Indira Gandhi National Open University
National Centre for Disability Studies

MCFTE-006

Substance Abuse Counselling and Family Therapy

MANUAL FOR SUPERVISED PRACTICUM

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Dear Learner,

The optional course 'Substance Abuse Counselling and Family Therapy' has 2 credits of theory (MCFTE-003) and 4 Credits of Supervised Practicum (MCFTE-006). The 4 Credits of Supervised Practicum are divided into five practicals that have been described in this Manual, which you should complete along with your theory Course in the specific period of time. This Supervised Practicum (MCFTE-006) helps you to understand better the theoretical concepts which you have studied. This would help you to apply these concepts later in work.

These practicals emerge out of the theory syllabus. The practical activities will help you to get hands-on experience of working with individuals and families in different settings. It provides information to deal with substance abuse like tobacco, alcohol, drugs, etc.

Here, we would like you to understand that in Supervised Practicum, you have to work under the overall supervision of the Academic Counsellor, generally called Counsellor or Supervisor in this Block. Further, before starting the practical activities, it is very important for you to read this Manual for Supervised Practicum carefully. Go through this Manual in order to understand what has to be done.

With best wishes,

Programme Coordinators
IGNOU

INTRODUCTION AND GUIDELINES

The optional course 'Substance Abuse Counselling and Family Therapy' has 2 credits of theory (MCFTE-003) and 4 Credits of Supervised Practicum (MCFTE-006). The focus of this Supervised Practicum (MCFTE-006) is on understanding the applications and interventions related to substance abuse counselling and family therapy. As a counsellor and family therapist, we provide you different areas to specialise in. This Supervised Practicum is intended to enhance your learning and experience in the area of substance abuse counselling and family therapy.

In this supervised Practicum you are provided with a basic Unit giving detailed practical explanation of substance abuse and a case illustration exemplifying the same. Basic Unit 3 acquaints you with the fundamentals of doing and recording case work, which you need to refer to for doing the counselling and family therapy case works in Practicals 3 and 4. Various practicals have been prescribed in this Manual to facilitate learning by doing.

You are required to carry out the Supervised Practicum under the guidance and supervision of an approved Academic Counsellor/Supervisor, to whom you are assigned for the purpose by your PSC/SC. You will read more about this apect a little later in this Section.

Suggested Schedule

It is advised that you should start the Supervised Practicum as soon as you go through the theory component of this course. Before starting the practical activities, therefore, you should devote your time to:

i) Reading and understanding the related Units.

ii) Attending the theory counselling sessions which will be organised by the respective Programme Study Centre/Study Centre, you are attached with.

It is advisable to complete the practical activities as per the scheduled time. You are suggested to do the practicals in a series, that is, to complete one Practicum first and then move to the next one.

Duration of Supervised Practicum MCFTE-006

The Supervised Practicum comprises five practicals, the details of which are given in this Manual. You have to complete these practicum in a total of 30 working days which include 30 compulsory contact classes (sessions) with the Counsellor, each of 1 hour duration. As stated earlier, you must spend the remaining 3 hours of each of the 30 working sessions for carrying out field work pertaining to the 5 practicals prescribed in this Manual. Some extra working sessions have been kept to allow for the fact that you may need some extra time and working sessions in some of the practicals. The tasks pertaining to the practicals, including conducting/participating in counselling/family therapy sessions, organizing an awareness generation compaign, report writing etc. are included in this time assigned for field work.

If the Supervised Practicum takes more time than this scheduled duration, then you can rearrange your work accordingly, but only after discussing it with the Supervisor/Academic Counsellor you are attached with at the Programme Study Centre/Study Centre.

You have to complete all the practicals for submitting the Practicum File. Please do not copy the illustrated examples as you will be asked to resubmit the Practicum File and this will lead to delay in award of the Degree. Also,

do not copy from your peers/friends, as both would repeat the whole practicum again.

Role of the Academic Counsellor in Supervised Practicum

The Supervised Practicum has to be esentially done under the guidance and supervision of the Academic Counsellor/Supervisor. The Academic Counsellor is a qualified professional in the field, allotted by the Programme Study Centre/Study Centre to which you are attached. The Counsellor will supervise and guide for the Practicum Activities, during the academic year. The Supervisor can also be identified by you.

For doing the Supervised Practicum, you may identify an Academic Counsellor who is working as a counsellor/family therapist in an organisation working in related area of your specialisation such as university, college, hospital, rehabilitation centre, prison, drug deaddiction centre, tobacco cessation centre, etc. and NGOs or governmental or private organisations working in the area of substance abuse control.

The essential qualification of the Academic Counsellor is as follows: 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 disciplines, with at least five years of relevant experience.

It is essential that the Academic Counsellor/Supervisor be approved by the Programme Coordinators at IGNOU headquarters. Mere possession of degrees and experience does not mean the 'Counsellor' would be approved. The detailed biodata of the proposed counsellor has to be submitted for approval by the Programme Incharge at the PSC/SC to the Programme Coordinators at IGNOU Headquarters keeping the Regional Centre in the loop. The student may obtain the biodata form may to be used for the purpose from the Programme Incharge at the Programme Study Centre or the Study Centre Coordinator.

You have to spend 1 hour of each of your 30 working sessions with the Supervisor/Counsellor, in which she or he will guide you on the method in which the Practicum Activity has to be performed, as well as the analysis of the same. Besides this, you can seek the help of the Counsellor at any time during the sessions. Each working session is deemed to be of 4 hours duration.

The Counsellor may or may not be associated with the individuals or families you identify for the practicum activity, but she or he can help you in identifying the same.

To conduct practicum activities, you have to meet the Counsellor first, discuss the practical you are going to conduct as well as the method that you are going to use for the purpose, take her or his advice and then visit your respondent(s). Here, in this programme of study, respondent is also called 'participant' and at times 'subject' or 'client'. It is advisable to report to your Counsellor after you complete each session, and discuss what had transpired in the course of the session, along with planning the next session.

After completing each practical, you need to write each and every detail in your report. If you have any problem or query regarding report writing, then contact your Academic Counsellor/Supervisor for the same.

Apart from guiding and supervising, the Counsellor will also evaluate your work. Thus, the Counsellor will evaluate and mark each Practical. The evaluation sheet to be used is given at the end of this Manual.

Important Guidelines for Working with Individuals and Families in Different Settings

Identify the family/individual needing counselling/family therapy for each counselling and family therapy case record – from intial phase to termination phase.

Inform the Counsellor about the selected individual/family and the counselling/family therapy approach to be used with them.

Seek the consent from the family/participant before conducting the practicum activity. The consent form is enclosed at the end of this Manual.

The time schedule for conducting the practicum activity should be planned according to the convenience of the family or the individual with whom the practical activity is 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.

Before conducting any practicum, you should have thorough knowledge of its theoretical component and complete understanding of the procedure of performing the practicum activity.

Before starting any practical, spend some time with the respondent(s) to establish rapport and create an environment comfortable for conversation or activity; this is generally termed as rapport building.

Use the case history taking formats, mental status examination forms, and family interview schedule as given in the first year Supervised Practicum course material, as per the requirement of the case.

Respect the views of respondents 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, sharing it only with the Supervisor. Do not discuss it with any other person including your friend, spouse, parents and other family members.

In case the family or the individual does not cooperate with you, or you feel that you are not making any headway in counselling/family therapy, or there is unplanned termination, you would need to admit the same. Report this in your file. Also, find another respondent – individual/family to carry out your case work for the required number of sessions.

The awareness generation campaign should be well planned and well organised at the community level, creating awareness under the overall guidance of the counsellor/supervisor.

Important Points for Writing a Report

1. Basic Information

Please mention all relevant details of your student status (enrolment number, study centre etc.) clearly on each Practicum Report, as well as on the cover of the Supervised Practicum File. The File should be presentable and legibly written. Attach all other materials in the File (audio tapes/CDs and transcripts or sheets of paper on which you had taken notes during the sessions etc.) and list each one of them as *'enclosures'* in the File along with the number of such items.

2. Content

In most of the practicals, one has to give details of the activity or session conducted. As you would realise, others (especially your evaluators!) would not have access to this information unless you provide the same in the report of the Practicum. So do remember to provide all relevant information. At the same time, be true to yourself as you are learning important concepts from the practicum activity. Do not falsify the report or modify the record of the practicum activity to make it look 'good'. Don't worry if everything in the family does not fit a given, stereotypical norm of a family or a relationship. The idea here is to move away from being judgemental and learn to create a view that is unbiased, encompassing and sensitive to plurality. Your evaluations are going to be based on an objective and unbiased treatment of the same in analysis. Please use the concepts you have learnt in the Course in order to meet this end.

You need to have at least 7 sessions of counselling, and at least 12 sessions of family therapy in the respective case records. Conducting an awareness campaign in the community would require at least 4-5 sessions. Acclimatisation would require at least 4-5 sessions.

The content of your file will also be evaluated on how comprehensively and objectively you have dealt with the issues at hand. Your personal beliefs and preconceived notions should not hinder the understanding of the content.

3. Presentation

Your report for each practical should be comprehensive and analytical. Be organised and help the evaluator know that you have understood the concepts. Use pseudonyms rather than the actual names for the subjects and family members. But rest of the information should be truthful.

4. Length

Give all relevant details of each case/practicum. Be careful not to beat about the bush! The richness of content and organisation of your report carry more weight than how many pages it consists of or how long it is!

Supervised Practicum File

The Supervised Practicum File will be prepared by compiling the written records of all the practicals. You have to submit the complete Practicum File duly evaluated by your Practicum Supervisor at your Programme Study Centre/Study Centre, before the mentioned due date. The File would contain sheets on which you have written the report of each practical (along with

the requisite enclosures to support the same), duly evaluated by the Academic Counsellor, and the filled-in evaluation sheet given at 'Annexure A' at the end of this Manual.

The Counsellor will record the marks that you have obtained for the Practicum at the end of each practical in your Supervised Practicum File, and in Section 1 of the mark sheet provided at the end of this Manual at Annexure A. Sections 2 & 3 of Annexure A have to be left blank, as these are to be filled-in by the External Evaluator.

This Annexure A, with duly filled in Section 1 and blank Sections 2 & 3, must be included in the Supervised Practicum File that you submit.

In addition, the Counsellor will certify the Form given at Annexure B at the end of this Supervised Practicum Manual which declares that every practical was conducted by you under her or his supervision. You must also include this duly filled-in Annexure B in the File you submit.

