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Internship Report

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**Internship Report leading to the Degree of Master in Health Psychology
and Neuropsychology.**

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Work carried out under the Guidance of
Ângela Leite

DECLARATION OF INTEGRITY

I, Anaïs Cornéllia Laurence PRUNIER, declare that I have acted with absolute integrity in the preparation of this work, confirming that in all the work leading to its preparation I have not resorted to any form of falsification of results or to the practice of plagiarism (an act by which an individual, even by omission, assumes the authorship of the intellectual work belonging to another, in its entirety or in parts of it). I also declare that all the sentences I have taken from previous works by other authors have been referenced or reworded, in which case I have cited the bibliographic source.

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List of abbreviations

ARAP	Association Reflexion Action Prevention
CBT	Cognitive and Behavioral Therapy
CHU	University Hospital Center
CSAPA	Centre for Addiction Care and Prevention
CVS	Social Life Committee
EHPAD	Residential Establishments for Dependent Elderly People
ITP	Individualized Therapeutic Project
IUCS	Instituto Universitario de Ciências da Saude
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual or Ally
Mini-GDS	Mini Geriatric Depression Scale
MMS	Mini-Mental State Examination
NPI-ES	Neuropsychiatry Inventory for Care Team
ORYGEN	Optimiste, Psychosocial rehabilitation in psychiatry for the Youth Generation
PANSS	Positive and Negative Symptom Scale
PASA	Adapted Activities and Care Centre
SMART	Specific Measurable Achievable Relevant Time-bound
TA	Therapeutic Apartment
UNAFAM	National Union of Families and Friends of Psychiatrically ill and/or Disabled Persons
UP	Protected Unit
WAIS-IV	Wechsler Adult Intelligence Scale - Fourth Edition 2011

FIRST INTERNSHIP

1. Introduction

This report was produced as part of the internship included in the 2nd cycle of studies leading to the Master's degree in Health Psychology and Neuropsychology at the Instituto Universitario de Ciências da Saude (IUCS) at Cooperativa de Ensino Superior Politécnico E Universitário, Gandra University. The internship is an important part of a student's academic career. It's a crucial moment for applying the theoretical knowledge acquired during the previous four years of study. This experience enables us to make positive progress in our profession and in our personal development, even if this can be complicated. The main aim of this report is to explain my journey as an intern, explaining my daily life over four months and the personal development it brought me.

The internship took place, in the psychiatric department of the University Hospital Center in Nîmes, under the supervision of Julie Jourdan, neuropsychologist, and Professor Angela Leite, lecturer at the IUCS. It lasted four months and half, totalling 500 hours. First, we'll talk about the characterization of the internship site, from the general to the specific. Next, the role of the neuropsychologist at the placement. Finally, we'll describe the activities at the placement, including the observation period and the intervention period.

2. Characterization of the internship site

Description of the University Hospital Center (CHU)

The CHU brings together all short- and medium-stay services in two buildings: Hospital Sud and Hospital Nord. It has a capacity of 2083 beds, places and shifts, not including emergency hospitalizations. In 2022, the hospital workforce will number 5879 (CHU Nîmes, 2023). The CHU is organized into 10 medical divisions and 5 management divisions.

The medical divisions group together medical activities, and comprise (1) Imaging-guided Medical Activities and Functional Explorations cluster; (2) Anesthesia, Intensive Care, Pain and Emergencies cluster; (3) Biology - Pathology cluster; (4) Surgical Units cluster; (5) Women's - Children's cluster; (6) Internal Medicine, Medicine, Cardiology, Addictology, Geriatrics, Nephrology, Endocrinology, General Medicine, Follow-up and Rehabilitation Care; (7) Neurology, Infectiology, Rheumatology, Rehabilitation; (8) Oncology; (9) Pharmacy, Public Health; (10) Psychiatry. The management divisions bring together the various departments, and comprise (1) medical policy, strategy and innovation division; (2) care, quality and customer care division; (3) social policy division; (4) material resources division; (5) financial strategy and evaluation division (CHU Nîmes, 2023).

Description of department where internship took place

The internship took place in the psychiatric department. On Tuesdays, Wednesdays and Fridays, the internship was outside the hospital at the center that is link to the ORYGEN currency. ORYGEN is an acronym that stands for "Optimiste, psychosocial Rehabilitation in psychiatry for the Youth GENeration" (Orygen, 2023). The name was chosen by Australia's national youth mental health leadership center to reflect the institute's purpose. ORYGEN is a mental health research and care institute focusing on youth mental health, in particular the prevention and treatment of mental disorders in adolescents and young adults. As such, ORYGEN is internationally recognized for its work in the field of youth mental health, and has contributed significantly to the understanding and improvement of mental health care for this population (Orygen, 2023).

This center is an early intervention and community psychosocial rehabilitation center offering day care for young people with emerging thymic or psychotic disorders (Centre Ressource Réhabilitation, 2023). Patients are generally aged between 16 and 30, with a diagnosis of an emerging thymic or psychotic disorder, having presented initial psychic symptoms, or with a duration of illness of less than ten years. Patients wish to be supported in achieving clinical and functional remission, as well as personal recovery (Centre Ressource Réhabilitation, 2023). Care is focused on Nîmes and the surrounding area, so that visits can be made to the patient's home. Obviously, there are no strict diagnostic or age criteria for treatment.

