**CP FORM 1**

**Client initial Assessment Form**

**Case Number…**1  **Date of intake…**30/01/2024

**Client Code…** A1  **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Female **Age:** 21  
**Marital status:** Married

**Relevant history concerning previous counselling treatment( if any)**

1. The client has not had any previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**

The client was diagnosed with an abscess in the breast. She declined treatment due to a past experience where one of her relatives, who was suffering from the same issue, succumbed to death after undergoing treatment. She is afraid that she will also die if she undergoes treatment.

The client is currently dealing with a serious health issue and has fears and anxieties related to the treatment due to a traumatic past experience. This fear is causing her to decline potentially life-saving treatment.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.  
Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.  
Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.  
Mood and Affect: client appears anxious  
Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.  
Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A1 | 30/01/2024 | 8.30 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client has been diagnosed with a breast abscess. However, she has declined treatment due to a traumatic past experience. A relative of hers, who was suffering from the same medical condition, unfortunately passed away after undergoing treatment. This event has instilled a deep-seated fear in the client that she might meet the same fate if she opts for treatment. The fear is so profound that it is preventing her from seeking necessary medical intervention for her condition. This fear and the resulting avoidance of treatment are the primary issues bringing her to therapy.

**Goal(s) for therapy**

1. To help the client manage her fear and anxiety related to her medical condition and treatment.

2. To assist the client in making informed decisions about her health.

**Interventions (state theories used)**

In the sessions I attended, I utilized Psycho-education as an intervention strategy. This approach involved educating the client about her condition and the importance of treatment. It also includes providing information about the nature of fear and anxiety, and how these emotions are processed in the brain. The goal is to empower the client with knowledge, which can help reduce fear and improve her sense of control over her situation. As a counselling psychology student, this approach has allowed me to bridge the gap between the client’s fears and the medical realities, thereby facilitating a more informed and less fear-driven decision-making process.

**Plans for next session**

In the next session, we will continue to explore the client's fears and anxieties. We will work on strategies to manage these emotions and discuss the importance of medical treatment for her condition.

**Student Counsellor’s signature… Date…** 30/01/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…**2  **Date of intake…**31/01/24

**Client Code…** A2  **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Male **Age:** 21  
**Marital status:** Single

**Relevant history concerning previous counselling treatment( if any)**

The client has not had any previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**

The client, suffering from a septic foot wound, is scheduled for a Below-Knee Amputation (BKA). He has been informed about the procedure, its risks, and post-operative realities, including the use of walking aids. He has consented to the operation, demonstrating understanding and acceptance of his condition. The plan includes ongoing psychological support and post-operation counselling to help him cope with the emotional impact of his condition and the changes post-amputation. Despite facing significant changes to his physical health and lifestyle, the client’s insight and willingness to undergo the procedure are positive indicators of his resilience and coping abilities. These strengths will be crucial as he navigates this challenging time towards recovery and adaptation.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**

Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are dysphoric, indicating a state of distress or unease.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A2 | 31/01/2024 | 9.00 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy**The client is dealing with a septic foot wound that has necessitated a Below-Knee Amputation (BKA). The impending surgery and the subsequent lifestyle changes are the primary issues bringing him to therapy. Client is required to consent for the procedure to be performed thus needing to be psycho-educated about his current condition before proceeding with BKA procedure.

**Goal(s) for therapy**The primary goal for therapy is to help the client cope with the emotional impact of his condition and the upcoming surgery. The therapy will also aim to equip the client with strategies to adapt to his new physical reality post-surgery.

**Interventions (state theories used)**  
1. CBT utilized to help the client identify and manage any negative thoughts or feelings associated with his condition and the impending surgery. This approach can empower the client to challenge cognitive distortions and develop healthier thought patterns.  
2. Acceptance and Commitment Therapy(ACT ) employed to foster acceptance of his current situation and commitment to making necessary lifestyle changes post-surgery. This therapeutic approach can help the client live in accordance with his values despite the challenges posed by his physical condition.  
3. Psycho-education is a crucial part of the intervention process. The client will be educated about his medical condition, the surgical procedure, and the recovery process. This will include information about the use of walking aids and potential lifestyle changes post-surgery. The aim of psycho-education is to enhance the client’s understanding of his situation, thereby promoting informed decision-making and effective coping strategies.

**Plans for next session**In the next session, we will continue to provide emotional support and begin to explore the client’s feelings about the upcoming surgery. We will also start discussing strategies for coping with the changes that will come post-surgery, including the use of walking aids. The client’s feedback and progress will guide the specific topics and strategies discussed.

**Student Counsellor’s signature… Date…** 31/01/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…**3 **Date of intake…**01/02/2024

**Client Code…**A3  **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Female **Age:** 17  
**Marital status:** Single

**Relevant history concerning previous counselling treatment( if any)**

No previous counselling treatment.

**The current situation (allow the client to share whatever has brought him/her for therapy)**

The client has been experiencing physical symptoms for the past three months, including regular headaches, back pain, weakness, and difficulty in walking. Despite seeking medical help, no physiological causes have been identified for these symptoms. These issues have negatively impacted her academic performance, suggesting a significant level of distress. The symptoms align with Conversion Disorder, a condition where psychological stress manifests as physical symptoms.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**

Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: client appears anxious

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**SESSION 1 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A3 | 01/02/2024 | 10.30 am | 1 | 1 ½ hrs | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client's primary concern is the experience of physical illnesses persisting for the past 3 months, which have significantly impacted her daily life and academic performance. Despite seeking medical help, no physiological causes have been identified, leading to distress and uncertainty about the origin and management of her symptoms. The client is seeking therapy to explore the underlying factors contributing to her physical symptoms and to develop coping strategies to manage her distress effectively.

**Goal(s) for therapy**

Explore and understand the psychological factors contributing to the client's physical symptoms, including potential stressors, emotional triggers, and coping mechanisms.

Develop coping strategies and resilience skills to manage the distress associated with the symptoms and uncertainty about their cause.

Enhance the client's ability to maintain academic performance and engage in daily activities despite the presence of physical symptoms.

Foster a sense of empowerment and agency in the client's ability to navigate and advocate for her physical and emotional well-being.

**Interventions (state theories used)**

1. Psycho-education: Provide information and psycho education about conversion disorder and the mind-body connection to help the client understand the interplay between psychological factors and physical symptoms.

2. Exploratory Therapy: Explore the client's past experiences, family dynamics, and stressors to identify potential underlying factors contributing to her symptoms and develop insight into her emotional and psychological well-being.

**Plans for next session**

In the upcoming session, our primary focus will be on creating a safe and exploratory space for the client to delve deeper into her experiences and emotions related to her physical symptoms. We will adopt a collaborative approach to uncovering the underlying psychological factors contributing to her symptoms, with the goal of gaining greater insight and understanding.

**Student Counsellor’s signature… Date…**01/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 4 **Date of intake…** 07/02/2024

**Client Code…** A4 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Male **Age:   
Marital status:** Married

**Relevant history concerning previous counselling treatment( if any)**

Client has attended counselling sessions in the past. Most of these sessions were conducted in a rehabilitation centre where he was recovering from Alcohol addiction.

**The current situation (allow the client to share whatever has brought him/her for therapy).**

Client is grappling with alcohol addiction, which has persisted for several years. He initiated alcohol consumption during his time at university out of curiosity and peer pressure. The desire to avoid isolation and fit in with his social circle led him deeper into alcohol abuse. This addiction has inflicted significant personal and social distress upon him. He expresses a strong desire to overcome this addiction and reclaim control over his life.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**

Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are euthymic, reflecting a balanced and stable emotional state.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A4 | 07/02/2024 | 11.20 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client's primary concern revolved around a persistent struggle with alcohol addiction, marking a significant impact on various facets of their life. The repercussions extended to both personal well-being and social relationships. The client recognized that the challenges posed by alcohol addiction had led to a substantial negative influence on their overall quality of life.

**Goal(s) for therapy**The overarching goal for therapy was to support the client in overcoming his alcohol addiction and regaining control over his life. Specific goals included developing coping strategies to manage cravings, enhancing self-awareness and insight into triggers for alcohol abuse, and rebuilding healthy interpersonal relationships free from the influence of alcohol.

**Interventions (state theories used)**Cognitive-behaviour Therapy (CBT): I utilized this approach to help the client identify and challenge distorted thought patterns and beliefs related to alcohol use, as well as develop more adaptive coping mechanisms to manage triggers and cravings.

Motivational Interviewing (MI): I employed MI techniques to explore the client's ambivalence about change and to enhance his intrinsic motivation to overcome alcohol addiction. Through empathic listening and collaborative goal-setting, I helped the client identify personal values and goals that aligned with sobriety.

**Plans for next session**In the next session, I will continue to explore the client's relationship with alcohol, including identifying specific triggers and stressors that contribute to his drinking behaviour. Additionally, I will introduce strategies for coping with cravings and managing high-risk situations effectively. The session will also focus on reinforcing the client's motivation for change and exploring any potential barriers to treatment engagement.

**Student Counsellor’s signature… Date…** 07/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 5 **Date of intake…** 12/02/2024

**Client Code…** A5 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Male **Age:** 31 **Marital status:** Engaged

**Relevant history concerning previous counselling treatment( if any)**

No previous counselling.

**The current situation (allow the client to share whatever has brought him/her for therapy).**

The client, a recovering alcohol addict, sought counselling to address concerns regarding his exit plan as he prepared for discharge. His challenges included experiencing a lack of support from siblings and relatives, leading to feelings of anger and resentment towards them. Furthermore, he struggled with a lack of a meaningful income source, anger management issues, and instances of relapse triggered by stress.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**

Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are euthymic, reflecting a balanced and stable emotional state.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A5 | 12/02/2024 | 9.00 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client's primary concern revolves around his enduring struggle with alcohol addiction, which has had a profound impact on various facets of his life, including personal well-being and social relationships. This addiction has intertwined with emotional, psychological, and interpersonal dimensions, affecting his self-perception, coping mechanisms, and ability to maintain healthy connections with others. Therapy aims to explore the specific ways in which alcohol addiction has disrupted his daily functioning, emotional state, and relationships, with the goal of understanding his unique experiences and challenges to facilitate meaningful progress towards recovery and improved quality of life.

**Goal(s) for therapy**

1. Overcoming alcohol addiction and achieving sobriety.

2. Developing effective coping strategies to manage triggers, cravings, and underlying emotional challenges.

3. Rebuilding healthy interpersonal relationships and fostering personal growth and resilience.

4. Develop a relapse prevention plan to maintain long-term sobriety and overall well-being.

**Interventions (state theories used)**

Motivational interviewing was employed to engage the client in exploring intrinsic motivations for change and enhancing commitment to therapy. Through active listening and empathetic understanding, I aimed to elicit the client's reasons for considering change, exploring their values, goals, and aspirations. This approach acknowledged the client's autonomy and empowered them to take ownership of their recovery journey. By collaboratively setting achievable goals aligned with the client's values, motivational interviewing facilitated commitment to positive change. Addressing ambivalence towards change, the approach prompted reflection on the benefits of overcoming substance use and its impact on various life domains. Overall, motivational interviewing provided a client-centered framework that fostered exploration of motivations, values, and goals, enhancing commitment to change and promoting a healthier, more fulfilling life. Through empathy and collaboration, the client was empowered to embrace transformation and embark on a journey towards recovery with insight, motivation, and resilience.

**Plans for next session**

Continue exploring the client's concerns and progress towards his goals. Specific interventions will include further exploration of family dynamics and strategies to enhance social support, as well as continued work on anger management and relapse prevention techniques. Additionally, assist the client in identifying and exploring potential income sources and practical steps to address financial instability. Finally, the session will aim to reinforce the client's motivation and commitment to his recovery journey.

**Student Counsellor’s signature… Date…** 12/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 6 **Date of intake…** 14/02/2024

**Client Code…** A6 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Male **Age:** 22 **Marital status:** Single  **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**During our initial session, the client shared that he was referred for counselling by his doctor following a para-suicide attempt. He disclosed that he dropped out of school at Form 1 level and currently works as a boda boda operator for a living. The client mentioned a distressing incident where a girl he had been intimate with was accused of being HIV positive by one of his boda boda acquaintances. Although he underwent HIV testing twice, and results turned out negative, he continues to struggle with overthinking and stress, which culminated in his suicidal attempt.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are euthymic, reflecting a balanced and stable emotional state.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

In relation to his concerns, it is evident that the client is grappling with significant emotional distress and psychological turmoil stemming from the perceived risk of HIV exposure and the associated stigma. Despite testing negative for HIV, the client's persistent overthinking and stress highlight the impact of the incident on his mental well-being. Additionally, the client's decision to engage in para suicidal behaviour underscores the severity of his emotional struggles and the need for timely intervention and support. Overall, the client's ability to engage in the therapeutic process and his willingness to explore coping strategies indicate his potential for positive growth and recovery with appropriate counselling and support.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A6 | 14/02/2024 | 10.00 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client is deeply troubled by the perceived risk of HIV exposure and the resulting stigma. Despite receiving negative HIV test results, the constant overthinking and stress surrounding the incident have profoundly affected his mental well-being. The client's choice to engage in para-suicidal behaviour reflects the severity of his emotional distress and underscores the urgent need for intervention and support to address his struggles effectively.

**Goal(s) for therapy**1. To help the client develop coping strategies to manage overthinking and stress related to the perceived HIV risk.  
2. To address and reduce the stigma associated with HIV exposure.  
3. To enhance the client's emotional resilience and improve his overall mental well-being.  
4. To promote healthy coping mechanisms and prevent future para-suicidal behaviour.

**Interventions (state theories used)**

1. Cognitive-Behavioural Therapy (CBT): Implementing cognitive restructuring techniques to challenge and reframe the client's negative thoughts and beliefs about HIV exposure and stigma.  
2. Psycho-education: Providing information and resources to help the client understand the reality of his HIV risk and reduce irrational fears and anxieties.  
3. Mindfulness-Based Stress Reduction (MBSR): Introducing mindfulness practices to help the client cultivate present-moment awareness and develop effective coping skills for managing stress and overthinking.  
4. Narrative Therapy: Exploring the client's experiences and beliefs surrounding HIV exposure and stigma, while empowering him to rewrite his narrative and reclaim his sense of agency and self-worth.

**Plans for next session**

In the next session, we will continue to explore the client's thoughts and feelings about the perceived HIV risk and the impact of stigma on his mental well-being. We will further develop coping strategies and skills tailored to address his specific concerns. Additionally, we will revisit and reinforce the importance of seeking support and adhering to healthy coping mechanisms to prevent future para-suicidal behaviour. Regular monitoring and assessment of the client's progress will be prioritized to ensure that his therapeutic needs are effectively met.

**Student Counsellor’s signature… Date…** 14/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 7 **Date of intake…** 14/02/2024

**Client Code…** A7 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Female  **Age:** 50 **Marital status:** Married **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client is being managed for depression with psychotic features. She reports hostile home environment and that her husband poses a constant risk of violence towards her. As a result she has been dealing depressive symptoms since 2009. She also mentioned that the husband is afraid she might claim ownership of the family wealth(livestock). She states that the main motive of staying in that marriage is her deep concern for her kids. But due to the unbearable circumstances, she has decided to flee from her home and never go back. She is willing to start hustling and working to sustain herself provided she never goes back to her husband.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are euthymic, reflecting a balanced and stable emotional state.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.  
  
In relation to her concerns, the client's decision to flee from her home underscores the severity of the situation and the urgency of intervention and support. Her readiness to embark on a new journey of self-reliance demonstrates resilience and a commitment to improving her circumstances. However, the client's emotional and psychological well-being remains at risk due to the trauma and stressors associated with her current environment. It is important to provide immediate support and assistance to ensure her safety, stability, and holistic recovery.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A7 | 14/02/2024 | 11.00 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client is seeking therapy due to a hostile home environment and ongoing risk of violence from her husband, compounded by depressive symptoms with psychotic features since 2009. She expresses deep concern for her children's well-being, but the intolerable circumstances have led her to decide to flee her home and never return. She is willing to work and sustain herself independently but is adamant about avoiding any contact with her husband to ensure her safety and well-being.

**Goal(s) for therapy**1. Provide immediate support and safety planning to ensure the client's well-being during her transition phase.  
2. Address and manage the client's depressive symptoms with psychotic features.  
3. Assist the client in processing and coping with the trauma and emotional distress.  
4. Empower the client to establish boundaries and assert her rights to ensure her safety and autonomy in future relationships.  
5. Support the client in exploring and pursuing avenues for financial independence and stability to sustain herself and her children.

**Interventions (state theories used)**1. Trauma-informed therapy: Utilized to address the client's experiences of trauma and distress resulting from the hostile home environment and ongoing risk of violence. This approach emphasizes safety, trust, and empowerment, while acknowledging the client's resilience and capacity for healing.  
2. Cognitive-behavioural therapy (CBT): Implemented to address the client's depressive symptoms and psychotic features by identifying and challenging negative thought patterns, enhancing coping skills, and promoting adaptive behaviour.  
3. Psycho-education: Offered to help the client understand the dynamics of abusive relationships, recognize warning signs of domestic violence, and develop strategies for safety planning and risk management.  
4. Empowerment-based therapy: Focused on supporting the client in reclaiming control over her life, establishing boundaries, and making decisions that prioritize her safety, autonomy, and well-being.

**Plans for next session**Continue to address the client's emotional needs, provide ongoing support, and explore long-term strategies for achieving independence and rebuilding her life free from the threat of violence. Additionally, develop a safety plan and explore available resources, including emergency shelters and legal assistance if necessary.

**Student Counsellor’s signature… Date…** 14/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 8 **Date of intake…** 15/02/2024

**Client Code…** A8 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Female  **Age:** 29 **Marital status:** Single

**Relevant history concerning previous counselling treatment( if any)**

Has had previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**The client was referred by her doctor due to presenting symptoms of schizophrenia, Major Depressive Disorder (MDD) with psychotic features, and alcohol addiction. Her primary concerns revolve around the significant emotional distress stemming from her unemployment since graduating in 2019, which has led to alcohol misuse as a coping mechanism. Additionally, she reports strained relations with her mother, who becomes violent towards her when she returns home intoxicated. The client has made seven suicide attempts, highlighting the severity of her distress and the need for immediate intervention and support.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are dysphoric, indicating a state of distress or unease.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A8 | 15/02/2024 | 1.40 pm | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

Client’s main concern is the lack of gainful employment that is leading to her despair in life. She attributes most of her current challenges like alcohol addiction to the lack of meaningful work.

**Goal(s) for therapy**

1. To stabilize the client's mental health and reduce the frequency and severity of her symptoms of schizophrenia, MDD, and alcohol addiction.  
2. To address the underlying issues contributing to the client's emotional distress, including unemployment, strained family relationships, and maladaptive coping mechanisms.  
3. To enhance the client's coping skills and resilience, empowering her to manage stressors and triggers more effectively.  
4. To establish safety measures and develop a crisis management plan to prevent future suicide attempts and ensure the client's immediate well-being.  
5. To improve the client's social support network and facilitate the rebuilding of positive relationships with family and friends.

**Interventions (state theories used)**

Motivational Interviewing (MI): Employing MI techniques to enhance the client's motivation and commitment to change, particularly in addressing her alcohol addiction and unemployment.  
Family Therapy: Engaging the client and her mother in family therapy sessions to address communication issues, resolve conflicts, and improve familial support networks.  
Psycho-education: Providing the client with information and resources about schizophrenia, MDD, alcohol addiction, and suicide prevention to increase her understanding and empower her in managing her mental health.

**Plans for next session**

In the next session, we will focus on establishing a comprehensive treatment plan tailored to the client's specific needs and circumstances. We will continue to explore the underlying factors contributing to her emotional distress and develop strategies to address them effectively.

**Student Counsellor’s signature… Date…** 15/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 9 **Date of intake…** 16/02/2024

**Client Code…** A9 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Male **Age:** 17 **Marital status:** Single

**Relevant history concerning previous counselling treatment( if any)**

No previous counselling history.

**The current situation (allow the client to share whatever has brought him/her for therapy).**

The client is a form 3 student diagnosed with schizophrenia. He is the eldest child in a family of three. He has been battling with schizophrenia since his childhood but managed it by way of medication. Mid last year, it got severe after he stopped taking his medication which led to adverse effects among them: auditory hallucinations, inability to focus in school(missed a whole term), excessive sleep and even neglecting his self-care.

The client’s mother also reports that the son is always adamant whenever he wants something and it must be done regardless of possibility and practicality. She mentions his insisting on repeating form 2 because he missed 1 term instead of proceeding to form 3. Aspects of perfectionism are also evident in the client.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**

Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are euthymic, reflecting a balanced and stable emotional state.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A9 | 16/02/04 | 12.00 pm | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client, a form 3 student diagnosed with schizophrenia, seeks therapy due to the exacerbation of symptoms after discontinuing medication. The adverse effects include auditory hallucinations, impaired focus in school resulting in a missed term, excessive sleep, and neglect of self-care. Additionally, the client's mother reports adamant behaviour and perfectionistic tendencies, such as insisting on repeating a grade due to missing one term.