Evaluation of Supervised Practicum File

The evaluation of Supervised Practicum 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

Every practical will be evaluated by the Academic Counsellor/Supervisor with whom you have been attached by the Programme Study Centre/Study Centre for this Supervised Practicum Course. For the purpose of evaluation, for each practical, the Academic Counsellor will judge your performance during interactive sessions and the counselling/family therapy sessions, as well as evaluate the written records which have been submitted by you in the Supervised Practicum File. This is called *Internal Evaluation.*

The marking scheme is as follows:

Maximum Marks for each of the Practicals 1 to 5:

- Maximum marks (MM) for review of organisation = 50
- Maximum marks (MM) for acclimatisation sessions = 100
- Maximum marks (MM) for counselling case record = 200
- Maximum marks (MM) for family therapy case record = 300
- Maximum marks (MM) for conducting awareness generation campaign = 150

Hence, total MM for the internal evaluation component of the Supervised Practicum (all the practicals) is 800.

Evaluation Level 2: External Evaluation (Evaluation of Practicum File at IGNOU Headquarters)

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

External evaluation will therefore be done on the basis of the Supervised Practicum File submitted by the learner.

Maximum marks for each of the Practicals 1 to 5:

- Maximum marks (MM) for review of organisation = 50
- Maximum marks (MM) for acclimatisation sessions = 100
- Maximum marks (MM) for counselling case record = 200
- Maximum marks (MM) for family therapy case record = 300
- Maximum marks (MM) for conducting awareness generation campaign = 150

The External Evaluator shall evaluate the Practicals as above. Thus, the total marks for the external evaluation component shall be 800.

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 Supervised Practicum MCFTE-006. It means you have to re-do all the Practicum activities, make a new Practicum 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 through the Programme Study Centre / Study Centre in any component of the Practicum.*

If the evaluator finds the practicum 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 practicum 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. 1500/- 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 Supervised Practicum File.

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

Submission of Supervised Practicum File

The complete Practicum File may be sent to the following address:

Student Evaluation Division

Indira Gandhi National Open University

Maidan Garhi, New Delhi – 110068

Note: *Before mailing the Practicum 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 Practicum

For this 4 credit Supervised Practicum Course, you have to spent 30 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 practicum is five months from the date of commencement of the Supervised Practicum for this Course.

At any given time, an Academic Counsellor shall have a maximum of only 6 learners attached to him/her. Once the Supervisor has been allotted, the Supervisor would be committed to the learner for supervised practicum for a maximum period of five months.

If for any reason a student is not able to complete the work in a maximum duration of 5 months, the student has to start afresh, and would be treated as a new student to the supervisor.

Student is NOT permitted to hop between different Supervisors/Counsellors.

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.

Date for submission of the Supervised Practicum File

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

  Thus, if your Supervised Practicum File reaches IGNOU between 1st November and 30th April it will be accounted for in the marksheet for the June examination, and if the Supervised Practicum File reaches IGNOU between 1st May and 31st October it will be accounted for in the marksheet for the December examination.
- In the first year of your registration, the first time you can appear in the term-end examination is in June. Subsequently you can appear for both June & December term-end examination.
- The file submitted will not be returned to you.
- Do remember to keep a photocopy of the File.

Checklist of Enclosures:

When submitting your Supervised Practicum File please ensure that you have included the following:

1) The cover page should clearly state the title ''Supervised Practicum File for the Course MCFTE-006''. 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 Practicum File is given on the next page.

3) Written record of the Practicals and corresponding enclosures like audio tape/CDs and transcripts, as well as other materials used.

   In Annexures or enclosures, you must include the written record of each interview as it took place. Also enclose the audio tape/CD, if used and the transcripts or the sheets on which you noted the answers of the respondents during the interview. The materials that you prepared/used for conducting the awareness programme in the community must also be enclosed.

4) Annexure A (Sections 1, 2 & 3) and Annexure B.

SUPERVISED PRACTICUM FILE

M.Sc. (CFT) — Second Year
(Optional Paper)

MCFTE-006

Name of the Student :

Enrolment No. :

Address :

Phone No. :

Study Centre/
Programme Study Centre :

Regional Centre :

Name & Address of
Supervised Practicum
Supervisor :

Phone No./Mobile No./
e-mail address of Supervisor :

Signature of the Student

Date :

PART I

UNDERSTANDING THE BASICS

BASIC UNIT 1 : PSYCHOSOCIAL INTERVENTIONS FOR SUBSTANCE USE

Recent years have seen a change in the onset of drug use. Even children have started experimenting with tobacco and alcohol use. People are using alcohol, opium, injectable drugs, cannabis and others drugs for various psychosocial reasons.

The important factors that maintain subtance use are as follows:-

Biological factors: The chemical effects of substance are strongly related to the conditioning and withdrawals that occur in many users. Due to its positive effect, people persist with substance use.

Behavioural factors: People learn to manage their psychosocial situations like stress, free time, period of excitement or mood upset or to feel relax, with substance use over course of time. These environmental cues stimulate the person to use substance.

Social/Cultural factors: Substance use/tobacco begins as a social activity or out of curiosity during teenage years and often continues because of social pressures and as a way of coping with various social situations (Reddy & Gupta, 2004). It occurs due to a person's inability to say no to friends, out of curiosity to use, media depiction of tobacco use, a sense of belongingness to users and easy availability.

Substance usages have led to various bio-psycho-social complications. Health damage commonly reported among drug users in India has been tuberculosis, HIV/AIDS, skin diseases and poor dental hygiene. Psychological symptoms include depression, anxiety, memory defects and social problems include social-economic and domestic violence. Unemployment among drug dependent persons ranged from 4-68%. Frequent absenteeism due to drug abuse also is common. 8-12% of the total drug users are in any formal treatment (National Survey, 2004). It requires a multi-pronged approach for its management at treatment centre as well as at NGO's level to motivate this group to seek and remain in treatment. Psychosocial interventions may be delivered in the context of abstinence-based treatment or in conjunction with pharmacological treatment. The level of intensity, frequency and duration of these interventions may vary depending on the approach and settings. Style and mode of delivering will also differ for group or individual work.

Intervention

It helps in enhancing the knowledge about substance use and its effects, coping behaviours, psychosocial functioning, treatment compliance and reducing the risk of relapse. It should be given to all the patients. The component of sessions may vary depending on the individual need. Intervention starts with **Assessment of substance use** (age of onset, type of substance use, minimum use, maximum use, situations associated with substance use, period of quitting, method used to quit, physical/psychological complications after quitting and motivation to quit). Involve family members as part of assessment and intervention. It provides more accurate information about the severity of his/

her substance related problems. If there is any suspicion about patient report, ask the patient to come with a family member on the next visit.

Every person who uses substances falls in one of these categories:

- Person *unwilling* to try to quit substance use
- Person *willing* to try to quit substance use
- Person who restarts/relapses to substance use

Person *unwilling* to try to quit substance use

Such persons do not recognize any significant problems due to use of substance. They justify its use in terms of psychological (feeling relaxed, to manage free time or to overcome boredom and low perceived susceptibility to health consequences), social (friends use tobacco/alcohol and drugs) and physical factors (to overcome fatigue).

There are usually four factors which govern change:-

1) Factors keeping a person in his/her current behaviour:
   - What I like about my substance use
   - What I fear about quitting substance
2) Factors encouraging change to a new behaviour:
   - What I dislike about my substance use
   - What I imagine the advantages of quitting substance would be

When the sum of the two factors discouraging change is greater than the sum of the two factors encouraging change, people are encouraged to maintain the status quo. Ignorance about the consequences of use or lack of knowledge about effective quitting strategies, denial of health problems, personal choices related to lifestyle or perceived self-image, anger and entitlement, defiance or even a fear of failure (because of earlier failed attempts at quitting) are the major factors that discourage change.

When people change or People who are willing to change

When the sum of the two factors encouraging change is greater than the sum of the two factors discouraging change, a person is likely to start thinking seriously about changing. He/she may discuss the problem with his or her caregiver, express desire to see the doctor and show reduction in his/her substance use. The desire to change is a dynamic phenomenon. Various psychosocial factors (support from others, feeling of well being, improvement in psychosocial domains, withdrawals, craving and encountering or facing situations associated with drug use) influence the maintenance of desire for change.

The clinician's goal is to help the person to maintain the change and develop various coping behaviours. Patient also need frequent sessions of motivation enhancement to maintain change. In the first three months, it can be every week. Subsequently, it can be phased out to fortnightly or monthly basis.

The process of change

1. Quitting is not a sudden phenomena – People go through various stages (pre-contemplation, contemplation, preparation, action and maintenance) on the way to achieve successful change.

2. Progress through the early stages is dependent on particular shifts in the person's decisional balance, i.e., how they see the pros and cons of quitting; and shifting the focus from external locus of control (family or office pressure) to internal locus of control (health, social, financial and other benefits associated with quitting).

3. Initiating and maintaining quitting requires a sufficient sense of confidence, self efficacy, i.e. belief in one's ability to actually carry out the actions required to change. We have to keep reinforcing their actions (by praising them for period of abstinence or reinforcing their coping behaviours) towards quitting substance use. People change as they progress through stages. In each of the stages a person has to cope with a different set of issues and tasks that relate to their substance use behavour.

Stages of Readiness to Change (Miller,1991; Miller and Heather, 1998)

There are five stages of change:

- Pre contemplation: Not thinking about quitting in the foreseeable future
- Contemplation: Thinking about quitting but not ready to quit
- Preparation: Committed to and getting ready to quit
- Action: Quitting
- Maintenance: Maintaining quitting behaviours

Pre contemplation

In the pre contemplation stage, people are not thinking seriously about changing within the next six months or so and are not interested in any kind of intervention to help them quit. They present to treatment facility due to external pressure. They are found to be in

Denial state (I do not have a problem or I am not neglecting any responsibility, I would like to get early discharge),

Argument (None of my friend have developed any health problems due to alcohol /tobacco use or I am not using in high amount),

Rationalize (I use because my family did not treat me well or I am an occasional user and to overcome stress related to work) or

Ignore (He would ignore your advice).

It can be attributed to lack of awareness about the personal consequences, memories of positive experiences and associations attached to their substance use, or a belief that they are too addicted to quit and discouragement with previous unsuccessful quit attempts.

Case Vignette

Mr X, 34 years old, software engineer using alcohol for the last 10 years and smoking for the last 14 years. He has been using alcohol (2 to 3 quarters) regularly for the last 5 years. Cigarette consumption varies from 10 to 15 a day. He did not have any history of abstinence. Medical history includes jaundice (4 years back) and persisting dental problems. He was brought to treatment by his family. Patient did not cooperate for the assessment/ intake for the substance use. Patient expressed following verbatims during intake: ''I would quit with my willpower"; ''It is not causing any harm in my psychosocial functioning (work, family functioning and other area)"; "I can exercise control on my intake"; "I can not leave smoking".

These verbatim reflect that person has not made up his mind to quit alcohol and smoking. He is still in pre contemplation state.

