



Internship Experience Report: A Comprehensive Overview of Professional Engagement at Mind Ease Pvt. Ltd.

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Abstract: This internship report presents a comprehensive account of the researcher's practical training experience at an institution in the field of clinical psychology. The organization is known for its commitment to excellence, client-centric approach, and emphasis on ethical practices. During the internship, the researcher undertook a range of roles and responsibilities, including client interaction, documentation, assessments, and assisting professionals which provided valuable exposure to real-world applications of theoretical knowledge. A central component of this internship involved engaging with and analyzing five detailed case studies, each presenting unique challenges and insights. These cases covered diverse concerns such as ADHD, Obsessive-Compulsive Disorder, Schizo-obsessive disorder, depression and anxiety allowing for the application of multiple intervention techniques and problem-solving approaches under professional supervision. The internship not only enhanced my practical skills, such as communication skills, critical thinking, empathy and report writing, but also deepened my understanding of professional ethics, multidisciplinary teamwork, and client management. Key learnings include the importance of adaptability, continuous self-reflection, and evidence-based practice in delivering effective outcomes. This experience has significantly contributed to my professional development and reinforced my interest in pursuing a career in clinical psychology.

Keywords: *Clinical Psychology, Internship, Case Studies, Mental Health, Psychopathology, Client Interaction, Therapeutic Skills, Psychological Assessment, Professional Development, Ethical Practice, Supervised Training, Counseling Techniques, Evidence-Based Practice*

1. About the Organization

The internship with Mind Ease-Psychological Services and Wellness Centre was completed throughout the summer. Two RCI-registered clinical psychologists, Ms. Rashmi Juneja and Ms. Anuja Kapoor, jointly own this private clinic. Both clinicians are quite experienced and skilled in this sector. They have a thorough awareness of operating in a global environment. They have a wealth of understanding on dealing with both government and private organizations. Additionally, they have authored numerous scientific publications.

They lend a helpful hand to all facets of human existence in order to lessen mental health discomfort and advance societal well-being. "We approach consultations with tact, empathy, and professionalism. People can openly express their worries during their sessions because they are safe spaces that are fully confidential. In order to assist those in need as effectively as possible, Mind Ease has clinical psychologists, clinical neuropsychologists, consultant criminal psychologists, counsellors, consultant psychiatrists, physiotherapists, speech advisors, special educators, and consultant occupational therapists all under one roof. They work to provide a quiet, compassionate, and nonjudgmental safe space for self-disclosure, critical thinking, and skill building to enhance mental development and well-being."

The goal of Mind Ease is to improve the long-term health of our community by offering individualized, high-quality care that is delivered with kindness, respect, and dignity. They are a group of compassionate medical experts who are known for fostering wellness through early detection and prevention.

For schools, MNCs, universities, and shooting academies, Mind Ease also provides workshops and several offline and online internship programs.

2. Roles and Responsibilities Undertaken

At the start of the internship, each student got the chance to introduce themselves, get to know their mentors, and network with other interns at an orientation session. The course outline,

division of hours, and internship timetable were then thoroughly described to us. Along with learning about what this internship would involve for us, we were also given an overview of the knowledge that the clinic's many mental health specialists could impart to us.

This time most of the focus in the internship was to learn about different scales, questionnaires and test which would be useful to us in our professional careers in the future and must be known to us. We first got the format of case study and MSE settled before diving into the scales.

The first scale we did was PGI Battery of Brain Dysfunction (PGIBBD). The PGI Battery of Brain Dysfunction (PGIBBD) is a psychological test battery developed in India, primarily for assessing brain dysfunctions. It is widely used in clinical neuropsychology to evaluate cognitive deficits that may arise from brain injuries, neurological disorders, or psychiatric conditions (Pandey and Medhi, 1990). Then The Binet-Kamat Test of Intelligence (BKT). It is an Indian adaptation of the Stanford-Binet Intelligence Scale, tailored for use in Indian cultural contexts. It assesses general intelligence in individuals aged 3 to 22 years. The BKT is widely used in clinical, educational, and research settings in India due to its cultural relevance. We learnt how to do the scoring and interpret the scores (Bhatia, 1955).

