PG DIPLOMA IN MENTAL HEALTH (PGDMH)

HANDBOOK ON INTERNSHIP

MPCA 055

Discipline of Psychology
School of Social Sciences
Indira Gandhi National Open University
Maidan Garhi, New Delhi – 110068

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CONTENTS

1.1 Introduction 5

1.2 Objectives 5

1.3 Work Centre 5

1.4 Activities to be carried out 6

1.5 Role of the Supervisor at the Work Centre 17

1.6 Guidelines for Learners 20

1.7 Internship Report 20

1.8 Evaluation 21

1.9 Term End Examination 21

Appendices:

Appendix–I Certificate Regarding Criteria for the Work Centre 22

Appendix–II Norms for Approval of Supervisor at Work Centre 23

Appendix-III Consent Letter 24

Appendix-IV Acknowledgement 25

Appendix-V Evaluation Scheme for Internship (MPCA-055) 26

Appendix-VI Certificate of Completion 27

Appendix-VII Remuneration Bill 28

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1.1 INTRODUCTION

Internship (MPCA 055) is an important component of the P.G. Diploma in Mental Health. It is an 8 credit course, i.e., the learner has to devote 240 hours for this course (one credit equals 30 hours of study). It offers the learners an opportunity to integrate their theoretical knowledge with the practice in the field. As part of the internship, the learners will be exposed to actual case studies and understand the details of case conceptualization and psychological intervention for the mental disorders. It will give them hands on experience of the mental illness anddisorders in the real context.

Increasing incidence of mental disorders especially depression, anxiety etc., irrespective of gender and socio economic status has created concern in the present times. This appears all the more prevalent in India with its increasing population, influence of westernization, increasing fast pace of work, high competition in the world of work and studies, and the variety of stress people are subjected to in their daily life and so on. This requires an urgent attention to the mental health needs and concerns. However, we are more aware about physical illness than mental illness and put more premium on the former, neglecting the latter. Mental health is crucial and has an important role in contributing to an effective, productive and healthy life. The mental health of individuals not only depends on the treatment of mental disorders but a lot on prevention, which needs early identification, diagnosis and intervention.

The learners under the able guidance of professional supervision will learn to deal with the issues of mental health in diverse population including children, adolescents and adults.

The practical training will help the learners to understand the cases of mental disorders in detail, identify signs of mental disorders and take measures for the prevention and intervention of mental disorders and illness. The learners will not receive training during this internship to provide medical intervention for the mental disorders. This training will enable the learners to carry outpsychological interventions for the mental disorders.

1.2 OBJECTIVES

The objectives of MPCA-055 Internship are to:

- enable the learners to understand case history in the context of mental disorders;
- understand and be trained in taking clinical interview;
- carry out mental status examination;
- explain the cases of mental disorders; and
- understand and provide psychological interventions.

1.3 WORK CENTRE

The Internship will be carried out at the Work Centre attached to the concerned Regional Centre that has agreed to provide training facilities. The learner needs to get in touch with the Supervisor at the Work Centre to carry out his/ her internship training.

Further, the learner can also have any other centre as their work centre. It needs to be ensured that the centre fulfills the eligibility criteria as given in Appendix I, II, and III. The learner needs to submit Appendix I, II, III, and IV to the Programme Coordinator, PGDMH, SOSS, IGNOU, Maidan Garhi, New Delhi – 110068 for approval.

Learners may also do the internship at their workplace provided necessary requirements are fulfilled. In this regard, they need to submit the Certificate **(Appendix-I)** duly signed by the Head/ Director of the Hospital/ Institution/ University along with the Consent letter from the supervisor **(Appendix-III)** including his/ her bio-data. The Supervisor has to be from the same place where the learner is working. The learner will submit both these to the Programme Coordinator (PGDMH), Discipline of Psychology, IGNOU, New Delhi for approval. The criteria for being a supervisor is given in **Appendix-II**.

The learner will carry out the activities related to the internship course only after getting the approval from the IGNOU Headquarter.

1.4 ACTIVITIES TO BE CARRIED OUT

The learner is required to put in 240 hours of work at the Work Centre. If the learner devotes 3 hours per day, then he/ she has to spend 2 months and 20 days to complete the 240 hours of supervised internship training.

The learner will observe cases being handled by the clinical psychologist/ psychiatrist in the hospital or institution. S/he will learn about assessment and diagnosis, including interviewing, case history taking, conducting mental status examination and therapeutic interventions.