Indication of Pre-contemplation state: Lack of motivation for treatment, absence of need for treatment and lack of knowledge.

Contemplation

In contemplation stage, the substance users seriously think about quitting sometime within the near future (often defined as three to six months). People in this stage are more aware of the personal consequences of their use and they spend more time thinking about their substance use as a problem. But they are also attracted toward the benefits of continuation of substance use.

Patient verbatims are,''It is OK for me to quit, but I do not have non drug user friends", ''It is difficult for me to displease them" ; "I do not know how to overcome my fatigue or somatic distress, with drugs I feel better".

The main goal of intervention is to help the patient to overcome this ambivalence and strengthen their commitment for change.

Case Vignette

Mrs S, 46 years old, working woman, using alcohol for the last 20 years. She initiated the use of alcohol in company of her husband and in social parties. She has been using 1 to 2 quarter everyday and using regularly for the last 7 years. She started using it to overcome fatigue and loneliness. She attributed multiple health problems jaundice, forgetfulness, change in mood states and seizure to alcohol use. She has been maintaining its use due to its positive effects to overcome fatigue, loneliness and to feel good.

The verbatims expressed were "I do not know how to overcome alcohol use"; "Sometime I do feel like quitting, but I need it also". Therapist elicited the positive and negative effects of maintenance/quitting from the patient.

	Positive effects	Negative effects
Continue substance use		
Quitting substance use		

Therapist made her discuss the negative effects of using substance and positive effects of quitting substance. This discussion helped her to recognize the positive effects of quitting. During the course of discussion, therapist has to enhance the person's self confidence (by reinforcing the decision to quit or by discussing the positive effects of quitting) to shift them to next stage of determination.

Indication of contemplation state: Indecisiveness, self efficacy and lack of knowledge.

Determination/Preparation

Preparation is characterized by experimentation with small changes and a resolution to make a serious attempt in the near future (usually defined as being within the next month). Clients now see the reasons for quitting as outweighing the cons, and they are less ambivalent about quitting. Their motivation for quitting is reflected by statements such as: "I've got to do something about this – this is serious"; "Something has to change"; "What can I do?". They begin to feel the personal responsibility of change in a way that enables them to prepare for quitting and they begin to experiment with different ways of modifying their behaviour. Clients will be making small behavioural changes, e.g., they start postponing their use of substance. Ambivalence decreases and the experience gained through experimentation supports commitment, problem-solving and the development of a quit plan.

Action

In this stage the successful quitter goes beyond willpower and relies on skills, support from others and/or pharmacological aids. The action stage is believed to last about 6 months. During this time clients are at the greatest risk for relapse as they try to negotiate their way through a variety of challenging circumstances day-to-day. However, they tend to be open to receiving help. To the extent that they see themselves as being successful; they will develop greater confidence in their ability to change. Typically, clients in this stage are focused on the consistency of their behaviour and are modifying their physical and interpersonal environments to support the change attempt. On a cognitive level, they remain aware of the reasons supporting their attempt and develop coping strategies to deal with pressures or situations that may throw them off track. They increasingly believe they have sufficient self control to change their substance use behaviour. They started using various coping behaviours like avoidance of substance using friends/situations associated with substance use, develop alternative pleasurable activities (reading, spending time with children, yoga and play activities) and maintaining treatment contact.

Cognitively, they review their commitment to themselves and develop plans to deal with both personal and external pressures/situations that may lead to slips. They may use short term rewards to sustain their motivation and analyze their behaviour change efforts in a way that enhances their self confidence.

Case Vignette

Mr. S, 36 years old, an engineer presented with history of smoking for the last 10 years. He has been using 20 cigarettes a day. He attributed the persistence of smoking to work related pressure and to pass free time. Medical history revealed presence of mouth ulcers and discolouring of teeth. He presented to treatment due to dental problem as well as wife did not like his

smoking. He made the attempt to reduce the consumption by delaying the use and drinking water. He came for treatment on his own and was looking for counselling and pharmacological help.

Indication for Action Stage: Reduction in substance use, presence of coping behaviours and self referred for treatment.

At this stage, counsellor has to help the person in identifying coping behaviours to maintain substance free behaviours and should praise him for whatever success he/she has achieved. It will help him/her to maintain quitting behaviour.

Maintenance

Maintenance is the last stage and involves being able to successfully avoid any temptations to return to substance use. This person has a lot of skills and is less vulnerable to relapse. In this stage the person needs to learn how to deal with the most common threats to abstaining – negative emotional states and stress. Success involves strengthening one's confidence in being able to avoid or cope with situations that test one's capacity for self-control. Clients use specific skills in this stage to anticipate high risk situations and develop strategies in advance to deal with them. They may still remind themselves of why changing is important to them, and they respond to slips by analyzing what led up to the slips and regaining control. They remain aware that what they are striving for is personally worthwhile and meaningful. They are patient with themselves and recognize that it often takes a while to let go of old behaviour patterns and adopt new ones. If they slip and have a tobaccoa/alcohol/drug use, they don't see themselves as having failed. Rather, they define it as an indication that they have to learn to cope differently and analyze how the slip happened. This gives them a stronger sense of self control and the ability to get back on track. They tend to remind themselves of how much progress they have made.

Relapse

The majority who successfully quit do not follow a linear path to maintenance. Along the way to permanent cessation, most people experience relapse. Relapse is often accompanied by feelings of discouragement and seeing oneself as a failure. Rather than being an indication of failure, relapse episodes reflect vulnerability and bring opportunities for recognizing high-risk situations and learning coping strategies to deal with them. Recovering from relapse requires reusing skills employed in earlier stages, and identifying the personal vulnerabilities and situational factors that led to it. Consequently, the model considers relapse to be a normative event – those who relapse return to a previous stage of readiness to change and remain in the process.

Relapses can be important opportunities for learning and becoming stronger or they can be excuses to give up. There is a real risk that the person will experience an immediate sense of failure that can seriously undermine their self confidence. The key to assisting in recovery from a relapse is to review the quit attempt up to that point, identify personal strengths and weaknesses, and develop plans to resolve those weaknesses and solve similar problems the next time they occur. Help this client recognize how much progress they have actually made, and how to analyze the episode with a view to planning more effective coping strategies.

Case Vignette

Mr. M, 47 years, labourer, is using Opium for the last 20 years. He has undergone inpatient treatment 12 times in the past. Last inpatient treatment was 2 years back. Mr. M attributed the reason for relapse to peer pressure, craving, fatigue and sexual problem. Personal history showed presence of unprotected sex with multiple partners. Family support was adequate. Patient expressed guilt for not being able to quit. Verbatims expressed were "It just happened…"; ''I cannot say no to my friend" ; "I do not know how to overcome fatigue".

Indication for relapse state: Inability to maintain significant period of quitting, lack of coping behaviours to manage high risk situations.

People who have relapsed may need to learn to anticipate high risk situations more effectively, control environmental cues that tempt them to use substance (like being around good friends who smoke), and learn how to handle unexpected episodes of stress without substance use.

Termination

It occurs when the behaviour change is so well learned and stable that relapse is highly unlikely. Less than 20% of individuals who have ever had nicotine or alcohol dependence ever progress to termination. Therefore, for most individuals with substance use disorders, we must view these disorders as chronic, requiring ongoing care perhaps for the rest of a person's life. We expect relapses, and the goal of the practitioner is to reduce as much as possible frequency, duration, and severity of the relapses – just as we do when treating cancer, heart attacks, strokes, diabetes, arthritis, depression, and schizophrenia.

[Counsellor/Family Therapist needs to be sensitive to various reasons associated with substance use, use of coping behaviour, lapse (single use after a significant period of abstinence — 3 to 6 months) or relapse, early contact in case of lapse or relapse.]

Interventions

The goals of intervention are sustained abstinence, change of life style and improved quality of life.

1. Psycho-education
2. Motivational counselling
3. Brief intervention
4. Relapse prevention
5. Family therapy
6. Self–help group

1. Psycho-education

Psycho-education means educating a client about the nature of problem, giving information about lapse (single use after significant period of quitting) / relapse (regular use after significant period of quitting), duration of medicines and effects of use and negative consequences resulting from it.

Educate the family about it. It will enable the family to cope in an effective manner.

- Explained problems should be personalized (problems/consequences experienced by the patient due to substance use, how his/her substance use is likely to worsens his/her condition).
- Check for the understanding (whether patient has any problem in understanding the imparted information).
- Self-help material in form of pamphlets can also be given.

2. Motivational Counselling

Have agenda for the session:

- Allow the person to speak about his/her problem. Do not make it a question-answer session.
- Use open ended questions. These type of questions start with "What? How?, When?, How often?, Could?, Would?''
- Elicit self motivational statements: While conducting the sessions focus on:-
  - — *Problems due to substance use* (What is not so good about the substance use?)
  - — *Concern* (What are your worries, concerns about substance use?)
  - — *Motivation to change* (What benefits are you going to experience after quitting?)
  - — *Self confidence* (How confident are you in implementing the steps?)

Ask about positive aspects of substance use:

- What are the good/positive things about...?
- People usually use substance because it helps them in some way — how have they helped you? (it could be in terms of physical, occupational, psychological and social)
- What do you like about the effects...?
- What would you miss if you weren't...?
- Frequently summarize whatever you have elicited. It should be 3 to 4 times in a session and check for the person's comfort level; if he/she is not comfortable, check reasons for discomfort or discontinue the session.
- Summarize what the patient has said — I understand from what you say…..?; I hear you telling me that…..In the end ask the patient whether he/she wants to say anything or does he/she want any other information.
- Give praise and support, self efficacy.

Ask about the not so positive aspects:

– What are not so good things about substance use?

– What are some aspects you are not so happy about your substance use?

– What are the things you wouldn't miss if you stopped?

– Are there aspects of your life that might improve if you were to stop?

Explore life goals:

– What are the things important to you?(Explore personal, family, occupation, social)

– What are some of the good things your friends or family say about you?

– What do you want to achieve in next 6 months? (in any of psychosocial areas)

– Give praise and support, self efficacy

Compare pros and cons to highlight discrepancy:

– How does your (substance use) fit in with your goals?

– How are you going to change yourself to achieve these goals?

– What is going to happen, if you continue to use substance..?

- Ask for a decision

To stop or reduce intake of substance use.

If there is No Decision or a Decision to Continue Use:

– Accept no decision.

– Empathize with difficulty of ambivalence or difficulty in quitting.

– Make a contract if he/she can come to see you again. So in future, if he/she is amenable, he/she can be helped.

– Check, is there any thing else (information, time, etc.) which would help to make a decision?

If Decision to Quit:

– Plan a short term goal (it could be one month to three months).

– What are you going to do with substance use in the next few weeks?

– How are you going to achieve the goal?

– Have you already been doing things to achieve this? Can you do more of this?