As a center that aims to be socially responsible and, consequently, socially useful and effective, its primary objective is rehabilitation and reintegration into the workplace, family and society. To achieve this, the center offers an integrated and personalized range of services and activities, tailored to the unique needs of each individual (Centre Ressource Réhabilitation, 2023).

The center focuses on a number of objectives: (a) to raise awareness of mental health issues among the general population, and young adults in particular, and to help reduce the stigma attached to mental disorders and the need for psychiatric care; (b) to facilitate access to psychiatric care for young adults; (c) to ensure early management of emerging psychotic and thymic disorders in order to minimize their impact on daily life; (d) develop personalized care plans aimed at promoting medical and personal recovery; (e) encourage young adults to become aware of their personal resources; (f) strengthen the skills, autonomy and self-esteem of those in care; and (g) provide support for users' families (Centre Ressource Réhabilitation, 2023).

In addition, the center has a number of patient-focused missions (Centre Ressource Réhabilitation, 2023). The first mission is reception. Prior to reception, the patient's request for care is discussed and validated by the multidisciplinary team. Initial contact is then made with the patient and his or her family. If the patient is hospitalized, this first contact is generally made at the place of hospitalization. Subsequently, a Case Manager is assigned to the patient, and a tour of the center is organized. Secondly, when the patient agrees to be accompanied, an initial assessment is carried out, followed by the development of an Individualized Therapeutic Project (ITP) according to the patient's needs and objectives. The ITP takes into account the user's objectives, motivations, skills and difficulties. Depending on the objectives to be achieved, specific rehabilitation actions are defined. The ITP is validated by the team and regularly reassessed every 6 months, with adjustments made if necessary. Thirdly and lastly, the patient is invited to meet the various members of the disciplinary team, if necessary, depending on the user's state of health and request. The multidisciplinary assessment may include (1) a psychiatric assessment by a psychiatrist; (2) a clinical and functional assessment by a case manager and a psychologist; (3) a neurocognitive and social cognition assessment by a neuropsychologist; (4) a social assessment by a social worker; (5) a vocational assessment by a job coach; (6) a somatic assessment supervised by a case manager, in collaboration with the general practitioner and, if necessary, a specialist.

As mentioned above, the team of professionals consists of a health executive, two psychiatrists, six case managers including four nurses and two care assistants, a psychologist specialized in neuropsychology, a psychologist, a social worker and a job coach. The Case Manager ensures the coherence and continuity of the multi-disciplinary

support, overseeing the therapeutic alliance. The multi-disciplinary team is based on an optimistic, destigmatizing approach to psychiatric care, as well as day-to-day support for users in their care and life projects (Centre Ressource Réhabilitation, 2023).

PEPSY Research project

The PEPSY platform is the result of a public-private partnership between three experienced institutions in the field of mental health. Its main aims are to improve access to care for young people aged 16 to 30 presenting with a first episode of psychosis, to coordinate care provision in the Occitanie region through two complementary schemes, PEPSY 31 and REPEPS, and to raise awareness among health and youth professionals. The aim of the project is to gain a more precise understanding of the specific needs of this population and to design personalised interventions tailored to their individual backgrounds.

The PEPSY platform is a specific care tool designed to avoid breakdowns in care and improve the quality of life of young people and their families. The research process involves a multidisciplinary team and includes clinical interviews, psychometric assessments, file reviews and collaboration with other departments at Nîmes University Hospital (Pepsy, 2023).

One of the key features of the PEPSY project is its integrative approach, combining the perspectives of clinical psychology, psychiatry and social work to form a holistic approach to care. The ultimate ambition is to facilitate access to early intervention in response to international recommendations.

This initiative reflects the commitment of the center and the CHU de Nîmes to promoting excellence in psychosocial care and contributing to the advancement of knowledge in child and adolescent mental health.

Meeting/Training

As a psychosocial and rehabilitation center aims to broaden its partnerships to provide better support for more people in need. With this in mind, we have initiated meetings with various organisations, including the Association Reflexion Action Prevention (ARAP) Rubis association and the Centre for Addiction Care and Prevention (CSAPA).

ARAP Rubis, which initially focused on community health in prostitution, has broadened its remit in response to the changing needs of its members. In addition to HIV and sexually transmitted infection prevention, it now offers support for professional integration, parenting support groups, child-parent drop-in centers, lesbian - gay - bisexual - transgender - queer or questioning - intersex - asexual or ally (LGBTQIA+) drop-in centers, trans self-help groups and assistance for victims of human trafficking. The partnership focuses on three main areas: prostitution, the LGBTQIA+ community and the family. The aim is to provide psychiatric support, where necessary, to the people cared for by the association (Association ARAP-Rubis À Nîmes Dans Le Gard, 2022).

As for the CSAPA, a service within the CHU, the center has established a contact in order to keep abreast of the latest developments in the field of addictions. In addition, the center comes to this service to receive referrals from patients suffering from addictions, who also fall within the scope of the care offered by the center. The

aim of this partnership is to strengthen collaboration for a comprehensive approach to the mental health and rehabilitation of people affected by addiction problems.

3. Neuropsychology and the role of the neuropsychologist

According to Eustache (2011), neuropsychology has its roots in the pioneering work of the 19th century, notably with Paul Broca and Carl Wernicke, who identified specific brain regions associated with linguistic functions. Over the course of the 20th century, technological advances such as brain imaging and methods for studying brain lesions considerably enriched our understanding of the links between brain structure and behavior.