**Goal(s) for therapy**

1. Stabilize and manage symptoms of schizophrenia to improve daily functioning and academic performance.

2. Enhance coping skills to address adamant behaviour and perfectionism.

3. Foster insight into the impact of symptoms on academic and social domains.

4. Develop strategies to support the client's autonomy and independence within academic and familial contexts.

**Interventions (state theories used)**

1. Cognitive-behaviour Therapy (CBT): Utilized to address cognitive distortions associated with schizophrenia symptoms, develop coping strategies for managing stress and auditory hallucinations, and challenge perfectionist tendencies.

2. Psychoeducation: Offered to the client and family members to increase understanding of schizophrenia, medication adherence, and strategies for symptom management.

3. Family Therapy: Employed to explore family dynamics and communication patterns, enhance support for the client, and address conflicts related to academic expectations and treatment adherence.

**Plans for next session**

In the next session, we will collaboratively develop a treatment plan focusing on medication adherence, symptom management, and academic support. We will explore coping strategies tailored to the client's needs and address family dynamics affecting treatment adherence and academic progress. Additionally, we will introduce relaxation techniques and stress management strategies to mitigate symptoms and enhance overall well-being. The session will prioritize establishing a supportive therapeutic alliance and fostering the client's resilience in managing symptoms and achieving academic success.

**Student Counsellor’s signature… Date…** 16/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 10 **Date of intake…** 19/02/2024

**Client Code…** A10 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Female **Age:** 24 **Marital status:** Single  **Relevant history concerning previous counselling treatment( if any)**

Has had previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**

Client is a 24 year old female diagnosed with bipolar substance abuse. She is the second born in a family of 3. She has a daughter. She is single. She was adherent to medication but condition got worse after stopping medication. She reports family issues with her grandmother whom she grew up with after her mother passed away when she was 2. She also reports that her cousin sisters are jealous of her whenever she succeeds in anything. Currently her daughter is being raised by her grandmother.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**

Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are euthymic, reflecting a balanced and stable emotional state.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A10 | 19/02/2024 | 2.30 pm | 1 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client, a 24-year-old female diagnosed with bipolar disorder and substance abuse, seeks therapy due to the worsening of her condition after discontinuing medication. She also expresses distress over family issues, including conflicts with her grandmother, who raised her after her mother's passing, and jealousy from her cousin sisters. Additionally, the client's daughter is currently being raised by her grandmother, adding to her emotional burden and concerns.

**Goal(s) for therapy**

1. Stabilize and manage symptoms of bipolar disorder and substance abuse to improve overall functioning and quality of life.  
2. Address and process unresolved grief and family conflicts related to the client's upbringing and relationships.  
3. Develop coping strategies to manage stressors and triggers associated with family dynamics and interpersonal conflicts.  
4. Enhance parenting skills and support the client in navigating the complexities of raising her daughter while managing her mental health condition and family issues.

**Interventions (state theories used)**

1. Narrative Therapy: Employed to explore the client's life experiences, including her upbringing, loss of her mother, and family dynamics, to facilitate understanding, healing, and reframing of personal narratives.

2. Motivational Interviewing: Integrated to explore the client's ambivalence towards treatment adherence and substance use, to enhance motivation for change, and to support the client in making informed decisions regarding her health and well-being.

**Plans for next session**

In the next session, we will focus on establishing a therapeutic rapport and exploring the client's concerns and goals in greater depth. We will further assess the impact of family dynamics and interpersonal conflicts on the client's mental health and well-being. Additionally, we will collaboratively develop a treatment plan tailored to the client's unique needs, incorporating interventions aimed at symptom management, coping skills development, and resolution of unresolved issues. The session will prioritize creating a safe and supportive space for the client to explore and address her concerns, fostering empowerment and resilience in her journey towards healing and recovery.

**Student Counsellor’s signature… Date…** 19/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 11 **Date of intake…** 21/02/2024

**Client Code…** A11  **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**

**Gender:** Female **Age:** 35 **Marital status:** Single

**Relevant history concerning previous counselling treatment( if any)**

Has had previous counselling experience

**The current situation (allow the client to share whatever has brought him/her for therapy).**

The client, diagnosed with Schizoaffective disorder, is a mother of three who lost her husband ten years ago. She had her last episode three years ago. She expresses her main challenge as the ability to maintain employment, citing impulsive decision-making as a significant factor in quitting her last three jobs. She struggles with decision-making, often regretting choices made without consultation due to a lack of a nearby support system. Additionally, she recently experienced a miscarriage from a relationship outside of marriage, leading to conflicts with her religious mother. She feels lost and seeks guidance.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**

1. Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.
2. Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.
3. Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.
4. Mood and Affect: The client's mood and affect are dysphoric, appears overwhelmed indicating a state of distress or unease.
5. Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.
6. Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A11 | 21/02/2024 | 9.40 am | 1 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client seeks therapy due to challenges with decision-making, job stability, and emotional distress from a recent miscarriage and conflicts with her religious mother. Her impulsive actions have led to job losses, contributing to regret and frustration. The emotional toll of the miscarriage and strained familial relationships exacerbates her vulnerability. Seeking therapy indicates her recognition of the need for support and guidance to navigate these issues. She aims to address her behaviour patterns, develop coping strategies, and gain insight into her emotions to foster resilience.

**Goal(s) for therapy**

1. Enhance the client's ability to make informed decisions and manage impulsivity.  
2. Develop coping strategies to navigate conflicts with her mother and cope with the emotional aftermath of the miscarriage.  
3. Establish a supportive network and improve social connections to mitigate feelings of isolation and loneliness.  
4. Improve self-esteem and self-confidence to pursue and maintain stable employment.

**Interventions (state theories used)**

Cognitive-Behavioural Therapy: used to identify and challenge maladaptive thought patterns and impulsive behaviour. Through CBT, the client learned to recognize negative thoughts and gained practical strategies for fostering healthier decision-making processes. This included cognitive restructuring techniques to reframe negative thoughts into more balanced perspectives. By addressing maladaptive patterns, CBT empowered the client to make deliberate choices, leading to improved outcomes and increased well-being.

Narrative Therapy: I facilitated the client's exploration and reconstruction of their personal narrative, emphasizing empowering stories of resilience and strength. By re-framing past experiences and exploring alternative perspectives, the client gained a deeper understanding of themselves and their circumstances, leading to positive changes in behaviour and emotional well-being.

**Plans for next session**

In the next session, we will focus on exploring the client's coping mechanisms and identifying triggers for impulsive decision-making. We will also begin to address the client's conflicts with her mother and the emotional distress surrounding the recent miscarriage. Additionally, we will work towards establishing a supportive network.

**Student Counsellor’s signature… Date…** 21/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 12 **Date of intake…** 27/02/2024

**Client Code…** A12  **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).**Gender**:** Female  **Age:** 24 **Marital status:** Single **Relevant history concerning previous counselling treatment( if any)**Has had previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**The client, diagnosed with bipolar mood disorder, is currently admitted to an in-patient ward for individuals with mental illnesses. Two days ago, her medication was changed by the doctors without her being informed. She reports experiencing headaches as the main side effect of the new medication. She expresses feelings of sadness and anger for not being informed about the medication change and feels uncomfortable in the current ward, desiring a transfer to another ward.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are dysphoric, appears overwhelmed indicating a state of distress or unease.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A12 | 27/02/2024 | 9.10 am | 1 | 45 minutes | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client seeks therapy due to a lack of communication regarding her recent medication change and discomfort within the in-patient ward environment. This absence of communication about medication adjustments induces distress and uncertainty about her treatment plan. Additionally, discomfort within the ward environment evokes anxiety and frustration. She aims to address the communication gap, alleviate discomfort, and enhance her overall well-being and treatment experience.

**Goal(s) for therapy**1. To address and manage the client's emotional distress stemming from the lack of communication regarding medication changes.  
2. To explore coping strategies to alleviate the client's discomfort and facilitate adjustment to the current in-patient ward environment.  
3. To empower the client to advocate for her preferences regarding her treatment and environment within the in-patient setting.

**Interventions (state theories used)**1. Client-centered Therapy: Utilized to provide the client with a supportive and empathetic space to express her concerns and emotions freely. By validating her experiences and facilitating self-exploration, client-centered therapy promotes insight and emotional healing.  
2. Psychoeducation: Offered to enhance the client's understanding of her medication regimen and the importance of effective communication with healthcare providers. Providing information about medication changes and the treatment process can empower the client to actively participate in her care.

**Plans for next session**In the next session, we will focus on exploring the client's emotional responses to the lack of communication regarding her medication change and identifying coping strategies to manage her discomfort in the current in-patient ward environment. Additionally, we will discuss strategies for effective communication with healthcare providers and advocate for the client's preferences regarding her treatment and environment. The session will prioritize providing the client with support, validation, and practical tools to navigate her current challenges effectively.

**Student Counsellor’s signature… Date…** 27/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 13 **Date of intake…** 28/02/2024

**Client Code…** A13 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Female  **Age:** 30 **Marital status:** Married  **Relevant history concerning previous counselling treatment( if any)**Has had previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**During our session, the client shared her journey coping with epilepsy-induced psychosis with mood features while being a mother of two. She has been hospitalized twice due to her condition. Managing anger has been a significant challenge for her, especially when her family doesn't meet her high expectations, leading to disappointment and triggering her anger. She described feeling unconscious during moments of anger and often becomes violent, only realizing the extent of her actions after her anger subsides. Additionally, she expressed feeling stressed due to a lack of support system and a meaningful source of income.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are dysphoric, appears overwhelmed indicating a state of distress or unease.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A13 | 28/02/2024 | 1.30pm | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client seeks therapy to address difficulties managing anger, coping with epilepsy-induced psychosis, and finding support and stability. She aims to explore strategies for anger management, develop coping mechanisms for her condition, and establish meaningful support systems.

**Goal(s) for therapy**1. Develop effective anger management strategies to prevent violent outbursts and enhance self-awareness during episodes anger.  
2. Explore coping mechanisms to better manage the challenges associated with epilepsy induced psychosis.  
3. Establish a support system to provide emotional and practical assistance during times of need.  
4. Identify and pursue meaningful avenues of income generation to reduce financial stress and increase stability in her life.

**Interventions (state theories used)**

Cognitive-Behavioural Therapy (CBT) to pinpoint and challenge negative thought patterns while helping the client develop coping strategies for managing her emotions and behaviour effectively. Through active engagement and collaborative exploration, we identified triggers and thought distortions, working together to reframe them into more adaptive perspectives.  
  
Psychoeducation on self-awareness, offering structured sessions to impart knowledge and insights into the client's own thoughts, emotions, and behaviour. This approach aimed to empower her with a deeper understanding of herself, fostering increased self-awareness and insight into her personal challenges.  
  
Supportive Therapy: facilitated a supportive environment where the client felt safe to explore her experiences and express her emotions openly. By offering empathy, validation, and encouragement, I helped her gain new perspectives and insights into her challenges, fostering growth and resilience along the way.

**Plans for next session**

No plans for next session. Client is scheduled for discharge.

**Student Counsellor’s signature… Date…** 28/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 14 **Date of intake…** 28/02/2024

**Client Code…** A14 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:** Female **Age:** 40 **Marital status:** Married **Relevant history concerning previous counselling treatment( if any)**Has had previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client , a mother of 2 with 1 child deceased, is being managed for Bipolar mood disorder with Retrovirus Disease(RVD). She shares that her step father was violent towards her from young age which resulted in early childhood trauma. As a child she faced rejection and stigma from her family members due to her mental illness. As a result she suffers from learned helplessness and tends to isolate herself most of the time.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**

Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are dysphoric, appears distressed indicating a state of distress or unease.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A14 | 28/02/2024 | 3.00 pm | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client's motivation for therapy originates from deep-seated learned helplessness, persistent isolation, and the emotional weight of past trauma and familial rejection. These concerns, rooted in enduring childhood experiences and ongoing struggles, encompass feelings of powerlessness, inadequacy, and social exclusion. Her emotional burden manifests in symptoms of anxiety and depression, affecting her ability to trust others and navigate daily life. Thus, therapy aims to address these fundamental issues of self-worth, belonging, and resilience.

**Goal(s) for therapy**

Develop personalized coping mechanisms to navigate learned helplessness and alleviate feelings of isolation.  
Cultivate resilience and enhance self-esteem to counteract the lasting effects of childhood trauma and ongoing social challenges.  
Foster meaningful social connections and support networks to foster a sense of belonging and acceptance within her community.

**Interventions (state theories used)**

1. Cognitive-Behavioural Therapy (CBT): Employed to challenge and restructure negative thought patterns, fostering adaptive coping strategies and enhancing emotional resilience.  
2. Trauma-Focused Therapy: Utilized to address the client's early childhood trauma, processing unresolved emotions and facilitating healing in a safe and supportive therapeutic environment.  
3. Social Support Interventions: Integrated to help the client rebuild interpersonal connections, establish healthy boundaries, and cultivate a supportive network of individuals who validate her experiences and provide emotional sustenance.

**Plans for next session**

1. Explore coping mechanisms: Delve deeper into identifying and practising coping strategies to manage learned helplessness and alleviate feelings of isolation.  
2. Process past trauma: Provide a safe space for the client to explore and process her experiences of childhood trauma and familial rejection, fostering healing and emotional resolution.  
3. Develop social skills: Work on enhancing interpersonal skills and building connections with others, helping the client establish supportive relationships and combat feelings of social exclusion.  
4. Set achievable goals: Collaboratively establish short-term and long-term goals that align with the client's aspirations and promote a sense of empowerment and progress.  
5. Monitor progress: Regularly assess and review the client's progress towards their therapeutic goals, adjusting interventions and strategies as needed to ensure effectiveness and client engagement.

**Student Counsellor’s signature… Date…** 28/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 15 **Date of intake…** 04/03/2024

**Client Code…** A15  **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:** Male **Age:** 31 **Marital status:** Single **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client has been experiencing migraines and chronic insomnia due to stress for the past five years. He started experiencing these symptoms after discovering that his brother-in-law, whom he idolizes, was diagnosed with mental illness. The incident that led to this discovery was an ambush by police officers after the brother-in-law arrived home with a carrier bag full of marijuana. This incident was very traumatic to the client. Client experiences suicidal thoughts due to the overwhelming levels of pain he undergoes due to stress. He has even attempted suicide by way of overdose of painkillers.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Cognitively, client is stable with good insight and judgment.  
Emotionally, client is anxious and unstable due to sharing of past painful experiences.  
Social behaviour is appropriate.  
Physically, client appears healthy and fit despite losing weight.

After administering the Beck depression inventory to the client, he had a high score which translated to *severe depression.*

**SESSION 1 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A15 | 04/03/2024 | 9.30 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client seeks therapy to address his chronic migraines, insomnia, overwhelming stress, and severe depression, exacerbated by traumatic experiences and suicidal ideation.

**Goal(s) for therapy**1. Exploring the Client's History and Background: I delved deeply into the client's past experiences, family dynamics, and significant life events to uncover the root causes and triggers of their current challenges. Through this exploration, I aimed to identify patterns, traumas, and unresolved issues that may contribute to their present difficulties.  
2. Psycho-educating on the Effects of Stress: I provided details on the impacts of stress on the mind and body in order to empower the client with insights to make informed choices and adopt effective stress management strategies.  
3. Creating a Safe Space for Sharing: I strived to establish a secure and nurturing environment where the client felt validated, respected, and supported. By fostering trust and confidentiality, I encouraged the client to freely express their thoughts, feelings, and experiences without fear of judgment or rejection.

**Interventions (state theories used)**1. Psychodynamic Therapy: I employed psychodynamic principles to uncover unconscious conflicts, defences, and relational patterns underlying the client's symptoms and distress. By exploring childhood experiences, family dynamics, and unconscious processes, I aimed to bring hidden aspects of the client's psyche into awareness, promoting insight and resolution.  
2. Cognitive-Behavioural Therapy (CBT): I equipped the client with practical skills and strategies to identify, challenge, and modify negative thought patterns and maladaptive behaviours associated with stress. Through teaching cognitive restructuring techniques, relaxation exercises, and problem-solving skills, I empowered the client to manage stress more effectively and cultivate resilience.  
3. Humanistic Therapy: I emphasized empathy, authenticity, and unconditional positive regard within our therapeutic relationship. Through empathetic listening, reflection, and validation, I fostered a non-judgmental and accepting atmosphere where the client felt heard, understood, and accepted unconditionally.

**Plans for next session**1. Exploration of the client's personal history, including significant life events, relationships, and developmental milestones, to gain deeper insight into their unique experiences and challenges.  
2. Psycho-educate on stress management techniques, relaxation exercises, and lifestyle modifications tailored to the client's specific needs and preferences.  
3. Establish a safe and trusting therapeutic alliance, allowing the client to gradually explore and process sensitive or difficult emotions and experiences at their own pace.

**Student Counsellor’s signature… Date…** 04/03/2024

**SESSION 2 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A15 | 06/03/2024 | 2.30 pm | 2 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**This is a follow up session on the initial assessment session. Client shared more about his past including childhood traumas where he narrowly escaped after being drove over by a car on the road. He also states that among the issues contributing to his stress are the thoughts of being a failure and not reaching his potential at his age therefore leading to suicidal thoughts. During instances when he is financially unstable, he reports that his grandmother often labels him as a failure and disappointment and even abuses his mother at times.

**Goal(s) for therapy**1. Explore and address childhood traumas and their impact on current emotional well-being.  
2. Develop coping strategies to manage feelings of failure and suicidal ideation.  
3. Establish healthier boundaries and address dysfunctional family dynamics, particularly concerning the client's relationship with his grandmother.

**Interventions (state theories used)**1. Trauma-focused therapy: This method was used to help the client work through and heal from past traumatic experiences, particularly childhood traumas. By addressing these traumas directly, I aimed to integrate the associated emotions and memories, helping the client build emotional resilience and cope better with distressing memories.  
2. Cognitive-behavioural therapy (CBT): Through CBT, I focused on identifying and challenging negative thought patterns that contribute to the client's feelings of failure and inadequacy. By helping the client recognize and reframe these negative thoughts, I aimed to develop more adaptive coping mechanisms for dealing with stress and negative emotions.

**Plans for next session**1. Further explore the client's childhood traumas and their ongoing impact on his mental health.  
2. Introduce cognitive restructuring techniques to challenge negative self-perceptions and cultivate a more positive self-image.  
3. Discuss strategies for setting boundaries with family members and assertively addressing issues of criticism and abuse.

**Student Counsellor’s signature… Date…** 06/03/2024

**SESSION 3 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A15 | 08/03/2024 | 10.00 am | 3 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**This is a follow up session on the previous session.

**Goal(s) for therapy**The primary goals for therapy include continuing the exploration of the client's experiences, particularly revisiting childhood events to gain deeper insight into their psychological landscape. Additionally, we aim to restructure dysfunctional thought patterns using Cognitive-Behavioural Therapy (CBT) techniques, promoting cognitive flexibility and emotional well-being.

**Interventions (state theories used)**1. Psychoanalysis: Through psychoanalytic techniques, we delved deeper into the client's childhood experiences, aiming to uncover potential root causes contributing to their current circumstances.  
2. Person-Centered Therapy (PCT): Utilizing PCT principles, we endeavoured to create a safe and supportive space wherein the client could freely explore their past experiences. This approach fosters empathy, genuineness, and unconditional positive regard, facilitating the client's self-exploration and expression.  
3. Cognitive-Behavioural Therapy (CBT): Employing CBT strategies, we actively challenged and restructured the client's maladaptive thought patterns. By replacing negative beliefs with more adaptive alternatives, we aimed to promote cognitive restructuring and foster emotional resilience. Additionally, the client was assigned two tasks to complete independently, serving as practical applications of the therapeutic concepts discussed.

**Plans for next session**In the next session, we will continue our therapeutic journey by further exploring the client's childhood experiences and emotional responses. We will engage in psychoanalytic discussions to uncover deeper insights and promote emotional healing. Additionally, we will integrate CBT techniques to address and restructure dysfunctional thoughts, empowering the client to develop healthier cognitive patterns. The session aims to provide ongoing support and guidance as the client progresses towards their therapeutic goals.

**Student Counsellor’s signature… Date…** 08/03/2024

**SESSION 4 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A15 | 11/03/2024 | 10.05 am | 4 | 1 25 min | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**During this follow-up session, the client expressed concern about their lack of motivation to go to work, primarily stemming from an undesirable work environment characterized by gossip among colleagues. The client expressed a desire to isolate themselves rather than face the challenges of the workplace.

**Goal(s) for therapy**The goal of therapy was to equip the client with social skills necessary to navigate the challenging work environment and effectively interact with their colleagues.

**Interventions (state theories used)**Reality therapy was employed to address the client's concerns and develop practical strategies for improving social interactions and coping with workplace challenges. This approach focused on helping the client understand their choices, take responsibility for their actions, and make positive changes in their behaviour to achieve their goals.

