reach the goal together with the client and explain the same.
- Evaluate your own progress at the end of each session as well as after completion of the process of counselling/family therapy.
- Use circular questioning with your client(s).
- Observe neutrality in your sessions.
- Involve all family members who are willing to participate in your session.
- Try to involve the important (who influence the client) family members in the family sessions.
- Assign home work assignments and ask about the follow-up in the next session.
- Clearly hypothesize the reasons for the problem.
- Discuss which therapy has to be used with the client(s) with your Supervisor. Substantiate your choice of therapy with reasons.
- Evaluate the success or failure of your therapy and critically analyse the reasons for the same.
- Inform the client 2-3 sessions early about the termination of family therapy/counselling.

Tips for Counselling/Therapy Sessions

Note whether the client was on time, late, or much before time for the meeting. This should be noted especially for the first appointment, and also for all other subsequent meetings.

Explanation of the meaning of the term family therapy and counselling to the client(s) needs to be done.

Note down the number of family members to be involved in the therapeutic sessions; and the number and relations of family members who can participate in the sessions.

Write a brief description of the problem diagnosed in the patient/family/or the index patient in the family. Here Index Patient would be the person or family member who is thought by the family members to have a problem and is the basic reason for the family to seek intervention or family therapy.

Make an assessment of the environment or climate as seen at the time of each therapeutic meeting/session and note it down; for instance: whether the emotional atmosphere was warm, the rapport between the client(s) and the therapist and the rapport among the family members. The following terms are commonly used:

Noisy – The client(s) were fighting with each other or one person was cutting the other person's thoughts.

Cool – The client(s) pretended not to be affected by the problems so displayed a cool behaviour.

Anger – At a particular family member.

Loud – The client(s) were shouting.

Calm – The client(s) calmly participated in the session.

Warm – The client(s) displayed warmth towards each other.

For each therapeutic session this has to be noted. At times the atmosphere may change from beginning to the end; it should also be noted.

You and the client should agree to a contract containing long term goals of therapy.

Short term goals of therapy need to be outlined with the client(s).

Intake is to be a small session of 20-30 minutes. The therapist needs to understand the presenting complaint in systemic perspective.

During your student/trainee period when studying this course, you are NOT permitted to charge your patients i.e. take money/gifts. But, later on as a professional in actual practice, before and during your intake session you should tell about fees of a session and approximately how many sessions you would have, the frequency of the sessions and timings of the same to the client in the first meeting. At times you may take 2-3 sessions to decide upon the problem and number of sessions required.

Now, after understanding the client(s)' problem you have to decide upon the specific theory(s) and therapy(ies) you would use. You have to give reasons for the choice of theory and therapy after understanding the client(s)' problem.

In most of the cases, you would have to psychoeducate the index patient's family regarding the problem/mental disorder the patient is suffering from.

Here, we would like you to give a description of what psychoeducation you provided and how did you go about it.

In dealing with especially children, adolescents and at times young adults with poor social mental functioning you may need to do social skills training and provide life skills education.

Here, we would like you to give a description of what and how you provided social skills training and/or life skills education.

In your family interview of the client(s) you have to note down the family life cycle stage of that person. Note down the roles and responsibilities, tasks carried out by the family, disciplinary techniques used by the family, understand the individual life span development of the individual, and so on. You have to find this by asking various relevant questions.

Then, ask the questions related to the previous family life cycle stages of that person; for a married couple start from the beginning family and for an unmarried person go to his remembrance from early childhood onwards.

In your understanding of the client(s) understand the deviations from the norms as specified by the culture to which one belongs. These understandings have to be from both life span and family life cycle perspectives.

Identify the stressors, hierarchy, power arrangements, alignments, triangulations, etc. in the family.

While doing individual counselling/therapy you have to note down the perceptions of the individual regarding the family members and their impact on the individual.

Please remember that it is the perception that one has about others' thoughts and feelings that has influence on us and our therapy.

Note down how did you as a counsellor/family therapist manage your personal issues, stress and anxiety.

Were you able to maintain the confidentiality issues? Now, please remember that as a trainee your have to discuss all the issues and concerns of the client with your Guide/ Supervisor. You are not breaching confidentiality issues!

Note down if the client(s) had sought help before, when, what was the reason for seeking help and was the 'help' successful in resolving the client(s)' problem.

Note down client(s)' expectations from therapy. In family therapy sessions, each family member's expectations from therapy need to be ascertained. Then a common therapy goal among the family members needs to be found out.

Note the instances that describe your understanding of the following:

- What did the facial expressions of the client(s) indictace?
- Was these maintenance of eye contact?
- Was there failure at times in maintaining eye contact?
- What was the body position of you and your client(s)?
- How much space was there between you and your client(s)?
- Did you fall in the common therapist's traps in your therapeutic sessions?
- How did you get out of the trap?
- What was 'your role'/your self's role in therapy?
- What kind of therapist/counsellor and client relationship get formed?
- What professional and ethical issues did you take special care of?
- In what kind of therapeutic sessions were you an effective active listener?
- Did you preach too much on moralistic grounds?
- Did you allow your client to speak?
- Did you allow your client to speak on non-relevant issues?
- Were you able to bring the client to speak on the relevant issues?
- How did you stop the client from diverting from the main issue or speaking on not-relevant issues of that particular session — were you blunt or polite, how did you handle it?
- Was your relationship with your client affected by the client's and therapist's age, gender, disability, socio-economic status, sexual orientation, religion, ethnicity, spirituality, client being affected by STDs (sexually transmitted diseases), HIV/ AIDS, cultural differences etc.? Please elaborate.

- What special efforts did you make to understand your client(s)' culture and its impact on the real life of the client?
- How was the attitude of the index patient towards counselling/family therapy?
- What was the attitude of the other family members called for therapy towards counselling/family therapy?
- Who decided who all would attend the family therapy sessions?
- Describe the client's and his/her family's motivation for change?
- How did you use reflection with your case?
- Explain use of transference and counter-transference in your client - counsellor/ therapist relationship.
- What kind of resistance did you face during therapy?
- How did you handle resistance to therapy?
- Explain one situation that required your coping skills during counselling and family therapy sessions.
- How did you deal with this situation?
- When and how did you discuss these situations with your Supervisor?
- What was the role of your Supervisor in these situations?

To bring the client back to the point you may say, "All right, what issue you are discussing is important, but at present we need to focus on .... we will come to this issue later".

Never adopt a high-handed attitude in a session.

Note down the home work tasks assigned to the client. Remember to take feedback regarding the home work assignment from your client in the next sessions.

If you will not take feedback, then they would think it is not important to follow the home work tasks.

You have to ask your client regarding their anxieties, fears and expectations.

Note down the kind of the environment that was present during each therapy/counselling session.

Note down, if any specific therapeutic technique was used, why did you use it and details related to it. Obtain your Supervisor's permission to use that technique.

Do proper record keeping.

One session is equal to one hour approximately.

Note down the number of sessions, duration of a session, as well as details of each session.

In your file, submit as appendices and enclosures the audio/video cassette/CD, record sheets used at the time of interviewing/observing/counselling etc. as well as transcription sheets.

In actual practice, gap between sessions should be neither too less nor too much. However, for your Course you need keep the sessions with less gap.