The learner is required to do the following activities:

- Case History Taking : write two detailed case histories
- Clinical Interviewing & MSE : carry out mental status examination (MSE) of two patients and write verbatim report of how the interview was conducted
- Case Vignettes : write report on two case vignettes, one focusing on diagnosis and one on psychological intervention
- Case intervention : observing two cases where intervention is being carried out, suggesting intervention and writing report on it

Interviewing is one of the most important skills in the practical. It helps gain information about various details about the client/ patient. Here the learner will have an understanding about how to take case history and to conduct Mental Status Examination.

The above mentioned activities are to be written in the Internship Report. However, the learner is required to observe more number of cases and interact with the supervisor at the work centre frequently to develop adequate knowledge and understanding.

CASE HISTORY

It is necessary to take case history of a client/patient so as to understand his/ her background. Case history covers personal information like name, age, gender, religion, education, income, socio economic status etc. It further covers information about family, job if any, medical

complaints, medical or any other treatment or help sought by the patient.

A sample of Case History Format is given as follows:

1) **Personal details:** These are mainly for the identification of the patient and to understand his/ her basic details. This will be followed by certain other details about the patient. They may be :

Name:

Address:

Contact No.:

Sex: Male/ Female

Age:

Marital status:

Occupation:

Referred by:

Main/ Present/ Chief Complaint:

2) **Personal History/Development:** This can cover various aspects like early development, childhood, school, adolescence, occupation, menstrual history, sexual history, marital history, details about children, social network, habits, leisure and forensic history.

3) **History of Present Illness:** These are details of problems experienced by the client/ patient. This covers common psychiatric symptoms , comment on the impact of the illness on the patient's life, work, social relations and self-care. Details of previous treatment are also to be noted down with details about current problem and psychiatric issues. Further, details of previous episodes of illness, previous psychiatric admissions/treatment, suicide attempts/ drug and alcohol abuse, interval functioning (how is the patient like between episodes/ when "well').

4) **Medical History:** The details of medical treatment that the patient has undergone or is undergoing has to be noted down.

5) **Family History:** It includes information on parents and siblings, nature of the relationships between family members and family tensions, stresses and family models of coping. Family history of psychiatric illness (including drug/alcohol abuse, suicide attempts) are to be noted.

6) **Social History:** The social interactions of the patient, including behaviour at work or in school or during social gatherings is to be noted down.

7) **Educational History**: It includes the academic performance, peer interaction and behavior of the client during school and college years.

The learner will conduct the initial interview which will contain information about the following in the given order, though depending on the case, the order may be somewhat altered. The intake information to be taken is given below.

Intake information

Registration No: Name :

Age : Sex :

Address :

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Educational qualification:

Occupation:

Income:

Marital status:

Does the patient stay with parents/spouse :

Does the patient has any siblings, if so, how many:

What is the position of the patient in the family: Eldest, middle or youngest or only child:

Any one in the family is suffering/has suffered from any mental disorder:

Anyone in the family is suffering/has suffered from any physical disorder:

Presenting complaints: (This should be recorded exactly the way the patient narrates what s/he is feeling i.e. verabtim) :

Date of onset of illness (the first attack):

Precipitating factor if any:

Duration of illness:

Intensity of illness (on a scale of 10):

Treatment taken:

Got well at any time in between; duration of such period of wellness:

Was there any precipitating factor at each relapse:

How many relapses:

Any other treatment tried in between:

What was the effect:

In what ways the illness causes inconvenience?

- Has to take leave from work place / school/ college
- Cannot carry on even the routine works
- Has to depend on others for everything
- Want to lie down and take rest
- Don't want to do anything
- Any other

Interview with family members:

- Their view point in regard to all of the above.
- In what ways the illness causes them inconvenience?

All the above things need to be recorded in detail as told by the patient/family members.

MENTAL STATUS EXAMINATION

A Mental Status Examination (MSE) is an assessment of a patient's level of cognitive (knowledge-related) ability, appearance, emotional mood, and speech and thought patterns at the time of evaluation.

It is one part of a full neurologic (nervous system) examination and includes the examiner's observations about the patient's attitude and cooperativeness as well as the patient's answers to specific questions.

The purpose of a mental status examination is to assess the presence and extent of a person's mental impairment. The cognitive functions that are measured during the MSE include the person's sense of time, sense of place, and personal identity, memory, speech, general intellectual level, mathematical ability, insight or judgment, and reasoning or problem-solving ability.

The MSE is an important part of the differential diagnosis of dementia and other psychiatric symptoms or disorders. The MSE results may suggest specific areas for further testing or specific types of required tests. MSE can also be given repeatedly to monitor or document changes in a patient's condition.