– How is your family going to help you?

– Help me to list out steps to avoid substance use (it could be avoiding substance using friend, getting family support, developing alternative pleasurable activities and compliance to treatment).

– Praise and support, self-efficacy.

3. Brief Intervention (Surgeon General Report, 2002)

Brief intervention essentially can be used with numerous types of behaviour change. It takes 5-15 minutes. It is more useful to those who are not dependent on substance and smoke or drink only occasionally.

The 5 major steps in this intervention are:

i) **ASK** — about substance use

ii) **ADVISE** — Advise to quit

iii) **ASSESS** — commitment and barriers to change

iv) **ASSIST** — patients committed to change

v) **ARRANGE** — Arrange follow-up to monitor progress

ASK – Ask all patients about substance use. It should be done at the time of first contact. For example:

- I would like to ask questions about your drug use, would it be OK
- How did it start?; How old were you when you used it first time?; What are the reasons for initiation?; also enquire about maintaining factors; How old were you when you started using it regularly?; Check for quantity, history of quitting/treatment attempts, coping behaviours used during quitting

ADVISE – Explain to the patient in a **clear** (I think that it is good for you to quit substance use), **strong** (as your doctor or mental health expert/ counsellor/family therapist). I advise you to quit for your good health) and **personalized manner** (link the current use to his/her health status and functioning in other areas).

ASSESS – Assess motivation to change by asking open ended questions like ''How do you feel about your drug use?; What are you going to do with your substance use?''.

Listen to the answer and judge whether he/she is motivated or not.

''If the person says''; ''I have had enough with drugs, now I have to do something''; ''I have already reduced it but I want to achieve drug free life style'', these statements reflect that **person has commitment to change (stage of determination/action).**

If the person says ''I do not see any problem in my substance use''; ''I am managing everything well, so why should I quit'', such statements reflect lack of commitment (**stage of pre contemplation**).

Assessment yields three groups:

A. For patients willing to change

B. For the patient unwilling to change

C. For the patient who has recently quit

A. For Patients Willing to Change

ASSIST :

1. Reinforce commitment to change (For example, good, you have taken the right decision; You can do it.).
2. Help make a plan (make start with short term plan of 3 to 6 months, subsequently make long term plan beyond 6 months)
3. Help develop strategies to manage triggers or situation associated with substance use (by avoiding substance using friends, change of environment, exercise or any other pleasurable activities, use of medication, enhancing social/family support and joining Anonymous group).
4. Help foresee possible weaknesses in plan (any reasons for restart or not being able to quit).
5. Implementation: Have a quit date? (It could be in another one or two months, birthday and anniversary date). It will help the person to organize himself. Advice him/her to contact the counsellor or treatment centre in case of reuse or his /her inability to manage craving or situation associated with substance use.

ARRANGE for follow up. It can be weekly, fortnightly or monthly depending on the case. On each follow up, check about his/her substance use and reinforce if he/she is able to quit. In case if he/she is finding problem in managing the trigger, help them out.

B. For the Patient Unwilling To Change: Promoting the Motivation To Quit

Patients unwilling to make a quit attempt during a visit may lack information about the harmful effects of substance, lack of preparedness, may have fears or concerns about quitting, may be demoralized because of previous relapse or may have come due to external pressure. Such patients may respond to a motivational intervention that provides the clinician an opportunity to educate, reassure, and motivate, such as the motivational intervention built around the "5 R's": *relevance*, *risks*, *rewards*, *roadblocks*, and *repetition*.

Relevance

Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is related to a patient's disease status or risk, family or social situation (e.g. children's academic problem or problems at home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks

Ask the patient to identify potential negative consequences of substance use. The clinician may suggest and highlight those that seem most relevant to the patient.

Acute risks: Health

Long-term risks: Health problems and dysfunction in psychosocial areas

Environmental risks: In case of tobacco use increased risk of lung cancer and heart disease in spouses; higher rates of smoking by children of tobacco users; increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of smokers.

Rewards

The clinician should ask the patient to identify potential benefits of stopping. The clinician may suggest and highlight those that seem most relevant to the patient. It could be better health, saving money, spending more time with family, improved family functioning, self image and occupational functioning.

Roadblocks

The clinician should ask the patient to identify barriers or impediments (withdrawals, enjoyment of drug using friends' company, absence of alternative pleasurable activities, inability to manage mood states/fatigue) to quitting. Patient can be motivated to use pharmacotherapy/psychological means to manage these barriers.

Repetition

The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

C. For the Patient Who has Recently Quit

4. Relapse Prevention

Because of the chronic relapsing nature of substance use, clinicians should provide brief effective relapse prevention treatment. When clinicians encounter a patient who has quit use recently, they should reinforce the patient's decision to quit, review the benefits of quitting, and assist the patient in resolving any residual problems arising from quitting. Although most relapse occurs early in the quitting process, some relapse occurs months or even years after the quit date. Therefore, clinicians should engage in relapse prevention interventions even with former users who no longer consider themselves actively engaged in the quitting process.

Relapse prevention interventions are especially important soon after quitting and can be delivered by means of either scheduled clinic visits, telephone calls, or any time the clinician encounters an ex-user. The commonly encountered situations and their management are as follows:

Situations	***Management***
Craving	Use deep breathing, drink glass of water, distraction and delay the use.
In company of drug users	Ask them not to smoke; say no to them when offered in loud and clear voice; tell them you have quit; let us have tea/coffee instead or...; I am taking medicine, I can not take drink.
Thoughts about drug use	Challenge these thoughts (it could be related to drug or overconfidence about quitting) by saying it is not good for me or nothing

	can tempt me: think about the positive effects of quitting.
Boredom	Plan out pleasurable activities for the person.
Stress	Identify situations associated with stress, learn problem solving method and learn relaxation.
Flagging motivation	Reassure the patient these feeling are common, reward his/her quitting period, check reasons for craving, help him/her to manage them.

5. Family Therapy

Substance use affects every member of the family. It influences the family emotional climate, family identity, family tasks and relationships among them. Family therapy includes marital intervention and family therapy which includes the children of substance users along with their parent(s) is quite effective. It is also carried out with unmarried patients and their parents.

It can be planned for the following groups:

- Family members who have started avoiding or criticizing the alcohol or drug users, or indulge in verbal or physical aggression.
- Spouse has taken extra responsibilities to support the family. It leads to his/her decreased involvement in pleasurable activities or development of affective disturbance.
- Problem in communication among family members.
- Children show difficulty in coping with common developmental stressors and have started showing behavioural problems including drug use.

The sessions can be carried out with a patient and his/her family. The sessions are carried out by one therapist and in some cases with a co-therapist.

Skills required: It consists of making contact, balancing interaction and moderating intensity.

Making contact: It is first step in creating a relationship with the family. It can be done by introducing himself/herself, asking their names while interacting with them.

Balancing interaction: It means giving everyone a chance to have a say about the family problems. It can be achieved by setting rules for sessions. It includes (a) only one person in the family talk at a given time, (b) each family member will speak for himself/herself, (c) involving the silent/quiet member in the discussion by asking direct questions.

Managing emotions: It can be done by advising everybody to speak only to the therapist.

Formulation of goals: It deals with the ability to negotiate mutually acceptable goals for the treatment. It provides a framework for the rest of the treatment.

Steps in intervention:

Assessing and engaging the family: Families can be at a different stage of coping when client seeks help for substance abuse. The therapist can validate and acknowledge their efforts and problems in managing the person.

Talk about change: Discuss with them what they can do to bring change in their life style, enhance their interaction with others, psycho-educate the family about drug use and its relapsing nature and enhance their support to the patient.

Supporting and rewarding behaviours: Advise them to reinforce the positive change in patient behaviour in all psychosocial domains. Enhance interaction between partners, ask them to take non drug related topic for discussion, teach children coping behaviour and problem solving skill and help them to identify various situations associated with drug use in patient and teach them how to motivate the patient to avoid it.

6. Self help Group

It is meant to help the abstainers/users to maintain their quitting status or quit substance.

Expanding the Available Approaches

In recent years, considerable progress has been made in the provision of effective treatments, both behavioural and pharmacological, for substance use. There are a number of factors which influence the outcome. Drop out and non-compliance rate is very high among this group, sometime it is also linked to therapist skill and patient variables. Consistent findings from the literature indicate good treatment outcome for those counsellors/family therapists who show empathy, form therapeutic relationship with clients, whereas patient characteristics which promote substance cessation include good internal locus of control (self referred cases or showing reduction in substance use) do well with the treatment. In the Indian context, research on the role of indigenous systems such as yoga and ayurveda as cessation facilitators should be systematically designed and conducted.

The major challenge for India in the twenty-first century is to make treatment available to all users, evolve treatments that are culturally relevant and appropriately tailored to individuals and various groups.

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BASIC UNIT 2 : ILLUSTRATION OF A SUBSTANCE ABUSE CASE

Socio-demographic Details

Name : V

Age/Sex : 17/M

Educational Status : Currently in class XII

Occupational Status : Student

Marital Status : Single

R/O (Resident of) : New Delhi

Socio-economic Status : Upper Middle class

Religion : Hindu

Refd by (Referred) : Self

Informant (s)

1. Mother and father

   Reliability: Coherent, Consistent, Comprehensive and Chronological account

2. Self

   Reliability: Coherent, Consistent, Comprehensive and Chronological account

Chief Complaints

Type of Drug(s)	Usual Dose	Maximum Dose	Last Dose
Fluid Use	2-3 bottles per day	6 bottles	Yesterday night

Playing videogames since 3-4 years

SECTION 1 : UNDERSTANDING THE PATIENT (CASE)

History of Present Illness

Patient was maintaining well about 5 years ago when he was a student of class VII. At that time there was change of his school on account of distance from residence and better reputation. Patient was not happy with his father's decision, but had to agree to it. At the new school, he would have difficulty in making friends. He would hesitate to answer questions in the class for the fear that his classmates would laugh at him. And similarly, in playground, he would constantly have negative thoughts that his playmates would crack jokes on him. For these reasons he would interact very less, mostly remain aloof, have his lunch alone and would also come home alone inspite of the fact that

several of his classmates would share the same route back home. At home he would often cry, remember his old friends and even miss school.

During the same time, there would be quarrels between his parents on account of property dispute, which his father was having with his paternal uncles. There would be lengthy discussions among his parents and relatives on account of this. Though the child was never actively involved in the quarrels and was not aware of the developments, he would overhear them when they would be speaking loudly. This continued everyday in the evening for next 1 month. During this time, a maternal uncle, who consumed alcohol, also used to stay in their home and sometimes come home in an intoxicated state especially when the father wasn't around. In an intoxicated state, he would shout loud enough to wake all family members up. The child would also wake up and thereafter would not be able to fall asleep for the next few hours. Previously, the patient was very close to the maternal uncle. So, he would be very much distressed by these events. Finally, after 1½ months, the maternal uncle was asked to leave the house.