Preparation of Case Records

In your Internship Report, as described in Section 2 of this Manual, you are required to submit four case records; two pertaining to individual counselling and two pertaining to family therapy, from the stipulated areas. The minimum number of sessions, each of about 1 hour duration is 8-10 for a counselling case work and 13-15 for family therapy case work. You may, of course, conduct more sessions in a case, if required.

For the pupose of the Internship Report/File, your case record (that would be evaluated by an external expert) would need to be a summative, critical account of all the sessions put together, with relevant excerpts and examples interwoven as required. Details of individual sessions (including details of each session; transcript of each session; and records pertaining to case history, mental status examination, genogram analysis , family interview, etc. and audio/video cassette/ CD) are to be provided as appendices/enclosures in the Report/File, for the external expert to refer to.

Table 4.1 : Framework of Case Records

Referral & Intake

Assessment of the family in terms of:

- Knowledge about illness
- Physical/Emotional/Financial/Household routine burden
- Basic needs of the family
- Social support available to the family
- Social support available to the index patient
- Reaction of family members to the index patient's illness
- Impact of illness on the index patient.

Intervention Adopted

- What was the specific counselling/family therapy technique adopted with the client(s).
- Why was this technique chosen? Give clear reasons, with examples from your patient's case.
- How was the counselling/therapy implemented? Give details of the sessions.

Psychoeducation

- Whether needed
- Was it done
- How

Difficult situations encountered

- List down all the situations with your client which you found difficult to handle. Explain in detail.
- How did you handle these situations.

Reflections

- Note down your reflections for the case.
- Were you always right in your reflections? Give examples of when your reflections were right and when wrong.

Barriers in Communication and Handling Emotional Outbursts

- Were you able to handle the communication with the client effectively in all the sessions?
- List examples when you were not able to manage proper communication.
- What measures were undertaken by you to handle communication.
- How did you handle emotional outbursts.

Termination and Follow up

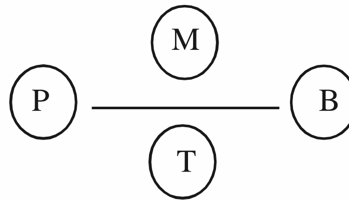
- Did you terminate on the appropriate time or abruptly? Was the termination planned or unplanned? Give details.
- Did the client stop coming without information?
- Were some tasks given at termination to be assessed in the follow up sessions? Write details.
- Did you follow up the case?
- Was therapy showing any positive/negative/no impact in the life of the client(s) after termination of the therapy? Elaborate with examples.

For each session, following points have to be recorded

- ☞ Number of participants
- ☞ Details of participants
- ☞ Aim of the session (Intake/which phase of therapy)
- ☞ Emotional atmosphere (how was the emotional atmosphere during the session)
- ☞ Duration of the session
- ☞ Date
- ☞ Main themes in each session
- ☞ Details of any psychological assessment/tool if used or carried out.

- Sitting arrangement (Shows how clients and toherapist were sitting, who was proximally closer to the therapist, etc.)

Examples:-

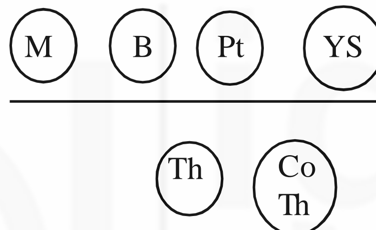


Here, P - Patient

M - Mother

B - Brother

T - Therapist



Here, M - Mother

B - Brother

Pt - Patient

YS - Younger Sister

Th - Therapist

Co Th - Co-Therapist

Please Note

- You have to submit 4 case works complete with intake, initial phase, middle phase, termination and follow up.
- Two of the case works should involve counselling, and two should involve family therapy, from the specified areas.
- Each counselling case record should include 8-10 sessions, while a family therapy case record should include 13-15 sessions. While you may take more sessions if required in a case, taking lesser number of sessions than stipulated is not permitted. Such a case would be rejected, and the Internship deemed incomplete.
- Remember each session is of about 1 hour.

SECTION - 5

REPORT WRITING AND EVALUATION

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SECTION 5
REPORT WRITING AND EVALUATION

PARAMETERS FOR CASE EVALUATION

The report you prepare should be so designed and presented that it showcases your knowledge, skills acquired and competencies achieved for practice in counselling and family therapy profession. These are points which have to be noted by the Supervisors also.

Each case would be evaluated on the following tasks performed by you:-

- Intake
- Initial phase
- Middle phase
- Termination
- Follow up
- Your understanding of the case
- Planning a therapeutic (counselling/family therapy) session
- Handling of ethical issues
- Sensitivity and skills applied with the case
- Adequacy and effectiveness of counselling/therapy
- Suggestions for improvement
- Honest reflections
- Regularity

Submission of original transcriptions of the sessions, along with CDs/audio tapes is compulsory.

You have to submit ***four complete case records.***

Two case records have to be from counselling perspective and two case records have to be from family therapy perspective.

Internship Report/File

The Internship Report/ File will be prepared by compiling the written records of the acclimatisation sessions and of the four case works. The duly filled in requisite annexures and enclosures must also be included. You have to submit the complete File, duly evaluated by your Supervisor at your Programme Study Centre/Study Centre.

Preparation of the Internship Report

1) As you have read earlier, the Internship Report/File must include the following:
   - A detailed and critical review of acclimatisation sessions.
   - An insightful and summative report of each of the four complete case works; two involving counselling and two involving family therapy, from the prescribed areas and comprising the stipulated number of sessions.
   - The requisite appendices/enclosures pertaining to each case work; including transcript of each session (along with the audio/video cassettes/CD, as the case may be); other details of each session; records related to case history taking, mental status examination, genogram, family interview etc.
   - Duly filled in Annexures A, B, C & D; given at the end of this Manual.

The Internship Supervisor will record the marks that you have obtained for the case records at the end of each case record in your Internship Report (the Supervisor's Comments Form provided at the end of this Manual may be used for this purpose). as well as in Section 1 of the Evaluation Sheet provided at the end of this Manual at Annexure B. Sections 2 & 3 of Annexure B have to be left blank, as these are to be filled-in by the External Evaluator.

This Annexure B, with duly filled-in Section 1 and blank Sections 2 & 3, must be included in the Internship Report that you submit.

In addition, the Supervisor will certify the Form given at Annexure C at the end of this Internship Manual which declares that the Internship work was conducted by you for the required duration under her or his supervision. You must also include the duly filled-in Annexures C and D in the File you submit.

Evaluation of Internship Report

The evaluation of Internship Report is done at two levels. These are:

- Evaluation Level 1 : Internal Evaluation
- Evaluation Level 2 : External Evaluation

Evaluation Level 1: At the Programme Study Centre/Study Centre by the Academic Counsellor/Supervisor

The Internship Report will be evaluated by the Academic Counsellor/Supervisor with whom you have been attached by the Programme Study Centre/Study Centre for the Internship component of this Programme of study.

The marking scheme is as follows:

Report of acclimatisation sessions
Maximum marks (MM)= 100

For Each Counselling Case Work (minimum 8-10 sessions)
Maximum marks (MM) = 200

For Each Family Therapy Case Work (minimum 13-15 sessions)
Maximum marks (MM) = 300

Hence, total MM for the internal evaluation component of the Internship is 1100.