The Positive and Negative Syndrome Scale (PANSS) was what we did after that. It is a 30-item scale that measures the severity of schizophrenia symptoms in adults. It is a widely used tool in the study of antipsychotic therapy. It's also used to measure treatment response in bipolar and schizoaffective disorders (Kay, Fiszbein and Opler, 1987). Then we did MISIC (Malin's Intelligence Scale for Indian Children). MISIC is an adaptation of the Wechsler Intelligence Scale for Children (WISC) designed for Indian children aged 6 to 15 years. It measures overall intellectual functioning through verbal and performance subtests, providing a comprehensive IQ score (Malin, 1969); VSMS (Vineland Social Maturity Scale) evaluates an individual's social competence and adaptive behavior across different life areas. It assesses social maturity from infancy to adulthood by measuring daily living skills, communication, and social interaction. This test is commonly used to diagnose developmental delays, intellectual disabilities, and assess adaptive functioning (Doll, 1936) & DST (Draw-a-Man Test by Goodenough-Harris) is a projective psychological assessment used to evaluate cognitive development and intellectual maturity in children aged 3 to 15 years. It involves asking the child to draw a human figure, with

the drawing scored based on detail and accuracy. It is often used as a quick screening tool for intelligence and developmental progress (Goodenough, 1926).

We also did The House-Tree-Person (HTP) Test is a projective psychological assessment where individuals draw a house, a tree, and a person. It helps evaluate personality characteristics, emotional functioning, and cognitive abilities by analyzing the drawings' content, style, and details. It is commonly used with both children (Buck, 1948) and adults and NIMHANS SLD (Specific Learning Disabilities) which is a standardized tool developed by the National Institute of Mental Health and Neurosciences (NIMHANS) to diagnose learning disabilities in children. It evaluates cognitive, academic, and neuropsychological functions to identify difficulties in reading, writing, and mathematics. The test is widely used in India for clinical and educational interventions (Shankar and Raj, 2009).

Along with this we also got to partake in client observation and observed how the psychologist interacts with the client, their body language, mannerisms and how to weave questions so that the client can answer.

3. Case Studies

Below are the case studies listed that were observed by me during the period of my internship: -

3.1 Case Study 1

Ms. C is a 5-year-old female from an upper socioeconomic background, brought in for psychological evaluation following concerns raised by both her parents and school authorities regarding her behavior, social interactions, and attention difficulties. Her mother, who served as the primary informant, described a pattern of unusual behaviors observed both at home and in academic settings. Ms. C has a strong inclination toward organizing her belongings and play items in structured patterns or lines, particularly when playing with toys and playdough. Any disruption to these patterns leads to intense emotional reactions, such as anger or distress. She often talks to her toys or animated characters on television, showing signs of imaginative or solitary play that are not developmentally inappropriate but seem more intense and ritualistic than typical for her age.

Ms. C exhibits a preference for routine and order. For example, she taps her foot exactly three times before stepping down each stair, a behavior consistent with repetitive motor rituals. She also struggles with social communication: she avoids eye contact, speaks out of context, and

interrupts conversations. During the clinical interview, she appeared restless, unable to sit still, and shifted between topics without clear transitions, occasionally laughing inappropriately. These behaviors were exacerbated in unfamiliar settings or when she felt pressured.

Academically, Ms. C has been described as intelligent and inquisitive with a good command of language, particularly English. However, she has recently shown difficulty sustaining attention during class activities, especially in group settings with background noise or distractions. Her ability to follow instructions improves significantly when provided in a one-on-one format. This difficulty in maintaining focus has led to a decline in academic performance, prompting her parents to repeat her kindergarten year. Despite this, her struggles persisted, which led to the recommendation for psychological assessment.