The MSE cannot be given to a patient who

1) Cannot pay attention to the examiner, for example as a result of being in a coma or being unconscious; or
2) Is completely unable to speak (aphasic); or
3) Is not fluent in the language of the examiner.

Description: Given below is the description of all aspects of MSE to be conducted. The history and Mental Status Examination (MSE) are the most important diagnostic tools to make an accurate diagnosis. Although these important tools have been standardized in their own right, they remain primarily subjective measures that begin the moment the patient enters the psychologist's room.

Steps to be followed are given here:

Step 1: The psychologist must pay close attention to the following regarding the patient:

1) Patient's presentation,
2) Patient's personal appearance,
3) Patient's social interaction with office staff and others in the waiting area,
4) Whether the patient is accompanied by someone (this helps to determine if the patient has social support).

The above few observations can provide important information about the patient that may not otherwise be revealed through interviewing or one-on-one conversation.

Step 2: When patients enter the office, pay close attention to the following:

1) Note the personal grooming.
2) Note things as obvious as hygiene.
3) Note things such as whether the patient is dressed appropriately according to the season.
4) These types of observations are important and may offer insight into the patient's illness.
5) Note if patient is talking to himself or herself in the waiting area.
6) Note if the patient is pacing up and down outside the office door.
7) Record all observations.

Step 3: Establish rapport

The next step for the psychologist is to establish adequate rapport with the patient by introducing himself or herself. Speak directly to the patient during this introduction, pay attention to whether the patient is maintaining eye contact. Mental notes regarding such things may aid in guiding the interview later. Note if patients appear uneasy as they enter the office, then immediately attempt to ease the situation by offering small talk or even a glass of water. Many people feel more at ease if they can have something in their hands. This reflects an image of genuine concern for patients and may make the interview process much more relaxing for them. A complete MSE is more comprehensive and evaluates the following ten areas of functioning:

1) **Appearance:** The psychologist notes the person's age, sex, civil status, and overall appearance. These features are significant because poor personal hygiene or grooming may reflect a loss of interest in self care or physical inability to bathe or dress oneself.

2) **Movement and behavior**. The psychologist observes the person's gait (manner of walking), posture, coordination, eye contact, facial expressions, and similar behaviors. Problems with walking or coordination may reflect a disorder of the central nervous system.

3) **Affect**. Affect refers to a person's outwardly observable emotional reactions. It may include either a lack of emotional response to an event or an overreaction.

4) **Mood**. Mood refers to the underlying emotional "atmosphere" or tone of the person's answers; whether the person is in a sad mood, happy mood, angry mood etc.

5) **Speech**. The psychologist evaluates the following

    a) the volume of the person's voice,
    b) the rate or speed of speech,
    c) the length of answers to questions,
    d) the appropriateness of the answers,
    e) clarity of the answers and similar characteristics.

6) **Thought content**. The examiner assesses what the patient is saying for indications of the following. These are indicative of certain typical disorders. Each of the following will have to be checked by the trainee.

Hallucinations: Hallucinations are false or distorted sensory experiences that appear to be real perceptions. These sensory impressions are generated by the mind rather than by any external stimuli, and may be seen, heard, felt, and even smelled or tasted.

To test for hallucination the questions to be asked are:

1) Do you sometimes hear some voice telling you to do something or not to do something?
2) Do you sometimes hear some voice when no one is present?
3) Do you feel that someone is talking about you and loudly saying whatever you are doing?

Delusions: A delusion is an unshakable belief in something untrue. These irrational beliefs defy normal reasoning, and remain firm even when overwhelming proof is presented to dispute them. To test for delusions the questions to be asked are

1) Do you sometimes feel that people are after you?
2) Do you sometimes feel that people are talking about you?
3) Do you sometimes feel that your phone is tapped?
4) Do you sometimes feel people are overhearing your conversation?

Dissociation: Dissociation refers to the splitting off of certain memories or mental processes from conscious awareness. Dissociative symptoms include feelings of unreality, depersonalization, and confusion about one's identity. The questions to be asked will include:

1) What is your name?
2) Who are you?
3) What work do you do?
4) Do you sometimes feel that you do not know who you are?

Obsessions: It is a persistent unwanted idea or impulse that cannot be eliminated by reasoning.

To find out about obsessions, the questions to be asked include the following:

1) Do you feel that a particular thought keep coming to your mind again and again despite your not wanting it?

2) Do you feel sometimes a strange idea or feeling which you think is not correct keeps coming and however much you try the thought does not go?

3) Do you find sometimes an impulse to keep washing your hands or do other things at home repeatedly, even though you know it is unwarranted?