Evaluation Level 2: External Evaluation (Evaluation of Intership Report at IGNOU Headquarters)

An expert from the panel, nominated by IGNOU, will evaluate the Internship File. This is called *External Evaluation.* The External Evaluator will record the marks in Sections 2 and 3 of Annexure B of this Internship Manual, that you would have enclosed in the File.

External evaluation will therefore be done on the basis of the Internship Report submitted by the learner.

The marking scheme is as follows:

Report of acclimatisation sessions
Maximum marks (MM)= 100

For Each Counselling Case Work (minimum 8-10 sessions)
Maximum marks (MM) = 200

For Each Family Therapy Case Work (minimum 13-15 sessions)

Maximum marks (MM) = 300

Hence, total MM for the external evaluation component of the Internship is 1100.

Weightage of Two Levels of Evaluation

The two levels of evaluation carry equal weightage towards final marks:

- The marks given by the Supervisor at Level 1, known as *'Internal Assessment',* will be calculated as 50% weightage; and
- The marks given by the Expert at Level 2, known as *'External Assessment',* will also be calculated as 50% weightage.

You have to secure 40% as pass marks in both the assessments, internal as well as external. If you are not able to secure 40% marks in either assessment, you have to repeat the complete Internship MCFTP-001. It means you have to re-do all the activities, make a new Internship File and submit it.

Note: *The panel of experts nominated by IGNOU, who are going to evaluate your Practicum File have the right to moderate the Internal Assessment marks awarded in any component of the File.*

If the evaluator finds the internship work NOT up to the standard desired, the evaluator may suggest minor/major changes and/or corrections, ask for clarifications and also can reject the manuscript. All instructions and advice to the student for subsequent modifications are made through the programme incharge. The internship supervisor will have the responsibility to have the student make the suggested changes for the final copy and resubmit the report for re-evaluation.

In case of failed students, a pro-rata fee of Rs. 2500/- by way of a demand draft in favour of IGNOU and payable at the city where the Regional Centre is located should be remitted along with the resubmission of the Internship Report.

If the student is unsuccessful in the internship, she or he has to re-do the whole cycle, right from requesting the Programme Incharge for a Supervisor and re-submitting the Internship File.

Submission of Internship Report

The duly complete Internship Report may be sent to the following address:

Student Evaluation Division
Indira Gandhi National Open University
Maidan Garhi, New Delhi – 110068

Note: *Before mailing the Internship Report/File, you must keep a photocopy of the File with yourself, so that in case of loss in transit or misplacement, you would be able to submit the copy of that file.*

Maximum Duration of the Internship

For 6 credit Internship Course, you have to spent 45 sessions of which one hour is with your Counsellor or Supervisor and 3 hours are to be devoted to the field work. The maximum time you can take to complete the internship is four months from the date of commencement of the Internship.

Date for Submission of the Internship Report

- If you wish the marks of the Supervised Practicum to be included in the June Term-end Examination marksheet then your Supervised Practicum File must reach SED, IGNOU, Maidan Garhi, New Delhi latest by 30th April. The File should be duly verified and evaluated by your Supervisor before submission for external evaluation.

- In case the Internship Report is submitted after 30th April, and before 31st October, marks would be included in December term-end examination marksheet.

  Thus, if your Internship Report reaches IGNOU between 1st November and 30th April it will be accounted for in the marksheet for the June examination, and if the Internship Report reaches IGNOU between 1st May and 31st October it will be accounted for in the marksheet for the December examination.

- The Internship Report submitted will not be returned to you.

- Do remember to keep a photocopy of the Internship Report.

Points to Remember:

When submitting your Internship Report/File, please ensure that you have included the following:

1) The cover page should clearly state the title ''Internship Report for the Course MCFTP-001''. Your name and enrolment number must also be mentioned on the cover page.

2) The first page or the face sheet must also have your name; enrolment number; full address; name, designation and address of your Supervisor; as well as name and address of your PSC/SC. The format for the face sheet of the Internship Report is given on the next page.

3) The Internship Report is to be sent in hard binding for evaluation. Loose file or spiral binding is not permitted.

4) The File must contain reports/case records with requisite enclosures, as stipulated.

5) All annexures (A, B, C & D - duly completed) must be enclosed in the File/ Report, as explained earlier.

INTERNSHIP REPORT FILE

M.Sc. (CFT) — Second Year

MCFTP-001

Name of the Student	:
Enrolment No.	:
Address	:
Phone No.	:
Study Centre/ Programme Study Centre	:
Regional Centre	:
Name & Address of Internship Supervisor	:
Phone No./Mobile No./ e-mail address of Supervisor	:
Name and Address of your PSC/SC	:

Signature of the Student

Date :

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UNFAIR MEANS

Students shall not use unfair means in connection with the Internship. The University will take the unfair means cases of Internship seriously, and refer such cases to the Examination Discipline Committee of IGNOU for necessary action.

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SECTION - 6
TOOLS

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SECTION - 6
TOOLS

You can use the following formats to elicit information from the patient/client and accompanying informant who is generally a family member staying with the patient or some close friend/relative.

TOOL 1
CASE HISTORY TAKING OF AN ADULT

A) Background Information of Client/Patient*:

*(*Please note that respondent has also been called client/patient.)*

Date of assessment: ....

Name (When including the case record in the Internship Report you may give a fictitious name to the client): ....

Age of patient/respondent: ....

Date of Birth: ....

Sex: ....

Education: ....

Occupation: ....

Residence: ....

Family Structure: Nuclear/Joint/Other ....

Background Information of Informant:

Name of the informant: ....

Relationship with the patient: ....

Length of acquaintance: ....

Adequacy of information: ....

Reliability of information: ....

B) Specific Information

1. PRESENTING COMPLAINTS (chief complaints that prompted the individual/ family to come to the hospital/centre/or seek intervention/help)

According to patient: ....

According to informant: ....

2. DURATION OF ILLNESS**

(** The term 'illness' has been used to refer to the behavioural problem, symptom/condition/ presenting complaint for which the (index) patient has come, or has been brought, for counselling/ family therapy.)

How long the patient has been ill?

..............................days / ....months / .... years

3. PRECIPITATING FACTORS

Onset (acute or gradual): ....

Course of illness (time when the patient is unwell and period when he feels better)

There could be some events for example, marriage, and change of job which could precipitate an illness. Find out if any such things have happened in the patient's life before the illness started.

....

....

4. FAMILY HISTORY

Family type: Nuclear/ Extended/ Joint

Socio-economic status: Upper/ Middle/ Lower

Family tree:

Sl. No.	Relation with patient	Age	Education	Occupation	Health & Personality

Family interaction and communication:

....

Family history of psychiatric illness:

....

5. PERSONAL HISTORY

Date of birth: ....

Place of birth: ....

Mother's condition during pregnancy: ....

Full term birth/ normal delivery/others: ....

Any delay in early developmental milestones (for example: neck holding, sitting, walking, talking etc.): Yes/ No

If yes, please mention details: ....

Neurotic symptoms in childhood (like temper tantrums): Yes/ No

If yes, please mention: ....