Neuropsychology emerged as a distinct specialty in France in the 1960s and 1970s. At that time, French researchers and clinicians made significant contributions to the understanding of cognitive deficits associated with brain damage. The establishment of the Society of Neuropsychology of French Language in 1976 testifies to the recognition and consolidation of this discipline.

Neuropsychology can be defined as the branch of psychology that studies the links between the brain and behavior, with particular emphasis on understanding cognitive functions. Neuropsychologists use a variety of methods, including neuropsychological assessments, brain imaging, and the study of patients with brain damage, to understand the mechanisms underlying mental functions.

According to Chazaud (2004), neuropsychology has found an important place in the field of psychiatry, particularly in the assessment and understanding of mental disorders linked to cerebral dysfunction. Neuropsychologists often work in collaboration with psychiatrists to assess patients' cognitive functions, develop treatment plans and contribute to cognitive rehabilitation.

4. Activities Conducted During the Internship

Observation Period

At the center, the psychologist is part of an inter- and multidisciplinary team responsible for implementing therapeutic strategies, in collaboration with the patients. These strategies aim to stimulate their biopsychosocial functioning, co-monitor the progress made, and co-evaluate the results achieved at the end of the intervention process. Simultaneously, and in conjunction with the rest of the team, she strives to establish a strong therapeutic alliance with the patients, continuously providing them with information to encourage their involvement throughout the rehabilitation program.

To foster the therapeutic alliance and a positive evolution in the management of the disorder, the team implements various activities tailored to the patients' needs. The activities implemented by the multidisciplinary team, in which I had the opportunity to collaborate as an intern, are presented below.

Initial Interview

The initial assessment must be multidisciplinary to account for the person's daily functioning, lifestyle, autonomy capabilities, goals, and desires (Bon, 2018). It aims to highlight both the deficits and capacities of individuals, proposing the most suitable orientations closely aligned with their vision of recovery and its implications. Given the role of the cognitive dimension, a neuropsychological assessment is systematically included (Bon, 2018). In rehabilitation, the assessment does not have a diagnostic or selective purpose; the emphasis is always on the fact that any identified difficulties will lead to proposing targeted means of addressing them. Psychosocial rehabilitation tools are introduced after symptomatic stabilization, and it is often beneficial to combine

several of these tools (Bon, 2018). They act on various dimensions, including insight, social interactions, and information processing (Bon, 2018).

Patients are welcomed at the center, either following a redirection from another facility or upon admission to CHU. Generally, the case manager is the first point of contact with the patient. During this initial interaction, the case manager introduces the facility, asks initial questions to better understand the patient's childhood, education, daily life, hobbies, substance use, and other aspects of their life. Subsequently, the patient meets with the doctor. Following this, the patient completes their ITP, marking the beginning of their tailored care. Patients have access to various activities organized by the center and other facilities, along with support from multiple professionals.

Family Intervention

The center also focuses its care on the family. The family is contacted, with the patient's consent, from the beginning of their treatment. In this way, the family is included in the patient's care, especially during their appointment for the ITP, where they interact with other individuals regularly in contact with their loved one, fostering a comprehensive collaboration.

The significant contribution of the family to the patient's well-being is emphasized by Bantman (2013). Families possess specific skills related to the daily management of an individual with an illness, which can benefit not only the patient but also the doctor and the healthcare teams by providing valuable insights into family support, its limitations, and the quality of intrafamilial relationships. The integration of psychosocial rehabilitation and a family-focused approach appears promising for the future of comprehensive patient care. Furthermore, the establishment of a positive therapeutic alliance is highlighted as a factor favoring the prevention of relapses and

recurrences. This is explained by an improved understanding by family members, resulting in enhanced support for the patient (Bantman, 2013 & Bon, 2018). To achieve this, families receive comprehensive information about the illness, medication, appropriate attitudes in routine or crisis situations through psychoeducational interventions (Bantman, 2013). The term psychoeducation refers to a set of educational interventions regarding psychiatric illnesses and their treatments (Bon, 2018). Additionally, psychoeducational interventions with families reduce patients' relapse rates by half in the first year, as well as the duration of hospitalizations, and facilitate medication compliance (Bantman, 2013 & Bon, 2018). The goals of these interventions include empowering caregivers, reassuring the interveners, alleviating guilt associated with their loved one's illness, and establishing a therapeutic connection (Bantman, 2013). To ensure that the family/caregiver can be a strong social support, the center has implemented several activities such as BREF and LEO.

The psychoeducational programs BREF and LEO were developed by the Lyon Centre for Psychiatric Caregivers in collaboration with the National Union of Families and Friends of Psychiatrically ill and/or Disabled Persons (Unafam, 2023) and the collective schizophrenias. UNAFAM is a French association founded in 1963. Its main objective is to support families and friends of individuals suffering from mental health disorders. It works to inform, accompany, and defend the interests of families facing these situations, promoting the exchange of experiences, public awareness, and the advocacy of the rights of individuals with mental health disorders. It also plays an active role in promoting improvements in the care and conditions of those affected (Rey, 2023).

BREF.