7) **Thought process**: Thought process refers to the logical connections between thoughts and their relevance to the main thread of conversation. Irrelevant detail, repeated words and phrases, interrupted thinking (thought blocking), and loose, illogical connections between thoughts, may be signs of a thought disorder. These can be noted by the psychologist and recorded as and when these occur.

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8) **Cognition.** Cognition refers to the act or condition of knowing.

   The evaluation assesses the person's

   1) orientation (ability to locate himself or herself) with regard to time (ask the person what time is it now?

   2) orientation to place (ask the person where are you now?)

   3) orientation to personal identity (ask who are you and what your name is?)

   4) long- and short-term memory (ask the person what he had for breakfast. To test long term memory, tell me the name of the school in which you studied.)

   5) ability to perform simple arithmetic (counting backward by threes or sevens)

   6) general intellectual level or fund of knowledge (identifying the last five Presidents, or similar questions)

   7) ability to think abstractly (explaining a proverb)

   8) ability to name specified objects and read or write complete sentences (show some objects and ask the person to name the same. Show simple sentences and ask the person to read or write the same.)

   9) ability to understand and perform a task (showing the examiner how to comb one's hair or throw a ball)

   10) ability to draw a simple map or copy a design or geometrical figure (draw a design like square or a triangle and ask the person to draw it after you.)

   11) ability to distinguish between right and left. (touch the person's left hand and ask what hand is it? Repeat same thing with the right hand.)

9) **Judgment:** The examiner asks the person what he or she would do about a commonsense problem, such as running out of a prescription medication. Or ask the person what he would do if he or she finds a sealed envelope on the road)

10) **Insight:** Insight refers to a person's ability to recognize a problem and understand its nature and severity. (Do you think you are ill? If the person says he or she is not ill and that the family member who has brought him or her is ill, that shows lack of insight)

Note: The length of time required for a Mental Status Examination depends on the patient's condition. It may take as little as five minutes to examine a healthy person. Patients with speech problems or intellectual impairments, dementia, or other organic brain disorders may require fifteen or twenty minutes. The trainee may choose to spend more time on certain portions of the MSE and less time on others, depending on the patient's condition and answers.

After the Mental Status Examination is over, record the entire thing in detail. Then take up the interview with the family member or members who have accompanied the patient.

The interview with the family members

The interview with family members should cover all aspects that are covered in the interview with the patient. In addition, the following need to be covered.

Relationship: Patient's relationship with family member:

If unmarried, with

Mother :

Father :

Brothers :

Sisters :

Any other relative staying with patient :

With Friends: How many friends does the patient have? How does the patient relate to them?

With neighbours :

With school and class mates :

With the teachers in school :

With other authority figures :

With playmates :

In the games field :

Educational history:

In School / College:

How is the patient in studies and academic performance?

Does the patient come up to the expectations of parents and teachers?

How has the performance been over the years?

Do they find that there is sudden deterioration in studies and academic performance?

Have they received any complaints from the school authorities regarding the patient's performance?

Since when have they noted that the patient is not the same in regard to academics as he or she used to be?

Have they done anything about it so far? If so, what?

Had there been any improvement after their efforts?

When did they decide to consult a mental health specialist?

Work history:

What occupation/job is the patient doing?

How regular is the patient for work?

Has the patient been complaining about work place? If so, what?

Has the patient been on leave? If so, for how long?

When was the time they noticed that the patient was reluctant to go for work?

What reasons were given by patient for not attending to work?

Generally how has the patient been fairing in work?

Has there been any complaint about non performance etc. about the patient?

What is their perception about patient's relationship in the workplace?

With Boss:

With colleagues:

With subordinates:

Has the patient ever mentioned about any one bothering his/her at workplace? How much importance have they given to patient's such complaints?

If Married: Relationship with spouse in terms of

Day to day dealings :

Sex life :

Work relationship (if spouse is working) :

Relationship with children :

Relationship with opposite sex persons :

Decision making (who takes the decision – spouse or self) :

Sharing of work at home with the spouse :

Relationship with spouse's relatives :

Relationship with spouse's friends :

Record every issue in detail verbatim, that is as is being narrated by the patient's family members. All these cases should be written verbatim in a narrative style. What questions were asked by the trainee/psychologist and what answer was given by the patient. At the time of answering the

questions how was the patient answering? (For instance was the patient hesitating? Was the patient free in communicating? Was the patient evading any question? Was the patient focusing on the interview? Was the patient getting easily diverted and distracted? Had the questions to be repeated a number of times before the patient replied? What was the general demeanour of the patient while answering in the interview session? Was the patient in a hurry to finish the interview and go off? Was the patient showing unwillingness to continue with the interview? Was there a pause in the replies to certain questions? Was the patient cooperative and ready to answer? Was the patient showing concern about the illness?