Night terrors: Yes/ No

Behaviour problems like thumb sucking or nail biting etc.: Yes/No

If yes, please mention: ....

Health during childhood

If patient suffered from any childhood infections or illness? Yes/ No

If yes, please mention if there was any effect of illness on development?

....

If patient suffered from any infantile convulsions? Yes/No

School: ....

Special abilities/disabilities: ....

Performance in academics: ....

Number of friends: ....

Relationship with peers: ....

Participation in co-curricular activities like drama/sports etc.: ....

Hobbies and interests: ....

Occupation

Age of starting work: ....

Ambition in life: ....

Present jobs held:

- Designation: ....
- Wages: ....

Satisfaction in work: ....

Present economic conditions: ....

Menstrual history (for female patients)

Age of 1st period: ....

Regularity/duration: ....

Amount of pain: ....

Sexual inclinations and practice

Sexual information/how acquired: ....

Masturbation/sexual fantasies: ....

Homosexuality/heterosexuality: ....

Marital history

Spouse's age: ....

Occupation: ....

Personality: ....

Compatibility: ....

Mode and frequency of sexual intercourse: ....

Sexual satisfaction: ....

Contraceptive measures: ....

Children

Chronological list of children and miscarriages: ....

....

S.No.	Years of birth	Name	Sex	Personality

Medical history

Did the patient undergo any:

- major illness
- operation
- accidents
- surgical problem

If yes, Please mention details: ....

Past psychiatric history

Information of patient's past psychiatry record:

- Dates: ....
- Duration: ....
- Symptoms: ....
- Diagnosis: ....
- Treatment: ....

Pre-morbid Personality

Ask the patient and informant to describe her or his personality before the illness started. For instance:

i) Social relations with

- Family: ....
- Friends: ....
- Relatives: ....
- Society: ....
- Workmates: ....

ii) Intellectual activities like:

- Hobbies: ....
- Interests: ....
- Memory: ....
- Observation: ....
- Judgement: ....

iii) Mood of patient:

- Bright/cheerful: ....
- Despondent: ....
- Optimistic : ....
- Pessimistic: ....
- Self depreciative: ....
- Satisfied: ....
- Stable: ....
- Unstable: ....

iv) Character

- Attitude to work or responsibility: ....
- Interpersonal relationships: ....
- Standards in religious/social/health matters: ....

v) Fantasy life

- Frequency and content of day dreaming: ....

vi) Habits

- Eating/alcohol consumption: ....
- Self medication: ....
- Tobacco consumption: ....

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TOOL 2
CASE HISTORY TAKING OF A CHILD/ADOLESCENT

The performa for taking case history in children and adolescents is given below. In this more emphasis is placed on early development and adjustment in school. In this proforma, use only what is relevant with your respondent and for other items, it may be written as not relevant.

A) Background Information of client/patient*

*(*Please note that respondent has also called client/patient.)*

Date of assessment: ....

Name (When including the case record in the Internship Report, you may give a fictitious name to the client): ....

Age of patient/respondent: ....

Date of Birth: ....

Sex: ....

Education: ....

Occupation: ....

Residence: ....

Background Information of Informant:

Name of the informant: ....

Relationship with the patient: ....

Length of acquaintance: ....

Adequacy of information: ....

Reliability of information: ....

B) Specific Information

1. **PRESENTING COMPLAINTS (chief complaints that prompted the individual/ family to come to the hospital/centre/or seek intervention/help)**

   According to patient: ....

   According to informant: ....

2. **DURATION OF ILLNESS**

   (The term illness has been used to refer to the behavioural problem/symptom/condition/ presenting complaint for which the index patient has come, or has been brought, for counselling/family therapy.)

   How long the patient has been ill?

   .... days / .... months / .... years

3. PRECIPITATING FACTORS

Onset (acute or gradual): ....

Course of illness (time when the patient is unwell and period when she/he feels better)

There could be some events; for example, birth of a sibling or change of school, which could precipitate an illness. Find out if any such things have happened in the patient's life before the illness started.

....

....

4. FAMILY HISTORY

Family type: Nuclear/ Extended/ Joint

Socio-economic status: Upper/ Middle/ Lower

Family tree:

Sl. No.	Relation with patient	Age	Education	Occupation	Health & Personality

Family interaction and communication:

....

Family history of psychiatric illness:

....

5. PERSONAL AND DEVELOPMENTAL HISTORY

History of Early Development

- Parental attitude towards pregnancy: wanted/unwanted ....
- Mother's health during pregnancy:
  - (i) Any illness
  - (ii) X-ray exposure
  - (iii) Prolonged drug administration

(iv) Attempted abortion

(v) Any other

- Nature of birth:

  (i) Full term normal delivery

  (ii) Premature birth

  (iii) Instrumental or operation

  (iv) Complicated delivery

  (v) Head injury

  (vi) Jaundice, cyanosis

  (vii) Delayed cry after birth

- Feeding habits in early childhood :

  (i) Breast

  (ii) Bottle

- Age of :

  (i) Neck holding

  (ii) Tooth eruption.

  (ii) Sitting

  (iv) Standing (unsupported)

  (v) Walking

  (vi) First word

  (vii) Three-word sentence

  (viii) Bowel control

  (ix) Bladder control...

- Developmental problems (if any) of speech, language, motor function.

  ....

  ....

  ....

- Any delay in early developmental milestones (for example: neck holding, sitting, walking, talking etc.): Yes/ No

  If yes, please mention details: ....

  ....

  ....

- Neurotic symptoms in childhood (like temper tantrums): Yes/ No

If yes, please mention details: ....

Night terrors: Yes/ No

- Behaviour problems like thumb sucking or nail biting etc.: Yes/ No

If yes, please mention details: ....

Health during childhood

If patient suffered from any childhood infections or illness? Yes/ No

If yes, please mention if there was any effect of illness on development?

....

If patient suffered from any infantile convulsions? Yes/ No

School

Special abilities/disabilities: ....

Performance in academics: ....

Number of friends: ....

Relationship with peers: ....

Participation in co-curriculum activities like drama/sports etc.: ....

Hobbies and interests: ....

Occupation ***(if applicable)***

Age of starting work: ....

Ambition in life: ....

Present jobs held: -Designation: ....

-Wages: ....

Satisfaction in work: ....

Present economic conditions: ....

Menstrual history ***(if applicable)***

Age of 1st period: ....

Regularity/duration: ....

Amount of pain: ....

Sexual inclinations and practice *(if applicable)*

Sexual information/how acquired: ....

Masturbation/sexual fantasies: ....

Homosexuality/heterosexuality: ....

Marital history *(if applicable)*

Spouse's age: ....

Occupation: ....

Personality: ....

Compatibility: ....

Mode and frequency of sexual intercourse: ....

Sexual satisfaction: ....

Contraceptive measures: ....