BREF is a program designed for caregivers. This program has been in place at the center for 2 years. It is a didactic and therapeutic intervention aimed at providing information to caregivers about psychiatric disorders and promoting coping skills. It is a short and family-focused psychoeducation program (Rey, 2020). There are benefits for caregivers' health, reducing work absences and alleviating their burden, as well as benefits for the patient's health by reducing relapses and re-hospitalizations.

This program consists of 3 one-hour sessions facilitated by a pair of healthcare professionals. This professional pair should not be involved in the patient's care, and the patient may not be under the care of the facility (Rey, 2020). The objectives include individualizing early and systematic reception, connecting with available resources, demystifying hospitalization and/or psychiatric care, and developing a therapeutic alliance. The program extends over 1.5 months, with a session every two weeks depending on the availability of the family and facilitators (Rey, 2020). Additionally, there is a pre-program evaluation with a socio-demographic questionnaire, a questionnaire about caregivers' experiences before BREF, and depression symptomatology assessment (CES-D scale). A post-program evaluation focuses on depressive symptomatology (CES-D scale), and three months later, the family is contacted through a telephone call (Rey, 2020).

The first session allows relatives to share their experiences, express their difficulties, feelings, and prioritize their questions. During this session, aids like illustrated cards addressing various themes help initiate discussions. With the answers to questions and selected cards, the facilitators revisit factors, causes, provide initial answers, and explain symptoms (Rey, 2020).

The second session involves discussing the situation of the ill family member, such as diagnosis, illness, treatment, and care organization. This session is also based on what families feel due to social isolation, internalization under constraint, and/or perceived exhaustion (Rey, 2020).

The third session focuses on discussions about the family impact and resources available for caregivers. It is co-facilitated by a UNAFAM volunteer, a strong point allowing richer exchanges. Peer-to-peer support promotes families' awareness of the need to be helped to become caregivers. It also encourages connections with family associations and other structures offering interventions for caregivers, thus enhancing caregiver support (Rey, 2020).

Three months after the last session, a team member contacts the participants to review what has happened since the last meeting, potentially address new questions, evaluate the program, motivate participants to connect with family associations, avoid isolation, and seek assistance from various available resources. An evaluation also includes an assessment of depressive symptomatology (CES-D scale), satisfaction level, and changes in the caregiver's journey (Rey, 2020).

LEO.

The LEO program is a psychoeducational support and a multi-family program. The goal is to improve communication, maintain motivation for one's loved one, reconnect with oneself, and find additional support through the presence of other caregivers.

The program consists of 8 sessions, each lasting 3 hours, spread over 8 weeks and facilitated by four healthcare professionals. The first session provides information

on medical knowledge, led by a psychiatrist. This session offers theoretical knowledge about the brain and stress, symptoms and diagnoses, and appropriate treatments.

From the second to the fifth session, the focus is on improving communication with one's loved one using methods provided to better support them. There is a blend of theoretical input and playful elements with role-playing games based on situations experienced by family caregivers. During these sessions, caregivers practice motivational interviewing techniques, such as asking open-ended questions, making affirmations, using reflections, summarizing, and providing advice, with the aim of facilitating behavior change. Additionally, caregivers receive training to express their dissatisfaction, set boundaries, and optimize their requests.

From the sixth to the eighth session, techniques are introduced to reduce stress using the Zurich Resource Model, based on validated neuroscientific models developed by Dr. Frank Krause and Dr. Maja Storch at the University of Zurich. Participants gradually build their own motto to sustainably adopt a new attitude towards challenging situations or approach a personal goal. This model takes into account both reason and the body. If the body and reason are in harmony, motivation becomes stronger, and the likelihood of adopting and maintaining new behaviors increases. Additionally, emotions, relationships, and mindfulness are addressed.

Three months after the eighth session, caregivers are encouraged to participate in an optional session, allowing them to sharpen the skills previously taught through the resolution of concrete situations. To promote the acquisition of these skills, a significant portion of the time is dedicated to active training. Specifically, sessions 2 to 8 are structured as follows: one hour of theoretical presentation followed by two hours of practical training.

Therapeutic Apartments

With the goal of achieving autonomy and living alone, or if living with family proves challenging, a Therapeutic Apartment (TA) can be implemented. TAs are housing facilities that offer a form of supervision provided by healthcare professionals specializing in psychiatry or social workers (Velpry, 2010). Therapeutic Apartments allow residents to live independently while receiving support for their treatment and, most often, assistance with daily life management. They serve as a bridge between medical care and social support, providing an alternative to hospitalization (Velpry, 2010). Therapeutic intervention is limited to the requirement of regular consultations with a psychiatrist and managing medication intake. As a result, daily activities are left to the discretion of the patient.

Cognitive and Behavioral Therapy

Since the 1950s, Cognitive and Behavioral Therapy (CBT) has experienced growing success in treating depression, anxiety disorders, and certain personality disorders (Leclerc, 2008). However, its application in the treatment of psychoses dates back only a decade. CBT promotes rehabilitation by enhancing the quality of life, strengthening specific skills, reducing distress and symptoms, and improving overall functioning, contributing to a reduction in relapses (Leclerc, 2008). CBT works by modifying an individual's beliefs or thoughts, teaching the connection between perceptions. This enables patients to observe their own behavior and develop new strategies (Leclerc, 2008 & Bon, 2018). It also aims to enhance interactions by influencing the reception, processing, and transmission of social information, leading to reciprocal social feedback (Bon, 2018).