An example of how to write the interview session is given below:

Patient's name:

Interview No:	Date:
Session No:	Time:

Purpose of the Interview:

The patient was referred to me for taking a detailed case history and Mental Status Examination.

Start of the session:

The patient Mr. X came in. He looked a little confused as to whether he was in the right place. I saw the patient entering and told him to please come in. I then offered the seat opposite to my chair to sit. He was accompanied by his wife and son who appeared around 20 years old. I offered them also a seat. However as the interview started I asked Mr. X if it would be all right we both talked alone and his wife and son waited for a while outside. It is always important that we meet the patient alone first and hear the patient's version before interviewing those who accompany the patient. The reason is that such behaviour on the part of the psychologist makes the patient feel that he is a person of worth and capable of telling him many things that he would like to. This is the first step in establishing rapport.

However if the patient is violent, unruly and is not coherent and cannot talk etc., it would be better to talk to the family members who accompany the patient.

Patient's appearance: The patient was well dressed, neat and clean. He looked depressed and also anxious. He looked a little nervous and confused.

He sat down and was rubbing his hands as if he is anxious and nervous.

I decided to make sure that the patient is comfortable and told him that he is in the right place.

I am a psychologist working here and would like to talk to him.

Mr. X smiled and said that he knew I am a clinical psychologist and wondered why he has been referred to me.

I said, well, if you tell me about yourself and the problem for which you approached the hospital, I will be able to tell you why you are here.

I continued as I found the patient silent. I asked him if he had any particular problem or illness or symptoms that are bothering him. May be I could help if he tells me something about the reason for his approaching the hospital.

Then Mr. X started to tell me that he has not been doing well for the past few months. He is constantly sad, depressed and disinterested in life in general. He has no inclination to go to work nor does he want to stir out of his room despite his wife and children trying to make him get up and talk to them etc. (He looked sad and sounded worried. I nodded my head to indicate that I understand his problem and asked him to continue.)

Symptoms as told by Mr.X : (To be clearly written)

……………………………………………….

……………………………………………….

Next question:

The patient's reply (along with the learner's observations):

How did the interview session end?

For example, as the time allotted to the patient was one hour, I ended the interview in the following manner.

Mr. X. I think today we have discussed your problem particularly from the relationship and your experience angles. It has been possible to understand when your problems started, what precipitated it and how you have been handling the same. Your efforts are really appreciated.

However there are many things we need to discuss with each other. For instance, the difficulties you are facing in your office and your relationship with your family members in the last few years need further exploration. Do you think I have understood your problems correctly? Would you like to come for another session sometimes next week as is convenient to you? Can we fix up next Thursday 12 p.m. for the next session? May be we would like to give some psychological tests which may help us to understand your problem better. The patient responded he would like to come next week at the time specified which was suitable to him also. We both stood up, shook hands and the patient took leave.

My observation: When the patient left I found that he was looking slightly more relaxed and smiled before he left. My feeling is that his talking about his problems and verbalizing his feelings had relaxed him considerably.

Plan of action: Continue the interview and gather more information about the dynamics underlying the various conflicts that he has expressed. I need also to talk to his family members to understand the problem from their points of view.

The purpose with which today's session was started was achieved.

Important: Everything being told by the patient and by the learner should be recorded verbatim as given above. The impression that the learner has about the patient and the manner in which the patient answers, the various gestures that the patient makes, the hesitation between sentences, the gaps and the time taken to answer question, the discomfort expressed by the patient etc. should all be noted.

1.5 ROLE OF THE SUPERVISOR AT THE WORK CENTRE

Learners will be closely supervised by the supervisor who will give them feedback about their performance.

The supervisor is required to help and guide the learner in carrying out the various activities of the Practical. S/he should interact and discuss cases with the learner.

For this there is a need to schedule a learner-supervisor conference as and when needed, preferably once in 15 days. The supervisor can include all the learners s/he is supervising in the conference.

The supervisor needs to provide cases, case vignettes to the learner. The supervisor will expose the learner to case history taking and conducting mental status examination of the patients. The learner can then take case histories and carry out MSE on his/her own. Further, the learner can also be part of the treatment team and learn about the therapeutic interventions. The supervisor can also give the learner some materials to read if necessary.