Children *(if applicable)*

Chronological list of children and miscarriages:

Sl. No.	Years of birth	Names	Sex	Personality

6. SOCIAL AND PERSONAL HISTORY

Habits

(a) Sleep:

(i) Normal

(ii) Over-sleeping

(iii) Others

(b) Feeding:

(i) Fussy

(ii) Over-eating

(iii) Others

(c) Personal care:

(i) Adequate

(ii) Unkempt

Neurotic traits:

(i) Nail biting

(ii) Thumb sucking

(iii) Morbid fears of persons, animals, darkness

(iv) Nightmares

(v) Night terrors

(vi) Obstinacy

(vii) Temper tantrums

(viii) Enuresis, encopresis beyond 3 years

Behaviour problems:

- Stealing
- Lying
- Truancy
- Disobedience
- Others

Play:

- individual/group
- company: a few/many
- play mates – older/younger/same age
- good/bad/both/others ....

Sexual history – masturbation, preoccupation

Normal/Malpractices

Medical history

Has the patient undergone any:

- Illness
- Operation
- Accident
- Surgical problem

If yes, please mention details: ....

Past psychiatric history

Information of patient's past psychiatry record:

- Dates: ....
- Duration: ....
- Symptoms: ....
- Diagnosis: ....
- Treatment: ....

Pre-Morbid Personality

Ask from patient and informant to describe her or his personality before the illness started. Like:

i) Social relations with
    - Family: ....
    - Friends: ....
    - Relatives: ....
    - Society: ....
    - Classmates/playmates: ....

ii) Intellectual activities like
    - Hobbies: ....
    - Interests: ....
    - Memory: ....
    - Observation: ....
    - Judgement: ....

iii) Mood of patient
    - Bright/cheerful: ....
    - Despondent: ....
    - Optimistic : ....

- Pessimistic: ....
- Self depreciative: ....
- Satisfied: ....
- Stable: ....
- Unstable: ....

iv) Character

- Attitude to work or responsibility: ....
- Interpersonal relationships: ....
- Standards in religious/social/health matters: ....

v) Fantasy life

- Frequency and content of day dreaming: ....

vi) Habits

- Eating/alcohol consumption: ....
- Self medication: ....
- Tobacco consumption: ....

7. EDUCATIONAL HISTORY

1. Qualified upto ....
2. Educated at
   (i) home
   (ii) school
   (iii) hostel
3. Started reading at.. years
4. Educational problems (if any)
   (i) poor progress
   (ii) repeated absences
   (iii) poor peer relationships
   (iv) problem with teachers,
   (v) scholastic skills development
   (vi) any others.

   (also make a global assessment of functioning at school here)

5. Failures if any

   Class .... no. of failures ....

6. Problem in attention, concentration, difficulty with any particular subject.

8. TEMPERAMENTAL CHARACTERISTICS

Activity:

Rhythmicity: ....

Approach-Withdrawal: ....

Adaptability: ....

Mood:

Intensity of Reaction: ....

Threshold of Responsiveness: ....

Attention-Span: ....

Persistence: ....

Distractibility in infancy and later stages: ....

9. FAMILY HISTORY

Family Tree [with age, sex, personality descriptions and any history of mental illness in the family]

....

....

....

....

Family functioning (any discord between family members, lack of interaction or communication, any problems with the family as a whole, e.g. isolated family).

....

....

....

Parent-child interaction (lack of warmth, hostility towards/scapegoating of child, abuse)

....

....

....

10. PATTERNS OF PARENTAL FUNCTIONING:

Permissiveness/rigidity ....

Consistency/inconsistency ....

Strictness of discipline/liberal (any inappropriate supervision) ....

Approval of interests/disapproval ....

Protectiveness/non-protectiveness (any overprotection) ....

Toleration of deviance/non-toleration ....

Expectations from the child (any pressures, deprivation) ....

Reactions towards the illness ....

11. SOCIAL AND ENVIRONMENTAL CONDITIONS

(Mention any aspect of living conditions which you might consider stressful for the child)

Type of dwelling ....

Degree of crowding ....

Type and amount of help in the care of the child ....

Affluence of the family/degree of financial stress ....

12. SPECIAL ENVIRONMENTAL CIRCUMSTANCES

(like birth, death, illness, accident, divorce, hospitalization, etc. in the family. If present, mention the effect of the life event on the child, e.g. on self-esteem.)

....

....

....

....

TOOL 3
MENTAL STATUS EXAMINATION INVENTORY

This is systematic observation on a standard format which you may use across age groups. Use the following format to observe the patient and ask the following questions.

1) GENERAL APPEARANCE & BEHAVIOUR

(This comprises a brief description regarding the patient's appearance, behaviour and manner of relating to the examiner. This helps to elicit any abnormalities that might be evident in the way the person appears and relates to the examiner, for example, a patient suffering from a psychotic episode may not be able to establish base on support with the examiner. He/she may look overdressed or untidy and may not cooperate with the examiner.)

i) General appearance

Record the following observations:

- Physique and body build:

Approximate height: ....

Weight: ....

Appearance: ....

- Looks: Comfortable/Uncomfortable
- Physical health:

Grooming: ....

Hygiene: ....

Self care: ....

- Dressing: appropriate/adequate/any peculiarities
- Non verbal expression : ....
- Mood: ....
- Effeminate/masculine: ....

ii) Attitude towards the Examiner

Is the patient

– Cooperative

– Guarded

– Evasive

– Hostile

– Attentive

– Interested/disinterested/apathetic

– Any odd behaviour

iii) Comprehension

Can patient understand the questions ?

– Intact/impaired (Partially/fully)

iv) Gait and posture

Posture	Normal	Abnormal
Way of sitting Standing Walking		

v) Motor Activity

This is observed while interacting with the patient.

- Increased/Decreased
- Excitement/Stupor
- Abnormal involuntary movements : Tics, Tremors
- Restlessness
- Catatonic signs:
  - Mannerisms (habitual involuntary movement)
  - Stereotypes (repetitions of physical activities)
  - Posturing (strange, fixed and bizarre bodily positions)
  - Waxy flexibility (condition in which person maintains the body position in which he or she is placed)
  - Negativism (verbal or non-verbal opposition to suggestion)
  - Ambitendency (making series of movements that don't reach the goal)
  - Stupor (state of decreased activity and less awareness of surroundings)
  - Echolalia (repetitions of words or phrases)
- Social withdrawal/autism
- Compulsive Acts: ....

  Rituals: ....

  Habits: ....

vi) Social manner with non verbal behaviour

– Increased

– Decreased

– Inappropriate

Eye contact: Gaze aversion

Staring vacantly

Hesitant eye contact

Normal eye contact

vii) Rapport

Whether a working empathetic relationship can be established with the patient? Yes/ No

viii) Hallucinatory behaviour

Ask the patient if she or he hears some voices in absence of any external stimuli or whether the family members notice the following kinds of behaviours in the patient:

– Smiling or crying without any reason

– Muttering/ talking to self (non social speech)

– Odd gesturing in response to auditory/visual/olfactory

– Tactile hallucinations

II) SPEECH

During the interview observe the rate of speech, new words being coined, stammering and articulation problem. The content of speech is also important to make diagnosis e.g. a manic patient will be over talkative and depressed patient will talk after lots of persuasion. You may record the rate of speech e.g. fast or slow, volume and tone of speech.

i) Rate with quantity of speech

Observe the patient during the interview for the following:

- Speech: Present / Absent
- Spontaneous speech: Yes/ No
- Productivity: Increased / Decreased
- Rate: Increased / Decreased / Appropriate
- Pressure or poverty of speech: ....