At about the same time, their servant (of the last 5 years) left the job because of objection by the father against his stay. The servant was a young boy, who was about the same age as the patient because of which he was very close to the patient. Previously, the patient used to play with him every day and also shared all his experiences at school. After he left, the patient would remember him repeatedly, would demand that he be brought back and on this account he also had missed school for a few days and even refused food on 2-3 occasions. However, such a state prevailed for only 2-3 weeks.

All the above events occurred within a very short period of about 1-2 months. During this time, the parents noticed that patient would remain sad for most part of the day. He started to prefer staying indoor and spend time by lying down or watching television. He would miss school often during this time on minor excuses. He would remain worrisome about his inability to study well and its probable poor consequences in the future. Sometimes, he would feel that it would be better if he would die but when his mother would assure him of the short lasting nature of the problems, he would be hopeful of success in his studies. Whenever he would feel sad he would watch his favourite cartoon programmes or detective stories on the television and this would cheer his mood. During this time, though he himself would not initiate jokes, he would respond with laughter and appear to enjoy jokes told by others. He would not prefer to go out to meet his friends as previously, but whenever they would come, he would interact with them as previously. He would accompany his parents and sister to outings and parties during this time. However, inspite of this, as described by the patient himself, he would appear to enjoy such events less than previously. His sleep and appetite was normal during this time.

Such a state prevailed for about 2-3 months. So he was shown to a private psychiatrist who prescribed for him anti-depressants. The patient or the parents did not perceive any benefit from the drug – so it was discontinued after 1 month without any follow-up. The psychiatrist had also emphasized upon the need for meeting a counsellor/family therapist for improving the child's condition, understanding and resolving the root problem, learning adequate relaxation techniques and different entertainment outlets. But the family did not meet any

counsellor/family therapist. His father thought that playing video games might cheer up his mood and well-being. Hence, he introduced him to playstation I (video games played offline). Soon after its introduction he appeared to enjoy playing the games – particularly the one involving destruction of enemy camp by hitting at some specific targets. Just after coming from school at 3-4 pm, he would sit and play for about 2-3 hours at a stretch and started to avoid going out to play outdoor games. Instead, he would ask his friends to come over at his place to play video games and he would insist upon his partner to continue playing with him until he would win. In the next 1-2 months, he noticed that he would have an increased sense of apprehension and palpitation regarding the outcome of his games and these would only be relieved after he would win. So, he would compulsorily play for about 3 hours after coming back from school. After studying an hour or so he would have an intense desire to play video games and in between study periods he would now play with it. On Sundays and other holidays he would be particularly more involved in playing, which lasted from 6-8 hours. This pattern continued for the next 2-3 months.

He had negotiated with his father for Play-station III video-games (played online) if he fared well in the mid-term examination, which he did and thus he was given Play-station III. He found that winning against participants from a distant country would be an enchanting experience. Within the next 1 month, he would wake up at 6 am all by himself and would start playing from the morning itself and keep on playing for 2-3 hours and then rush to get ready and go to school. Then he would again start playing from 4 pm till late night. Due to this his parents would scold him every day and ask him to concentrate on his studies. But he would not pay heed – even if he would study an hour or so, he would do so on the condition that he be allowed to play for an extra hour at night.

In the next 3-4 months, his playing habit increased so much that now he would skip school for minor excuses almost once in 2-3 weeks, particularly when his father would be away on tour. He would even skip brushing his teeth and taking bath, once in 2-3 weeks even in summer. He would always take care of his play-station machine. Due to increased playing he almost stopped studying and his academic performance dropped. Even when he would not be playing, he would be so engrossed by the games that he would sometimes call his friends by the names of the characters of his games. Due to long hours of sitting still and playing he would have problems in the form of eye strain, neck and back pain. After long hours of playing his fingers would be numb – but, he would still continue because of the pleasure he would derive after winning a game.

On the occasion of his 16th birthday he took inhalant fluid for the first time. On that day, one of his friends who was both his schoolmate as well as lived in the same locality, suggested that since birthday was a special occasion he should take something extra on that day. Before that day he had no information about the substance. As suggested by his friend they bought one erazex fluid for about Rs 20/-, poured the dilutents in the polythene bag and gently inhaled the fumes. After 10-15 minutes of initial irritation to the nasal mucosa, he had the feeling of well-being. They inhaled fumes for about 30 minutes and the effect lasted for about one hour. He had slurring of speech and walking, but was able to visualize some images like figures from his favourite

cartoon program or video games or elephants playing among themselves. These images appeared transiently for about 3-4 minutes and were somewhat blurred though he was able to discern their body colour, but wasn't able to appreciate the depth of the images and they would be much smaller than their real size and would be roaming in front of him. On seeing the figures he would laugh loudly in amusement. Thereafter, whenever he would have irritability and low mood on being denied playing he would take the fluid – mostly he would take it in the evening about once in 3-4 days. He would take either the dilutents or the whitener, sometimes both, their effects would appear similar, but the duration of effects would be longer for the dilutent and less for the whitener. He would take the fluid in a deserted place near their apartment along with his one or maximum two friends. The friend who introduced the fluid to him would buy it out of his own pocket money and they would share or sometimes have independent fluids depending upon the availability of money. The patient would sometimes manage money from parents on another pretext, sometimes would steal money from their wallet. During this time the parents were unaware of these developments and would only scold him for not studying properly.

Due to the problems of his poor academic performance, his father intervened and would forcibly prevent him from playing. Due to this, he would get irritable and even snatch the machine from the father, a behaviour that was unthinkable in the past. Though patient would feel guilty after that, but was unable to control his anger at that moment. During this time, he also increased his habit of taking erasex fluid. He would take 2 bottles per day – one after coming from school and one just before going to sleep. At home he would mostly take the fluid in the bathroom or in his room when he would be alone. But due to its effects on him his parents came to know about it. The supervision on him increased and patient would get very irritable and abusive when he was denied the money to buy the fluid. On a few occasions, he even tried to hurt himself or broke an object due to which his mother was forced to give him the money. Again, he was taken to a private psychiatrist, who put him on anti-depressants and psycho-educated him about the harmful effects of inhalant fluids. Initially, he tried to remain abstinent, but was unable to do so due to the strong desire to use. When he could not procure the erasax, he would take any deodorant, spray it over a polythene and gently try to inhale it – but according to him it would not produce any effect. So, he could abstain for only 1-2 days and again started taking fluid according to the previous routine. Again treatment was discontinued after a few weeks without adequate follow-up.

During this time he bargained with his father that he would study only in case he gets to play videogames. His father agreed to allow him. Again, he started playing games for 4-5 hours a day and would take fluid about a bottle in the evening. After 1-2 months, a friend advised him to use Fevibond instead of erasax as its effect lasted longer. So, he shifted to Fevibond tubes and used about 1-2 tubes per day. From the internet he came to know about the probable side effects like memory problems and sudden death and again tried to quit, but was unable to do so. In March 2010, patient was finally bought to Counsellor/family therapist for treatment in association with psychiatrist.

Negative history

No history suggestive of any other substance use, legal complications, running away from home for any duration, any self harm attempt, head injury, altered sensorium leading to disorientation with respect to time, place and person, seizures, pedal edema, jaundice, altered sensation /numbness in the limbs.

(h/s/o — history of)

No h/s/o any child abuse.

No h/s/o irresistible urge to pluck hair, set things on fire or steal others' objects

No h/s/o any free floating anxiety

No h/s/o any fixed firm false unshakable belief which is out of keeping with social and cultural background

No h/s/o thinking that he is being referred to on seeing two other persons talking among themselves

No h/s/o own thoughts being known to other people without being told or own thoughts being taken away or new thoughts being inserted in mind through external agency

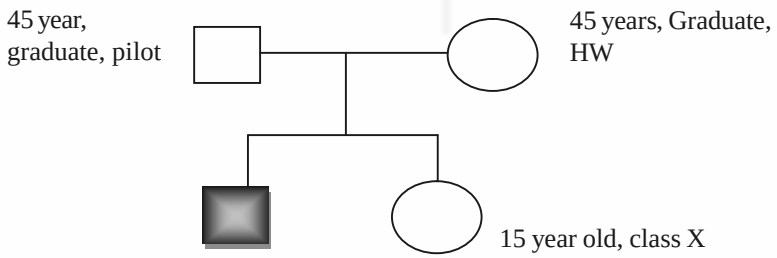
No h/s/o own actions/feelings/impulses being created or controlled by external agency

No h/s/o hearing voices which other surrounding persons would not be able to hear.

Past history

No history of malaria, jaundice, tuberculosis, bronchial asthma or any psychiatric illness.

Family history



Patient belongs to a middle socio-economic status Hindu nuclear family. There is family history of depression in father and he takes alcohol occasionally (on holidays or when he is off-duty). There is also history of presence of Nicotine dependence syndrome in mother and probable Alcohol Dependence Syndrome in maternal uncle.

Personal history

Birth and development: Born out of full-term normal vaginal delivery. Perinatal history was uneventful. Honey was given just after birth. He was breastfed and weaning started from 4 months of age. All developmental milestones achieved at proper time.

Childhood history: Vaccinated according to schedule – no major childhood illness. No H/s/o temper tantrums, nail-biting, nocturnal enuresis, thumb sucking, no *h/s/o* ADHD and conduct traits like truancy, cruelty towards animals, excessive bullying, stealing (except for substance use) and frequent lying (except for substance use).

Academic history: Started schooling at 3 years of age in a school in Kolkata, thereafter shifted to Delhi in class V and again school was changed two years thereafter, this time against his will. He was an average student, but his performance declined after starting videogames and further after use of inhalants.

Peer group: He always had a group of friends with whom he played. However, due to frequent residence change, he never had close friendships. Moreover, he also expressed difficulty in initiating friendships but was able to maintain them. He would feel even more shy while talking to girls.

Sexual history: Normal secondary sexual characteristics developed at the usual age of 14-15 years and he masturbated for the first time at the age of 15 years. Thereafter, he would masturbate only once in a month or even more infrequently.

Pre-morbid temperament:

The child was normally active – however, he was more active in places where he was more comfortable, like home as compared to other places, like school. He would be predictable in terms of the timing of his essential biological functions. He had difficulty in initiating conversations with others and took some time to open up to others. He was also scared of taking risks. He had difficulty in answering questions asked by teachers due to the fear of being ridiculed. He was always more comfortable interacting at a one-to-one level even with authority figures. He was a responsible child. He had difficulty in asserting himself. In a new or altered situation, after the initial difficulty, he would be able to adjust himself. He would get easily disturbed especially with conflicts in the house. He would show normal attention span and persistence.

