



**File for exam:
End of Master Course Part II**

This file documentation will be used for the exam in the end of Master Course part II. The participants will prepare 5 cases which have been documented, supervised, and are over.

- 2 cases – long term therapy – more than 50 sessions (personality structure or disorder therapy, OCD, bipolar, recurrent depression, etc.)
- 3 cases – short-term or medium therapy – 20-50 sessions

The case **must be presented as a story of the therapy**, following the structure below. The case must have at least 1000 words.

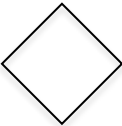
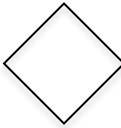
A. General data of the patient _____ (initials)					
Age			Family status		
Profession/Occupation			Number of sessions ____ frequency _____		
Conditions of help provided	<input type="checkbox"/> inpatient <input type="checkbox"/> outpatient <input type="checkbox"/> telephone	<input type="checkbox"/> online <input type="checkbox"/> house call <input type="checkbox"/> unusual time	<input type="checkbox"/> individual therapy <input type="checkbox"/> couple therapy <input type="checkbox"/> group therapy	<input type="checkbox"/> combined therapy <input type="checkbox"/> one therapist <input type="checkbox"/> few therapists	Who will cover expenses and missed sessions?
DSM/ICD diagnoses			OPD-2		
Who referred (recommended or forced) patient for therapy?					
Why did the patient come especially to you? Why now?					
Are there any connections between you and the patient?					

1. Observation-distancing

B. Symptoms, their meaning and history	Dynamics
Compliances	Spontaneous declaration in the first session
Brief case history / recent changes / psychosomatic symptoms etc.	Appearance and behaviours. Ability: to name own feelings? to describe his/her attitude to the actual situation?

	to reflect his/her inner dynamic? to take responsibility for own reactions? etc.
Actual conflict (if any) - with whom/what? - involved secondary AC expectation reality - immediate conflict reaction: body achievement relationships imagination	Style of attachment in presented situations / relationship with the therapist Key conflict in presented situations / relationship with the therapist Primary positive interpretation of the symptom/conflict Reaction of the client to the positive interpretation
Perceived suffering is mostly <input type="checkbox"/> physical <input type="checkbox"/> psychological <input type="checkbox"/> social <input type="checkbox"/> existential Expected help is mostly <input type="checkbox"/> physical <input type="checkbox"/> psychological <input type="checkbox"/> social <input type="checkbox"/> existential Expected relief is mostly <input type="checkbox"/> physical <input type="checkbox"/> psychological <input type="checkbox"/> social <input type="checkbox"/> existential	Are those desires of the patient realistic/contradictory? Are you ready/competent to meet those expectations? Do you have your own goal in therapy (explicit or implicit) that patient tries to avoid?

2. Inventory

D. Background	
4 areas of life balance (usually, without the presented problem) 	how it is affected by the presented problem 

Macro-traumas within 5-10 years	Learned assumptions
<p>Basic conflict.</p> <p>What concepts were formed in what areas of modelling (I, You, We, Primary We)?</p>	<p>What primary needs/capacities were associated with what secondary capabilities?</p> <p>What was the associated physical reactions?</p> <p>What was the associated patterns of typical interactions?</p>
<p>Inner conflict</p> <p>Conceptualization of the case</p>	<p>Do you have any memories and associations about experiences presented in therapy? Can you name them? How do they effect the dynamics?</p>

3. Stimulation and situational encouragement

E. What positive aspects of the symptom were mentioned and/or noticed	
	Reaction for the positive interpretation.
How have those aspects appeared in relationships with - mother? - father? - siblings? - actual partner/situation? - future perspectives?	How does this work in therapeutic relationships?
What capacities do you encourage in the client/patient?	How did he/she respond to those encouragements?
What recourses are available for the client/patient?	What does he/she feel about these resources?
What symbols/metaphors have been used? For what?	How did he/she accept those?

4. Verbalization

F. Goals of the therapy	
What are the focusses and goals of the therapy?	
What is the treatment plan and the criteria of the progress?	
Did you define them together with the patient?	
Have you explained the limitations of the therapy to the patient?	
Who is responsible for the progress and its evaluation?	
What are the therapeutic prognoses (results, longitude, frequency etc.)?	
Do you have any agreed rules and/or conditions?	

What is the plan of self-help?	
How capable is the patient to maintain agreed rules/self-help?	

G. What interventions were used? What dynamic has it provoked (feelings, impulses, insights, behaviours etc)?	
	a.
	b.

H. Therapeutic relationships (transference/counter transference)		
How was the dynamic of 3 stages of interactions developed?	Therapist to the patient	Patient to the therapist
- Emotional bond (empathy)		
- Separation		
- Independency		
What do you feel about the patient?		
What, according to you, does the patient feels about you?		
What do you think about him/her?		
What fantasies/wishes/fears do you have about your patient?		

5. Goals broadening

I. Goals for the future	
What is the feedback of the client/patient about the therapy process and outcomes so far?	
What does he/she plan for him/herself?	