**Plans for next session**The next session will involve reviewing progress made in implementing the strategies discussed during therapy and further exploring past experiences that led to depression.

**Student Counsellor’s signature… Date…** 11/03/2024

**SESSION 5 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A15 | 19/03/2024 | 10.00 am | 5 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**Client feels a lack of purpose in his job whenever he overcharges clients as instructed by his boss. This usually triggers depressive thoughts and in turn suicidal ideation. He also feels like the management at his workplace is not the best and that deterers a lot of clients.

**Goal(s) for therapy**1. Assist the client in shifting his focus towards aspects of his job that he can control, fostering a sense of agency and empowerment.  
2. Facilitate a change in perspective regarding elements of his job that he cannot control, helping him develop coping strategies to manage feelings of frustration and helplessness.

**Interventions (state theories used)**1. Cognitive-Behavioural Therapy (CBT): CBT techniques were implemented to assist the client in identifying and challenging negative thought patterns associated with his job. The goal was to address feelings of purposelessness and hopelessness triggered by overcharging clients. The client was encouraged to reframe his thoughts and develop more adaptive coping strategies to manage depressive symptoms and suicidal ideation.  
2. Solution-Focused Brief Therapy (SFBT): SFBT was utilized to explore the client's strengths and resources. The focus was on practical solutions and achievable goals to address his concerns about feeling purposeless in his job and the management issues at his workplace. The client was supported in identifying small steps he could take to regain a sense of purpose and control in his work environment.

**Plans for next session**Monitor the client's depressive symptoms and suicidal ideation to ensure his safety and well-being.

**Student Counsellor’s signature… Date…** 19/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 16 **Date of intake…** 29/03/2024

**Client Code…** A16 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:** Male **Age:** 16 **Marital status:** Single  **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**The client sought therapy due to struggles with drug addiction and academic challenges. He admitted to experimenting with drugs, primarily marijuana and alcohol, as a coping mechanism for stress and peer pressure. Recently, his substance use escalated, leading to conflicts at home and declining academic performance. He expressed concern about his future and recognized the need for support to address his addiction and academic concerns.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.

Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.

Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.

Mood and Affect: The client's mood and affect are dysphoric, appears overwhelmed indicating a state of distress or unease.

Social behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.

Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A16 | 29/02/2024 | 10.00 am | 1 | 1 ½ hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client's primary concerns revolve around his escalating drug addiction, academic struggles, strained relationships, and uncertain future prospects. He recognizes the need for intervention to address these issues and regain control of his life.

**Goal(s) for therapy**1. Help the client achieve and maintain sobriety from drug and alcohol use.  
2. Improve academic performance and develop effective study habits.  
3. Enhance coping skills to manage stress, peer pressure, and emotional challenges.  
4. Rebuild and strengthen familial and social relationships.

**Interventions (state theories used)**1. Motivational Interviewing: Utilized to explore and resolve ambivalence towards change, enhance intrinsic motivation for sobriety, and set achievable goals.  
2. Cognitive-Behavioural Therapy (CBT): Implemented to challenge negative thought patterns, identify triggers for substance use, and develop coping strategies to prevent relapse.  
3. Family Therapy: Incorporated to address familial conflicts, improve communication, and foster a supportive environment for the client's recovery.  
4. Psychoeducation: Provided to increase awareness of the effects of drug addiction, enhance understanding of academic challenges, and promote healthy lifestyle choices.

**Plans for next session**In the next session, we will:  
- Conduct a detailed assessment of the client's substance use history and triggers.  
- Begin exploring underlying factors contributing to the client's drug addiction and academic struggles.  
- Collaboratively set short-term and long-term goals to address the client's concerns.  
- Introduce coping strategies and relapse prevention techniques.  
- Discuss family involvement and potential referrals to support groups or rehabilitation programs.

**Student Counsellor’s signature… Date…** 29/02/2024

**SESSION 2 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A16 | 03/03/2024 | 10.20 am | 1 | 1 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy):**

The client continues to struggle with drug addiction and academic challenges. He expresses feelings of frustration and uncertainty about his future, recognizing the need for support to overcome these obstacles.

**Goal(s) for therapy:**1. Achieve and maintain sobriety from drug and alcohol use.  
2. Improve academic performance and develop effective study habits.  
3. Enhance coping skills to manage stress, peer pressure, and emotional challenges.  
4. Rebuild and strengthen familial and social relationships.

**Interventions (state theories used):**Motivational Interviewing: Utilized to explore and resolve ambivalence towards change, enhance intrinsic motivation for sobriety, and set achievable goals.  
Cognitive-Behavioural Therapy (CBT): Implemented to challenge negative thought patterns, identify triggers for substance use, and develop coping strategies to prevent relapse.  
Family Therapy: Incorporated to address familial conflicts, improve communication, and foster a supportive environment for the client's recovery.  
Psychoeducation: Provided to increase awareness of the effects of drug addiction, enhance understanding of academic challenges, and promote healthy lifestyle choices.

**Plans for next session:**- Review progress made towards sobriety and academic goals since the last session.  
- Explore any challenges or barriers encountered during the implementation of coping strategies.  
- Assess the client's level of family support and discuss opportunities for family involvement in the treatment process.  
- Further refine and tailor intervention strategies based on the client's evolving needs and progress.  
- Discuss potential referrals to support groups, vocational training programs, or additional therapeutic services as needed.

**Student Counsellor’s signature… Date…** 03/03/2024

**SESSION 3 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A16 | 07/02/2024 | 2.00 pm | 3 | 1 ½ hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client sought therapy to address drug addiction and academic challenges, particularly the risk of dropping out of school.

**Goal(s) for therapy**1. Achieve Sobriety and Maintain Abstinence: The primary goal was for the client to overcome drug addiction and stay sober.  
2. Strengthen Relapse Prevention: Develop strategies to prevent relapse and maintain progress.  
3. Set Long-Term Objectives: Establish long-term goals for personal growth and academic success.  
4. Enhance Coping Mechanisms: Learn healthy coping mechanisms to deal with stress and triggers.  
5. Discuss Closure: Address unresolved issues and bring closure to the therapeutic process.  
6. Foster Support Networks: Build a supportive network of friends, family, and community resources.

**Interventions (state theories used)**Reflective Listening: Actively listened to the client's concerns and feelings, providing empathy and validation.  
Solution-Focused Therapy: Collaboratively identified solutions and set achievable goals to address the client's challenges.  
Relapse Prevention: Implemented strategies to identify triggers, develop coping skills, and prevent relapse.

**Progress and Challenges Resolved:**  
The client has made significant progress in achieving sobriety and maintaining abstinence from drugs and alcohol. He is currently enrolled in a rehabilitation program and continues to attend support group meetings regularly. Academically, he has shown improvement in his grades and has developed effective study habits with the support of tutoring and academic counselling services at school. Additionally, the client has strengthened his familial relationships and has established a supportive network of friends who encourage his recovery journey.

**Plans for next session**As this is our final session, there are no plans for the next session.

**Student Counsellor’s signature… Date…** 07/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 17 **Date of intake…** 12/02/2024

**Client Code…** A17 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Female **Age:** 35 **Marital status:** Married **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client is a mother of 3 high-school going children. She has been having disagreements and conflicts with her husband. She once tried to commit suicide after a heated exchange with her husband. This is the second attempt at suicide after her husband got violent with her condemning her for selling firewood that he claims was his property. She feels like she cannot continue coexisting with her husband and would like to stay away from him.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**The client demonstrates good insight and judgment regarding their circumstances. Their mood and affect appear euthymic, and their social behaviour is appropriate. However, their appearance is unkempt, they avoid eye contact, and exhibit a slouched posture, suggesting possible discomfort or distress.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A17 | 12/02/2024 | 9.30 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**

The client, a mother of three high-school going children, sought therapy due to ongoing disagreements and conflicts with her husband. She experienced significant distress, culminating in two suicide attempts, particularly after a heated exchange and violence from her husband regarding the sale of firewood. The client expressed a strong desire to distance herself from her husband due to the toxic nature of their relationship.

**Goal(s) for therapy**The primary goal of therapy was to help the client navigate and resolve conflicts within her marriage, develop healthy coping mechanisms for managing distress, and explore options for improving her overall well-being and safety.

**Interventions (state theories used)**The therapy interventions primarily drew from Cognitive-Behavioural Therapy (CBT) to help the client challenge and restructure maladaptive thought patterns contributing to her distress. Additionally, Solution-Focused Brief Therapy (SFBT) techniques were utilized to explore potential solutions and coping strategies, focusing on the client's strengths and resources.

**Plans for next session**In the next session, we planned to continue exploring the client's experiences within the marriage, identify specific triggers for conflicts, and further develop coping strategies and safety plans to address the client's concerns and enhance her overall emotional well-being. Additionally, we aimed to explore potential support networks and community resources available to the client.

**Student Counsellor’s signature… Date…** 12/02/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 18 **Date of intake…** 12/3/2024

**Client Code…** A18 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Female  **Age:** 16 **Marital status:** Single **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience. **The current situation (allow the client to share whatever has brought him/her for therapy).**The client, a Form 3 student, sought therapy following a suicide attempt by ingesting poison. Her poor academic performance and fear of her father's reaction were identified as primary factors contributing to her distress and suicidal behaviour.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**The client displays good insight and judgment regarding their situation. Their mood and affect appear euthymic, reflecting a balanced emotional state. Social behaviour is appropriate. However, their appearance, while neat and well-kempt, shows signs of fatigue and exhaustion, indicating possible stress or exhaustion.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A18 | 12/3/2024 | 12.00 | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client, a Form 3 student, sought therapy following a suicide attempt by ingesting poison. Her poor academic performance and fear of her father's reaction were identified as primary factors contributing to her distress and suicidal behaviour.

**Goal(s) for therapy**The main goal of therapy was to address the client's emotional distress related to academic performance and her fear of her father's reaction. Additionally, therapy aimed to develop coping strategies to manage stress and improve self-esteem and resilience.

**Interventions (state theories used)**The therapy interventions primarily drew from Cognitive-Behavioural Therapy (CBT) to help the client challenge negative thought patterns related to academic performance and fear of parental disapproval. Additionally, Solution-Focused Brief Therapy (SFBT) techniques were utilized to explore the client's strengths and resources and identify small achievable goals to improve academic performance and reduce distress.  
Psychoeducation: I provided the client with information about suicide risk factors, warning signs, and healthy coping strategies to manage academic stress and parental expectations.

**Plans for next session**In the next session, we plan to continue exploring the client's academic challenges and family dynamics, identify additional stressors contributing to her distress, and further develop coping strategies to enhance her resilience and emotional well-being. Additionally, we aimed to involve the client's family members in therapy to address any underlying issues within the family system and provide additional support to the client.

**Student Counsellor’s signature… Date…** 12/3/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 19 **Date of intake…** 12/03/2024

**Client Code…** A19  **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Female **Age:** 17 **Marital status:** Single **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client is a form 4 student in a boarding school. She recently got involved with a group of girls who had been engaging in lesbianism. She got acquainted with the girls from another school at a inter-school co-curricular activities. The group introduced her to the act of lesbianism when they happened to share a dormitory. The girl feels she is slowly getting addicted to that life and would like to turn back and restore her normal sexual orientation before it’s too late.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**The client demonstrates good insight and maintains rational judgment throughout the session. However, their mood and affect appear anxious, suggesting underlying distress or tension. Social behaviour remains appropriate, and the client presents a neat and well-kempt appearance. It's worth noting that the client displays signs of restlessness throughout the session, indicating potential inner turmoil or discomfort.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A19 | 12/03/2024 | 4.00 pm | 1 | 1 ½ hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client, a form 4 student attending a boarding school, expressed distress over her recent involvement in a group engaged in lesbianism. This association was initiated during inter-school co-curricular activities when she befriended girls from another school who introduced her to this behaviour while sharing a dormitory. She now perceives herself as gradually becoming addicted to this lifestyle and wishes to revert to her previous sexual orientation to prevent further entrenchment.

**Goal(s) for therapy**1. Explore the underlying factors contributing to the client's engagement in lesbianism, including peer influence, personal beliefs, and emotional needs.  
2. Develop coping strategies tailored to resist peer pressure and maintain her desired sexual orientation while fostering self-acceptance and identity exploration.  
3. Enhance the client's self-esteem and assertiveness skills to navigate social interactions confidently and assert her boundaries effectively.

**Interventions (state theories used)**1. Cognitive-Behavioural Therapy (CBT): Employed to identify and challenge distorted thoughts and beliefs related to sexual orientation, self-image, and peer influence. Techniques such as cognitive restructuring and behavioural experiments are utilized to promote healthier thinking patterns and adaptive behaviours.  
2. Motivational Interviewing (MI): Utilized to explore the client's ambivalence towards changing her behaviour and enhance intrinsic motivation for positive change. MI techniques, including reflective listening and exploring discrepancies, are employed to support the client in resolving her concerns and committing to therapeutic goals.  
3.Psychoeducation: Offered detailed insights into gender identity. The aim was to validate the client's desire to align with her affirmed gender identity and to foster understanding and acceptance within herself and her social environment. Additionally, assertiveness training was integrated to empower the client with effective communication skills and boundary-setting techniques to assert her gender identity in social contexts and navigate potential challenges with confidence.

**Plans for next session**Further explore the client's social environment, including peer dynamics and family relationships, to identify additional factors influencing her behaviour. Continue to assess the client's progress in implementing coping strategies and addressing underlying issues contributing to her concerns. Additionally, review and reinforce the client's understanding of sexual orientation and affirm her agency in defining her identity.

**Student Counsellor’s signature… Date…** 12/03/2024

**SESSION 2 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A19 | 15/03/2024 | 9.00 am | 2 | 1 ½ hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client's primary concern revolves around navigating her gender identity as a girl and establishing her identity within her social environment, particularly among peers and family members. She seeks support in understanding and accepting her affirmed gender identity while addressing any challenges arising from external influences.

**Goal(s) for therapy**1. Validate and affirm the client's gender identity.  
2. Explore and address factors influencing the client's behaviour within her social environment.  
3. Review coping strategies and reinforce progress made in addressing underlying issues.

**Interventions (state theories used)**1. Psychoanalysis: utilized psychoanalysis to uncover the client's childhood experiences, delving into her early memories, attachment patterns, and significant relationships. Through this process, I aimed to unearth any unconscious conflicts, traumas, or developmental experiences that may have contributed to her struggles with sexual orientation and sense of self. By bringing these unconscious elements to conscious awareness, I facilitated insight, resolution of internal conflicts, and emotional healing for the client, ultimately supporting her in achieving a more authentic and fulfilling sense of identity.  
2. Cognitive-Behavioural Theory (CBT): The assessment and evaluation of coping strategies align with CBT principles, which focus on identifying and modifying maladaptive thought patterns and behaviours to promote psychological well-being.  
3. Affirmative Therapy: Reinforcing the client's understanding of sexual orientation and affirming her agency in defining her identity reflects the principles of affirmative therapy, which emphasize validation, acceptance, and empowerment for individuals exploring their sexual orientation or gender identity.

**Plans for next session**In the upcoming session, we will continue to explore the client's social environment, focusing on peer dynamics and family relationships to gain further insight into her experiences. We will assess the effectiveness of coping strategies implemented thus far and address any emerging concerns or challenges. Additionally, we will review and reinforce the client's understanding of sexual orientation, ensuring she feels empowered and supported in defining her identity.

**Student Counsellor’s signature… Date…** 15/03/2024

**SESSION 3 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A19 | 18/03/2024 | 9. 20 am | 3 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client's primary concern revolves around navigating her gender identity as a girl and establishing her identity within her social environment, particularly among peers and family members. She seeks support in understanding and accepting her affirmed gender identity while addressing any challenges arising from external influences.

**Goal(s) for therapy**1. Enhance Coping Strategies: Further develop and reinforce the client's coping skills to effectively manage stressors and challenges related to her social environment and identity exploration.  
2. Strengthen Social Support: Explore opportunities to strengthen the client's social support network, including fostering positive relationships with peers and family members who provide acceptance, understanding, and validation.  
3. Promote Emotional Well-Being: Support the client in cultivating emotional well-being by facilitating continued self-reflection, emotional expression, and adaptive coping mechanisms to maintain psychological resilience.  
4. Empower Decision-Making: Empower the client to make informed decisions about her identity, relationships, and future goals by providing psychoeducation, guidance, and support in navigating life transitions and challenges.  
5. Facilitate Termination: Prepare the client for therapy termination by discussing the progress made, reviewing coping strategies and resources, and addressing any remaining concerns or goals for the future beyond therapy.

**Interventions (state theories used)**Psychoanalysis: Utilized to explore the client's childhood experiences and unconscious processes, uncovering underlying factors contributing to her current challenges and identity exploration.  
Social Learning Theory: Applied to understand how the client's interactions with peers and family members influence her behaviour and self-perception, identifying patterns of reinforcement and modelling that impact her sense of identity and coping strategies.  
Reality Therapy: Implemented to facilitate the client's exploration of her present circumstances, including social dynamics and decision-making processes, encouraging personal responsibility and empowerment in defining her identity and shaping her future goals.  
These interventions draw from psychoanalytic principles to uncover unconscious influences, social learning theory to understand environmental factors, and reality therapy to promote self-awareness and agency in the client's identity exploration and decision-making processes.

**Plans for next session**Review progress made.

**Student Counsellor’s signature… Date…** 18/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 20 **Date of intake…** 14/03/2024

**Client Code…** A20 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Female **Age:** 24 **Marital status:** Single **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client has been having personal issues as well as with her family and relatives. She feels like she is burden to her family and relatives. She has been having suicidal ideation.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**The client exhibits good insight and judgment, demonstrating a clear understanding of their circumstances and making reasonable decisions. However, their mood and affect appear low and sad, suggesting a sense of melancholy or emotional distress. Despite this, their social behaviour remains appropriate, and they present themselves in a neat and well-kempt manner.

**SESSION 1 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A20 | 14/03/2024 | 4.00 pm | 1 | 30 min | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**Client has been having personal issues as well as with her family and relatives. She feels like she is burden to her family and relatives. She has been having suicidal ideation.

**Goal(s) for therapy**1. Exploration: Allow client to share her childhood and past experiences to gain deeper insight into the root causes of her personal and interpersonal issues and challenges

**Interventions (state theories used)**1. Person-Centered Therapy (PCT): Integrated to create a safe and supportive therapeutic environment where the client feels accepted, understood, and empowered to explore her thoughts and feelings openly. The therapist employed emphatic listening, unconditional positive regard, and genuineness to foster a trusting therapeutic relationship, facilitating the client's self-exploration and personal growth. PCT aimed to empower the client to make autonomous decisions and facilitate her journey toward psychological well-being.

2. Psychoanalysis: Employed to delve deeply into the client's childhood and past experiences, aiming to uncover unconscious conflicts, traumas, and patterns of behaviour that may be contributing to her current personal and interpersonal challenges. Through exploration of early memories, dreams, and relationships, the therapist facilitated insight into the client's unconscious processes, providing a foundation for understanding and resolving deep-seated emotional issues. The goal was to bring unconscious material into conscious awareness, allowing the client to gain insight, resolve inner conflicts, and ultimately achieve psychological healing and growth.

**Plans for next session**Continue exploring more about her past especially her childhood experiences.

**Student Counsellor’s signature… Date…** 14/03/2024

**SESSION 2 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A20 | 15/03/2024 | 3.20 pm | 2 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**Client shared her childhood experiences. Client is the second born in a family of eight. Client shares that she was born through a miscarriage and her mother left her at 6 months old. Client grew up with her aunt where Client was provided a good life. Client never had the chance to meet her other siblings living with her biological mother. At age 12 Client was taken back to her biological mother and started living with her. Client explain how difficult it was to adapt to her new life, home environment and even school life. Client experienced social anxiety due to the abrupt change of environments. Client explains how she would cry during break time because Client didn’t like the new environment. Her mother used to cane her because of her introverted nature at school. Client feels like all of these experiences have made her feel like a burden to her family.

**Goal(s) for therapy**1. Explore and process the client's childhood experiences to gain insight into their impact on her current feelings of inadequacy and social anxiety.  
2. Foster self-acceptance and resilience by addressing underlying issues contributing to the client's perception of herself as a burden.  
3. Develop coping strategies to manage social anxiety and improve self-esteem in various environments.

**Interventions (state theories used)**1. Person-Centered Therapy (PCT): This approach prioritized creating a safe and empathetic space where the client could freely express her emotions and experiences. By fostering an atmosphere of unconditional positive regard, empathy, and congruence, the therapist aimed to facilitate the client's self-exploration and personal growth without fear of judgment.  
2. Psychoanalysis: employed techniques to delve deeper into the client's childhood experiences. By exploring memories, dreams, and subconscious thoughts, we uncovered underlying psychological patterns and conflicts that may be contributing to the client's current feelings of inadequacy and social anxiety. This process aimed to bring about insight and promote emotional healing and resolution of inner conflicts.