Developmentally, Ms. C was born via C-section after a full-term pregnancy, complicated by maternal illness in the final trimester and mild neonatal jaundice, which was resolved without complications. There is no reported history of seizures, head injury, intellectual delays, hallucinations, mood disturbances, or phobias. Her temperament is generally described as easy-going, and she enjoys leisure activities like painting. She tends to interact more with children who are slightly older or younger than peers of her own age.

Based on the history and clinical observations, Ms. C has been given a provisional diagnosis of Asperger's Syndrome (F84.5), characterized by social difficulties, repetitive behaviors, and intense interests, with comorbid Mild Attention Deficiency (F90.9). A differential diagnosis of ADHD - Disturbance of activity and attention (F90.1) is also being considered, given her inattention and restlessness. However, the rigidity in behavior, preference for sameness, and social communication deficits are more characteristic of Autism Spectrum features than ADHD alone. Further observation and assessment are recommended to confirm the diagnosis and guide intervention.

3.2 Case Study 2

Mr. A is an 18-year-old male from an upper middle-class background, brought in for psychological evaluation following the emergence of distressing symptoms since the beginning of college in 2021. He reports significant mood swings, lethargy, excessive sleep and appetite, and repetitive intrusive thoughts, which have interfered with his daily functioning and academic performance. These symptoms emerged after a significant shift in his family dynamics: Mr. A was

raised in a highly structured and controlled environment until grade nine, followed by a sudden withdrawal of supervision in grade ten, which left him confused and emotionally unsettled.

Following his transition to college, Mr. A began exhibiting impulsive behaviors, such as getting a tattoo and trying self-harm, the latter he describes as a way to reduce anxiety rather than an attempt to end his life. He also began vaping, although he later discontinued it after understanding its negative impact. He occasionally consumes alcohol in social settings. Mr. A strongly suspects that his parents are once again attempting to control his life, which adds to his distress. He struggles with concentration, emotional numbness, and finds comfort in eating due to his continuous need to chew.

Mr. A was prescribed Fluoxetine, which has helped reduce the frequency and intensity of his intrusive thoughts and improved his emotional regulation. He reports more control over his behavior and improved adjustment after transferring to a different college and staying in the hostel. Clinical observation and history suggest obsessive-compulsive disorder (F42.2) as a provisional diagnosis, due to his compulsive rituals (e.g., bathing twice daily due to irrational fears), repetitive thoughts, and need for control. The course of illness is fluctuating with an insidious onset, and there is no significant past psychiatric or medical history. He does not report hallucinations, mood episodes, phobias, or intellectual impairments. Further psychological assessment is recommended to clarify underlying mood components and evaluate possible comorbidities such as mood or anxiety disorders.

3.3 Case Study 3

Mr. V, a 14-year-old male from an upper-social strata background, was brought in for consultation by his mother due to persistent behavioral and emotional concerns. His mother's account, though adequate, is not entirely reliable as it may be influenced by her own distress and perceptions. Mr. V presents with a longstanding pattern of unusual behaviors that have become increasingly prominent and disruptive. Since early childhood, he has shown repetitive motor behaviors such as hand-flapping when excited, rigid patterns in eating (e.g., using separate spoons for each dish and not allowing food items to touch), heightened sensitivity to dirt, and compulsive handwashing. He also exhibits marked distress with any perceived criticism, often reacting with verbal aggression towards his mother. More recently, since around April, there has been a noticeable shift in his functioning—he mumbles, avoids eye contact, zones out, and experiences

transient auditory intrusions, often hearing voices that repeat past criticisms from his family. These episodes are not persistent but are distressing and appear tied to dissociative-like states.