He was an introverted child with high degree of neuroticism and high need for experience.

Mental Status Examination

General Appearance and Behaviour:- A young boy of stated age, thin built and wearing shirt and trousers, well-kempt entered interview room in normal gait. He greeted the examiner and sat on chair facing the examiner. No mannerisms or excessive movements noticed. Eye-to-eye contact was made and maintained. Rapport could be established. He was fidgety with his hands.

Speech:- Speech was spontaneous, relevant, coherent and goal directed. Volume, tone and reaction time was within normal limits. Speech output was adequate.

Affect:- Appropriate to thought content. Subjective- *"Theek hoon."*
Objective- euthymic.

Reactivty was present, range was full**.**

Thought:- Flow appeared to be adequate. No formal thought disorder could be elicited. Content revealed guilt regarding use of inhalant. Anger at being denied playstation.

Perception:- No perceptual abnormalities.

Higher mental functions:-

- Was oriented to time/place/person
- Attention could be aroused and sustained
- Memory functions were found to be intact
- Average intellectual functioning
- Intact abstract ability
- Intact personal, social and test judgement

Insight:- "Fluid is not good. It destroys brain cells and creates symptoms of madness. I become violent after taking fluids. So, I have not taken it for past 1 *week now. But I like playing videogames. What's wrong with that? If I study, then why can't I play for some time."*

Motivation:- Action phase for inhalants, pre-contemplation for videogames.

Diagnosis

Mental and Behavioural disorder due to use of volatile solvents: Dependence syndrome currently abstinent (F 18.20)

Habit and Impulse Disorder, unspecified (F 63.9) {For games}

Used ICD-10 for Diagnosis

PLAN

Once the history was taken, diagnosis formulated and areas requiring intervention were identified, it was decided that both individual and family counselling would need to be carried out. Since the patient had school, which he could not miss every week, he was called once in two weeks for individual sessions. In the week that he could not come, his parents were called for family therapy sessions. It was decided to hold joint session as and when required and possible.

SECTION 2: INDIVIDUAL ASSESSMENT AND THERAPY

Goals of Individual Therapy

- To rule out other comorbidities
- To assess patient's level of depressive symptoms and management
- To psycho-educate the patient about the harmful effects of various substances
- To teach relapse-prevention strategies for inhalants
- To develop contingency contracting plan regarding video game
- To improve relationship with parents, especially father

Sessions 1-2 : Assessment

After building adequate rapport with the patient, he was explained the agenda for the next two sessions. He was told that it was important to carry out detailed assessment of his cognitive functioning and to rule out any other

psychiatric comorbidity as these would help in deciding the management plan. For assessment of intelligence, depression and presence of other health problems, various psychological tests were used.

His intelligence was found to be in the range of 95-100, which reveals Average Intellectual Ability and his cognitive functioning was found to be intact and revealed presence of depression. No other psychiatric comorbidity was found.

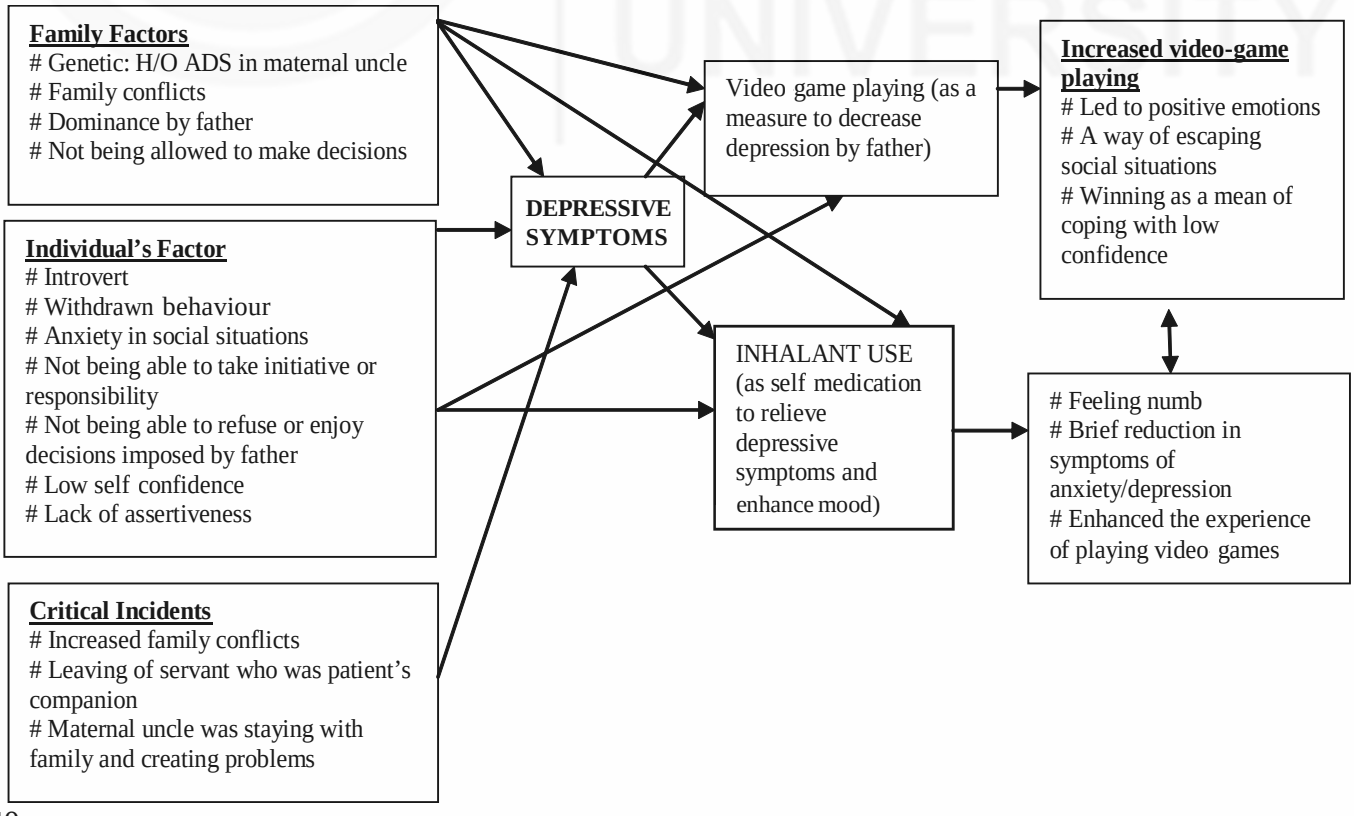
In consultation with the treating psychiatrist, patient was put on anti-depressants and psycho-educated about need to comply with the medicine regimen.

He was helped in structuring his day to include pleasurable activities (excluding video games for the time being), personal care, mandatory activities (e.g. doing home work) and physical exercise (gym/walking). He was also taught breathing exercise and was asked to practice at home.

Session 3: Psycho-education

In the beginning of the session, his last 2 weeks were reviewed. The therapist checked for medication compliance as well as homework and difficulty faced while doing it. He reported taking medicines regularly. He could not follow activity scheduling daily but practiced breathing exercise regularly. He reported feeling slightly better, but missed playing video games. He often had craving for inhalants and had used it on 2 occasions in the past 2 weeks. He was praised for his efforts and reassured that craving would take time to go and he can be taught how to deal with the cravings. He was then given factual information about short term and long term effects of inhalants and tobacco. He also showed curiosity to know about cannabis and he was given information regarding the same.

A brief formulation about his problem was discussed with him as shown below.



Once patient agreed to case-formulation, the goals of therapy were discussed and finalized. And in the session, patient was taught breathing and relaxation exercises and pranayama to deal with his anxiety symptoms. He was explained the steps well and was made to practise the same 2-3 times in the session to learn the same. Also, as a home work assignment, he was asked to maintain an A-B-C chart for all the events in which he had craving for inhalants or actually used them.

Session 4: Relapse Prevention

About 15 minutes were spent in reviewing the previous two weeks and the homework assignment. He reported decrease in depressive symptoms and being more regular in home work. He did not use inhalants, however, had craving on 3-4 occassions which he noted down. He was explained the concept of lapse and relapse. Further, the discussion focused on various types of external and internal triggers.

His triggers for use of inhalants were then explored with the help of the A-B-C chart that he had maintained. The primary triggers were: boredom, not being able to assert self in front of others especially father, and feeling sad. Thus, the session focused on improving his daily life so as to reduce time that he spent alone or in which he got bored. He used to like badminton and was asked to join coaching classes for the same. He was also asked to take initiative in contacting his old friends. The plan for the next session was to teach communication skills to patient.

Session 5: Communication Skills

First, the previous two weeks were reviewed. Patient was more regular with the homework and reported decrease in anxiety as well. He did have craving, but was able to follow the techniques taught and did not use inhalants. Following steps were used on building communication skills.

STEP 1: Typically, the session begins with the rationale for improving communication skills. It is important here to emphasize that the therapist is helping the patient develop appropriate communication skills to deal with parents as well as other interpersonal relationships.

STEP 2: The therapist then assesses the quality of interaction that happens at home during the discussion of: (1) Problematic topics (e.g. drug use) and (2) Non-problematic topics (e.g. movies). On a scale of 0-10, ask the patient to rate the quality of communication for both the topics.

STEP 3: The patient was taught rules of effective communication:

(1) Listen actively (Do not think of counter-arguments while talking to the other person);

(2) Reflect back or give an "understanding" statement (e.g. *"I know you don't like my playing video games for such long hours"* or *"I know your work schedule is very hectic and people can be difficult"*);

(3) Take partial responsibility (e.g. *"Sometimes, I unnecessarily become stubborn"* or *"I know I should not be using inhalants."*);

(4) Express your thoughts/emotions clearly (e.g. *"I got angry because I think you treat me as a kid, which I am not"* or *"Sometimes, I end up taking out other's anger on you."*); and

(5) Offer to work on a solution together/offer help (e.g. *"Can we find a middle path to work out things."*).

STEP 4: Say NO in a clear and firm tone. Use "I" statement. For example, *"I feel hurt when you make me follow everything you say."* And be specific focusing on here and now.

The steps were role played in the session with the therapist alternating between role of mother or father. Homework of previous session was repeated and the next session was a joint session between parents and patient to practice communication skills.

Session 6: Joint session of parents and patient (Discussed in detail in section 3; refer to next page)

Session 7: Joint session with parents to develop contingency contracting

By 7th session (week 14), patient's depressive symptom rating had come down to mild. He was going to school regularly and studying for 2 hours daily. He also followed the daily schedule as much as possible and practiced breathing exercises regularly. He reported being abstinent from inhalants for 5 weeks now and the craving had also reduced. However, he still wanted to play video games and was keen to do it with some terms and conditions. Thus, a joint session between parents and patient was held to develop a contract. Before the session began, 15 minutes were spent with all three of them to reflect upon the homework assignment of practicing communication skills at home. The difficulties encountered were discussed and resolved and all three were appreciated for their efforts.