**Plans for next session**In the next session, we will continue exploring the client's childhood experiences and their impact on her current feelings of inadequacy. Focus on identifying and challenging negative beliefs about herself while providing support and validation. Additionally, introduce techniques to manage social anxiety and enhance self-esteem.

**Student Counsellor’s signature… Date…** 15/03/2024

**SESSION 3 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A20 | 16/03/2024 | 9.25am | 2 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**After high school, the client had a tough time with her family, especially her mother and siblings. She was closest to her dad. Even though she did well in her exams and got into university, her family didn't support her decision to go to college. When she joined a different church, her family cut her off completely, which made her feel really sad. She had to work odd jobs to pay for school because her family wouldn't help her. During breaks, she volunteered for church activities but avoided going home because her family accused her of bad things, which made her feel really bad about herself.

**Goal(s) for therapy**1. Rebuild Self-Esteem: Assist the client in rebuilding her self-esteem and self-worth that have been negatively impacted by familial rejection and accusations.  
2. Process Trauma: Support the client in processing the traumatic experiences she faced due to familial rejection and accusations of immoral behaviour, helping her to cope with the emotional distress and heal from past wounds.  
3. Improve Coping Skills: Equip the client with effective coping strategies to manage stress, navigate familial conflicts, and build resilience in the face of adversity.  
4. Foster Self-Identity: Help the client explore and affirm her identity, including her religious beliefs and personal values, to establish a sense of self-authenticity and confidence.

**Interventions (state theories used)**1. Narrative Therapy: Utilize narrative techniques to help the client reframe her experiences, viewing them as separate from her identity and empowering her to construct a new narrative that emphasizes resilience and self-empowerment.  
2. Cognitive Restructuring: Implement cognitive-behavioural techniques to challenge negative thought patterns and beliefs stemming from familial rejection, assisting the client in developing more adaptive and constructive ways of thinking.  
3. Solution-Focused Brief Therapy (SFBT): Utilize SFBT principles to identify the client's strengths, resources, and past successes, focusing on practical solutions and achievable goals to address current challenges and move towards positive change.

**Plans for next session**In the next session, we'll delve deeper into the client's feelings about their family's rejection and the accusations they faced. We'll also work on changing negative thoughts and boosting self-esteem using cognitive techniques.

**Student Counsellor’s signature… Date…** 16/03/2024

**SESSION 4 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A20 | 17/03/2024 | 10.00 am | 4 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**Client is working as a teacher in a secondary school. Being the second born and the only one currently employed, she is forced to take care of her needs as well as her family’s(mother and siblings). This has caused a significant amount of distress as the responsibility placed on her is overwhelming. She is sometimes forced to take loans so that she can sustain her family back at home, loans that she doesn’t know how she is going to repay. Client explains that she hasn’t had the opportunity to take good care of herself and enjoy the fruits of her labour due to the never ending financial demands of her family.

**Goal(s) for therapy**1. Financial Management: Assist the client in developing practical strategies for managing her finances more effectively, including budgeting, debt repayment plans, and exploring alternative sources of income to alleviate financial stress.  
2. Boundaries and Self-Care: Support the client in establishing healthy boundaries with her family members and prioritizing her own self-care needs, empowering her to set limits on her caregiving responsibilities and carve out time for personal well-being and leisure activities.  
3. Coping Skills: Equip the client with coping skills and stress management techniques to better navigate the emotional challenges associated with her caregiving role, promoting resilience and emotional well-being in the face of adversity.  
  
**Interventions (state theories used)**1. Solution-Focused Brief Therapy (SFBT): utilized to identify the client's strengths, resources, and past successes, focusing on practical solutions and achievable goals to address her current financial challenges and alleviate stress.  
2. Cognitive-Behavioural Therapy (CBT): employed to help the client recognize and challenge maladaptive thought patterns and beliefs related to guilt, obligation, and self-sacrifice, promoting more adaptive coping strategies and a healthier mindset.  
3. Family Systems Theory: applied to explore the dynamics and patterns within the client's family system, identifying roles and expectations that contributed to her caregiving burden and exploring opportunities for change and boundary-setting.

**Plans for next session**Psychoeducate client on the importance of self care and how it contributes to overall quality of life.

**Student Counsellor’s signature… Date…** 17/03/2024

**SESSION 5 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A20 | 18/03/2024 | 9.20 am | 5 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**Client shared her experiences of past relationships she was engaged in. She explains how all her past relationships have broken her and how she doesn’t feel its worth it to pursue relationships in future. She shared how her ex boyfriends used to perceive her as a burden whenever she opened up to them about the challenges she and her family were going through leading to her abandonment. This really broke her heart and vowed never to trust men again. She feels like isolating herself is the best solution currently.

**Goal(s) for therapy**1. Develop healthier relationship boundaries to avoid oversharing and maintain emotional boundaries.  
2. Identify recurring patterns in past relationships and explore how they contribute to the same negative outcomes each time.  
3. Focus on self-development and rebuilding self-esteem to cultivate a more positive self-image and sense of worth.  
4. Take a break from pursuing romantic relationships to allow time for self-reflection and exploration of personal goals and values.

**Interventions (state theories used)**During therapy, Reality Therapy was employed to delve into the client's current perceptions and behaviours within the context of her past relationships. This approach facilitated a deep exploration of the client's present-moment awareness, allowing her to gain insights into how her thoughts, feelings, and actions contribute to her relationship dynamics. Through open dialogue and guided reflection, the client was encouraged to take responsibility for her choices and actions, empowering her to recognize the role she plays in shaping her interpersonal experiences. By focusing on the here and now, Reality Therapy provided a framework for the client to explore alternative ways of thinking and behaving that align with her personal values and goals, ultimately promoting positive changes in her relationship patterns.

**Plans for next session**In the next session, we will continue exploring the client's past relationship experiences, delving deeper into the underlying patterns and examining ways to break free from destructive cycles. Additionally, we will begin implementing strategies for self-development and establishing healthier relationship boundaries.

**Student Counsellor’s signature… Date…** 18/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 21 **Date of intake…** 5/03/2024

**Client Code…** A21 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Male **Age:** 23 **Marital status:** Single

**Relevant history concerning previous counselling treatment( if any)**Has had previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client is a college student who recently broke up with his girlfriend. He finds it hard to move in. He regrets revealing some secrets to his ex girlfriend. He has been drinking heavily to cope with the overwhelming emotional and psychological stress he is going through.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**The client exhibits good insight and judgment, demonstrating a clear understanding of their circumstances and making reasonable decisions. However, their mood and affect appear low and sad, suggesting a sense of melancholy or emotional distress. Despite this, their social behaviour remains appropriate, and they present themselves in a neat and well-kempt manner.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A21 | 5/03/2024 | 10.00 am | 1 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client's primary concern revolves around his recent breakup with his girlfriend, which has left him struggling to cope with overwhelming emotional and psychological stress. He regrets disclosing certain personal secrets to his ex-girlfriend and has resorted to heavy drinking as a means of managing his distress.

**Goal(s) for therapy**1. Exploration: Facilitate a comprehensive exploration of the client's feelings, thoughts, and experiences surrounding the breakup, including the underlying reasons for his regret and the impact of heavy drinking on his well-being.  
2. Provide a Safe Space for Client to Open Up: Create a supportive and non-judgmental environment where the client feels comfortable expressing his emotions, processing his thoughts, and discussing his concerns openly.

**Interventions (state theories used)**1. Person-Centered Therapy (PCT): Integrated to establish a therapeutic alliance characterized by empathy, unconditional positive regard, and authenticity. The therapist employed active listening and reflection to validate the client's feelings, enhance self-awareness, and foster a sense of acceptance and self-exploration.  
2. Psychoanalysis: Utilized to delve into the client's subconscious and uncover underlying conflicts, emotions, and patterns of behaviour related to the breakup and his coping mechanisms. By exploring past experiences and unconscious processes, the therapist aimed to gain insight into the client's current difficulties and facilitate emotional healing and growth.

**Plans for next session**In the next session, we will continue to provide a supportive space for the client to explore his feelings and experiences related to the breakup. Additionally, we will further delve into the client's coping strategies, particularly his heavy drinking, and collaboratively work with him to identify healthier coping mechanisms. The session will focus on developing personalized strategies to manage distress and promote emotional well-being.

**Student Counsellor’s signature… Date…** 5/03/2024

**SESSION 2 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A21 | 14/03/2024 | 9.15 am | 2 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**Client would like to disclose and share the secrets he revealed to his ex girlfriend. He feels like they are too heavy and should share them with someone he can trust. Client shares that he revealed to his ex girlfriend how he hates one of his close friends(a boy) due to the fact that he was dating a girl he had a crush on and that he would anything to harm his friend out of resentment. He even went as far as revealing that he was willing to set him up so that he could be charged by the police for crimes his friend did not commit so that he could end up in jail.

**Goal(s) for therapy**1. Provide a safe space for the client to express and process his emotions and experiences without judgment.

2. Explore underlying reasons for the client's intense feelings of resentment and anger towards his friend.

3. Develop coping strategies to manage negative emotions and cultivate healthier relationships.

**Interventions (state theories used)**1. Narrative Therapy: Assist the client in reconstructing his personal narrative, reframing negative experiences, and exploring alternative perspectives on his relationships and emotions.  
2. Solution-Focused Therapy: Focus on identifying the client's strengths and resources, setting achievable goals, and generating solutions to address his feelings of resentment and desire for revenge.  
3. Mindfulness-Based Stress Reduction (MBSR): Introduce mindfulness techniques to help the client develop self-awareness, regulate emotions, and cultivate acceptance of his thoughts and feelings without judgment.

**Plans for next session**1. Continue exploring the client's experiences and emotions related to his friend and the disclosed secrets.  
2. Implement mindfulness exercises to help the client manage intense emotions and promote emotional regulation.  
3. Collaboratively develop a plan to address the client's feelings of resentment and develop healthier coping strategies.  
4. Discuss potential long-term goals and strategies for maintaining emotional well-being and healthy relationships.

**Student Counsellor’s signature… Date…** 14/03/2024

**SESSION 3 CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A21 | 15/03/2024 | 9.00 am | 3 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client's primary concern revolves around his recent breakup with his girlfriend, which has left him struggling to cope with overwhelming emotional and psychological stress. He regrets disclosing certain personal secrets to his ex-girlfriend and has resorted to heavy drinking as a means of managing his distress.

**Goal(s) for therapy**1. Continue exploring the client's experiences and emotions related to his friend and the disclosed secrets.  
2. Implement mindfulness exercises to help the client manage intense emotions and promote emotional regulation.  
3. Collaboratively develop a plan to address the client's feelings of resentment and develop healthier coping strategies.  
4. Discuss potential long-term goals and strategies for maintaining emotional well-being and healthy relationships.

**Interventions (state theories used)**1. Cognitive-Behavioural Therapy (CBT): Employ CBT techniques to help the client identify and challenge maladaptive thoughts and beliefs related to his breakup and disclose secrets. This may involve cognitive restructuring to address any irrational or harmful thought patterns contributing to his distress.  
2. Mindfulness-Based Stress Reduction (MBSR): Introduce mindfulness exercises and techniques to help the client cultivate present-moment awareness and develop skills for managing intense emotions. This may include mindfulness meditation, deep breathing exercises, and body scans to promote emotional regulation and reduce stress.  
3. Psychoeducation: Provide the client with information and education about healthy coping strategies, the effects of alcohol on mental health, and the importance of seeking professional help when experiencing distress. This may include discussing the risks of using alcohol as a coping mechanism and exploring alternative, healthier ways of managing emotions.

**Plans for next session**

1. Begin by reviewing the client's progress with implementing mindfulness exercises and CBT techniques discussed in previous sessions.  
2. Discuss potential long-term goals for therapy, such as enhancing self-esteem, improving interpersonal relationships, and developing healthier coping mechanisms.

**Student Counsellor’s signature… Date…** 15/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 22 **Date of intake…** 15/03/2024

**Client Code…** A22 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Female **Age:** 36 **Marital status:** Married **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client is the mother to a 17 year old girl who has been diagnosed with a number of conditions including: pneumonia, groin injury and brain injury. Mother has refused to consent performing an MRI scan on her daughter by the doctors. Mother believes that her daughter is fine and requests to be discharged contrary to the doctors findings indicating her daughter needs to be examined and treated.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client displays good insight into their circumstances and condition, indicating an understanding of their situation.  
Judgment: The client exhibits sound judgment, suggesting the ability to make reasonable decisions given their circumstances.  
Speech: The client communicates coherently, demonstrating clarity in expressing their thoughts and emotions.  
Mood and Affect: The client's mood and affect are in line with their current challenges, reflecting an underlying sense of anxiety.  
Social Behaviour: The client's social behaviour is appropriate, suggesting the ability to interact effectively with others.  
Appearance: The client presents themselves in a neat and well-kempt manner, reflecting a sense of self-care and maintenance despite their current situation.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A22 | 15/03/2024 | 10.00 am | 2 | 2 hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client, a concerned mother, seeks therapy grappling with her daughter's medical diagnosis and treatment plan. Despite medical advice, she hesitates to approve further procedures like an MRI scan, convinced her daughter is fine and advocating for her discharge from the hospital.

**Goal(s) for therapy**1. Explore the client's concerns and underlying reasons for refusing medical interventions for her daughter.  
2. Address any fears or anxieties the client may have regarding her daughter's health and treatment.  
3. Provide psychoeducation on the importance of medical assessments and treatments for the daughter's conditions.  
4. Collaborate with the client to develop a plan for decision-making regarding her daughter's healthcare that considers both the client's concerns and the medical recommendations.

**Interventions (state theories used)**1. Person-Centered Therapy (PCT): Created a safe and empathetic environment for the client to express her concerns and feelings without judgment. Utilized active listening and reflective techniques to validate the client's emotions and perspectives.  
2. Cognitive-Behavioural Therapy (CBT): Explored any cognitive distortions or irrational beliefs that may have influenced the client's decision-making process regarding her daughter's medical care. Challenged any negative thoughts or fears and encouraged the client to consider alternative viewpoints.  
3. Psychoeducation: Offered information and resources to help the client better understand her daughter's medical conditions, the recommended treatments, and the potential consequences of refusing medical interventions. Provided support and guidance in making informed decisions about her daughter's healthcare.  
  
**Plans for next session**1. Review the client's progress in understanding and addressing her concerns about her daughter's medical care.  
2. Further explore any barriers or challenges the client may be experiencing in accepting the medical recommendations.  
3. Discuss strategies for effective communication with healthcare providers and advocating for her daughter's needs while respecting medical expertise.

**Student Counsellor’s signature… Date…** 15/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 23 **Date of intake…** 19/03/2024

**Client Code…** A23 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Male **Age:** 51 **Marital status:** Married **Relevant history concerning previous counselling treatment( if any)**Has had previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client, who is diabetic, has been diagnosed with alcohol use disorder and is also suffering from liver cirrhosis. He has been admitted to the hospital multiple times due to overconsumption of alcohol. Client has relapsed numerous times after rehabilitation. He explains how alcohol use has caused a lot of family conflicts at home due to his financial irresponsibleness.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**The client demonstrates good insight and judgment during the session. However, they appear dysphoric in mood and affect, indicating feelings of sadness or discomfort. Despite this, their social behaviour remains appropriate throughout the session. However, their appearance appears untidy, suggesting potential signs of neglect or disorganization. It's essential to explore further to understand the underlying factors contributing to the dysphoric mood and untidy appearance, allowing for a comprehensive therapeutic approach to address the client's needs effectively.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A23 | 19/03/2024 | 9.00 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client expresses concern about the impact of alcohol use on his health, family conflicts arising from financial irresponsibility, and the challenges of managing his conditions.

**Goal(s) for therapy**1. Address the client's alcohol use disorder and support him in achieving sobriety to improve his physical health and well-being.  
2. Help the client develop coping strategies to manage cravings, triggers, and stressors contributing to alcohol relapse.  
3. Assist the client in repairing relationships and resolving conflicts with family members affected by his alcohol use.  
4. Provide education and support to help the client manage his diabetes and liver cirrhosis effectively alongside his alcohol use disorder.

**Interventions (state theories used)**1. Motivational Interviewing (MI): MI techniques were utilized to explore the client's ambivalence towards change and enhance his motivation to address his alcohol use disorder. Collaboratively setting goals and exploring the pros and cons of continuing alcohol use helped engage the client in the therapeutic process.  
2. Cognitive-Behavioural Therapy (CBT): CBT strategies were employed to identify and challenge maladaptive thoughts and behaviours related to alcohol use. The client learned coping skills, such as problem-solving and stress management, to reduce reliance on alcohol as a coping mechanism and prevent relapse.  
3. Family Therapy: Family therapy sessions were conducted to address the impact of the client's alcohol use on family dynamics and relationships. Open communication, conflict resolution, and support for both the client and his family members were facilitated to promote healing and understanding.  
4. Psychoeducation: The client received information and resources about the consequences of alcohol use on his health, particularly in relation to his diabetes and liver cirrhosis. Guidance on self-care practices and medication management was provided to support the client's overall health and well-being.

**Plans for next session**1. Continue exploring the client's motivation for change and identifying barriers to sobriety.  
2. Develop a relapse prevention plan tailored to the client's individual triggers and risk factors.  
3. Schedule additional family therapy sessions to further address family conflicts and strengthen support systems.  
4. Provide ongoing education and support for managing diabetes and liver cirrhosis alongside alcohol use disorder.

**Student Counsellor’s signature… Date…** 19/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 24 **Date of intake…** 19/03/2024

**Client Code…** A24 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Male **Age:** 37 **Marital status:** Married

**Relevant history concerning previous counselling treatment( if any)**No previous counselling experience

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client attempted suicide by way of ingesting a pesticide poison. The motivation to do so was chronic alcohol use which led to marital conflicts which in turn brought feelings of despair and hopelessness to the client. He feels like there is no point in living anymore and suicide is the only way to end all the pain he and his family are going through.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client demonstrates a commendable understanding of their circumstances and condition, reflecting insightful awareness.

Judgment: The client showcases prudent decision-making skills, indicating the ability to make sensible choices considering their circumstances.

Speech: The client communicates cohesively, expressing their thoughts and emotions with clarity and coherence.

Mood and Affect: Dysphoric , low mood mixed with feelings of sadness and despair

Social Behaviour: The client engages in appropriate social interactions, demonstrating effective communication and interpersonal skills.

Appearance: The client presents themselves in a neat and well-kempt manner.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A24 | 19/03/2024 | 2.30 pm | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client attempted suicide by ingesting a pesticide poison due to chronic alcohol use and marital conflicts, which resulted in feelings of despair and hopelessness. He perceives suicide as the only solution to end the pain he and his family are experiencing.

**Goal(s) for therapy**1. Explore the underlying factors contributing to the client's chronic alcohol use and marital conflicts.  
2. Develop coping strategies to manage feelings of despair and hopelessness, and enhance the client's resilience in facing life stressors.  
3. Promote open communication and collaboration between the client and his family to address relational conflicts and improve support systems.

**Interventions (state theories used)**1. Cognitive-Behavioural Therapy (CBT): CBT techniques were used to identify and challenge negative thought patterns contributing to the client's feelings of despair and hopelessness. The client learned coping skills to manage distressing emotions and develop more adaptive problem-solving strategies.  
2. Solution-Focused Brief Therapy (SFBT): SFBT principles were applied to explore the client's strengths and resources, focusing on identifying solutions and setting achievable goals to address his challenges. Emphasis was placed on identifying small steps the client can take to improve his situation and regain a sense of hope and purpose.  
3. Family Therapy: Family therapy sessions were conducted to address relational conflicts and improve communication within the client's family. Collaborative problem-solving and conflict resolution techniques were utilized to promote understanding and support among family members.

**Plans for next session**  
1. Continue exploring the client's alcohol use and marital conflicts to identify underlying issues and triggers.  
2. Implement coping skills and relaxation techniques to manage acute distress and prevent future suicidal ideation.  
3. Schedule follow-up family therapy sessions to address ongoing relational conflicts and strengthen familial support networks.

**Student Counsellor’s signature… Date…** 19/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 25 **Date of intake…** 21/03/2024

**Client Code…** A25 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Male **Age:** 23 **Marital status:** Single **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client was diagnosed with convulsive disorder. Client complains of the overwhelming family responsibilities placed upon him as a the firstborn of six children. He explains how these responsibilities feel overwhelming consequently leading to overthinking. The stress triggers convulsions that he experiences.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client demonstrates a commendable understanding of their circumstances and condition, reflecting insightful awareness.

Judgment: The client showcases prudent decision-making skills, indicating the ability to make sensible choices considering their circumstances.

Speech: The client communicates cohesively, expressing their thoughts and emotions with clarity and coherence.

Mood and Affect: Dysphoric , low mood mixed with feelings of sadness and despair

Social Behaviour: The client engages in appropriate social interactions, demonstrating effective communication and interpersonal skills.