The supervisor may advise the learner on professional development. The supervisor must make sure that the learner is not demoralized in any way and reinforce the positive aspects in the learner while pointing out clearly how the errors could be corrected and what the learner should do on his or her part.

The supervisory sessions are mainly meant for the following:

i) Guide learner how to take case history and conduct an interview, establish rapport etc.

ii) Guiding the learner regarding administering the tests, scoring and interpretation

iii) To arrive at a diagnosis based on the history and the tests administered

iv) To make the learner proficient in interviewing methods, working out case history, administering test, scoring and interpretation of the same.

v) To discuss the therapy sessions observed by the learner and help learner to understand the psychodynamics based on the sessions.

vi) To help learner to plan a therapy programme for the patient whom he or she had interviewed and also tested.

vii) To make sure that session by session there is some progress in the learner's understanding of the cases and where no progress is noted, finding out where the problem lies and helping the learner overcome the same.

viii) Evaluate the learner's work and progress session by session and also the skills and knowledge that the learner is acquiring over the period of time.

Below are given some items with regard to certain criteria for self evaluation by the learner and evaluation by the Supervisor. Both the supervisory evaluation and the learner's evaluation may be discussed at the evaluation conference between the supervisor and the learner. This evaluation conference is to make the learner understand how far s/he has acquired the needed skills and proficiency in dealing with patients/clients.

BOX: Items for self evaluation and evaluation by the supervisor

1) Name of the learner:
2) Name of the hospital/clinic/institution (work centre) in which the learner was placed for training:
3) Name of the supervisor at the work center:
4) Duration of training: Date of Joining and Date of completing
5) Attendance at the place of training : Regular / Irregular / Very irregular
6) Attendance at the supervisory conferences : Excellent / Average / Poor
7) No. of cases referred for Case history
8) No. of cases referred for testing:
9) No. of cases observed at therapy sessions:
10) What the learner has learned:
11) What the learner is good at:

The following statements about the learner are to be given rating according to Excellent (5), Very Good (4), Good (3), Average (2) and Poor (1).

A) Interpersonal and professional competence

1) Maintains professional conduct (timeliness, dress code, language etc) 5 4 3 2 1
2) Interacts well with supervisors 5 4 3 2 1
3) Interacts well with other trainees 5 4 3 2 1
4) Interacts well with office staff 5 4 3 2 1
5) Interacts well with other professionals 5 4 3 2 1
6) Interacts appropriately with patients and their families 5 4 3 2 1
7) Respects roles and boundaries 5 4 3 2 1
8) Is aware of how he / she impacts others 5 4 3 2 1
9) Is able to openly reflect on personal behaviour / choices 5 4 3 2 1
10) Is able to effectively resolve interpersonal problems 5 4 3 2 1
11) Maintains appropriate patient confidentiality 5 4 3 2 1
12) Adheres to ethical practices 5 4 3 2 1
13) Overall interpersonal and professional competency 5 4 3 2 1

B) Assessment

1) Obtains thorough and relevant patient history 5 4 3 2 1
2) Obtains relevant information from outside sources when appropriate (family members, agencies like school etc) 5 4 3 2 1
3) Observes and reports accurately on patient behavior 5 4 3 2 1
4) Administers psychological tests as per standard procedures 5 4 3 2 1
5) Accurately scores and summarizes the data 5 4 3 2 1
6) Properly interprets and integrates results of assessments 5 4 3 2 1
7) Demonstrates knowledge of diagnosis and is able to make differential diagnosis 5 4 3 2 1
8) Makes appropriate and useful treatment recommendations 5 4 3 2 1
9) Clearly communicates results of comprehensive assessment in written report 5 4 3 2 1
10) Submits written reports to supervisor by due date 5 4 3 2 1
11) Synthesizes feedback from supervisor's comments in written reports 5 4 3 2 1
12) Learns from previous mistakes in subsequent reports 5 4 3 2 1
13) Provides understandable and useful feedback to patients 5 4 3 2 1
14) Demonstrates knowledge and applicability of legal and ethical principles regarding assessment. 5 4 3 2 1
15) Overall Assessment Competency 5 4 3 2 1

C) Interviewing and understanding of therapy sessions

1) Demonstrates the ability to establish rapport with patients 5 4 3 2 1
2) Demonstrates empathy and caring for patients 5 4 3 2 1
3) Appears comfortable and confident in therapy sessions 5 4 3 2 1
4) Maintains appropriate boundaries with patients 5 4 3 2 1
5) Maintains necessary documentation and submits notes within allotted time 5 4 3 2 1
6) Develops appropriate and realistic treatment plans collaboratively with patients 5 4 3 2 1
7) Demonstrates knowledge of theoretical orientations and techniques associated with each 5 4 3 2 1
8) Demonstrates ability to conceptualise the patient's problem 5 4 3 2 1
9) Demonstrates sensitivity to diversity issues 5 4 3 2 1
10) Demonstrates appropriate termination of interview sessions 5 4 3 2 1