A contract was then developed between the three parties (therapist, patient, parents), which laid down terms for video game playing. It was made sure that terms and conditions were acceptable to all. Also, the terms of violating the contract by either party was laid down. Then all three parties signed it and a copy was given to all.

OUTCOME AFTER 3 WEEKS (Post session 7)

Patient had his exams and could not come for next three weeks. When he reported back, the following changes were noted:

- Patient had started learning guitar and had made a few new friends there.
- He was abstinent from inhalants for about 10 weeks and craving had reduced significantly.
- He was feeling less anxious in social situation.
- The family was able to communicate more effectively. Though conflicts were still present, but intensity and frequency had reduced.
- Patient was going to school regularly, doing his homework and his grades had improved.
- He played video game as per stipulated time. At times, he had an intense need to play more but controlled the urge and distracted himself.

Goals of Family Therapy

- To assess family dynamics
- To psycho-educate family members about patient's diagnosis, behavioural issues and management
- To facilitate catharsis of family members
- To improve family environment through enhanced communication and conflict resolution skills
- To break problematic triangulation and strengthen healthy dyads (e.g. mother-father)

Sessions 1-2 : Family Assessment

The first couple of sessions focused upon rapport-building with the parents and conducting a thorough family assessment. Sister could not come due to her school. Both parents were given ample opportunity to discuss their concerns and feelings about the family situation. Both parents were talked to individually as well as jointly. Talking to them individually gave detailed glimpses into their life and relationships, which was the purpose of the assessment. Talking to them together gave opportunity to observe their interactions. It was observed that both parents blamed each other and refused to take responsibility. Moreover, father would dominate the conversation while the mother sat very quietly. They also left a chair empty in the middle and did not make eye contact with each other. After the detailed assessment (as mentioned above), goals of family therapy were discussed and mutually agreed upon. In this session, therapist also provided the parents information about various diagnostic labels used for the patient, use of medication (anti-depressants) and importance of continuous follow-up. It was also emphasized that the therapist was not blaming the parents, but trying to change the overall family atmosphere. Also, the therapist praised the parents for their efforts in trying to help the child.

Currently, patient lives in a nuclear family with his parents and a younger sister.

His father is 45-yr-old, graduate working as an airbus pilot. He has to fly about four flights a week and for that reason would be involved in two 24 hours per week duty. Previously, he used to undertake international flights leading to more working hours, but now for his son he has curtailed his duty to bare minimum. The mother is 45-yr-old educated up to graduation, house-wife, she is currently using chewable tobacco in the form of gutkha for last 5 years. The patient is more free with the mother, shares his feelings with her and talking with her would cheer up his mood and he would feel relaxed. The younger sister has cordial relationship with her brother and she shares jokes with him. She is more extrovert and has lots of friends and is very caring towards the patient.

Parents had an arranged marriage, and differences cropped between them early on. Apparently, the father is very strict towards patient's mother as well as patient and his sister. He does not trust other family members, including

wife and is even suspicious towards servants. There have been verbal arguments between the two, leading to physical fights as well. These fights would also happen in front of the children. Due to these fights, they had to repeatedly change residences and never developed cordial relationships with the neighbours. Patient's father also had very formal relationships with others at workplace and never had any close friends. Patient and his sister are close to the mother and share their difficulties with her. A triangulation could be seen in form of the triad between mother and children. Patient also bears grudge against his father on account of the undue strictness imposed upon them. He feels that father is very authoritative and does not take his view point in account. According to patient, father makes all decisions and imposes on them.

Patient's father and his brothers are not on talking terms due to a property dispute. Though, the relationships on maternal side are normal. The family is supportive towards the child in terms of undergoing regular treatment. Though, both parents feel that inhalants is a problem and use of internet and not studying is just the child's stubbornness and does not require treatment. Also, the parents blame each other for patient's state.

In the subsequent sessions, the main aim of the therapist was to keep the discussion positive. This was done with the use of following techniques:

- Relabeling behaviour: They viewed his inability to cut down his internet as being stubborn, it was relabeled as a coping mechanism to escape anxiety evoked by social situations and experience positive emotions (that he got from winning).
- Curtail blaming: It was repeatedly emphasized that family needs to reduce the "blame-game". The concept of "identified patient" was explained to family and the need for family to come together and work as a whole.
- Increasing positive focus: The family was asked to think of the good and positive behaviours that the child has shown over the last few years.

Session 3-5: Communication Skills (Duration: 1 ½ hours each session)

The main aim of these three sessions was to improve the communication skills between the parents and patient. The first two sessions were held with parents only, while in the 5th session, patient was also called in. Role plays were extensively used in the sessions. Following steps were used in the first 2 sessions on building communication skills.

STEP 1: Typically, the session begins with the rationale for improving communication skills. It is important here to emphasize that the therapist is not downplaying the parent's ability to communicate, but that some guidelines may be useful in dealing with a problematic teenager.

STEP 2: The therapist then assesses the quality of interaction that happens at home during the discussion of: (1) Problematic topics (e.g. drug use) and (2) Non-problematic topics (e.g. movies). On a scale of 0-10, ask the parents to rate the quality of communication for both the topics.

STEP 3: The parents were taught rules of effective communication:

(1) Listen actively (Do not think of counter-arguments while talking to the other person);

(2) Reflect back or give an "understanding" statements (e.g. *"I know you have difficulty in making friends"* or *"I know your school schedule is very hectic and classmates and teachers can be difficult"*);

(3) Take partial responsibility (e.g. *"Sometimes, I unnecessarily lose my temper on you."* or *"I know I turn strict with you at times."*);

(4) Express your thoughts/emotions clearly (e.g.*"I got angry because I was wrried about your well-being"* or *"Sometimes, I end up taking out other's anger on you."*);

(5) Offer to work on a solution together/offer help (e.g. *"Can we find a middle path to work out things."*).

In session 3, these skills were practised with each parent individually with the therapist acting as the other spouse. Then the parents were given home work to practise these skills at home.

At the beginning of session 4, the last week was reviewed along with the progress made and the difficulties encountered during practice of the skills. Both parents reported some relaxation in home atmosphere, but reported that at times, this exercise felt too artificial. They were reassured that it was normal to feel that way as they were doing something that was not part of their habit repertoire, but it would gradually start feeling normal. They promised to try harder.

In session 4, the same skills were again practised with both parents together while the therapist acted as the patient. The home-work again was to practise the skills with each other, that is, mother and father.

In session 5, patient was also called in and the session was a real role play of interaction between patient (who was also taught similar skills in his individual session on "Communication Skills") and parents. The therapist acted as an observer and after each role play provided the required feedback. Two each of "problematic" and "non-problematic" situations were role-played in the session. The homework was practising of these skills between the parents as well as with the patient.

Sessions 6-7: Relationship Building Skills (Duration: 1½ hours each)

As with the previous sessions, this session also opens with the rationale. It is useful to emphasize to the parents that relationships in the family become very fragile once a child has started using substances. And that itself becomes a reason for frequent relapses. Thus, it is important to strengthen relationships within the family in an attempt to present relapses. Since the parents also shared a conflictual relationship, session 6 focused on relationship building between the parents. The following ground rules were explained for relationship-building:

- Focus on here and now
- Make sure to say positive things about each other (at least one everyday)
- Not indulging in "blame game"
- Expressing negative emotions using "I" statements

- Do something "nice" for the other person
- Work jointly as a family to resolve problems.

In the session, parents were asked to list down three positive things about each other. Then they were made to sit facing each other and tell the other person those positive aspects while making eye-to-eye contact. Then they were asked to list down one negative aspect of the other person. They were made to communicate this negative aspect using "I" statement (e.g. *"I feel very hurt when you shout at me in front of the children."*). The home-work was to practice each of these skills with each other.

In session 7, feedback regarding the homework was obtained. Parents did report difficulties in the form of not being able to focus on the present at the time of conflict. However, they tried to do one nice thing for their spouse and reported feeling good. They also tried to look at something positive during the day that they could tell each other at night.

In this session, the patient was also involved. He was also explained the relationship-building skills and like previously, role play was done in the session with the parents and the patient. The therapist observed and provided feedback after end of each role play. All family members were asked to practice the same at home.

Outcome after 2 weeks (post session 7)

After 2 weeks, the family reported improvement in family atmosphere. On a Visual Analogue Scale (0-10), they rated quality of family life to be 6, whereas earlier they had reported it to be about 3-4. The family was reinforced and encouraged to continue to practice the skills. Follow-up sessions were held once in two weeks to discuss any hindrances and issues that arose while implementing the skills at home.

SECTION 4: FOLLOW-UP

As requested by the family, the regular sessions were terminated. All family members were appreciated for their efforts and the positive changes. They were asked to continue practising the same techniques till it became a part of their habit repertoire and they were asked to come for follow-up once every 2 months.

BASIC UNIT 3 : FUNDAMENTALS OF DOING AND RECORDING CASE WORK

INTRODUCTION

Important guidelines for working with cases

For working with a case you have to first identify the case — an individual with a substance abuse problem, 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 Supervised Practicum. You would then need to identify another case to carry out your work.
- Your Supervised Practicum File must have two case works, one involving individual counselling (minimum 7 sessions) and one involving family therapy (minimum 12 sessions).

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, mental status examination and semi-structured family interview schedule were given in the first year supervised practicum courses. Use the ones relevant for the individual whom you have identified for the specific case. For adults you will use Case History Taking of an Adult and Mental Status Examination Inventory. For children/ adolescents you would use Case History Taking of Child/Adolescent and Mental Status Examination Inventory. From the Family Interview Schedule, use the areas/topics relevant for the individual/family, whom you have identified for the specific case work. In the first year practicum courses, you have also learnt about assessment through genogram.

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 therapeutic approach 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/Family 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 substance abuse 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(ies) 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 substance abuse and related problems that 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) indicate?
- Was there 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 counselling/family therapy 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 and transcripts, record sheets used at the time of interviewing/observing/ counselling/family therapy, etc.

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 Supervised Practicum File as described in this Manual, you are required to submit two case records; one pertaining to individual counselling and one pertaining to family therapy, from the stipulated area. The minimum number of sessions, each of about 1 hour duration is 7 for a counselling case work and 12 for family therapy case work. You may, of course, conduct more sessions in a case, if required.

For the pupose of the 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 and transcript sheets) are to be provided as appendices/enclosures in the Report/File, for the external expert to refer to.