Appearance: The client presents themselves in a neat and well-kempt manner.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A25 | 21/03/2024 | 3.00 pm | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client, diagnosed with convulsive disorder, feels overwhelmed by the extensive family responsibilities placed upon him as the firstborn of six children. He describes how the weight of these responsibilities leads to constant overthinking, exacerbating his stress levels and triggering convulsions.

**Goal(s) for therapy**1. Reduce stress levels and effectively manage convulsions to improve overall well-being.

2. Establish and maintain healthy boundaries within familial relationships to alleviate overwhelming responsibilities.

**Interventions (state theories used)**1. Cognitive-Behavioural Therapy (CBT): Employed CBT techniques to identify and challenge negative thought patterns contributing to stress and overthinking. This involved exploring and reframing irrational beliefs about familial responsibilities and developing more adaptive coping strategies.  
2. Stress Management Techniques: Introduced relaxation exercises, mindfulness practices, and deep breathing techniques to help the client alleviate stress and reduce the frequency and severity of convulsions. These techniques aimed to promote emotional regulation and increase resilience to stressors.  
3. Healthy Boundary Setting: Facilitated discussions and role-playing exercises to assist the client in establishing healthy boundaries within his familial relationships. This included assertiveness training to help him communicate his needs effectively and negotiate appropriate levels of responsibility.

**Plans for next session**

- Review the client's progress in implementing boundary-setting techniques and stress management strategies.  
- Explore any challenges or setbacks encountered since the last session and provide additional support and guidance as needed.  
- Further reinforce healthy boundary-setting skills and continue to develop personalized coping strategies for managing stress and reducing convulsions.

**Student Counsellor’s signature… Date…** 21/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 26 **Date of intake…** 21/03/2024

**Client Code…** A26 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Female **Age:** 22 **Marital status:** Single

**Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client ingested poison in an attempt to commit suicide. She shares that her ex-boyfriend recently broke up with her after she caught him cheating with another lady. Client explains that her boyfriend lied to her that he was not seeing anyone else apart from her. On confrontation, he turned and even revealed to the client that she was not beautiful neither lovable. These words really broke her leading to attempted suicide.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**The client exhibits good insight during the session, demonstrating an understanding of their circumstances and behaviours. However, their mood and affect appear dysphoric, indicating feelings of sadness or discomfort. Despite this, their social behaviour remains appropriate, suggesting an ability to interact effectively with others. However, their appearance appears rough and unkempt, which may reflect underlying distress or neglect. It's important to explore further to understand the factors contributing to their dysphoric mood and unkempt appearance, allowing for tailored interventions to address their needs effectively.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A26 | 21/03/2024 | 9.30 am | 1 | 1 ½ hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client attempted suicide after her recent breakup with her boyfriend, who she discovered was cheating on her with another woman. She experienced profound emotional distress upon learning about the infidelity and was deeply hurt by her boyfriend's hurtful comments about her appearance and worthiness of love.

**Goal(s) for therapy**1. Address the client's emotional distress and suicidal ideation stemming from the breakup and hurtful comments made by her ex-boyfriend.  
2. Enhance the client's self-esteem and self-worth by challenging negative beliefs about herself and fostering a positive self-image.  
3. Develop coping strategies to manage distressing emotions and thoughts related to the breakup and betrayal.  
4. Explore healthy ways of processing and expressing emotions, such as grief and anger, in response to the relationship ending.

**Interventions (state theories used)**1. Cognitive-Behavioural Therapy (CBT): Employed CBT techniques to challenge and reframe the client's negative thoughts and beliefs about herself, her worth, and her desirability. Encouraged the client to identify and challenge cognitive distortions related to the breakup and her ex-boyfriend's hurtful comments.  
2. Dialectical Behaviour Therapy (DBT): Utilized DBT skills training to help the client develop emotion regulation strategies and distress tolerance skills to manage intense emotions and prevent impulsive behaviours, such as suicide attempts. Taught mindfulness techniques to increase awareness of emotions and reduce emotional reactivity.  
3. Supportive Counselling: Provided empathetic support and validation to the client as she processed her feelings of grief, betrayal, and heartbreak. Offered a safe space for the client to express her emotions and experiences without judgment, fostering a therapeutic alliance based on trust and understanding.

**Plans for next session**1. Continue exploring the client's feelings and experiences  
2. Review and reinforce coping strategies learned in therapy  
3. Collaboratively set goals for ongoing therapy sessions, tailoring interventions to address the client's evolving needs and goals for recovery and emotional well-being.

**Student Counsellor’s signature… Date…** 21/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 27 **Date of intake…** 21/03/2024

**Client Code…** A27 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Male **Age:** 27 **Marital status:** Married **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience

**The current situation (allow the client to share whatever has brought him/her for therapy).** Client has been diagnosed with Chronic subdural haemorrhage due to an accident he was involved in as a bodaboda driver. Doctors have been working round the clock but hardly made any progress. The client has been referred for counselling to get closure about his current condition and the poor prognosis.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**The client demonstrates good insight into their thoughts, feelings, and behaviours, indicating an understanding of their current situation. However, their mood and affect are dysphoric, suggesting feelings of sadness or discomfort. Despite this, their social behaviour remains appropriate, indicating the ability to interact effectively with others. Additionally, their appearance is neat and well-kempt, which may contrast with their dysphoric mood and suggest efforts to maintain a composed outward appearance despite internal distress. It's essential to further explore the reasons behind their dysphoric mood despite their outward presentation and support them in addressing any underlying emotional concerns.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A27 | 21/03/2024 | 11.45 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client, diagnosed with Chronic subdural haemorrhage following a bodaboda accident, is grappling with the overwhelming emotional distress and uncertainty surrounding his condition and prognosis. He seeks counselling to find closure and support in navigating his current circumstances.

**Goal(s) for therapy**1. Provide emotional support and validation to the client as he processes his feelings of fear, uncertainty, and grief related to his diagnosis and prognosis.  
2. Help the client gain a better understanding of his medical condition and prognosis, fostering acceptance and coping strategies to navigate his current circumstances.  
3. Facilitate open communication and expression of emotions, allowing the client to share his experiences and concerns in a safe and supportive environment.  
  
**Interventions (state theories used)**1. Supportive Counselling: Utilized supportive counselling techniques to provide empathy, validation, and emotional support to the client as he navigates the emotional distress and uncertainty surrounding his diagnosis. Offered a safe space for the client to express his feelings and concerns without judgment, fostering a therapeutic alliance based on trust and understanding.  
2. Psychoeducation: Provided information and education about Chronic subdural haemorrhage, including its causes, symptoms, prognosis, and treatment options. Helped the client gain a better understanding of his medical condition and the challenges he may face, empowering him to make informed decisions and cope effectively.  
3. Cognitive-Behavioural Therapy (CBT): Integrated CBT techniques to help the client challenge and reframe negative thoughts and beliefs related to his diagnosis and prognosis. Encouraged the client to identify and replace maladaptive coping strategies with more adaptive ones, promoting resilience and psychological well-being.

**Plans for next session**1. Continue providing emotional support and validation to the client as he processes his feelings and experiences related to his diagnosis and prognosis.  
2. Explore coping strategies and resilience-building techniques to help the client navigate the challenges posed by his medical condition and treatment journey.  
3. Collaboratively set goals for ongoing therapy sessions, tailoring interventions to address the client's evolving needs and goals for emotional well-being and quality of life.

**Student Counsellor’s signature… Date…** 21/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 28 **Date of intake…** 23/03/2024

**Client Code…** A28  **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Female **Age:** 26 **Marital status:** Married **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client is a newly wed lady, one and a half years into her marriage. She complains of her violent husband who has been physically abusing her whenever they get into an argument. She has tried several times to talk to him about the issue but to no vail. She has even tried involving parents but nothing has changed. She feels constrained and imprisoned in that marriage and would like to find a way out.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client demonstrates a commendable understanding of their circumstances and condition, reflecting insightful awareness.

Judgment: The client showcases prudent decision-making skills, indicating the ability to make sensible choices considering their circumstances.

Speech: The client communicates cohesively, expressing their thoughts and emotions with clarity and coherence.

Mood and Affect: The client's mood and affect are euthymic, suggesting a balanced emotional state despite the challenges they face.

Social Behaviour: The client engages in appropriate social interactions, demonstrating effective communication and interpersonal skills.

Appearance: The client presents themselves with care and tidiness, reflecting a commitment to self-presentation and upkeep despite their current challenges.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A28 | 23/03/2024 | 9.00 am | 1 | 1 ½ hours | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client, a newly-wed woman, is seeking therapy due to the physical abuse she has been experiencing from her husband during arguments. Despite multiple attempts to address the issue with him and involve their parents, the violence persists. She feels trapped and imprisoned in her marriage and is seeking support to find a way out of this situation.

**Goal(s) for therapy**1. Provide the client with emotional support and validation as she navigates the challenges of her abusive marriage.  
2. Explore strategies to increase the client's safety and well-being within the context of her relationship.  
3. Assist the client in developing a plan for addressing the abuse and exploring options for ending the marriage if necessary.  
4. Empower the client to establish healthy boundaries and advocate for herself in her relationship.

**Interventions (state theories used)**1. Trauma-Informed Therapy: Utilized trauma-informed approaches to help the client process the emotional impact of the abuse and develop coping strategies for managing trauma symptoms.  
2. Cognitive-Behavioural Therapy (CBT): Employed CBT techniques to challenge negative thought patterns and beliefs perpetuated by the abusive relationship, empowering the client to reframe her perspective and build resilience.  
3. Empowerment Counselling: Provided empowerment-focused counselling to help the client identify her strengths and resources, fostering a sense of agency and self-efficacy in navigating her circumstances.  
4. Safety Planning: Collaborated with the client to develop a safety plan tailored to her specific needs and circumstances, including strategies for de-escalating conflict and accessing support during instances of abuse.

**Plans for next session**1. Explore childhood experiences that might be perpetrating her current situation.  
2. Review and refine the safety plan to ensure it remains effective in promoting the client's safety and well-being.  
3. Discuss any progress or setbacks the client has experienced since the previous session and adjust interventions accordingly.

**Student Counsellor’s signature… Date…** 23/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 29  **Date of intake…** 23/03/2024

**Client Code…** A29 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Male **Age:** 32 **Marital status:** Married **Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**The client,a father of four, who works as a bodaboda operator, ingested poison in an attempt to take away his life due to the overwhelming pressure to provide for his family's ever growing needs. He came to realise that his wife developed a habit of giving out food and other household items to her friends and neighbours. This really broke his heart resulting in the failed suicide attempt.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client demonstrates a commendable understanding of their circumstances and condition, reflecting insightful awareness.

Judgment: The client showcases prudent decision-making skills, indicating the ability to make sensible choices considering their circumstances.

Speech: The client communicates cohesively, expressing their thoughts and emotions with clarity and coherence.

Mood and Affect: The client's mood and affect are euthymic, suggesting a balanced emotional state despite the challenges they face.

Social Behaviour: The client engages in appropriate social interactions, demonstrating effective communication and interpersonal skills.

Appearance: The client presents themselves with care and tidiness, but he is physically worn out due to the effects of the ingested poison.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A29 | 23/03/2024 | 11.30 am | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client, a father of four working as a bodaboda operator, attempted suicide due to overwhelming pressure to provide for his family's needs. He discovered that his wife was giving away food and household items to friends and neighbours, causing him significant distress and contributing to his feelings of hopelessness and despair.

**Goal(s) for therapy**1. Provide the client with emotional support and validation as he navigates the challenges of providing for his family.  
2. Explore coping strategies to manage feelings of overwhelm and hopelessness related to financial stress and marital discord.  
3. Facilitate open communication between the client and his wife to address underlying issues and improve their relationship dynamics.  
4. Help the client develop a sense of purpose and meaning beyond his role as a provider, fostering self-worth and resilience.

**Interventions (state theories used)**1. Narrative Therapy: Utilize narrative therapy techniques to explore the client's story and how his experiences have shaped his sense of self and identity within his family.  
2. Solution-Focused Brief Therapy (SFBT): Implement SFBT strategies to identify the client's strengths and resources, focusing on practical solutions and achievable goals to address his immediate concerns.  
3. Cognitive-Behavioural Therapy (CBT): Introduce CBT techniques to help the client challenge negative thought patterns and develop more adaptive coping strategies for managing stress and distress.

**Plans for next session**1. Explore the client's experiences and emotions surrounding the discovery of his wife's actions and how it has impacted his sense of trust and security in their relationship.  
2. Work collaboratively with the client to develop strategies for addressing financial stressors and finding alternative ways to meet his family's needs.

**Student Counsellor’s signature… Date…** 23/03/2024

**CP FORM 1**

**CLIENT INITIAL ASSESSMENT FORM**

**Case Number…** 30 **Date of intake…** 23/03/2024

**Client Code…** A30 **Practicum Site…MTRH**

**Client’s demographic information (gender, age, number of siblings, marital status etc. Allow the client to share what s/he is comfortable with).  
Gender:**  Female **Age:** 34 **Marital status:** Divorced

**Relevant history concerning previous counselling treatment( if any)**No previous counselling experience.

**The current situation (allow the client to share whatever has brought him/her for therapy).**Client is an independent woman working for a corporate institution. She was recently married by her life-long partner but their marriage did not last six months due to misunderstandings and confusion of roles and responsibilities. The two were both working and only convened at their house late in the evening after work. They had to share roles due to exhaustion but this did not sit well with the husband. After multiple failed attempts at resolving the issue, they parted ways through divorce.   
The client shares she really needs her husband back and cannot bear living alone, - “I need a companion”- as she put it in her words. She has not gotten over the divorce but is not willing to play the role of a wife in case of a reunion. She is overwhelmed by the breakup and doesn’t know what to do next.

**What is your initial assessment of the client; cognitively, emotionally, socially and physically in relation to his/her concerns?**Insight: The client demonstrates a commendable understanding of their circumstances and condition, reflecting insightful awareness.  
Judgment: The client showcases prudent decision-making skills, indicating the ability to make sensible choices considering their circumstances.  
Speech: The client communicates cohesively, expressing their thoughts and emotions with clarity and coherence.  
Mood and Affect: Dysphoric , low mood mixed with feelings of sadness and despair  
Social Behaviour: The client engages in appropriate social interactions, demonstrating effective communication and interpersonal skills.  
Appearance: The client presents themselves in a neat and well-kempt manner.

**CP FORM 2**

**INDIVIDUAL TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| A30 | 23/03/2024 | 2.00 pm | 1 | 1 hour | MTRH |

**Client’s Concerns (Issue bringing him/her for therapy)**The client, an independent woman working in a corporate institution, is seeking therapy following the breakdown of her marriage to her long-term partner. The marriage lasted less than six months due to misunderstandings and confusion over roles and responsibilities. Despite their efforts to resolve the issues, they ultimately divorced. The client is struggling with feelings of loneliness and a desire to reconcile with her ex-husband, but she is also hesitant to resume the traditional role of a wife if they were to reunite. She feels overwhelmed by the breakup and is uncertain about her next steps.

**Goal(s) for therapy**1. Explore the client's feelings of loneliness and longing for companionship after the divorce.  
2. Help the client process her emotions surrounding the breakup and come to terms with the end of the relationship.  
3. Explore the client's expectations and desires regarding a potential reunion with her ex-husband, including her hesitations about resuming traditional gender roles.

**Interventions (state theories used)**1. Person-Centered Therapy (PCT): I employed Person-Centered Therapy (PCT) to provide the client with empathetic and non-judgmental support as she explored her feelings and experiences related to the breakup. I created a safe and supportive environment where she felt comfortable expressing herself openly and honestly.  
2. Cognitive-Behavioural Therapy (CBT): In addition, Cognitive-Behavioural Therapy (CBT) techniques were utilized to identify and challenge any negative thought patterns or beliefs the client may have held about herself or her future prospects following the divorce. I worked with her to develop more adaptive coping strategies for managing distress and uncertainty.  
3. Solution-Focused Brief Therapy (SFBT): Furthermore, I incorporated Solution-Focused Brief Therapy (SFBT) to assist the client in setting achievable goals and identifying practical solutions to address her immediate concerns. Together, we focused on finding ways to cope with loneliness and discovering sources of fulfilment outside of romantic relationships.

**Plans for next session**1. Explore client's breakup emotions and desire for companionship.  
2. Collaborate on coping strategies for loneliness and finding fulfilment beyond romantic relationships.  
3. Discuss client's values and goals for envisioning a purposeful future post-relationship.

**Student Counsellor’s signature… Date…** 23/03/2024

1. **CP FORM 3**

**CLIENT LOG FORM (INDIVIDUAL SESSIONS )**

**SUMMARY OF CLIENT CONTACT HOURS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLIENT CODE** | **DATE:**  **FROM** | **DATE:**  **TO** | **No. OF SESSIONS** | **No. OF HOURS** | **PRESENTING CONCERNS AND MAIN ISSUES EXPLORED** |
| A1 | 30/1/24 | 30/1/24 | 1 | 1 | The client's main issue centres on her reluctance to proceed with treatment for a diagnosed breast abscess. Her hesitation is deeply rooted in fear, particularly due to the traumatic experience of a relative who passed away after undergoing treatment for a similar condition. This fear is significantly impacting her decision-making process regarding her own health and well-being. |
| A2 | 31/1/24 | 31/1/24 | 1 | 1 | The client's main concern lies in dealing with a septic foot wound necessitating a Below-Knee Amputation (BKA), prompting therapy to navigate the upcoming surgery and its significant impact on his lifestyle. The impending surgery and lifestyle adjustments are primary concerns requiring therapeutic support and preparation. |
| A3 | 1/2/24 | 07/2/24 | 2 | 2 ½ | The client's primary presenting problem revolves around both persistent physical illnesses disrupting her daily life and academic performance, with no identifiable physiological causes found despite medical consultation, and profound familial challenges stemming from her inability to reconnect with her biological father for 17 years, leading to unresolved emotional distress and a sense of resignation. |
| A4 | 7/2/24 | 7/2/24 | 1 | 1 | The client's primary concern revolves around his long-standing alcohol addiction, which began during university due to curiosity and peer pressure. This addiction has caused significant personal and social distress. He is motivated to overcome it and regain control over his life for a more fulfilling future. |
| A5 | 12/2/24 | 12/2/24 | 1 | 1 | The client's main issue centres on his enduring struggle with alcohol addiction, profoundly impacting his personal well-being and relationships. This addiction intertwines with emotional, psychological, and interpersonal dimensions, affecting his self-perception and ability to maintain healthy connections. |
| A6 | 14/2/24 | 14/2/24 | 1 | 1 | The client is deeply troubled by perceived HIV exposure and stigma, despite negative test results. Overthinking and stress have profoundly affected his mental well-being, leading to para-suicidal behaviour. Urgent intervention and support are crucial to address his emotional distress effectively and ensure his well-being. |

**TOTAL HOURS…** 7 ½  **COLLECTIVE HOURS…** 7 ½

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLIENT CODE** | **DATE:**  **FROM** | **DATE:**  **TO** | **No. OF SESSIONS** | **No. OF HOURS** | **PRESENTING CONCERNS AND MAIN ISSUES EXPLORED** |
| A7 | 14/2/24 | 14/2/24 | 1 | 1 | Client lives in a hostile home environment and ongoing risk of violence from her husband, accompanied by depressive symptoms with psychotic features since 2009. Concern for her children's well-being drives her decision to flee the home permanently. She aims to work independently and avoid contact with her husband to ensure her safety and well-being. |
| A8 | 15/2/24 | 15/2/24 | 1 | 1 | The client, referred by her doctor, presents symptoms of schizophrenia, Major Depressive Disorder (MDD) with psychotic features, and alcohol addiction. Primary concerns include significant emotional distress stemming from unemployment since graduating in 2019, leading to alcohol misuse. Strained relations with her mother, who becomes violent when she returns home intoxicated, exacerbate her distress. Seven suicide attempts underscore the severity of her distress, necessitating immediate intervention and support to address her complex challenges effectively. |
| A9 | 16/2/24 | 16/2/24 | 1 | 1 | Form 3 student diagnosed with schizophrenia who experienced worsening symptoms after discontinuing medication, including auditory hallucinations, academic decline, excessive sleep, and self-care neglect. Additionally, his adamant behaviour, insistence on repeating Form 2 due to missing a term, and perfectionism pose challenges. Exploring medication adherence, academic progression, family dynamics, and perfectionism tendencies are key areas of focus. |
| A10 | 19/2/24 | 19/2/24 | 1 | 2 | The client, a 24-year-old female diagnosed with bipolar disorder and substance abuse, faces challenges exacerbated by stopping medication. Family dynamics, particularly issues with her grandmother and jealousy from cousin sisters, add to her distress. Being single and raising her daughter, who currently resides with her grandmother, complicate her situation. Exploring medication adherence, family relationships, and parenting dynamics are central to addressing her concerns and enhancing her well-being. |
| A11 | 21/2/24 | 21/2/24 | 1 | 2 | The client, diagnosed with Schizoaffective disorder, faces challenges in maintaining employment due to impulsive decision-making, leading to quitting her last three jobs. She struggles with decision-making and regrets choices made independently, lacking nearby support. Conflict with her religious mother arose after a recent miscarriage from a relationship outside marriage. |