ii) Volume with tone of speech

On the basis of your interaction with the patient notice whether the speech is:

- Increased/decreased (its appropriateness)
- Low/high/normal pitch

iii) Flow with rhythm of speech

Observe the patient's speech; whether it is:

- Smooth/hesitant
- Sudden blocking (disruption of thought or break in flow)
- Derailment (breakdown in logical connections between ideas)
- Stuttering/stammering
- Circumstantialities (including irrelevant details and returning to the point)
- Tangentiality (responding to the topic being discussed but not answering the question posed)
- Word salad (incoherent mixture of words)
- Verbal stereotypy (repeating similar words again and again)
- Flight of ideas (shifting from one idea to the next)
- Clang association (thoughts associated with sounds rather than words; eg., band, lang, tang)

III) MOOD WITH AFFECT

Inquire from the patient how her or his mood is usually. This helps to elicit the emotions felt by the person cross-sectionally and over a period of time. For example, a patient suffering from a depressive episode may describe his predominant feelings as that of sadness and appear as feeling depressed.

Mood (Pervasive feeling tone, which is sustained, total experience of a person)

Observe and enquire from the patient about the following:

i) ***Quality of mood***

Subjectively: How do you feel?

Objectively: By examination

- ***Stability of mood****:* Over a period of time
- ***Reactivity of mood:*** Variation in mood with stimuli
- ***Persistence of mood:*** Length of time the mood lasts

ii) ***Affect*** (Outward expression of the immediate experience of emotion at a given time)

Observe what the patient's demeanor reflects about the following:

- ***Quality of affect***
- ***Range of affect*** (of emotional changes displayed over time)
- ***Depth or intensity of affect***: Normal/increased/blunted

- ***Appropriateness of affect*:** In relation to thought and surrounding environment
- ***Mania*:** Euphoria, elation, exaltation, ecstasy
- ***Anxiety*:** Anxious, restless
- ***Depression*:** anxious, restless, sad, irritable, angry, auhedonia
- ***Schizophrenia*:** Shallow, blunted, indifferent, restricted, inappropriate, labile, auhedonia

IV) Thought

It helps to elicit the patient's thoughts and ideas, as well as their attitude towards various aspects of their life. E.g., a patient suffering from psychosis may express that people around him are plotting against him or that the newspaper and T.V sets are broadcasting his thoughts.

i) Stream and form of thought

Based on the way the person verbally interacts with the examiner, the following observations regarding the thought can be made:

- Spontaneity: Present/ Absent
- Productivity: Present/ Absent
- Flight of ideas (shifting from one idea to the next) : Present/ Absent
- Prolixity/ordered flight of ideas: Present/Absent
- Poverty of content of speech: Present/Absent
- Thought blocking (sudden disruption in flow of thoughts): Present/ Absent
- Continuity of thought: Present/ Absent
- Relevant to questions asked: Yes/ No

Observe the following behaviour in the patient:

- Any loosening of associations: Present/ Absent
- Tangential circumstantialities: Present/Absent
- Illogical thinking: Present/Absent
- Preservation: Present/Absent
- Variegation: Present/Absent

ii) Content of thought

- Obsessions: Present/Absent
- Contents of phobia: Present/Absent
- Delusion: Present/Absent
- Over valued ideas: Present/ Absent

Observe the following contents in thoughts of the patient:

- Ideas of persecution : ....
- Reference : ....
- Grandeur : ....
- Love : ....
- Jealously : ....
- Guilt : ....
- Nihilism : ....
- Poverty : ....
- Somatic symptoms : ....
- Hopelessness : ....
- Haplessness : ....
- Worthlessness : ....
- Suicidal ideation : ....

V) Perception

(This helps to understand how the patient makes sense of her or his environment and processes information. For example, a person suffering from paranoia may perceive that her or his family members are plotting against him or wanting to poison him.)

i) Hallucinations

- Auditory/visual/olfactory/gustatory/tactile (whether the patient hears voices discussing something about him/her, smells any unusual odours, feels certain sensations in the absence of any external stimuli): Yes/ No

If 'yes' :

Elementary (sounds) or complex (voices) (hears certain sounds like the dripping of a tap or a sound which is repetitious in nature): Yes/ No

What is heard/how many voices, when, male or female, 2nd or 3rd person?

....

During wakefulness/hypnagogic (while going to sleep) or hypnopompic (while getting up from sleep); for example, sees a human figure while falling asleep or waking up? ....

ii) Ask the patient regarding whether she or he reports to have experienced any of the following:

- Illusions/misinterpretations (misperception of certain stimuli like mistaking a rope for a snake): Yes/ No
- Depersonalization/de-realization (feelings of unreality regarding self or the environment): Yes/ No
- Somatic passivity phenomenon (feeling that any external agency is controlling one's actions like making one do certain acts): Yes/ No

VI. Cognitive Assessment

This helps to assess the patient's higher mental functions. For example, a person suffering from delirium may have confusion in thought.

i) Consciousness

Check for whether person is in a wakeful state by observing her or him as well as through the way she or he responds verbally and non-verbally towards the examiner.

- Conscious
- Confusion
- Somnolence
- Clouding
- Delirium
- Stupor
- Coma

ii) Orientation

- Time : Ask Time:...

  Date: ....

  Day: ....

  Month: ....

  Year: ....

  Reason: ....

  Time spent in centre/hospital: ....
- Place: Ask present location: ....

  Building: ....

  City: ....
- Person: Ask name: ....

  Her or his role in the setting: ....

  People around him/her: ....

iii) Attention

- Easily aroused/sustained
- Can repeat digit

iv) Concentration

- 100 – 7 test
- 40 – 3 test (keep on subtracting 3 from 40 until he/she reaches 0 like 40, 37, 34)
- Count backward from 20
- Names of months /days of week in reverse order

v) Memory

- Immediate memory

  Digit span test (ask the patient to repeat the digits spoken by the examiner forwards or backwards)

- Recent memory

  Ask how did the patient come to the room/hospital? : ....

  What foods did he have for breakfast? : ....

  What foods did he have the previous night? : ....

- Remote memory

  Birth date: ....

  Date/place of marriage: ....

  Any relevant questions from past: ....

vi) Intelligence

- General information

  E.g. Current Prime Minister, capital of India or any state etc.

- Simple tests of calculations (e.g., 4 + 5?)

vii) Abstract thinking

- Proverb testing: Atleast 3 simple proverbs, for example, the examiner should ask the patient what does it mean — ‘every cloud has a silver lining’; ‘people who live in glass houses should not throw stones’; ‘Sour grapes’.
- Similarities with analogies: For example, ask “what is similar between banana and orange, dog and cat, table and chair?”.

VII. INSIGHT

This describes the acceptance of whether a patient feels she or he is suffering from an illness as well as whether she or he is able to understand the factors which may have caused the illness. Example, a person suffering from obsessions and compulsions may communicate that she or he is having repeated thoughts which compel her or him to wash hands repeatedly and that these thoughts are irrational.

On the other hand, a patient who is having hallucinations or delusions says that he/she doesn't have a problem and says that she/he is normal. Such a patient is said to have an insight rating of 1, that is, she or he has no insight about her/his illness.