Psychologists can use evaluative measures to detect fluctuations in symptoms, cognitions, mood, or self-esteem (Leclerc, 2008). In the context of schizophrenia, CBT demonstrates effectiveness in mood regulation, executive functions, overall functioning, and interpersonal problem-solving, with the added benefit of long-term maintenance of acquired social skills (Bon, 2018).

Overall, CBT is a versatile therapeutic approach that can be adapted to meet the specific needs of patients with various mental health issues. Its benefits include improved quality of life, symptom reduction, enhanced social skills, relapse prevention, and the development of positive coping strategies, contributing to a more holistic management of mental health disorders.

Role-Playing

The role-playing workshop is a therapeutic session lasting 4 hours per week, involving 4 patients. Role-playing serves several objectives such as training in social and intellectual skills, exposure therapy, assertiveness, self-esteem, and fostering connections between the participants.

Role-playing is an enjoyable activity in which participants assume fictional roles and interact within a given scenario (Varrette et al., 2022). Participants create and develop characters, make decisions on behalf of these characters, and contribute to the progression of the story by verbally describing the actions, emotions, and thoughts of their characters. Players must collaborate to create a coherent story and overcome challenges presented to them.

Therapeutic role-playing workshops provide an opportunity to make friends and feel accepted in a playful and non-judgmental environment. The workshop takes place

in a store with actual customers, offering an excellent opportunity for patients to enhance their social skills and ability to interact with others (Varrette et al., 2022).

An article by Causo and Quinlan (2021) indicates that role-playing has facilitated the development of emotional, cognitive, and social skills among participants. Furthermore, the results highlight that role-playing addresses crucial social needs, such as relationship-building. Players have the opportunity to infuse their characters with values and skills they possess, creating a connection between the game and their own personal experiences. This activity requires imagination and creativity, allowing participants to work on character creation and embodiment, enabling them to step into someone else's shoes and explore different ways of reacting to complex situations. By providing a space for emotional expression, creativity, and skill development, role-playing workshops can play a significant role in the rehabilitation and mental well-being of participants.

The role-playing workshop provides an environment conducive to the development of cognitive skills, including mental flexibility (adapting to changes), planning (managing actions to achieve goals), memory (recalling scenario details, game rules, and character traits), and decision-making (crucial in problem-solving) (Varrette et al., 2022).

Metacognitive Training Group

This group is based on the manual "Metacognitive Training for Patients with Borderline Personality Disorder (B-MCT)" by Moritz et al. (2013) and "Metacognitive Skills Training for Patients with Schizophrenia (MCT)" by Moritz et al. (2017). It focuses on metacognitive training specifically tailored to patients with borderline personality disorder. The approach emphasizes the development of metacognitive skills

in these patients, aiming to improve their ability to understand and regulate their thoughts and emotions. The manual provides strategies and practical exercises to strengthen metacognition, serving as a practical guide for mental health professionals working with individuals with this disorder. The program is divided into 9 one-hour sessions, including an introductory session.

The first module, "Attribution Errors," focuses on recognizing common errors in interpreting social interactions. Patients learn to identify cognitive distortions related to the incorrect attribution of others' intentions, thereby promoting a more accurate understanding of interpersonal relationships.

The second module, "Rumination and Catastrophic Thinking," aims to help patients recognize patterns of rumination—repetitive and intrusive thoughts—and catastrophic thinking that can amplify negative emotions. The exercises aim to interrupt these patterns and develop coping strategies.

The third module, "Theory of Mind," explores the ability to understand the perspectives and emotions of others. Patients work on developing their theory of mind, thereby strengthening empathy and improving social skills.

The fourth module, "Discovering the Positive," focuses on changing perspective. This module encourages patients to recognize and appreciate the positive aspects of their lives and daily interactions, promoting the development of a more balanced view of themselves and others.

The fifth module, "Memory," challenges patients to question their memory when relying solely on the vividness of memories, emphasizing the need for additional evidence, especially in crucial interpersonal situations such as conflicts.

The sixth module, "Drawing Conclusions Without Evidence," guides patients to recognize and question hasty or unfounded conclusions they may draw in various situations. The module aims to promote more nuanced and evidence-based thinking.

The seventh module, « Mood » explores the relationship between thoughts, emotions, and behaviors. Patients learn to identify and regulate their moods by understanding how their thoughts influence their emotions, and vice versa. Strategies for managing emotional fluctuations are taught. Each module offers specific exercises, discussions, and practical activities aimed at strengthening patients' metacognitive skills, fostering positive changes in their thinking, feeling, and responding to the challenges of daily life.

Intervention Period

During my work placement, I was able to put my theoretical knowledge into practice and apply the valuable advice given to me by my placement tutor during my observation period. This experience enabled me to put my theoretical knowledge into practice in a real-life context, reinforcing my understanding and mastery of the concepts I had studied. I also had the opportunity to manage the rating of various scales.

Initial assessment

During my training period as a neuropsychologist, the initial assessment of the people who call on our services was fundamental, and the first interview, focusing on the anamnesis, was a crucial stage in the care process. I had the opportunity to conduct several of these initial interviews, for which I developed my own framework of questions. This approach enabled me to cover exhaustively all the important issues to be raised when gathering background and relevant information.