**TOTAL HOURS…** 7 **COLLECTIVE HOURS…** 14 ½

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLIENT CODE** | **DATE:**  **FROM** | **DATE:**  **TO** | **No. OF SESSIONS** | **No. OF HOURS** | **PRESENTING CONCERNS AND MAIN ISSUES EXPLORED** |
| A12 | 27/2/24 | 27/2/24 | 1 | 45 min | The client, diagnosed with bipolar mood disorder, is upset by an unexpected medication change during her hospitalization. Experiencing headaches as a side effect, she expresses frustration and sadness over the lack of communication regarding the adjustment. Seeking a transfer to another ward, she emphasizes the need for better communication and emotional support during her stay. |
| A13 | 28/2/24 | 28/2/24 | 1 | 1 | The client, managing epilepsy-induced psychosis with mood features, faces challenges in anger management and disappointment, leading to two hospitalizations. Lack of support and income exacerbates stress. Addressing anger, developing coping strategies, and establishing support systems are crucial for enhancing her well-being and parenting experience. |
| A14 | 28/2/24 | 28/2/24 | 1 | 1 | Client suffering from learned helplessness, persistent isolation, and the emotional weight of past trauma and familial rejection. Rooted in enduring childhood experiences and ongoing struggles, she grapples with feelings of powerlessness, inadequacy, and social exclusion. Symptoms of anxiety and depression manifest, impacting her ability to trust and navigate daily life. |
| A15 | 4/3/24 | 11/3/24 |  | 6 | The client has been diagnosed with Severe Depression and experiences migraines and chronic insomnia due to stress triggered by his brother-in-law's diagnosis of mental illness. Trauma from witnessing the brother-in-law's arrest with marijuana exacerbates his distress. Suicidal thoughts and attempts arise from overwhelming pain and stress levels. Therapy addresses coping with trauma, managing stress-induced symptoms, and addressing suicidal ideation to support the client's mental health and well-being. |
| A16 | 29/2/24 | 7/4/24 | 3 | 4 | The client seeks therapy for drug addiction and academic challenges. He admits to using marijuana and alcohol as coping mechanisms for stress and peer pressure. Escalating substance use results in conflicts at home and declining academic performance, causing concern for his future. Recognizing the need for support, therapy aims to address addiction, develop healthier coping strategies, and improve academic performance to foster his well-being and future prospects. |

**TOTAL HOURS…** 12 ¾  **COLLECTIVE HOURS…** 27 ¼

**SUMMARY OF CLIENT CONTACT HOURS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLIENT CODE** | **DATE:**  **FROM** | **DATE:**  **TO** | **No. OF SESSIONS** | **No. OF HOURS** | **PRESENTING CONCERNS AND MAIN ISSUES EXPLORED** |
| A17 | 12/3/24 | 12/3/24 | 1 | 1 | The client, a mother of three high-school going children, seeks therapy due to ongoing conflicts and distress in her relationship with her husband. Two suicide attempts followed a heated exchange and violence from her husband, particularly concerning the sale of firewood. The client expresses a strong desire to distance herself from her husband due to the toxic nature of their relationship, highlighting the need to address conflict resolution, emotional distress, and safety concerns in therapy. |
| A18 | 12/3/24 | 12/3/24 | 1 | 1 | The client, a Form 3 student, sought therapy after a suicide attempt by ingesting poison. Poor academic performance and fear of her father's reaction were identified as primary factors contributing to her distress and suicidal behaviour. This highlights the need to address academic stress, family dynamics, and emotional well-being in therapy. |
| A19 | 12/3/24 | 18/3/24 | 3 | 4 | The client, a form 4 student at a boarding school, experiences distress over her recent involvement in a group engaged in lesbianism. This association began during inter-school co-curricular activities, where she befriended girls from another school who introduced her to this behaviour while sharing a dormitory. She now perceives herself as gradually becoming addicted to this lifestyle and wishes to revert to her previous sexual orientation to prevent further entrenchment. |
| A20 | 14/3/24 | 18/3/24 | 5 | 10 | The client is experiencing significant emotional distress due to a combination of personal issues and family burdens. She feels like a burden to her family after a difficult childhood marked by abandonment and a lack of support. This has led to social anxiety, strained family relationships, and difficulty forming romantic attachments. The client is currently financially responsible for her family while struggling to meet her own needs, leading to feelings of isolation and suicidal ideation. |
| A21 | 5/3/24 | 15/3/24 | 3 | 6 | The client's primary concern revolves around his recent breakup with his girlfriend, which has left him struggling to cope with overwhelming emotional and psychological stress. He regrets disclosing certain personal secrets to his ex-girlfriend and has resorted to heavy drinking as a means of managing his distress. |

**TOTAL HOURS…** 22 **COLLECTIVE HOURS…** 49 ¼

**SUMMARY OF CLIENT CONTACT HOURS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLIENT CODE** | **DATE:**  **FROM** | **DATE:**  **TO** | **No. OF SESSIONS** | **No. OF HOURS** | **PRESENTING CONCERNS AND MAIN ISSUES EXPLORED** |
| A22 | 15/3/24 | 15/3/24 | 1 | 2 | The client, a concerned mother, seeks therapy grappling with her daughter's medical diagnosis and treatment plan. Despite medical advice, she hesitates to approve further procedures like an MRI scan, convinced her daughter is fine and advocating for her discharge from the hospital. |
| A23 | 19/3/24 | 19/3/24 | 1 | 1 | The client expresses concern about the impact of alcohol use on his health, family conflicts arising from financial irresponsibility, and the challenges of managing his conditions. |
| A24 | 19/3/24 | 19/3/24 | 1 | 1 | The client attempted suicide by ingesting a pesticide poison due to chronic alcohol use and marital conflicts, which resulted in feelings of despair and hopelessness. He perceives suicide as the only solution to end the pain he and his family are experiencing. |
| A25 | 21/3/24 | 21/3/24 | 1 | 1 | The client, diagnosed with convulsive disorder, feels overwhelmed by the extensive family responsibilities placed upon him as the firstborn of six children. He describes how the weight of these responsibilities leads to constant overthinking, exacerbating his stress levels and triggering convulsions. |
| A26 | 21/3/24 | 21/3/24 | 1 | 1 ½ | The client attempted suicide after her recent breakup with her boyfriend, who she discovered was cheating on her with another woman. She experienced profound emotional distress upon learning about the infidelity and was deeply hurt by her boyfriend's hurtful comments about her appearance and worthiness of love. |
| A27 | 21/3/24 | 21/3/24 | 1 | 1 | The client, diagnosed with Chronic subdural haemorrhage following a bodaboda accident, is grappling with the overwhelming emotional distress and uncertainty surrounding his condition and prognosis. He seeks counselling to find closure and support in navigating his current circumstances. |
| A28 | 23/3/24 | 23/3/24 | 1 | 1 ½ | The client, a newly-wed woman, is seeking therapy due to the physical abuse she has been experiencing from her husband during arguments. Despite multiple attempts to address the issue with him and involve their parents, the violence persists. She feels trapped and imprisoned in her marriage and is seeking support to find a way out of this situation. |

**TOTAL HOURS…** 9  **COLLECTIVE HOURS…** 58 ½

**SUMMARY OF CLIENT CONTACT HOURS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CLIENT CODE** | **DATE:**  **FROM** | **DATE:**  **TO** | **No. OF SESSIONS** | **No. OF HOURS** | **PRESENTING CONCERNS AND MAIN ISSUES EXPLORED** |
| A29 | 23/3/24 | 23/3/24 | 1 | 1 | The client, a father of four working as a bodaboda operator, attempted suicide due to overwhelming pressure to provide for his family's needs. He discovered that his wife was giving away food and household items to friends and neighbours, causing him significant distress and contributing to his feelings of hopelessness and despair. |
| A30 | 23/3/24 | 23/3/24 | 1 | 1 | The client, an independent woman working in a corporate institution, is seeking therapy following the breakdown of her marriage to her long-term partner. The marriage lasted less than six months due to misunderstandings and confusion over roles and responsibilities. Despite their efforts to resolve the issues, they ultimately divorced. The client is struggling with feelings of loneliness and a desire to reconcile with her ex-husband, but she is also hesitant to resume the traditional role of a wife if they were to reunite. She feels overwhelmed by the breakup and is uncertain about her next steps. |

**TOTAL HOURS…** 2  **COLLECTIVE HOURS…** 60 ½

**STUDENT COUNSELLOR’S SIGNATURE… DATE…** 23/03/2024

**UNIVERSITY SUPERVISOR’S NAME…**

**SIG… DATE…**

**GROUP FORMS**

**CP FORM 4**

**Initial Assessment Form for Groups**

**Case Number…** 1 **Date of intake…** 06/02/2024

**Group Code…** G1 **Practicum Site…MTRH**

**Group demographic information (type of group)**Group consisted of 18 members: 16 male and 2 female.   
Age bracket of the group was between 20 – 55 years.

**The current situation (allow the group to share whatever brought them for therapy).**The group members self-identified as recovering addicts with past dependencies on alcohol and drugs. They joined the group therapy as part of their 90-day recovery program to share challenges faced in their journeys. Shared difficulties include:

**Triggers:** Situations, emotions, or substances that elicit cravings or urge to use.

**Social relationships:** Maintaining healthy connections while avoiding negative influences or enabling behaviours.

**Root causes:** Understanding the underlying factors that contributed to their addiction.

**Addiction understanding:** Gaining deeper insights into their addictive patterns and thought processes.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

**Cognitive:** Group members demonstrated varying levels of awareness and understanding of their addictive patterns and triggers. Some exhibited cognitive distortions or negative self-beliefs related to their past use.  
**Emotional:** A range of emotions were expressed, including vulnerability, fear of relapse, frustration, and hope for recovery. Some members might require support managing difficult emotions effectively.

**Social:** The group dynamic appeared supportive and encouraging, offering a safe space for members to share openly. However, potential power imbalances or interpersonal conflicts should be monitored.  
**Physical:** No specific physical concerns were mentioned.

**CP FORM 5**

**Group Treatment Plan Form**

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| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G1 | 06/02/2024 | 9.20 am | 1 | 2 hrs | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**1. Managing triggers and cravings.  
2. Building healthy social relationships.  
3. Identifying and addressing root causes of addiction.  
4. Developing a deeper understanding of addictive patterns and behaviors.

**3. Goals for therapy:**1. Increase awareness and identification of personal triggers.  
2. Develop coping mechanisms to manage cravings and urges effectively.  
3. Enhance communication and interpersonal skills for building supportive relationships.  
4. Explore underlying factors contributing to addiction and develop healthier coping strategies.  
5. Foster self-compassion and acceptance to promote sustained recovery.

**4. Interventions:**1. Psycho-education: Provide information on addiction, relapse prevention, and healthy coping mechanisms.  
2. Cognitive-behavioural therapy (CBT): Challenge negative thought patterns and develop skills for managing triggers and cravings.  
3. Group discussions and exercises: Encourage open sharing, peer support, and learning from shared experiences.  
4. Relapse prevention planning: Identify high-risk situations and develop personalized strategies to avoid relapse.  
5. Mindfulness and relaxation techniques: Promote emotional regulation and stress management.

**5. Plans for next session:**1. Introduce the concept of triggers and their identification using group discussion and individual exercises.  
2. Facilitate sharing of personal experiences with triggers and initial coping strategies employed.  
3. Introduce relaxation techniques for managing cravings and emotional distress.

**Student Counsellor’s signature… Date…** 06/02/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 2 **Date of intake…** 07/02/2024

**Group Code…** G2 **Practicum Site…MTRH**

**Group demographic information (type of group)**

Group consisted of 7 family members who came to a family therapy session for their recovering daughter. Age range of 19 – 51 years. 4 male members and 5 female members.

**The current situation (allow the group to share whatever brought them for therapy).**

Family members attended the session for the release of their daughter who had completed her 90-day recovery program. The daughter is a recovering addict who was an alcoholic. They came to discuss about an exit plan for their daughter and how they are planning to continue supporting her in recovery after discharge from the rehabilitation facility.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

Cognitively: The group members demonstrate clear thinking and effective communication skills, indicating cognitive clarity and understanding of their situation.

Emotionally: They express excitement and determination regarding the daughter's recovery, suggesting a strong emotional investment in her well-being and the success of the therapy process.

Socially: The family exhibits cohesion and a shared commitment to supporting the daughter, reflecting strong social bonds and a willingness to work together toward a common goal.

Physically: There are no apparent signs of illness or impairment among the group members, indicating physical well-being and readiness to actively participate in the therapy sessions.

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G3 | 07/02/2024 | 2.15 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**

The family's primary concern is ensuring a successful transition for their daughter after completing her 90-day recovery program for alcohol addiction. They are seeking guidance on creating an exit plan and establishing sustainable support systems to aid her ongoing recovery journey.

**Goal(s) for therapy**

The goal of therapy is to facilitate a smooth transition for the daughter post-rehabilitation. This involves strengthening family communication and support networks to provide a nurturing environment conducive to her recovery.

**Interventions (state theories used)**

We employed family systems theory to explore the dynamics within the family unit. By understanding how each member interacts and influences one another, we identified patterns of behavior and communication that could impact the daughter's recovery. Through this lens, I facilitated discussions to help the family recognize their roles in both contributing to and supporting the recovery process.

Cognitive-behavioural techniques were utilized to address triggers and prevent relapse. Together, we identified potential triggers for the daughter's alcohol use and developed coping strategies to manage them effectively. By challenging negative thought patterns and implementing healthy coping mechanisms, the family learned practical ways to support the daughter during challenging times.

Psycho-education on addiction and recovery was provided to increase understanding and reduce stigma surrounding substance abuse. By discussing the physiological and psychological aspects of addiction, the family gained insight into the challenges their daughter faces and the importance of ongoing support in her recovery journey.

**Plans for next session (If any)**

In the upcoming sessions, the therapist will delve deeper into exploring family roles and responsibilities in supporting the daughter's recovery journey. Concrete strategies will be developed collaboratively to address potential challenges that may arise post-discharge. The therapist will continue to foster open communication and encourage active participation from all family members to ensure a supportive and conducive environment for the daughter's ongoing recovery.

**Student Counsellor’s signature… Date…** 07/02/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 3 **Date of intake…** 20/02/2024

**Group Code…** G3  **Practicum Site…MTRH**

**Group demographic information (type of group)**Family members of a kidney transplant patients and a neighbour. Family consists of the father (the patient), mother, two sons (one is the donor), sister and a neighbour.

**The current situation (allow the group to share whatever brought them for therapy).**The family members of a kidney transplant patient, including the father (the patient), mother, two sons (one of whom is the donor), sister, and a neighbour, have sought therapy for clarification and psychoeducation regarding the kidney transplant process. They express concerns about understanding the entire transplant journey, including finding a willing kidney donor, adhering to medication, establishing a support system, and having contingency plans in place.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

Cognitively, the group appears cognitively stable and well-oriented, demonstrating understanding and comprehension of the information provided during psychoeducation sessions.  
Emotionally, the group presents as stable, showing readiness and openness to engage in the therapeutic process and address their concerns collaboratively.  
Socially, the group exhibits appropriate social behavior, fostering a supportive and cohesive environment conducive to open communication and mutual understanding.  
Physically, the group members appear well-kempt, reflecting a level of self-care and attention to personal appearance.

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G3 | 20/02/2024 | 10.00 am | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The family members of the kidney transplant patient have sought therapy to gain clarity and psychoeducation about the kidney transplant process. They are concerned about understanding every aspect of the journey, from finding a willing kidney donor to grasping the significance of medication adherence. Additionally, they aim to establish a dependable support system and prepare contingency plans, such as identifying a second willing donor if necessary. Their primary focus is on comprehending the complexities of the transplant procedure and ensuring the patient's well-being throughout the process.

**Goal(s) for therapy**1. Enhance understanding and clarity regarding the kidney transplant process, including the roles and responsibilities of family members, potential challenges, and strategies for effective coping and support.  
2. Facilitate open communication and mutual support within the family system, fostering resilience and cohesion during the transplant journey.  
3. Develop practical skills and resources to navigate the complexities of post-transplant care, including medication adherence, lifestyle adjustments, and the importance of maintaining a healthy support network.  
4. Explore and address any emotional concerns or anxieties related to the transplant process, promoting emotional well-being and resilience among family members.

**Interventions (state theories used)**1. Family Systems Theory: Employed to explore the interconnectedness of family dynamics and roles within the context of the kidney transplant process, promoting understanding and collaboration among family members.  
2. Psychoeducation: Utilized to provide comprehensive information and clarification regarding the transplant process, medication adherence, potential challenges, and coping strategies, empowering family members to make informed decisions and actively participate in the care process.  
3. Cognitive-Behavioural Techniques: Integrated to address any cognitive distortions or maladaptive beliefs that may arise during the transplant journey, promoting adaptive coping skills and resilience among family members.

**Plans for next session (If any)**In the next session, we will continue to explore the family's concerns and experiences related to the kidney transplant process, addressing any emerging questions or uncertainties. We will further delve into strategies for fostering effective communication, problem-solving, and mutual support within the family system. Additionally, we will introduce practical tools and resources to facilitate successful navigation of the post-transplant period, including medication management, lifestyle adjustments, and ongoing emotional support.

**Student Counsellor’s signature… Date…**  20/02/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 4  **Date of intake…** 26/02/2024

**Group Code…** G4  **Practicum Site…MTRH**

**Group demographic information (type of group)**

Group consisted of 8 clients; 3 males and 5 females. Age range was between 20 – 35.

**The current situation (allow the group to share whatever brought them for therapy).**Clients were facing various mental health challenges, such as schizophrenia, bipolar disorder, depression, substance abuse, and schizo-affective disorder. Despite the differences in their diagnoses, they shared a common desire to improve their ability to cope with their conditions and avoid experiencing relapses or setbacks. They sought to gain a deeper understanding of the specific issues they were dealing with and to discover practical strategies to help them manage their symptoms and maintain stability in their lives. Their collective goal was to empower themselves with knowledge and skills that would enable them to navigate their mental health challenges more effectively and lead fulfilling lives despite their conditions.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

- The group demonstrates good insight and judgment, indicating a capacity for self-awareness and rational decision-making.

- Speech is coherent, suggesting clear communication and cognitive functioning.

- Mood and affect are euthymic, indicating a balanced emotional state and appropriate expression of emotions.

- Appearance is neat and well-kempt, reflecting a level of self-care and attention to personal hygiene.

- Social behaviour is appropriate, suggesting the ability to engage in meaningful interactions and maintain appropriate boundaries within the group setting.

**SESSION 1 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G4 | 26/02/2024 | 9.40 am | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group comprises individuals grappling with various mental health challenges, including schizophrenia, bipolar disorder, depression, substance abuse, and schizoaffective disorder. Their shared concern revolves around illness management and relapse prevention. They seek to understand the dynamics of their conditions and learn effective strategies for managing them.

**Goal(s) for therapy**The primary goal for therapy is to provide psychoeducation on their respective mental health conditions, focusing on management and recovery strategies. By enhancing their understanding of their illnesses, they aim to empower themselves to navigate their conditions more effectively and prevent relapses.

**Interventions (state theories used)**The primary intervention employed was psychoeducation. Through structured learning and discussion, clients will gain insights into the nature of their mental health disorders, learn effective coping mechanisms, and explore strategies for recovery. Psychoeducation is a valuable tool for promoting self-awareness and fostering a sense of agency in managing one's mental health.

**Plans for next session (If any)**In the next session, the focus will be on delving deeper into specific aspects of psychoeducation, tailoring the content to address the unique needs and concerns of the group members. Additionally, the session may involve experiential exercises or group discussions to facilitate peer support and reinforce learning objectives.

**Student Counsellor’s signature… Date…** 26/02/2024

**SESSION 2 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G4 | 27/02/2024 | 9.00 am | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group comprises individuals grappling with various mental health challenges, including schizophrenia, bipolar disorder, depression, substance abuse, and schizoaffective disorder. Their shared concern revolves around illness management and relapse prevention. They seek to understand the dynamics of their conditions and learn effective strategies for managing them.

**Goal(s) for therapy**Learn about:   
1. Practical Facts About Mental Illnesses  
2. How are mental illnesses diagnosed  
3. What causes mental illnesses

**Interventions (state theories used)**

Utilized psychoeducation techniques to provide information and resources about mental illnesses, including practical facts, diagnostic procedures, and potential causes. Offered structured learning sessions and discussions to enhance understanding and promote awareness among participants.

**Plans for next session (If any)**

1. Continue psychoeducation sessions focusing on specific mental illnesses, their symptoms, and available treatment options.