D) Supervision

1) Comes prepared to supervision sessions 5 4 3 2 1
2) Uses supervision to gain skills and knowledge 5 4 3 2 1
3) Is open to and receives constructive feedback 5 4 3 2 1
4) Provides evidence of incorporating supervisor's suggestions in work with patients 5 4 3 2 1

5) Seeks extra super vision as needed 5 4 3 2 1

6) Effectively presents case formulation 5 4 3 2 1

7) Effectively presents assessment findings 5 4 3 2 1

8) Establishes and monitors personal goals for training 5 4 3 2 1

The description of the above ratings are as follows:

5 (Excellent)	=	**Exemplary competency**
4 (Very Good)	=	**Competent**
3 (Good)	=	**Developing competency**
2 (Average)	=	**Inadequate skills**
1 (poor)	=	**Incompetent / requires remediation**

1.6 GUIDELINES FOR LEARNERS

Learners/trainees are required to work with complete commitment and dedication and must follow the standards of ethical and professional conduct. Each institution/organization has its own ethical and professional standards. The learners need to adhere to these standards and display professionalism in their manner and functioning.

If the learners face any difficulties/ problem/ conflicts at the institution/organization, the same may be reported to the Regional Centre concerned/ Programme Coordinator.

The learner has to maintain a diary regarding his/ her activities of each day at the hospital/ institution/clinic where s/he is carrying out the internship. The diary will help the learner in furtherdiscussion and clarification with regard to cases with the supervisor.

1.7 INTERNSHIP REPORT

At the end of internship training, the learner has to prepare a report of the various activities carried out.

The learner needs to use the following format for writing the Report:

i) Case histories

ii) Report of MSE

iii) Case vignettes

iv) Intervention

v) Reflections – how you did the activities, how did it go and what you learnt from it

The learner should attach the certificate of completion **(Appendix VII)** in the Report. The learner will submit the Internship Report at the Regional Centre (last date of submission is 31st May for July batch and 30th November for January batch) and take acknowledgement **(Appendix-V)**. A copy of the Internship Report should be kept before submitting it.

1.8 EVALUATION

The total marks for Internship is 100. For successful completion of the course MPCA 055, a learner should secure a minimum of 40% marks separately under internal evaluation and external evaluation(see **Appendix VI** for Evaluation Scheme).

The distribution of marks under internal and external evaluation is given below:

Sl No	Internal Evaluation		External evaluation	
	Activities	**Maximum Marks**	**Activities**	**Maximum Marks**
1	Case history	15	Internship Report	15
2	MSE	15	Viva Voce	25
3	Case Vignette	20		
4	Intervention	10		
TOTAL MARKS		**60**		**40**

1.9 TERM END EXAMINATION

The Term End Examination (TEE) of MPCA-055 consists of evaluation of the Internship Report and Viva-Voce by the External Examiner. The learner has to appear in the TEE of MPCA-055 on the date scheduled by the Regional Centre. S/he also to pay the examination fee for appearing in the TEE of MPCA-055.

The examiner is to be selected from the approved list provided by the Discipline of Psychology. The examiner will go through the Report and conduct the viva of each learner. The evaluation consists of the following:

Internship Report – 15 Marks

Viva-Voce – 25 Marks

The viva voce will be organized by the Regional centre on any day as per their convenience during the time period as given below.

June TEE	1st July -14th August
December TEE	1st January – 15th February

The viva voce may be arranged for a single day or two days depending on the number of learners (around 25-30 learners in a full day).

APPENDICES

Appendix-I

CERTIFICATE REGARDING CRITERIA FOR THE WORK CENTRE

This is to certify that the Hospital/ Institution/ Clinic/ University ___________________________ ________________________________ fulfills the following criteria as mentioned below.

"The Work Centre can be located in a Hospital / Medical Institution / University having department of Psychiatry / Clinical Psychology/ Child Guidance Clinic with OPD and Indoor facility, with minimum 20 patients attending OPD each day and around 10 patients in Indoor facilities; and which possesses necessary infrastructure facilities and academic expertise as per the programme requirement for conduct of internship."