Insight is rated on 6 points scale given below:

1. Complete denial of illness. Yes/ No
2. Slight awareness of being sick and needing help, but denying it at the same time. Yes/ No
3. Awareness of being sick, but it is attributed to external or physical factors. Yes/ No
4. Awareness of being sick, due to something unknown in self. Yes/ No
5. Intellectual insight : Awareness of being ill, and that the symptoms/failures in social adjustment are due to over particular irrational feelings/thought ; yet does not apply this knowledge to the current/future experiences. Yes/ No
6. True emotional insight: Awareness of being ill leads to significant basic changes in the future behaviours and personality. Yes/ No

VIII) JUDGEMENT

This section involves whether a patient is able to communicate personal goals and respond to social situations in an appropriate manner. For example, the patient suffering from manic episode may sing and dance in the waiting area or during the interview and communicate that her or his goal is to be the President of India though it is not in accordance to her or his ability and education.

i) Observed during interview, the ability to assess a situation correctly and act appropriately in that situation like social judgement e.g., evaluation of personal judgement

ii) Test judgement by asking what patient would do in particular situations, by asking questions such as the following:

1. If you are walking on the road, and find a sealed envelope with address and stamp lying on the street, what will you do?

   ....

2. If you have gone to watch a movie in a theatre, and suddenly the theatre catches fire, what will you do?

   ....

3. If you find an injured child on the road, what would you do?

   ....

4. If it is raining outside, what should you do?

   ....

TOOL 4
FAMILY INTERVIEW SCHEDULE

You would be conducting family interviews and analysing the same on the basis of information gathered and learnt in different courses. Use of your insight and creativity would help you in this task. For this purpose, you would need to prepare a family interview schedule on the basis of the major areas to be covered; which have been listed below. We are providing you the semi-structured format of the interview schedule to be used with the respondents. You would need to adapt the interview schedule as per the characteristics of the individual and family to be interviewed.

i. Personal History — which includes age, education, occupation of self, income, socio-economic status, etc.

ii. Information regarding illness or problems suffered by the client.

iii. Socio-cultural background - Ethnicity and role of family in their society.

iv. Support available - which includes on whom the client(s) and his/her family can count on in distress and illness. It would include relatives, friends, neighbours, colleagues at work place, *panchayat*, etc.

v. Family History — which includes information about family, parents, siblings etc.

vi Family life cycle stages,

vii. Understanding power in the family.

viii. Understanding family functioning.

ix. Problem solving in the family.

x. Communication in the family.

xi. Roles of the various individuals in the family.

xii. Affective responsiveness in the family.

xiii. Affective involvement of family members.

xiv. Behaviour patterns and control in the family.

xv. Interactional pattern in the family.

xvi. Family strengths.

xvii. Family weaknesses.

xviii. Differentiation of individualism and familism of the individuals in the family.

xix. Issues related to sex.

xx. Issues related to money and property.

xxi. Expectations from self, spouse, parents, children, in-laws, work place, etc.

xxii. Meeting the needs of children.

xxiii. Childhood memories.

xxiv. Religious and spiritual issues.

xxv. Relationship with family members.

Start from the present family life cycle stage till the first family life cycle stage. Similarly, for individuals who are unmarried or young, start from the present stage of family life/ life cycle and go till the client can recall the past life stages (till infancy). Note down all the important events such as death, marriage, job, getting employment, retirement, leaving job, birth of new family members, close relationships developed. Ask about the tasks, responsibilities performed at each family life cycle stage, by whom and deviances in the same. Hierarchy, power, alienations, triangulations, present in the family at each family life cycle stage need to be ascertained.

In cases where the client is orphan or does not have immediate relatives, then the people important to him/her need to be mentioned and relevant details sought in proper order.

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ANNEXURES

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ANNEXURE A

CERTIFICATE OF ASSIGNING AN APPROVED GUIDE FOR INTERNSHIP

Student Enrol. No. : ....

PSC/Study Centre : ....

Regional Centre : ....

RC Code : ....

Student's Name : ....

Address : ....

E-mail : ....

Mobile/Tel. No. : ....

Particulars of Approved Counsellor/Guide/Supervisor being assigned to the student for Internship work:

Name of the Guide/Supervisor : ....

Designation : ....

Address of Centre Organization/ Institution with which associated: ....

E-mail : ....

Mobile/Tel. No. : ....

Educational Qualifications : ....

Working/Teaching Experience : ....

....

Reference details of communication from Programme Coordinators at IGNOU Headquarters approving the Guide/Supervisor (Letter No. & Date) : ....

Date of assigning the Supervisor to the student: ....

....

Supervisor's Signature

Supervisor's Name : ....

Signature of the Programme Incharge at the PSC/SC

Name : ....

Address : ....

E-mail : ....

Mobile/Tel. No. : ....

PSC/SC Code and Stamp : ....

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ANNEXURE B

EVALUATION SHEET

Remember to enclose this Annexure (Completed Section 1, and Blank Sections 2 & 3) in the Internship Report when you submit it for external evaluation at IGNOU. *Keep a copy with yourself.*

SECTION 1: **Internal Evaluation by the Internship Supervisor assigned at the Programme Study Centre/Study Centre**

The following is the format in which the Internship Guide / Supervisor is required to consolidate the marks for the 4 case records prepared by the student. These marks should also be stated on each written case work submission in the Internship Report.

No.	Title	Maximum Marks	Marks Obtained
1.	Record of Acclimatisation Sessions	100	
2.	Record of Counselling Case Work 1	200	
3.	Record of Counselling Case Work 2	200	
4.	Record of Family Therapy Case Work 3	300	
5.	Record of Family Therapy Case Work 4	300	
	Grand Total	**1100**	**Grand Total (A)**

- **Weightage of marks for Internal Evaluation is 50%. To calculate this, use the formula given below:**

$$\frac{\text{Total marks obtained by learner (A)}}{1100} \times 50 = \textbf{'N'}$$

Note : The pass percentage for Internal Evaluation is 40%. Therefore, if the learner gets **less than 20 marks** after calculating 50% weightage of total marks obtained, then the student has to **repeat the supervised practicum**. In other words, 'N' obtained should be at least 20 for the learner to pass.

The Internship Guide is required to use the given formula to calculate the final marks out of 50, obtained by the learner in internal evaluation and to write this final score in figures and in words.

$$\frac{\text{(A)}}{1100} \times 50 = \text{.........}$$

(Marks obtained out of 50 in internal evaluation to be written in both figures and words)

....

Internship Guide/Supervisor's overall comments about the learner (use additional sheets, if needed).

....
....
....
....
....
....
....

Date:

Place: **(Signature of the Internship Guide/ Supervisor)**

Name & Designation of Internship Guide/Supervisor : ....
....

Address of Internship Guide/Supervisor : ....
....

E-mail Address of Internship Guide/Supervisor : ....

Phone/Mobile No. of Internship Guide/Supervisor : ....

Date:

Place: **(Signature and Stamp of the Programme Incharge of PSC/Coordinator of SC)**

Name of Programme Incharge of PSC / Coordinator of SC : ....
....

Address of Programme Incharge/Coordinator : ....
....