Developmentally, Mr. V had some delays and challenges. Born via C-section after a full-term pregnancy complicated by maternal gestational diabetes, he had delayed motor milestones (e.g., started walking at 18 months) possibly due to congenital visual impairments requiring multiple surgeries. He was bullied in boarding school for being perceived as "feminine," which likely contributed to his social withdrawal and low self-esteem. Despite his intellectual interests—such as reading complex literature and writing poetry—he struggles with day-to-day functioning, hygiene, and emotional regulation. His behavior reflects rigid routines, obsessional thinking (e.g., counting tiles, rearranging items for safety), poor emotional insight (e.g., lack of visible grief after his grandmother's death), and paranoia about others' judgments. He has also expressed thoughts of self-harm when angry. Although he recently began medication (Inspiral) under another psychiatrist, it has led to fatigue and appetite suppression without notable behavioral improvements.

Clinically, Mr. V appeared withdrawn and emotionally flat during the session, frequently falling asleep and fixated on his gadget, with minimal verbal engagement. Taken together, the clinical picture suggests significant obsessive-compulsive traits, social communication difficulties, and emerging thought disturbances. Based on the current presentation, a provisional diagnosis of Schizo-obsessive disorder is considered, though further assessment is essential to clarify the extent and nature of the psychotic features and to rule out autism spectrum disorder (ASD) with comorbid OCD or early-onset schizophrenia spectrum disorders.

3.4 Case Study 4

Ms. N, an 18-year-old female from an upper-social strata background, presented to the clinic with increasing emotional distress, primarily characterized by anxiety, low mood, and intrusive thoughts. She self-referred and provided information that was both adequate and reliable. Ms. N reported a recent increase in anxiety and emotional overwhelm, often becoming tearful over seemingly minor issues. She described persistent lethargy despite sleeping for 12–14 hours a day and noted that her appetite is irregular and heavily influenced by physical activity. Additionally, she mentioned experiencing intrusive sexual thoughts while trying to fall asleep, which cause her discomfort and distress.

The onset of her current emotional disturbance appears to be insidious, with a continuous course beginning around May of this year. Ms. N traces the roots of some of her distress to a formative incident in seventh grade, when she accidentally discovered that her mother was involved in an extramarital affair. She continued monitoring her mother's interactions in secret for two years, experiencing inner conflict due to her love and loyalty towards her mother. Although she diverted her attention toward academics for a time, her emotional turmoil resurfaced during a recent visit home after her first year of college, when she again discovered signs of her mother's ongoing affair. These events stirred unresolved resentment and mirrored a personal betrayal she experienced in her own romantic relationship in grade 12, where she was cheated on.

Ms. N also reported difficulty with physical boundaries, expressing that she only feels comfortable being touched by her partner and becomes distressed if any boundaries are crossed, even unintentionally. She identifies as emotionally dependent in romantic relationships, often rushing into them out of a fear of being alone or inadequate in caring for herself. These dynamics may suggest unmet emotional needs and attachment-related vulnerabilities. Over the past two months, she has begun experiencing intense irritability, urges to throw things when angry, and occasional thoughts of self-harm, although she denies any concrete plans or attempts.

Clinically, she appeared somewhat anxious but remained cooperative and communicative during the interview. Her presentation, including the emotional lability, fatigue, intrusive thoughts, and difficulty regulating distress, is consistent with Depression with Anxiety (F41.2). Her relational patterns and history also suggest possible underlying attachment difficulties that may warrant further exploration. Immediate therapeutic goals would include mood regulation, anxiety management, and addressing maladaptive relational patterns, particularly those rooted in her early experiences and family dynamics.

3.5 Case Study 5

Ms. K, a 22-year-old female from an upper-middle-class background, presented with a long-standing history of obsessive and compulsive behaviors that have significantly interfered with various aspects of her daily life. The information provided by her is both reliable and adequate. Her complaints center around an overwhelming need for control, perfectionism, and repeated intrusive thoughts, often accompanied by compulsive behaviors such as list-making, reassurance-seeking, excessive checking, and avoidance. These symptoms have particularly impacted her academic performance, daily self-care, interpersonal relationships, and emotional well-being.