During these interviews, I adopted an attentive and empathetic attitude, seeking to create a solid therapeutic alliance from the outset. Open communication and active listening were key aspects of this approach. It was essential to ask relevant questions, focused on specific areas, in order to effectively guide subsequent treatment. This personalized approach fostered an in-depth understanding of the needs, concerns and individual contexts of the people we met. Ultimately, the first interview was an essential step in establishing an appropriate therapeutic framework, enabling a tailored and personalized intervention throughout the psychological follow-up process.

Following this initial interview, a follow-up is generally put in place.

Follow-up

During my placement, the psychological follow-up of patients was characterised by a comprehensive and regular approach, with consultations generally taking place every fortnight depending on the specific needs of each patient. This follow-up was designed to meet patients' individual needs, focusing on the issues raised during the sessions, such as anxiety, sleep disorders, negative thoughts, ruminations, stress, lack of motivation and energy, and self-confidence.

The methodology adopted is based on the use of various tools and techniques and cognitive restructuring. Among these approaches, the use of the sleep diary was favored to tackle sleep disorders, while square breathing and the practice of relaxation (Respirelax) were integrated to deal with anxiety attacks and anxiety. A detailed schedule allows patients to record the time and degree of anxiety during attacks, as well as how they were managed and how they felt afterwards. Other tools, such as a thought recorder (pro/con chart), were used to help the patient rationalize intrusive and unfounded thoughts. A vicious/virtuous circle was set up to reduce negative thought

patterns. Specific Measurable Achievable Relevant Time-bound (SMART) objectives were also defined, along with lists of the patient's qualities and abilities, and a weekly schedule to encourage organization. At the end of the consultation, we generally define specific goals that the patient tries to achieve for the following week.

During follow-ups, I adopt an attitude of empathy, active listening, benevolence and adaptability to the patient's discourse. I take an optimistic approach, aiming to put the difficulties encountered into perspective and to value the progress made by the patient.

Psychometric assessment

During my placement in neuropsychology, I administered various psychometric evaluations. This opportunity enabled me to put my psychometric assessment skills into practice while contributing to the development of mental health research. I ensured that rigorous test-taking protocols were implemented, guaranteeing the validity and reliability of the results obtained. This required clear communication with the participants to explain how the assessments were carried out and to answer any potential questions. Particular attention was paid to creating a supportive and reassuring environment, aimed at minimizing any stress factors that might influence participants' performance, so participants could choose where they wanted to take the assessment, at the center or at the CHU.

In this section, I'm not talking about the many self-assessments done with patients.

As part of the PEPSY research project, I carried out psychometric assessments on several patients. The assessment battery consists of several tests: (a) The Alcohol, Smoking, and Substance Involvement Screening Test; (b) Positive and Negative

Symptom Scale (PANSS); (c) Calgary Depression Scale for Schizophrenia; (d) Social and Occupational Functioning Assessment Scale; (e) Health of the Nation Outcome Scales; (f) Quality of Life Scale. The diversity of these different tests means that the test-taking methods need to be adapted and varied. Each test has its own specific requirements and procedures, making it necessary to develop an in-depth understanding of the characteristics of each assessment.

As part of my placement supervisor's doctoral programme, she is researching the topic of "Assessing narrative identity and its impact on multidimensional subjective well-being in the First Episode Psychosis". I have administered several scales: (a) Life Story Task; (b) Verbal Fluency; (c) California Verbal Learning Test - Second Edition; (d) Matrices; (e) Similitudes; (f) PANSS.

I also administered the Wechsler Adult Intelligence Scale - Fourth Edition 2011 (WAIS-IV), which consisted of an initial interview, administration and a report (c.f. Clinical Case).

As part of the follow-up, we may have to assess disorders on the basis of feedback from case managers. As part of this, I administered the Structured Clinical Interview for DSM-IV Axis I Disorders.

« *Think before you act* »

During my placement, I had the opportunity to lead a group, which was a rich learning experience. The sessions began with a general presentation by my tutor and a nurse. As the sessions progressed, the number of participants fell, from 4 patients at the first session to 3, then 2, and finally 1 patient for one of the last sessions. During the sessions, which I led in collaboration with the nurse, a number of postures and attitudes were necessary to ensure that the sessions ran efficiently and respectfully. Firstly, it was

crucial to present the module material, while interacting with the patients to assess their adherence to the topic. Particular attention was paid to time management, ensuring that participants spoke in a balanced manner, checking their understanding of the subjects covered and answering any questions they might have. A constant concern was to ensure that patients did not delve too deeply into their personal problems, as the group was not the appropriate place to deal in depth with these individual aspects. It was essential to maintain a balance between addressing participants' individual concerns and respecting the limits of group dynamics.

In the specific context of the « Memory » module, I had the opportunity to conduct a one-to-one session with a patient, offering a more personalised experience. This one-to-one approach was conducted with the same vigilance as the group sessions, emphasising the need for clear, empathetic communication geared towards the objectives of the module.

All in all, leading this group enabled me to develop valuable skills in group management, communication and creating a therapeutic environment conducive to learning and sharing.