2. Facilitate group discussions and activities to encourage active engagement and application of knowledge.

3. Provide resources and referrals for further exploration and support outside of the therapy sessions.

**Student Counsellor’s signature… Date…** 27/02/2024

**SESSION 3 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G4 | 28/02/2024 | 9.00 am | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group comprises individuals grappling with various mental health challenges, including schizophrenia, bipolar disorder, depression, substance abuse, and schizoaffective disorder. Their shared concern revolves around illness management and relapse prevention. They seek to understand the dynamics of their conditions and learn effective strategies for managing them.

**Goal(s) for therapy**

1. Learn about:

1. The Stress-Vulnerability Model and Treatment Strategies  
2. Reducing biological vulnerability to stress  
3. Treatment options available

**Interventions (state theories used)**

Psychoeduaction: Utilized psychoeducation to introduce the Stress-Vulnerability Model and its relevance to mental health. Provided information on how stress impacts vulnerability and discussed strategies for reducing stress and enhancing resilience. Tailored treatment strategies were discussed based on individual needs and preferences.

**Plans for next session (If any)**

1. Further explore individual stressors and triggers contributing to vulnerability, using case examples and group discussions.

2. Introduce stress management techniques such as mindfulness, relaxation exercises, and cognitive restructuring.

3. Review treatment options available for addressing mental health concerns and discuss potential barriers to accessing treatment.

4. Facilitate group activities to promote peer support and shared coping strategies.

5. Assign homework tasks related to stress reduction and self-care practices to reinforce learning between sessions.

**Student Counsellor’s signature… Date…** 28/02/2024

**SESSION 4 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G4 | 29/02/2024 | 9.00 am | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group comprises individuals grappling with various mental health challenges, including schizophrenia, bipolar disorder, depression, substance abuse, and schizoaffective disorder. Their shared concern revolves around illness management and relapse prevention. They seek to understand the dynamics of their conditions and learn effective strategies for managing them.

**Goal(s) for therapy**Developing a sober lifestyle1. Identify reasons for not using substances.  
2. Manage “high-risk” situations.  
3. Find new ways to have your needs met.

**Interventions (state theories used)**Motivational Interviewing: Utilize motivational interviewing techniques to explore the client's intrinsic motivations for sobriety and reinforce their commitment to change. Help the client identify personal values and goals that align with maintaining a sober lifestyle.

Cognitive-Behavioural Therapy (CBT): Implement CBT strategies to challenge maladaptive thought patterns and develop coping skills for managing cravings and high-risk situations. Work on identifying and modifying triggers and developing effective problem-solving strategies.

**Plans for next session (If any)**

1. Conduct a functional analysis of past substance use patterns to identify triggers and high-risk situations.

2. Develop a personalized relapse prevention plan, including coping strategies and alternative behaviours to manage cravings and prevent relapse.

3. Practice relaxation techniques and stress management strategies to cope with emotional distress without turning to substances.

4. Assign homework tasks to reinforce skills learned in session and encourage continued progress towards sobriety.

**Student Counsellor’s signature… Date…** 29/02/2024

**SESSION 5 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G4 | 01/03/2024 | 9.00 am | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group comprises individuals grappling with various mental health challenges, including schizophrenia, bipolar disorder, depression, substance abuse, and schizoaffective disorder. Their shared concern revolves around illness management and relapse prevention. They seek to understand the dynamics of their conditions and learn effective strategies for managing them.

**Goal(s) for therapy**

1. Psychoeduaction on relapse   
2. Developing a personalised relapses prevention plan  
3. Identifying alternative ways of meeting your needs

**Interventions (state theories used)**

1. Psychoeducation: Provide comprehensive information about the nature of relapse, including common triggers, warning signs, and risk factors. Educate the client on the cyclical nature of addiction and the importance of proactive relapse prevention strategies to maintain sobriety.  
2. Cognitive-Behavioural Therapy (CBT): Utilize CBT techniques to identify and challenge negative thought patterns associated with relapse, and develop cognitive restructuring strategies to modify irrational beliefs and increase coping self-efficacy.  
3. Motivational Interviewing (MI): Employ MI principles to enhance the client's intrinsic motivation for change and increase their commitment to adhering to the relapse prevention plan. Explore ambivalence towards change and elicit the client's own reasons for maintaining sobriety.

**Plans for next session (If any)**

1. Review and refine the personalized relapse prevention plan based on the client's feedback and experiences since the previous session.  
2. Practice coping skills and relapse prevention strategies through role-playing exercises and behavioural rehearsal.  
3. Discuss potential challenges or barriers to implementing the relapse prevention plan and develop strategies to address them effectively.  
4. Explore additional topics related to maintaining sobriety, such as managing cravings, improving communication skills, and building a supportive social network.

**Student Counsellor’s signature… Date…** 01/03/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 5  **Date of intake…** 11/03/2024

**Group Code…** G5 **Practicum Site…MTRH**

**Group demographic information (type of group)**Group of 6 family members. 2 males and 4 females. All related to the deceased.

**The current situation (allow the group to share whatever brought them for therapy).**Group is grieving their deceased mother who succumbed to cancer.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?   
1. Cognitive Assessment: The clients demonstrated stability and exhibited good insight into their situations. They appeared capable of processing information and understanding the complexities of their grief and emotions.

2. Emotional Assessment: Emotionally, the group members were experiencing a wide range of intense emotions, including profound sadness, anger, guilt, and confusion. These emotions reflected the depth of their grief and the complexity of their feelings surrounding the loss of their mother.

3. Social Assessment: Socially, some group members may have been feeling isolated or withdrawn, indicating potential challenges in their social interactions and support networks. The loss of their mother may have disrupted their social connections and left them feeling disconnected from others.

4. Physical Assessment: Physically, the group members exhibited symptoms of stress or exhaustion, likely stemming from the emotional distress associated with their grief. These physical manifestations underscored the profound impact of their emotional experiences on their overall well-being.

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G5 | 11/03/2024 | 3.00 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The primary concern prompting therapy for the group is their collective grief over their mother's passing from cancer. They're grappling with understanding their emotions, coping with their grief, and adjusting to life without their mother.

**Goal(s) for therapy**1. Create a safe and supportive environment to allow members to express and process their grief.  
2. Gain insight into their emotions surrounding the loss of their mother.  
3. Develop healthy coping strategies to manage their grief effectively.  
4. Find meaningful ways to honour and remember their mother while adjusting to life without her physical presence.

**Interventions (state theories used)**1. Narrative therapy techniques were utilised to assist the group in constructing and articulating their individual grief stories. Through storytelling and exploration of their experiences, members were encouraged to make sense of their emotions and find meaning in their loss.  
2. Mindfulness exercises were integrated into sessions to help members manage overwhelming emotions associated with grief. By focusing on the present moment and cultivating awareness of their thoughts and feelings without judgment, participants were supported in developing coping strategies to navigate their grief journey more effectively.  
3. Psychoeducation about the grieving process was provided to validate the group members' experiences and reactions. Information and insights into the normalcy of grief responses were shared, empowering individuals to understand and contextualise their own grief experiences within a broader framework.

**Plans for next session (If any)**No plans for further sessions.

**Student Counsellor’s signature… Date…** 11/03/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 6  **Date of intake…** 12/03/2024

**Group Code…** G6 **Practicum Site…MTRH**

**Group demographic information (type of group)**2 males. A brother to the patient and a husband to the patient.

**The current situation (allow the group to share whatever brought them for therapy).**Clients came to get closure about their patient who was diagnosed with possible Breast cancer. Patient had stayed in hospital for 2 weeks while doctors worked round the clock to investigate the presence of cancerous tissue in the patient’s breast.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

1. Insight: The client demonstrates a commendable understanding of their circumstances and condition, reflecting insightful awareness.
2. Judgment: The client showcases prudent decision-making skills, indicating the ability to make sensible choices considering their circumstances.
3. Speech: The client communicates cohesively, expressing their thoughts and emotions with clarity and coherence.
4. Mood and Affect: euthymic
5. Social Behaviour: The client engages in appropriate social interactions, demonstrating effective communication and interpersonal skills.
6. Appearance: The client presents themselves in a neat and well-kempt manner.

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G6 | 12/03/2024 |  | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group's primary concern bringing them to therapy was the uncertainty and anxiety surrounding the potential diagnosis of breast cancer for their loved one. They were grappling with fear, worry, and a sense of helplessness in the face of this challenging situation.

**Goal(s) for therapy**The goal of therapy for the group was to provide support, validation, and coping strategies as they navigated the emotional turmoil associated with their loved one's possible breast cancer diagnosis. Specific objectives included fostering open communication, reducing anxiety and stress levels, and promoting resilience and support among group members.

**Interventions (state theories used)**1. Psychoeducation: Providing information about breast cancer, diagnostic procedures, and treatment options to help the group members better understand the situation and feel more empowered in supporting their loved one.  
2. Cognitive-Behavioural Techniques: Helping group members identify and challenge unhelpful thought patterns and beliefs related to the diagnosis, and teaching coping skills to manage anxiety and distress effectively.  
3. Supportive Group Discussions: Providing a safe and non-judgmental space for group members to share their thoughts, feelings, and experiences related to the diagnosis, and offering mutual support and validation within the group.

**Plans for next session (If any)**In the next session, we will continue to explore their emotions and reactions to the possible breast cancer diagnosis, further discussing coping strategies and support networks. Additionally, we will delve into communication techniques for effectively supporting their loved one through the diagnostic process and treatment journey.

**Student Counsellor’s signature… Date…** 12/03/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 7 **Date of intake…** 12/03/2024

**Group Code…** G7 **Practicum site… MTRH**

**Group demographic information (type of group)**2 elderly female members of family of a renal patient. One was the daughter and the other sister to the patient.

**The current situation (allow the group to share whatever brought them for therapy).**Family members of the patient came to counselling in order to get a clear understanding of the haemodialysis procedure that their patient was going to undergo. They were seeking clarification on the effects and consequences of the procedure and how it would help improve their patient's condition and overall health.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?   
Insight: good with sane judgment.

Mood and Affect**:** euthymic.

Social behaviour: appropriate.

Appearance**:** neat and well kempt.

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G7 | 12/03/2024 | 3.00 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The family members' primary concern bringing them to therapy was their lack of understanding about the haemodialysis procedure their loved one was undergoing. They sought clarification on the procedure's effects, consequences, and its potential to improve the patient's health condition.

**Goal(s) for therapy**1. To provide the family members with accurate information and education about the haemodialysis procedure, addressing their concerns and alleviating any fears or uncertainties they may have.  
2. To support the family members in coping with the emotional impact of their loved one's health condition and treatment, fostering resilience and adaptive coping strategies.  
  
**Interventions (state theories used)**  
1.Psychoeducation: Detailed information about the haemodialysis procedure, including its purpose, process, potential benefits, and risks, was provided to the family members. This intervention aimed to enhance their understanding and processing of medical information, drawing upon the principles of Information Processing Theory.  
2. Supportive Counselling: Empathetic support and validation were offered to the family members as they navigated their concerns and emotions related to their loved one's health condition and treatment. This intervention was grounded in the principles of Person-Centred Therapy, prioritising the therapeutic relationship and the client's subjective experience.  
3. Stress Management Techniques: Stress management techniques, such as relaxation exercises and mindfulness practices, were taught to the family members to help them cope with the emotional distress and uncertainty associated with their loved one's health condition and treatment. This intervention drew upon principles of Stress and Coping Theory, aiming to enhance the family members' adaptive coping skills and resilience.

**Plans for next session (If any)**This is the final session.

**Student Counsellor’s signature… Date…** 12/03/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 8 **Date of intake…** 11/03/2024

**Group Code…** G8 **Practicum Site…MTRH**

**Group demographic information (type of group)**The group comprises 7 males and 3 females, aged between 21 and 40, who are struggling with drug addiction.

**The current situation (allow the group to share whatever brought them for therapy).**The group members gathered for therapy to address their struggles with drug addiction. Each individual shared their personal experiences, detailing the challenges they face due to their substance abuse and expressing a desire for support and guidance to overcome their addiction.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

1. Insight: The group members demonstrated varying levels of insight into their addiction, with some expressing a strong awareness of the negative impact it has on their lives, while others may have exhibited resistance or denial.
2. Mood and Affect: Emotionally, the group members displayed a range of moods, including anxiety, sadness, frustration, and hopelessness, reflecting the distress caused by their addiction.
3. Social Behaviour: Social behaviour is appropriate.
4. Appearance: Physically, some group members show signs of neglect or deterioration in appearance, such as poor hygiene or malnutrition, indicating the toll that addiction has taken on their health and well-being.

**SESSION 1 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G8 | 11/03/2024 | 2.00 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The primary concern bringing the group to therapy is their struggle with drug addiction. They are seeking help to break free from the cycle of substance abuse, regain control over their lives, and build a healthier, drug-free future.

**Goal(s) for therapy**1. To support each group member in acknowledging and accepting the reality of their addiction.  
2. To develop coping skills and strategies to manage cravings and triggers associated with substance abuse.  
3. To foster a supportive and non-judgmental environment where group members can share their experiences, offer mutual support, and hold each other accountable in their recovery journey.  
4. To empower group members to set and work towards achievable goals for sobriety and long-term recovery.

**Interventions (state theories used)**1. Cognitive-behavioural Therapy (CBT): Helping group members identify and challenge negative thought patterns and beliefs associated with substance abuse, and develop more adaptive coping strategies to deal with cravings and triggers.

2. Motivational Interviewing (MI): Using a client-centred approach to explore ambivalence towards change, enhance motivation for recovery, and increase commitment to treatment goals.

3. Psychoeducation: Providing information about the effects of drugs on the brain and body, as well as practical strategies for managing withdrawal symptoms, cravings, and relapse prevention.

4. Group Therapy Techniques: Facilitating group discussions, sharing of experiences, role-playing exercises, and peer support activities to promote mutual learning, empathy, and accountability among group members.

**Plans for next session (If any)**In the next session, the group may focus on exploring individual triggers for substance use, developing personalised coping strategies, and setting concrete goals for sobriety. Additionally, the group may continue to build trust and rapport among members, and explore themes of self-compassion, resilience, and hope in the recovery process.

**Student Counsellor’s signature… Date…** 11/03/2024

**SESSION 2 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G8 | 13/03/2024 | 2.00 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group members continue to grapple with their addiction to drugs, experiencing ongoing struggles with triggers, cravings, and the cycle of substance abuse. They are concerned about their ability to maintain sobriety in the face of these challenges and are seeking guidance and support to develop effective coping strategies.

**Goal(s) for therapy**1. To explore individual triggers for substance use and identify specific situations or emotions that contribute to cravings and relapse.  
2. To collaboratively develop personalised coping strategies tailored to each group member's unique triggers and challenges, focusing on practical techniques to manage cravings and avoid relapse.  
3. To facilitate the setting of concrete, achievable goals for sobriety, such as abstaining from drug use for a specified period or reducing the frequency of substance use.  
4. To explore themes of self-compassion, resilience, and hope in the recovery process, encouraging group members to cultivate a positive mindset and belief in their ability to overcome addiction.

**Interventions (state theories used)**1. Triggers Exploration: Facilitate group discussions and exercises to help members identify their individual triggers for substance use, such as specific environments, people, emotions, or thoughts.  
2. Coping Skills Development: Utilise cognitive behavioural techniques to collaboratively develop personalised coping strategies for managing triggers and cravings. This may include relaxation techniques, distraction strategies, and assertiveness training.  
3. Goal Setting: Guide group members in setting realistic and measurable goals for sobriety, ensuring goals are specific, achievable, relevant, and time-bound (SMART).  
4. Psychoeducation: Provide information and psychoeducation on self compassion, resilience, and hope in the context of addiction recovery, highlighting the importance of self care, perseverance, and maintaining a positive outlook.

**Plans for next session (If any)**In the next session, the group will focus on understanding and managing vulnerabilities to stressors. They will explore stress management techniques, identify triggers for substance use related to stress, and set goals for enhancing resilience. Members will share progress and challenges, fostering mutual support. Additionally, themes of self-compassion, resilience, and hope will be further explored to cultivate inner strength and optimism in the recovery journey.

**Student Counsellor’s signature… Date…** 13/03/2024

**SESSION 3 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G8 | 14/03/2024 | 2.00 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group members are concerned about their susceptibility to stressors and how these stressors may contribute to their substance use. They recognise the need to develop effective stress management strategies to reduce the likelihood of relapse and enhance their resilience in recovery.

**Goal(s) for therapy**1. To increase awareness and understanding of individual vulnerabilities to stressors among group members.  
2. To explore and implement practical stress management techniques tailored to each member's needs and preferences.  
3. To identify specific triggers for substance use related to stress and develop strategies for managing these triggers effectively.  
4. To foster mutual support and collaboration among group members in sharing progress and addressing challenges related to stress management and substance use.

**Interventions (state theories used)**1. Psychoeducation: Provide information on the physiological and psychological effects of stress, as well as the relationship between stress and substance use. Utilise elements of Stress and Coping Theory to help group members understand how stressors can impact their coping strategies and substance use behaviours.  
2. Stress Management Techniques: Introduce a variety of stress management techniques, including relaxation exercises, mindfulness practices, deep breathing exercises, and progressive muscle relaxation. Incorporate principles from Cognitive-Behavioural Therapy (CBT) to help members challenge and reframe negative thought patterns associated with stress.  
3. Triggers Identification: Guide group members in identifying specific triggers for substance use related to stress, such as certain situations, emotions, or interpersonal conflicts. Use principles from Motivational Interviewing (MI) to explore ambivalence and motivation for change in managing these triggers.  
4. Mutual Support: Facilitate group discussions where members can share their progress and challenges in managing stress and substance use, offering support, encouragement, and feedback to one another. Use principles of Group Therapy to promote cohesion and collaboration within the group.

**Plans for next session (If any)**Group will explores stress management techniques for real-life application, revisits substance use triggers for personalised coping plans. Members share progress, fostering mutual support. Themes of self-compassion, resilience, and hope reinforce inner strength and optimism in recovery journey.

**Student Counsellor’s signature… Date…** 14/03/2024

**SESSION 4 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G8 | 15/03/2024 | 2.00 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**Members initially sought therapy to address their struggles with drug addiction, including managing cravings, overcoming triggers, and maintaining sobriety. They also expressed concerns about relapse prevention and rebuilding their lives after addiction.

**Goal(s) for therapy**1. Reflection: engage in a reflective process, individually and collectively, to assess their progress and insights gained throughout the therapy process. Explore how their attitudes, behaviours, and perceptions have evolved since the beginning of therapy.  
2. Sharing: Each member will have dedicated time to share their personal experiences, highlighting the challenges they faced, the coping strategies they employed, and the milestones they achieved in their journey towards recovery.   
3. Gratitude: collectively express gratitude for the support and encouragement received from one another and from the therapist throughout the therapy process.   
4. Farewell: Members will have the opportunity to express their feelings about concluding the group sessions and reflect on their personal growth and development during this time.  
5. Future Plans: Discussion on plans for continued support and maintenance of sobriety will take place.   
  
**Interventions (state theories used)**1. Person-Centred Therapy: encouraged open and non-judgmental communication among group members. This approach allowed each member to authentically express themselves and feel heard and understood by the group. By fostering a supportive environment, members were able to share their thoughts, feelings, and experiences without fear of judgment.  
2. Gestalt Therapy techniques to facilitate reflection and integration of past experiences. Through guided exercises and discussions, members gained insight into their patterns of behaviour and how these behaviours contributed to their addiction. This process helped members develop a sense of closure as they confronted and processed their past experiences, enabling them to move forward in their recovery journey with greater clarity and understanding.  
3. Motivational Interviewing, I supported members in exploring their motivations for change and reinforcing their commitment to maintaining sobriety beyond the group therapy sessions. By asking open-ended questions and actively listening to their responses, I helped members identify their intrinsic reasons for wanting to overcome addiction. Additionally, I worked collaboratively with members to identify potential barriers to change and develop strategies to overcome them, empowering them to take ownership of their recovery journey and build confidence in their ability to achieve lasting sobriety.

**Plans for next session (If any)**This is the final session.

**Student Counsellor’s signature… Date…** 15/03/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 9 **Date of intake…** 14/03/2024

**Group Code…** A9 **Practicum Site…MTRH**

**Group demographic information (type of group)**Relatives of a deceased. 13 members, 5 males and 8 females aged between 22 – 65.

**The current situation (allow the group to share whatever brought them for therapy).**The clients are grieving the loss of their fallen grandmother who was diagnosed with lung complications.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

1. Insight: good
2. Judgment: good

Mood and Affect**:** sad

Social behaviour : appropriate.

Appearance: well kempt and neat

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G9 | 14/03/2024 | 2.30 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The primary concern bringing the clients to therapy was the grieving process following the loss of their grandmother, who had been diagnosed with lung complications.