The onset of her symptoms appears to be insidious, beginning around the age of 13, with a gradual worsening over the years. Initially, Ms. K was a diligent student who valued accuracy and perfection. However, by high school, her efforts to maintain high standards developed into obsessive checking and perfectionistic behavior, which eventually led to avoidance and procrastination. In college, she began to excessively emulate the routines of successful peers through extensive list-making and rigid planning, despite it not aligning with her personal style or comfort. These compulsive efforts left her emotionally and mentally drained, contributing to further avoidance and dysfunction.

Ms. K described that even simple household tasks, such as doing laundry or brushing her teeth, became prolonged rituals. For example, before brushing her teeth or washing clothes, she felt the need to extensively research the "correct" procedure, tools, or products to use, creating elaborate checklists before being able to complete the task. These rituals extended to showering and self-grooming, which became so time-consuming that she began reducing their frequency. Similarly, she withdrew from activities she once enjoyed, like playing musical instruments or going to the gym, if she couldn't perform them to perfection quickly, leading to a loss of interest. A major area of concern for Ms. K is her romantic relationship. For the past three years, she has experienced persistent obsessions surrounding her partner's past relationships, fidelity, and her own adequacy as a partner. She described frequent intrusive thoughts about her partner's ex-girlfriend, which often occur during intimate moments, causing her significant distress. These thoughts compel her to seek reassurance repeatedly from her partner and others, engage in compulsive online searching, and ruminate excessively. She also fears that her compulsions and irrational thoughts may negatively affect her relationship, which she deeply values.

Ms. K also reported health-related obsessions, such as intrusive thoughts about having a hidden disease, which prompt her to consider seeking medical attention even in the absence of symptoms. These thoughts are repetitive and anxiety-provoking, further contributing to her overall distress.

She has a continuous course of illness, with symptoms being present for approximately ten years, intensifying and becoming more impairing in recent years. She began therapy a year ago and started medication two weeks prior to her first session at Mind Ease.

Her premorbid personality was described as responsible and initiative-taking, with a preference for structure and excellence. She previously enjoyed hobbies like playing the ukulele

and piano but has since disengaged due to the perfectionistic tendencies that interfere with her ability to enjoy them.

Given the nature of her symptoms—marked by persistent obsessions, compulsions (e.g., checking, reassurance-seeking, list-making, avoidance), significant functional impairment, and distress—her presentation is consistent with obsessive compulsive disorder (F42.2). Treatment should focus on exposure and response prevention (ERP), cognitive restructuring, and addressing perfectionism and relational obsessions.

4. Key Learnings

During my internship, I gained practical exposure to a wide range of key psychological assessments, including the PGIBBD, BKT, PANSS, MISIC, VSMS, DST, HTP, and NIMHANS SLD, which significantly enhanced my diagnostic and evaluation skills. I learned the structure and format of clinical case histories and the Mental Status Examination (MSE), both of which are foundational tools for psychological assessment and report writing. Additionally, I developed skills in calculating scores and interpreting the results of various intelligence, neuropsychological, and projective tests, which helped in refining clinical judgment.

I also understood the importance of using culturally adapted tools like the BKT and MISIC to ensure accurate assessments within the Indian context. My training further included observing client-therapist interactions, paying close attention to non-verbal communication, question framing, and rapport-building techniques.

I acquired knowledge of tools such as the VSMS and DST, which are designed to evaluate social adaptability and cognitive development in children. Furthermore, I learned how to apply projective tests like the HTP to assess personality traits and emotional functioning.

One of the key areas I focused on was diagnosing Specific Learning Disabilities, using standardized tools like the NIMHANS SLD battery. Throughout the experience, I also observed the professional responsibilities and demeanor of clinical psychologists during real-life sessions, which contributed to enhancing my professional identity and awareness.

I participated in orientation and collaborative sessions that emphasized interdisciplinary learning, peer interactions, and mentorship, further enriching my practical experiences.

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