Psychoeducation program

During my placement, I had the opportunity to run several sessions on the BREF program for families, an experience that was enriching in many ways. During these sessions, my role consisted of taking the floor to share concrete tools and approaches adapted to the day-to-day realities of the families concerned, while going into greater depth on certain specific points of the program. The aim was not only to pass on theoretical knowledge, but also to provide practical solutions to support careers in their

often demanding role. Clear and accessible communication was essential to ensure optimum understanding of the concepts presented.

As a psychologist, this experience of leading BREF sessions has given me an in-depth understanding of family dynamics in relation to mental health problems. It has also enabled me to develop practical skills in communicating and passing on information tailored to a specific audience. Interacting with families made me more aware of the particular challenges faced by carers, strengthening my ability to approach these situations with empathy and understanding. Overall, this experience has been a significant catalyst in my learning as a psychologist, broadening my perspective on the needs and resources of families caring for a loved one with mental health problems.

5. Clinical Case.

Psychometric assessment

Psychometric assessment with the WAIS-IV is a fundamental component of psychometric evaluation. Its main objective is to measure an individual's overall intellectual functioning, in particular cognitive abilities such as verbal comprehension, perceptual reasoning, working memory and processing speed.

Generally speaking, a psychometric assessment takes place in three main stages: anamnesis, assessment and feedback. The anamnesis is an initial stage involving a meeting between the neuropsychologist and the patient to gather relevant information about the patient's development, medical history, level of education, family and social environment, as well as current concerns and mental health history. This enables the neuropsychologist to understand the patient's overall context and tailor the assessment to his or her specific needs. The WAIS-IV is administered individually, in a quiet,

distraction-free environment. Each test is administered according to standardized, timed instructions. The neuropsychologist carefully observes the patient's responses, takes note of his or her performance and ensures that the test runs smoothly. The aim of the feedback session is to discuss the results of the psychometric assessment and to provide personalized feedback if necessary. During this session, the neuropsychologist takes the time to explain the results in a clear and accessible way, highlighting the strengths and difficulties identified. The patient is encouraged to ask questions and express any concerns about the results of the assessment. This enables the resident to better understand his or her own cognitive abilities, as well as the implications of the assessment results for his or her daily life, education or career. Depending on the resident's needs, additional recommendations may be provided to help him or her build on strengths and overcome difficulties. This may include suggestions for environmental adaptations, specific learning strategies or referrals to appropriate support services.

Essentials of WAIS-IV Assessment

Before I began taking the WAIS IV test, I carried out extensive research, including reference to specialist books such as «*Essentials of WAIS-IV Assessment*» by Lichtenberger et al. (2012). This preparation enabled me to take note of recommendations and best practices for an effective and respectful assessment.

Before starting the test, particular attention should be paid to the preliminary explanation given to the patient. Explain that it's perfectly normal to find some questions easier or more difficult than others, and that the most important thing is to do your best.

During the test, care must be taken to follow the instructions in the manual precisely. While remaining reassuring, you can engage in light conversation with the

patient to put him or her at ease and reduce any tension. Pay close attention to fatigue and anxiety levels, offering the patient the opportunity to take breaks if necessary.

If the patient questions the timing of certain tests, we can adopt a calm, reassuring response, explaining that he or she need not worry about the time allowed.

In addition, care should be taken to ensure that the patient cannot see the scoring or the stopwatch during the test, as this could be distracting. Ensuring a calm, focused atmosphere is essential for accurate results and for the patient's emotional well-being throughout the assessment process.

Assessment

The first appointment is scheduled for October 4 at 1:30 p.m. and lasts one hour. At our first appointment, we establish a therapeutic alliance through an initial interview focusing on the patient's cognitive complaints. To this end, I use an initial interview framework to guide the discussion in a comprehensive and effective way.

During this first meeting, I also explain to the patient the principles of a psychometric assessment. I make sure they understand what the assessment entails and why it is necessary in their situation.

The appointment scheduled for November 21 at 9:45 a.m. was cancelled due to X's illness. His mother called 10 minutes before the scheduled time to inform them of the situation. A new appointment was agreed for the following week.

On November 28, the WAIS-IV test was scheduled for 1:45 p.m. and lasted about 45 minutes. On arrival, I asked X how he was feeling, whether he was tired or not, to which he replied that everything was fine. Between each test, I continued to check whether he was feeling well. We had to stop the test because X reported fatigue

after the matrices. I then asked X how he had felt during the test, and he said he had enjoyed it and found it interesting.

On December 12, the WAIS-IV test was scheduled for 3:00 p.m. and ran for around 30 minutes. During our session, I asked X for feedback on the previous session. The test took just 30 minutes to complete, and although six tests were scheduled, there was a noticeable difference between this session and the previous one. At the end of the test, he expressed satisfaction with his performance.

On December 19, the assessment report was drawn up (cf. appendix 1), which took around 15 minutes. Following the assessment, the report revealed a slight intellectual disability. I took the time to explain the results one by one, detailing the implications and associated recommendations, using everyday life as an example. Mr. X seemed disinterested. He reacted by expressing that he thought he was more intellectually challenged and that he was actually proud of himself for achieving better results than he had expected.

Reflection

I'd like to look at the comparison between the two testing sessions, which highlights a fact that is often underestimated in the field of psychometric assessment: the crucial importance of the patient's feelings and individual perception. Indeed, it is essential not only to look at quantitative results, but also to consider how the patient experiences and interprets his or her own cognitive work.