E-mail Address of Programme Incharge/Coordinator : ....

Phone/Mobile No. of Programme Incharge/Coordinator : ....

SECTION 2 : To be Used for External Evaluation at IGNOU

The following sheet will be used by the Expert Examiner identified by IGNOU headquarters to evaluate the Internship Report/File submitted by the Learner.

No.	Title	Maximum Marks	Marks Obtained
1.	Record of Acclimatisation Sessions	100	
2.	Record of Counselling Case Work 1	200	
3.	Record of Counselling Case Work 2	200	
4.	Record of Family Therapy Case Work 3	300	
5.	Record of Family Therapy Case Work 4	300	
	Grand Total	**1100**	**Grand Total (B)**

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- **Weightage of marks for external evaluation is 50%. To calculate this, use the formula given below:**

$$\frac{\text{Total marks obtained by the learner (B)}}{1100} \times 50 = \mathbf{M}$$

Note: The pass percentage for external evaluation is 40%. Therefore if the learner gets less than 20 marks after calculating 50% weightage, then the student has to repeat the Internship. In other words, 'M' obtained by the student should be at least 20 to pass.

The external evaluator is required to use the above formula to calculate the final marks, out of 50, obtained by the learner in external evaluation and to write this score in figures and in words.

$$\frac{(B)}{1100} \times 50 = \text{............}$$

(Marks obtained out of 50 in external evaluation to be written in both figures and words)

....

Date: **(Signature of External Examiner of IGNOU Panel)**

Place:

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SECTION 3 : Grand Total of Marks for Inclusion in the Learner's Final Marksheet

*Marks Obtained by the Learner in Sections 1 and 2 i.e. in both internal and external evaluation of Internship Report are to be consolidated below by the External Expert (who did evaluation in Section 2)***.**

Internship Report (MCFTP-001)

Internal Assessment *(External Expert to write marks as stated by the Learner's Supervisor as 'N' at the end of Section 1 of Annexure B)* ***(Marks out of 50)***	**External Assessment** *(External evaluator to write marks here given by her/him as 'M' at the end of Section 2 of Annexure B)* ***(Marks out of 50)***	**Total marks obtained (T)** *(Expert to add marks 'N' and 'M' and write the total here) (N+M=T)* ***(Marks out of 100)***

GRAND TOTAL OF MARKS OBTAINED BY THE LEARNER (T) : ....

(To be written in both figures and words)

....

Date: **(Signature of External Examiner of IGNOU Panel)**

Place:

Name of External Examiner : ....

Address of External Examiner : ....

....

E-mail Addess of External Examiner : ....

Phone/Mobile No. of External Examiner : ....

ANNEXURE C

Certificate of Completion of Internship

MCFTP-001

Remember to enclose this Annexure in your Practicum File. Keep a copy with yourself.

(To be certified by the Internship Supervisor and the Programme Incharge of the Programme Study Centre or Study Centre Coordinator)

We certify that the student Mr./Ms./Dr. .... with enrolment number ....has carried out the stipulated Case Records of the course Internship under our guidance and supervision. The Internship Report submitted herewith is the result of bonafide work done by the student for the Internship Course MCFTP-001 from .... (start date) to .... (end date).

Date:

Place: **(Signature of the Internship Counsellor/ Supervisor)**

Name & Designation of Supervisor : ....

....

Address of Academic Counsellor/Supervisor : ....

....

E-mail Address of Academic Counsellor/Supervisor : ....

Phone/Mobile No. of Academic Counsellor/Supervisor : ....

Date:

Place: **(Signature and Stamp of the Programme Incharge of PSC/Coordinator of SC)**

Name of Programme Incharge of PSC / Coordinator of SC : ....

....

Address of Programme Incharge/Coordinator : ....

....

E-mail Address of Programme Incharge/Coordinator : ....

Phone/Mobile No. of Programme Incharge/Coordinator : ....

ANNEXURE D

CERTIFICATE OF AUTHENTICITY

Enclose the authentication certificate in the format given herewith:

Authentication Certificate

STUDENT CERTIFICATE

The work embodied in this Internship Report has been carried out by me under the supervision of .... (*give the name of the Guide)* This work is original and has not been submitted by me for the award of any other degree of IGNOU or any other University. I also declare that no portion of any case record of this manuscript has been incorporated or lifted from elsewhere, in part or in whole.

....

Date : ....

Place : ....

(Signature and Name of the Candidate)

CERTIFICATE OF INTERNSHIP SUPERVISOR

I certify that the canditate Dr./Mr./Ms./Mrs .... has planned and carried out the stipulated internship activities under my guidance and supervision and that the report submitted herewith is a genuine, original, and bonafide work done by the canditate in .... (*Place*) from.......................... to .... *(Dates*).

Date : ....

Place : ....

....

(Signature and Name of the Supervisor)

....

Name, Signature of Programme Incharge
Stamp of Programme Incharge

Supervisor's Comment Form

Dear Learner,

Photocopy this page, and place the duly filled-in copy at the end of each case record in your Internship Report.

Case Record No. : ....

TO BE FILLED IN BY THE INTERNSHIP GUIDE/SUPERVISOR

Counsellor's Comments on performance during the sessions:

....

....

....

Comments on the comprehensiveness and analytical approach adopted in the written report (supplemented by audio/CD, and transcript of the sessions), submitted by the learner.

....

....

....

Marks : ....

(The total marks are to be written in both figures and words)

....

Any other Comment that the Guide/Supervisor wishes to make:

....

....

....

(Guide/Supervisor's Signature and Date)

....

(*Guide/Supervisor's* Name)

Sample of Permission Letter

I, ... (name of the student) am pursuing M.Sc. (CFT) programme from IGNOU. I am attached to .... Regional Centre at Study Centre / Programme Study Centre...

....

(Name, Address and PSC/SC No.). I am doing Case Record of the Course 'Internship' — MCFTP-001 under the guidance of my Academic Counsellor/ Supervisor .... (name of the Academic Counsellor/ Supervisor). For the completion of my course work, I need you to grant me permission to interview/interact with you for about an hour per session for a few sessions, as per your convenience. Please grant me permission and oblige.

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(Student's Signature & Name)

(Supervisor's Signature & Name)

(Name & Signature of the Person(s) agreeing for the Case Work)

Remuneration Bill for Guidance of Internship Work

(to be submitted with the Internship Report/File, but in a separate envelope)

To
The Director (SED)
IGNOU
Maidan Garhi
New Delhi-110068

1. Programme Code : M.Sc.(CFT)
2. Course Code : MCFTP-001
3. Name of Supervisor/Guide : ....
4. Residential Address: ....
....
5. Designation: ....
6. Official Address: ....
7. Telephone No. Office : ....
Mobile: ....
Residence : ....

Sl. No.	Name of the Student	Enrolment No.	PR No. (to be filled by SED)	Amount

Certified that I have guided the student for internship work.

Dated:.................   Signature of the Supervisor/Guide:.....................................

Note : The remuneration payable for guidance of Internship Work is Rs. 2000/- per student.

Certified that the above Internship Supervisor was approved and recommended by the concerned school of study and above claim may be admitted.

Dy./Asstt. Registrar   Section Officer   Dealing Assistant