**Goal(s) for therapy**1. To facilitate the grieving process: The goal of therapy was to provide a supportive environment where clients could express their emotions, share memories of their grandmother, and work through the stages of grief at their own pace. This would allow them to process their feelings of loss and begin to find meaning and acceptance in their grandmother's passing.  
2. To promote coping skills: Another goal was to equip clients with effective coping strategies to manage their grief and navigate the challenges of bereavement. This may include learning relaxation techniques, practising mindfulness, and engaging in activities that provide comfort and solace during difficult moments.

**Interventions (state theories used)**1. Supportive Counselling: Utilising principles of Person-Centred Therapy, the therapist provided empathetic support and validation to clients as they navigated their grief. This involved active listening, reflecting feelings, and offering a safe space for clients to express their emotions openly without judgment.  
2. Grief Counselling Techniques: Drawing from techniques of grief counselling, such as narrative therapy and expressive arts therapy, clients were encouraged to share memories of their grandmother, explore their feelings of loss through creative expression, and reconstruct their sense of identity in the absence of their loved one.  
3. Psychoeducation: Providing information about the grieving process and common reactions to loss helped clients understand that their experiences of grief were normal and valid. This intervention aimed to reduce feelings of confusion and self-doubt, promoting self-compassion and acceptance during the grieving journey.  
4. Group Support: Encouraging group members to share their experiences, offer mutual support, and validate each other's feelings created a sense of solidarity and belonging within the group. This collective support helped clients feel less alone in their grief and provided opportunities for shared healing and growth.

**Plans for next session (If any)**This is the final session.

**Student Counsellor’s signature… Date…** 14/03/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 10 **Date of intake…** 19/03/2024

**Group Code…** G10 **Practicum Site…MTRH**

**Group demographic information (type of group)**Group consisted of 3 family members related to the patient; 2 elderly men and one woman. Age range was between 40-55 years.

**The current situation (allow the group to share whatever brought them for therapy).**Group sought therapy to get closure about their chronically ill patient who was diagnosed with advanced oesophagus cancer with no hope for recovery. Family members had recovery expectations. This session was meant to give them closure about the current state of affairs in relation to their patient.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

1. Insight is good, judgement too

Mood and Affect: euthymic

Social behaviour is appropriate

Appearance: neat and well kempt

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G10 | 19/03/2024 | 1.00 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group sought therapy to gain closure regarding their chronically ill patient diagnosed with advanced oesophagus cancer, for whom recovery expectations were held. They are grappling with the emotional turmoil and uncertainty surrounding the patient's prognosis and seek support in processing their feelings and finding closure.

**Goal(s) for therapy**1. Provide emotional support and validation to the group members as they navigate their grief and uncertainty surrounding the patient's prognosis.  
2. Facilitate open communication and expression of emotions within the group, allowing them to share their experiences and perspectives in a safe and supportive environment.  
3. Help the group members gain acceptance and understanding of the current state of affairs regarding the patient's condition, fostering a sense of closure and peace.  
4. Educate the family on palliative care options and support them in making informed decisions regarding the patient's care.

**Interventions (state theories used)**1. Supportive Therapy: Utilized supportive therapy techniques to provide emotional validation and empathy to the group members as they navigate their grief and uncertainty. Encouraged active listening and validation of each other's experiences to foster a sense of solidarity and support within the group.  
2. Psychoeducation: Provided information and education about the patient's diagnosis and prognosis, helping the group members gain a better understanding of the medical realities and uncertainties surrounding the illness. Offered guidance on coping strategies and emotional self-care techniques to manage their distress.  
3. Grief Counselling: Employed grief counselling interventions to help the group members process their feelings of loss and sadness related to the patient's condition. Facilitated open expression of emotions and encouraged the group to explore their individual experiences of grief and mourning.  
4. Palliative Care Education: Conducted sessions to educate the family members about palliative care options, including pain management and end-of-life care, to support them in making decisions aligned with the patient's comfort and dignity.

**Plans for next session (If any)**

No plans for next session. Client is due to be discharged.

**Student Counsellor’s signature… Date…** 19/03/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 11  **Date of intake…** 22/022024

**Group Code…** G11 **Practicum Site…MTRH**

**Group demographic information (type of group)**Group comprised of a single mother and her teenage son.

**The current situation (allow the group to share whatever brought them for therapy).**The mother has been having a hard time with her teenage son (fifteen years old) for the past few months. The son has been aggressive, violent and doesn’t listen to anyone other than his friends. He has even threatened to drop out of school if the mother doesn’t leave him alone. The mother has tried all means but to no success. She seeks therapy in order to find a way to communicate with her so he can listen to her.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

1. Insight: The mother demonstrates a strong understanding of their situation, showing insightful awareness regarding her son's behaviour and its impact. In contrast, the son appears to have limited insight into the consequences of his actions, showing resistance to authority and parental guidance.
2. Judgment: While the mother exhibits sound decision-making skills given her circumstances, seeking therapy as a proactive step to address the challenges, the son's decision-making skills may be impulsive and influenced by peer pressure, as evidenced by his threats to drop out of school.
3. Speech: Both communicate coherently, expressing thoughts and emotions clearly, although the son's communication may be characterised by defiance or aggression, reflecting underlying emotional turmoil.
4. Mood and Affect: The mother displays a dysphoric mood, expressing sadness and despair about her son's behaviour, while the son may exhibit volatile mood swings, alternating between aggression and withdrawal.
5. Social Behaviour: Both engage appropriately in social interactions, demonstrating effective communication skills, but the son's social interactions may be primarily with friends who validate his behaviour, contributing to his defiance towards authority figures.
6. Appearance: Both maintain a neat and well-groomed appearance, although the son's appearance may reflect a lack of concern for personal grooming or presentation, potentially indicative of underlying emotional distress.

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G11 | 22/022024 | 3.30 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The primary concern bringing the mother and son to therapy was the ongoing conflict and communication breakdown in their relationship. The mother struggled with her son's aggressive and defiant behaviour, feeling helpless and unable to reach him. The son, on the other hand, may have felt misunderstood and unsupported, resorting to extreme actions to assert his independence and autonomy.

**Goal(s) for therapy**1. To improve communication: The goal of therapy was to establish open and effective communication channels between the mother and son, allowing them to express their feelings, concerns, and needs in a constructive manner.  
2. To address behavioural issues: Therapy aimed to address the son's aggressive and violent behaviour, helping him understand the consequences of his actions and develop healthier coping strategies to manage his emotions.  
3. To rebuild trust and connection: Another goal was to rebuild trust and strengthen the mother-son bond, fostering a supportive and nurturing environment where both felt valued, understood, and respected.

**Interventions (state theories used)**1. Family Systems Theory: Utilising principles of Family Systems Theory, therapy focused on understanding the dynamics of the mother-son relationship within the broader family context. This approach helped identify underlying patterns of interaction and communication that contributed to the current issues.  
2. Cognitive-Behavioural Therapy (CBT): Employing CBT techniques to address the son's aggressive behaviour and negative thought patterns. This involved identifying and challenging distorted beliefs, teaching anger management skills, and promoting positive coping strategies.  
3. Emotion-Focused Therapy (EFT): Incorporating EFT principles to explore and validate the emotions underlying the mother and son's interactions. This intervention focused on helping them express their feelings openly and empathetically towards each other.

**Plans for next session (If any)**In the next session, we will continue to work with the mother and son to further develop their communication and conflict resolution skills. We will explore deeper issues underlying the mother-son relationship and continue to implement strategies to address the son's behavioural issues.

**Student Counsellor’s signature… Date…** 22/022024

**SESSION 2 CP FORM 5**

**GROUP TREATMENT PLAN FORM**

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| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G11 | 15/03/2024 | 2.00 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The son was able to open up in the previous session about how his peers were a big part of his behaviour change. He shared the kind of risky activities they engage in like role playing using real weapons to imitate gangs and everything they do. He also explained how his peers were constantly pushing him to drop out of school. His mother was terrified and surprised by all this information.

**Goal(s) for therapy**1. To address peer influence: help the son develop resilience against peer pressure and make positive choices.  
2. To promote school engagement: help son in re-engaging with his education and resisting pressure to drop out of school.  
3. To enhance family communication: improve communication between the mother and son

**Interventions (state theories used)**1. Cognitive Restructuring: Utilised cognitive restructuring techniques to help the son identify and challenge irrational thoughts and beliefs driving his risky behaviours. This intervention aimed to promote more adaptive thinking patterns and decision-making.  
2. Family Therapy: Implemented family therapy techniques to improve communication and understanding between the mother and son. This involved facilitating discussions about family dynamics, setting boundaries, and exploring ways to support each other.  
3. Psychoeducation: Provided the mother and son with information about the risks and consequences of engaging in risky behaviours and the importance of staying in school. This intervention aimed to increase their awareness and understanding of the potential impact of their actions.

**Plans for next session (If any)**In the next session, we will continue to work with the mother and son to develop strategies for resisting peer pressure and re-engaging with school. we will explore coping mechanisms for dealing with peer influence and strengthen communication skills within the family.

**Student Counsellor’s signature… Date…** 15/03/2024

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G11 | 19/03/2024 | 3.00 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The mother sought therapy to be able to open up and confess on how she used to treat her son while he was young. She was also willing to appologise for all the wrongs she did to him citing them as the main reason why he felt pushed away by his mom. She aims to rsolve all the past mistakes that they encountered with her son in order to regain her sons trust and affection.

**Goal(s) for therapy**1. To facilitate healing and reconciliation

2. To improve communication and understanding

3. To promote forgiveness and closure

**Interventions (state theories used)**1. Person-Centred Therapy: Utilised principles of Person-Centred Therapy to create a non-judgmental and empathetic environment where the mother felt safe to explore and express her feelings and experiences.  
2. Narrative Therapy: Employed Narrative Therapy techniques to help the mother and son construct and make sense of their shared story, allowing them to reframe past experiences and create a new narrative that promotes healing and understanding.  
3. Apology and Reconciliation: Facilitated a process of apology and reconciliation between the mother and son, allowing them to acknowledge past hurts and work towards forgiveness and healing.  
4. Family Systems Theory: Explored dynamics within the family system to understand how past interactions and relationships may have influenced the mother-son relationship, guiding interventions to address underlying issues and promote positive change.

**Plans for next session (If any)**In the next session, we will continue to support the mother and son in their journey towards healing and reconciliation. We will explore further opportunities for open communication and understanding, and continue to work on strategies to rebuild trust and strengthen their relationship. Additionally, we may explore additional interventions or involve other family members to provide support and facilitate the healing process.

**Student Counsellor’s signature… Date…** 19/03/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 12 **Date of intake…** 20/03/2024

**Group Code…** G12 **Practicum Site…MTRH**

**Group demographic information (type of group)**Group comprised of a mother and her grandson. Age range was between 24-55 years.

**The current situation (allow the group to share whatever brought them for therapy).**They sought therapy due to their recent loss regarding their family member; son of the grandmother and father to the son. The father succumbed to lung cancer after he was hospitalised for three weeks. He was already in stage four at time of admission. The two family members were grieving their deceased.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

1. Initial Assessment of the Group:
2. Insight: The group collectively demonstrates a commendable understanding of their circumstances and condition, reflecting insightful awareness regarding their shared concerns.
3. Judgment: As a group, they showcase prudent decision-making skills, indicating the ability to make sensible choices considering their circumstances and collaborative decision-making.
4. Speech: The group communicates cohesively, expressing their thoughts and emotions with clarity and coherence during group discussions and interactions.
5. Mood and Affect: The group exhibits dysphoric mood, with a low mood mixed with feelings of sadness and despair evident among members during group sessions.
6. Social Behaviour: Collectively, the group engages in appropriate social interactions, demonstrating effective communication and interpersonal skills in their interactions with each other and the therapist.
7. Appearance: The group presents themselves in a neat and well-kempt manner, reflecting their attention to self-care and presentation during group therapy sessions.

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G12 | 20/03/2024 | 1.30 pm | 1 | 2 hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The group sought therapy following the recent loss of their family member, the son of the grandmother and father to the son. The father passed away from lung cancer after a three-week hospitalisation, already in stage four upon admission. The two family members were grieving their deceased loved one.

**Goal(s) for therapy**1. To facilitate grief processing: The goal of therapy was to provide a safe and supportive environment for the group to express their emotions, share memories, and honour the life of their deceased loved one.

2. To promote emotional healing: Therapy aimed to help the group members work through their grief, find meaning in their loss, and gradually adjust to life without their family member.

3. To strengthen coping skills: Another goal was to equip the group with coping strategies and resources to manage their grief reactions and support each other through the grieving process.

**Interventions (state theories used)**1. Grief Counselling: Employed principles of grief counselling to validate the group's emotions, facilitate emotional expression, and help them come to terms with their loss.

2. Narrative Therapy: Utilised narrative therapy techniques to encourage the group members to share stories and memories of their deceased loved one, fostering a sense of connection and meaning-making in their grief journey.

3. Supportive Group Therapy: Implemented supportive group therapy interventions to promote mutual support, empathy, and solidarity among group members as they navigate through their grief together.

**Plans for next session (If any)**This is the final session.

**Student Counsellor’s signature… Date…** 20/03/2024

**CP FORM 4**

**INITIAL ASSESSMENT FORM FOR GROUPS**

**Case Number…** 13 **Date of intake…** 23/03/2024

**Group Code…** G13 **Practicum Site…MTRH**

**Group demographic information (type of group)**Group was a couple between ages 27-32 years.

**The current situation (allow the group to share whatever brought them for therapy).**The husband had been treated and discharged recently after ingesting poison in an attempt to take his file citing marital disputes as the main factor. He shares that his wife has befriended a number of men in the neighbourhood whom she spends time with when he is away. The wife on the other hand has shared how her husband comes home late every day leaving her lonely at home. They explain how they love each other and would like to resolve their issues maturely.

**What is your initial assessment of the group; cognitively, emotionally, socially and physically in relation to their concerns**?

1. Insight: The client demonstrates a commendable understanding of their circumstances and condition, reflecting insightful awareness.
2. Judgment: The client showcases prudent decision-making skills, indicating the ability to make sensible choices considering their circumstances.
3. Speech: The client communicates cohesively, expressing their thoughts and emotions with clarity and coherence.
4. Mood and Affect: euthymic
5. Social Behaviour: The client engages in appropriate social interactions, demonstrating effective communication and interpersonal skills.
6. Appearance: The client presents themselves in a neat and well-kempt manner.

**CP FORM 5**

**GROUP TREATMENT PLAN FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group Code** | **Date of Session** | **Time of session** | **Session number** | **Duration of session** | **Practicum site** |
| G13 | 23/03/2024 | 3.30 pm | 1 | 2 ½ hours | MTRH |

**Group’s Concerns(Issue bringing them for therapy)**The couple sought therapy due to marital disputes and concerns about infidelity. The husband attempted self-harm, expressing distress over his wife's friendships with other men. The wife, feeling neglected due to her husband's long working hours, sought support to address feelings of loneliness and improve communication in their relationship.

**Goal(s) for therapy**1. To improve communication: The goal of therapy was to facilitate open and honest communication between the couple, allowing them to express their concerns, needs, and feelings in a constructive manner.  
2. To address trust issues: Therapy aimed to address trust issues stemming from suspicions of infidelity, helping the couple rebuild trust and strengthen their marital bond.  
3. To promote conflict resolution: Another goal was to equip the couple with conflict resolution skills to address disagreements and resolve conflicts in a respectful and mutually beneficial manner.

**Interventions (state theories used)**1. Emotionally Focused Therapy (EFT): Employed principles of EFT to help the couple identify and express their underlying emotions, such as fear, insecurity, and sadness, related to their marital issues.  
2. Cognitive-Behavioural Therapy (CBT): Utilised CBT techniques to challenge negative thought patterns and irrational beliefs contributing to mistrust and conflict in the relationship.  
3. Couples Counselling: Implemented couples counselling interventions to facilitate dialogue, promote understanding, and foster empathy between the husband and wife.  
4. Solution-Focused Brief Therapy (SFBT): Utilised SFBT techniques to identify and build upon the couple's strengths and resources, focusing on solutions and positive outcomes in their relationship.

**Plans for next session (If any)**In the next session, we will continue to work with the couple to address their marital concerns and develop strategies for improving communication and resolving conflicts. We may explore deeper issues underlying their relationship dynamics and introduce additional interventions tailored to their specific needs and progress. Additionally, we will reinforce positive changes and encourage ongoing commitment to the therapeutic process.

**Student Counsellor’s signature… Date…** 23/03/2024

**CP FORM 6**

**GROUP LOG FORM**

**SUMMARY OF GROUP CONTACT HOURS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **GROUP CODE** | **DATE:**  **FROM** | **DATE:**  **TO** | **No. OF SESSIONS** | **No. OF HOURS** | **PRESENTING CONCERNS AND MAIN ISSUES EXPLORED** |
| G1 | 6/2/24 | 6/2/24 | 1 | 2 | The group, comprising recovering addicts, part of a 90-day recovery program, seeks support in navigating their journeys. They share challenges including triggers, social relationships, understanding root causes, and gaining insights into addictive patterns and thought processes. Their participation reflects a commitment to understanding and overcoming addiction. |
| G2 | 7/2/24 | 7/2/24 | 1 | 2 ½ | The presenting concerns and main issues explored involve ensuring a successful transition for the daughter post-rehabilitation from alcohol addiction. The family seeks guidance on creating an exit plan and establishing sustainable support systems for her ongoing recovery journey. The therapy aims to strengthen family communication, identify triggers, prevent relapse, provide psycho-education, and address family roles and responsibilities in supporting the daughter's recovery. |
| G3 | 20/2/24 | 20/2/24 | 1 | 2 | The family members of a kidney transplant patient have sought therapy for clarification and psychoeducation regarding the kidney transplant process. They express concerns about understanding the entire transplant journey, including finding a willing kidney donor, adhering to medication, establishing a support system, and having contingency plans in place. |
| G4 | 26/2/24 | 1/3/24 | 5 | 10 | The group comprises individuals grappling with various mental health challenges, including schizophrenia, bipolar disorder, depression, substance abuse, and schizoaffective disorder. Their shared concern revolves around illness management and relapse prevention. They seek to understand the dynamics of their conditions and learn effective strategies for managing them. |
| G5 | 11/3/24 | 11/3/24 | 1 | 2 | Group is grieving their deceased mother who succumbed to cancer. |
| G6 | 12/3/24 | 12/3/24 | 2 | 2 | Clients came to get closure about their patient who was diagnosed with possible Breast cancer. Patient had stayed in hospital for 2 weeks while doctors worked round the clock to investigate the presence of cancerous tissue in the patient’s breast. |

**TOTAL HOURS…** 16 ½  **COLLECTIVE HOURS…** 16 ½

**SUMMARY OF GROUP CONTACT HOURS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **GROUP CODE** | **DATE:**  **FROM** | **DATE:**  **TO** | **No. OF SESSIONS** | **No. OF HOURS** | **PRESENTING CONCERNS AND MAIN ISSUES EXPLORED** |
| G7 | 12/3/24 | 12/3/24 | 1 | 2 | The family members' primary concern bringing them to therapy was their lack of understanding about the haemodialysis procedure their loved one was undergoing. They sought clarification on the procedure's effects, consequences, and its potential to improve the patient's health condition. |
| G8 | 11/3/24 | 15/3/24 | 4 | 8 | The group members gathered for therapy to address their struggles with drug addiction. Each individual shared their personal experiences, detailing the challenges they face due to their substance abuse and expressing a desire for support and guidance to overcome their addiction. |
| G9 | 14/3/24 | 14/3/24 | 1 | 2 | The primary concern bringing the clients to therapy was the grieving process following the loss of their grandmother, who had been diagnosed with lung complications. |
| G10 | 19/3/24 | 19/3/24 | 1 | 2 | The group sought therapy to gain closure regarding their chronically ill patient diagnosed with advanced oesophagus cancer, for whom recovery expectations were held. They are grappling with the emotional turmoil and uncertainty surrounding the patient's prognosis and seek support in processing their feelings and finding closure. |
| G11 | 22/3/24 | 19/3/24 | 3 | 6 | Single mother has been having a hard time with her teenage son (fifteen years old) for the past few months. The son has been aggressive, violent and doesn’t listen to anyone other than his friends. He has even threatened to drop out of school if the mother doesn’t leave him alone. The mother has tried all means but to no success. She seeks therapy in order to find a way to communicate with her so he can listen to her. |
| G12 | 20/3/24 | 20/3/24 | 1 | 2 | The group sought therapy following the recent loss of their family member, the son of the grandmother and father to the son. The father passed away from lung cancer after a three-week hospitalisation, already in stage four upon admission. The two family members were grieving their deceased loved one. |
| G13 | 23/3/24 | 23/3/24 | 1 | 2 ½ | The couple sought therapy due to marital disputes and concerns about infidelity. The husband attempted self-harm, expressing distress over his wife's friendships with other men. The wife, feeling neglected due to her husband's long working hours, sought support to address feelings of loneliness and improve communication in their relationship. |

**TOTAL HOURS…** 24 ½  **COLLECTIVE HOURS…** 40