(Signature)

Name of Authority:

Address:

Date:

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Appendix-II

NORMS FOR APPROVAL OF SUPERVISOR AT WORK CENTRE FOR PG DIPLOMA IN MENTAL HEALTH

The Supervisor at the Work Centre should have the following qualifications and experience:

M.A/ M.Sc. in Clinical Psychology/ Applied Psychology/ M.A with specialization in Clinical Psychology with 4 years of post-graduate teaching/ professional experience

Or

M.Phil/ Ph.D in Clinical Psychology with 2 years of post-graduate teaching/ professional experience

Or

M.D. in Psychiatry with one year of post-graduate teaching/ professional experience

Each Supervisor can supervise upto 10 number of students. The detailed bio-data alongwith necessary documents regarding the educational qualification and experience should be submitted for approval by the Discipline of Psychology, IGNOU.

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Appendix-III

CONSENT LETTER

This is to certify that the Internship (MPCA 055) for the partial fulfillment of P.G. Diploma in MentalHealth (PGDMH) of IGNOU will be carried out by Dr./Mr./Mrs. ____________

Enrollment No.___________________of Regional Centre _______________________________

under my supervision.

(Signature)

Name of the Supervisor :

Designation:

Address:

Date:

Appendix – IV

PROFORMA FOR APPROVAL OF WORK CENTRE AND SUPERVISOR FOR MPCA-055 OF PGDMH

Enrolment No.:____

Name and Address of the Learner:______________________________________
____
____

Phone No.: ____________________ **Email:**______________________________

Study Centre & Regional Centre:_______________________________________
____

Name and Address of the Work Centre: __________________________________
____

Name & Designation of Supervisor at Work Centre: _________________________
____

Phone No.: ____________________ **Email:**______________________________

Signature of the Student
Date:

***Appendix I, II, and III given in the Handbook on Internship (MPCA 055) need to be enclosed with this Proforma for approval. The proposal will not be considered without these enclosures.**

****This proforma needs to be submitted in duplicate; one copy will be returned to the Learner and the other copy will be kept by the Discipline of Psychology for record.**

Work Centre:	**Approved**	**Not approved**
Supervisor at Work centre:	**Approved**	**Not approved**

(Signature & seal of Faculty)
Programme Coordinator, PGDMH
Discipline of Psychology, SOSS, IGNOU, New Delhi

Appendix- V

ACKNOWLEDGEMENT

This is to certify that Dr./Ms./Mr./ ____
Enrolment No. ____________________ of PG Diploma in Mental Health (PGDMH) has submitted the Internship Report (MPCA-055).

(Signature)

Name :

Name of the Regional Centre:

Place:

Date:

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Appendix-VI

EVALUATION SCHEME FOR INTERNSHIP (MPCA- 055)

Name of the Programme: Course Code:

Study Centre: Regional Centre:

Name of the Learner:

Enrolment No.:

Internal Marks by the Supervisor at the Work Centre

Sl No.	Details	Maximum Marks	Obtained Marks
1	Case history	15	
2	MSE	15	
3	Case Vignette	20	
4	Intervention	10	
	Total Marks	**60**	

External Marks by External Examiner during TEE

Sl No.	Details	Maximum Marks	Obtained Marks
1	Internship Report	15	
2	Viva Voce	25	
	Total Marks	**40**	

Comments, if any by Supervisor: ____

____

Comments, if any by External Examiner: ______________________________________

____

Signature:

Name of Supervisor (Work Centre):

Address:

Date:

Signature:

Name of External Examiner:

Address:

Date:

Appendix-VII

CERTIFICATE OF COMPLETION

This is to certify that Dr./Ms./Mr.____,

Enrolment No.________________of Regional Centre _________________________________

pursuing PG Diploma in Mental Health (PGDMH) has conducted and successfully completed the internship activities of MPCA 055 at the place___________________________________.

____

Signature of the Learner

Place:

Date:

Signature of the Supervisor

Name:

Designation:

Name of the Organization:

Address:

Place:

Date:

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Appendix-VIII

REMUNERATION BILL

To
The Director (SR&E)
IGNOU
MaidanGarhi
New Delhi - 110068

Programme Code: PGDMH   Course Code: MPCA 055

Name of Supervisor: ____

Designation:____

Residential Address: ____

____

Official Address: ____

____

Telephone No. Office: ______________________

Mobile: ______________________

Sl.No.	Enrolment No.	Name of Student	Amount

Certified that I have supervised the above students for their Internship of Course MPCA 055.

Dated:______________Signature of the Supervisor: ________________________

Certified that the above supervisor for internship work of MPCA 055 was approved and recommended by the concerned school of study and above claim may be admitted.

Dy./Asst. Registrar   Section Officer   Dealing Assistant