FRAMEWORK OF CASE RECORDS

Referral & Intake

Assessment of the individual/family in terms of:

- Knowledge about substance abuse and related problems
- Physical/Emotional/Financial/Household routine burden
- Basic needs
- Social support available
- Reaction of family members
- Impact of substance abuse

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 at 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)

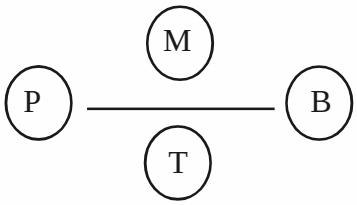
☞ Duration of the session

☞ 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:-

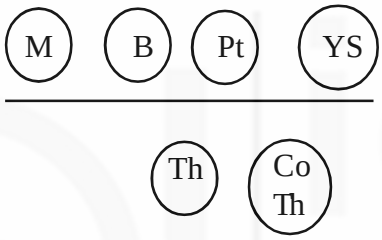


Here, P - Patient

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 2 case works complete with intake, initial phase, middle phase and termination.
- ➢ One of the case works should involve counselling, and one should involve family therapy, from the specified area.
- ➢ Each counselling case record should include at least 7 sessions, while a family therapy case record should include at least 12 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 Supervised Practicum deemed incomplete.
- ➢ Remember each session is of about 1 hour.

REPORT WRITING AND EVALUATION OF CASE RECORD

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 Supervisor also.

Each counselling/family therapy case record 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 ***two complete case records.***

One case record has to be from counselling perspective and one case record has to be from family therapy perspective.

PART II

PRACTICALS TO BE DONE

PRACTICAL 1: REVIEW OF AN ORGANISATION WORKING IN THE FIELD

You have to review one organisation or centre working in the area of substance abuse counselling and family therapy. Visit the organisation/centre, discuss with the functionaries and service providers, and also meet the beneficiaries and others to obtain the desired information.

You have to review the organisation/centre with respect to administration, therapeutic services provided, research and training, aim and mission of the organisation/centre etc. The organisation/centre identified by you for review should be one that is working in the area of substance abuse rehabilitation, management and cessation. It could be a rehabilitation centre, drug deaddiction centre, tobacco cessation centre, etc. on any governmental, private or non-governmental organisation/centre/institution etc., involved in providing substance abuse counselling and family therapy.

In your Report on the organisation/centre, include information pertaining to the following heads:

Name and address of the Organisation/Centre.

Organisational and administrative set up of the institution/organisation including board or governing bodies of the centre. History of the organisation.

Aim and mission of the centre/organisation.

Whether the organisation/institution is registered.

Professional support and services available at the centre/organisation. Focus on the domain of substance abuse counselling and family therapy.

The kind of benficiaries that approach the organisation/centre for help and the nature of problems/issues they seek help for.

Target group of beneficiaries, and how the services are envisaged to reach the target beneficiaries.

Funding sources of the organisation/centre.

Infrastructural facilities present.

Relationship with other governmental, non-governmental and private agencies, and type of association with them.

Relationship with local bodies like panchayats, community based organisations, etc.

Job description of employees.

Community recognition and awards received.

Future plans of the centre.

Your reflections about the centre (It should include your impression about the centre, its functioning, its strengths, its weaknesses, etc.; what insight you got from being at the centre; what you learnt in terms of knowledge, skills and attitudes; how could the centre be more productive according to you; and so on. Write the honest impression you had).

PRACTICAL 2: 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 substance abuse 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 Supervised Practicum File.

Thus, for this practical, you have to report in the File in detail how these sessions were carried out, and in what ways did these sessions help you.

PRACTICAL 3: COUNSELLING CASE WORK

In this supervised practicum, you are required to prepare a case record comprising 7-10 counselling sessions. Thus, you need to be involved in counselling an individual with a substance abuse problem, from the initial phase onwards, and prepare a record of the same. The case work must involve at least 7 counselling sessions; though you may take more counselling sessions with the client if required.

Steps to be followed:

- Identify an individual requiring counselling for problems related to substance abuse.
- Your counselling case work should start from the initial phase.
- In this practical, you have to apply therapeutic interventions from counselling perspective under the guidance and supervision of your Supervisor.
- **Refer to Basic Unit 3 in this Manual to learn about how you need to do the case work and record the same.**
- Prepare a record of the sessions and draw inference of each session in the end.
- At the summative level of the case record, give a summary about the client, the presenting problem, intervention strategy used, achievement or progress of each session, changes seen etc.

PRACTICAL 4: FAMILY THERAPY CASE WORK

In this supervised practicum, you are required to prepare a case record comprising 12-15 family therapy sessions. Thus, you need to be involved in family therapy of an individual (along with his/her family), from the initial phase till middle phase or termination (as the case may be), and prepare a record of the same. The case work must involve at least 12 family therapy sessions; though you may take more sessions if required.

Steps to be followed:

- Identify an individual needing family therapy interventions for problems related to substance abuse.
- The family therapy interventions would include not just the Index Patient, but also his/her family members.
- Your family therapy case work should start from intake/initial phase upto middle/termination phase, as the case may be.
- In this practical you have to apply therapeutic interventions from family therapy perspective under the guidance and supervision of your Supervisor.
- **Refer to Basic Unit 3 in this Manual to learn about how you need to do the case work and record the same.**
- Prepare a record of the sessions and analyse each session in the end.
- At the summative level of the case record, give a summary about the client, the presenting problem, intervention strategy used, achievement or progress of each session, changes seen, etc.

PRACTICAL 5: CONDUCTING AN AWARENESS GENERATION CAMPAIGN IN THE COMMUNITY

You are required to conduct an awareness generation campaign in the community, regarding aspects and issues pertaining to substance abuse.

You are expected to devote 4-5 working sessions for doing this activity.

Steps to be followed:

Decide on a topic/aspect/theme/issue related to substance abuse after discussing it with your Supervisor, that would be the focus of your awareness generation campaign.

In discussion with your Supervisor, plan the campaign. You would need to:

Decide on the methods and modalities of how you would conduct the awareness generation campaign in the community.

Consolidate the information, and the specific messages, that you would like to communicate to the community in the course of the awareness generation campaign.

Develop/prepare the materials to be used in the campaign.

Conduct the awareness generation campaign in the community, as per your plan and materials prepared. A multi-method approach is desirable.

Report of this practical must include details of:

- The rationale for the theme/issue selected by you for the awareness generation campaign. Give reasons for your choice of the particular topic.
- The planning of the awareness generation campaign. Provide detailed information on the above aspects.
- How you conducted the awareness generation campaign in the community. Provide detailed information on the modalities and methods adopted to disseminate the message or information on the theme selected, for awareness generation among community members. Enclose in the File, copies of materials you prepared and used in the campaign.
- The reaction and response of the people/community members.
- Impact of the awareness generation campaign, and how you assessed the same.
- Your accomplishments while conducting the campaign. Comment on how many people you were able to reach out to.
- Your limitations while conducting the campaign. What improvements would you bring about, if you were to conduct a similar campaign in future?
- Scope for future work in this direction.
- Your reflections on your attempt.

ANNEXURE A

EVALUATION SHEET

Remember to attach this Annexure A (Completed Section 1, and Blank Sections 2 & 3) with the Supervised Practicum File when you submit the File for external evaluation at IGNOU. *Keep a copy with yourself.*

SECTION 1: Internal Evaluation by the Academic Counsellor at the Programme Study Centre/Study Centre

The following is the format in which the Academic Counsellor/Supervisor is required to consolidate the marks for the 5 Practicals done by the student. These marks should also be stated on each written Practical submission in the Supervised Practicum File.

Practical No.	Name of the Practical	Maximum Marks	Marks Obtained
Practical 1	Review of an Organization Working in the Field	**50**	
Practical 2	Record of Acclimatisation Sessions	**100**	
Practical 3	Record of Counselling Case Work	**200**	
Practical 4	Record of Family Therapy Case Work	**300**	
Practical 5	Record of Conducting an Awareness Generation Campaign in the Community	**150**	
	Grand Total	**800**	**Grand Total (*x*)**

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

$$\frac{\text{Total marks obtained by learner } (x)}{800} \times 50 = \text{'N'}$$

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 Counsellor 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.

$$\frac{(x)}{800} \times 50 = ...$$

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

.....

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

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

Date:

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

Name & Designation of Academic Counsellor/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 : .....

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 Supervised Practicum File submitted by the Learner.

Practical No.	Name of the Practical	Maximum Marks	Marks Obtained
Practical 1	Record of Review of an Organization Working in the Field	**50**	
Practical 2	Record of Acclimatisation Sessions	**100**	
Practical 3	Record of Counselling Case Work	**200**	
Practical 4	Record of Family Therapy Case Work	**300**	
Practical 5	Record of Conducting an Awareness Generation Campaign in the Community	**150**	
	Grand Total	**800**	**Grand Total (*y*)**

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

$$\frac{\text{Total marks obtained by learner } (y)}{800} \times 50 = \mathbf{S}$$

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 Supervised Practicum. In other words, 'S' 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.

$$\frac{(y)}{800} \times 50 = \text{.....}$$

(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:

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 Supervised Practicum are to be consolidated below by the External Expert (who did evaluation in Section 2)

Supervised Practicum (MCFTE-006)

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

Certificate of Completion of Supervised Practicum MCFTE-006

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

(To be certified by the Academic Counsellor/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 5 practicals of the Supervised Practicum of the course 'Substance Abuse Counselling and Family Therapy' under our guidance and supervision. The Supervised Practicum File submitted herewith is the result of bonafide work done by the student for the supervised practicum MCFTE-006 from ..... (start date) to ..... (end date).

Date:

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

Name & Designation of Academic Counsellor/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 : .....

Dear Learner,

Photocopy this page, and place the duly filled-in copy at the end of each in your Supervised Practicum File.

Practical No. : .....

TO BE FILLED IN BY THE SUPERVISOR/COUNSELLOR

Counsellor's Comments:

.....

.....

.....

.....

.....

.....

MM for the Practical:.....

Maximum marks (MM) for review of organisation = 50

Maximum marks (MM) for acclimatisation sessions = 100

Maximum marks (MM) for counselling case record = 200

Maximum marks (MM) for family therapy case record = 300

Maximum marks (MM) for conducting awareness campaign = 150

Marks obtained by the learner :.....

(The marks obtained by the learner in the Practical are to be written in both figures and words)

.....

.....

(Counsellor's Signature and Date)

.....

(Counsellor's Name)

Sample of Permission Letter

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

.....

(Name, Address and PSC/SC No.). I am doing Supervised Practicum of the Course 'Substance Abuse Counselling and Family Therapy' — MCFTE-006 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 you for about 1½ -2 hours as per your convenience. Please grant me permission and oblige.

(Student's Signature & Name)

(Academic Counsellor's Signature & Name)

(Name & Signature of the Persons to be Interviewed)