In this case, the two sessions took place under similar conditions: both were scheduled in the afternoon, with good morale and no specific complaints from the patient. What's more, the office was the same for both sessions. Despite these

apparently identical conditions, results can differ significantly from one session to the next.

This leads us to reflect on the very nature of the psychometric assessment process. Indeed, it is important to recognize that these assessments do not necessarily reflect an individual's day-to-day cognitive functioning, but rather his or her cognitive functioning at a given point in time. Performance can be influenced by a variety of factors, such as the patient's emotional state, motivation, level of fatigue or even one-off environmental factors.

This underscores the importance of adopting a holistic approach that incorporates the subjective and contextual dimensions of assessment, rather than a purely quantitative interpretation of results. By fully understanding the complexity of the patient's individual experience, we can better pinpoint their needs and offer them tailored, personalized support.

I'd like to address a second point about X's reaction to the diagnosis of mild intellectual disability, which raises a series of important reflections. Firstly, it is striking to note that X greeted this news with apparent serenity. This reaction may be seen as unexpected, as such a diagnosis is often associated with emotions of disappointment, frustration or confusion. The fact that X shows no apparent negative reaction could raise questions about his level of understanding of the real meaning of the diagnosis, or his ability to recognize his own cognitive difficulties.

This situation highlights the complexity of individual emotions and perceptions when faced with a medical diagnosis, particularly when it comes to issues of cognition and intelligence. Each individual reacts uniquely to such an announcement, depending on his or her personality, experiences, beliefs and defense mechanisms. It is therefore

crucial for professionals to adopt an empathetic and personalized approach to communicating diagnostic results, and to provide psychological support tailored to each patient's specific needs.

Ultimately, this situation highlights the importance of recognizing the diversity of individual reactions to a diagnosis, as well as the need for a patient-centered approach in clinical mental health practice.

6. Personal reflection about global internship.

Thanks to my immersion in the psychiatric ward with young adults, I had the opportunity to conduct interviews and consultations, applying CBT principles, carry out psychometric assessments, as well as leading groups. This practical experience has been extremely beneficial on a personal level.

Through these various responsibilities, I have seen a significant evolution in my self-confidence and in my professional practice. Initially, I sometimes had doubts about my skills and my ability to meet patients' needs. However, as the internship progressed, I became more aware of my strengths and abilities. I learned to trust my knowledge and skills, which enabled me to approach clinical situations with greater confidence.

At the same time, this internship also gave me the opportunity to develop my ability to adapt. Every day was full of new and unexpected challenges, and I had to learn to adapt quickly to changing situations, and to each interview.

Finally, I've seen a significant improvement in my ability to assert myself and speak up. I learned to express my ideas concisely and defend my opinions.

All in all, this internship was a transformational experience that enabled me to grow not only professionally, but also personally. I gained confidence in my abilities, developed greater adaptability and honed my communication skills. These lessons will

be invaluable in my future career in health psychology and neuropsychology, and I'm grateful to have had the opportunity to acquire them through this enriching experience.

SECOND INTERNSHIP

7. Introduction to the second internship

The placement took place at the nursing home in Nîmes, under the supervision of Nathalie PINEL, health psychologist, and Professor Angela Leite, lecturer at the IUCS. It will last 2 months and involve 252 hours.

Firstly, we will talk about the characterisation of the placement site, from the general to the specific. Next, the role of the psychologist at the placement. Finally, we will describe the period of intervention.

8. Identifying the location of the second training course

Identifying the location of the second training course

The nursing home in Nîmes, founded in 1842, began by offering free care to the needy patients of the city's various Protestant churches. Thanks to the quality of the care provided, it quickly gained in popularity. In 1872, it was officially recognised as a public charity, reflecting its importance in the community. In 1866, a generous donor by the name of Léon Noguier funded the construction of a hospital, which became the main site of the nursing home. Subsequently, in 1921 and 1954, the institution acquired new premises on rue de Sauve, built in the 18th century as part of the development of the faubourg by Jacques Philippe Mareschal. These premises have historic value, having been partially listed as historic monuments since 2011. Today, the nursing home is an association focusing on the care of the elderly. It comprises three residential establishments for dependent elderly people (EHPAD), all located in Nîmes. These nursing homes offer a full range of medical and paramedical services tailored to the needs of the elderly residents, while ensuring that their dignity and well-being are preserved. The multi-disciplinary team includes a general manager overseeing the three

establishments, a deputy manager in each establishment, administrative staff, a nurse coordinator, a general practitioner, a coordinating doctor, a psychologist, an adapted physical activity educator, nurses, care assistants, catering staff, maintenance staff and hospital service agents.

These EHPADs are generally organised in a similar way, with the Adapted Activities and Care Centre (PASA), a variety of activities and personalised support. This organisation guarantees a complete environment that is adapted to the needs of residents, promoting their well-being and fulfilment on a daily basis.

PASA

The main aim of the PASA is to offer adapted activities and personalised care to residents with cognitive or behavioural problems. Inclusion criteria are generally defined by clinical assessments, such as mms= 6 to 20 and npi (repercussion) = 2 to 4. The PASA aims to provide a safe, stimulating environment adapted to specific needs, with the aim of improving quality of life and preserving functional abilities. The activities on offer include cognitive stimulation (fall prevention workshops), sensory stimulation (meal preparation) and motor stimulation (golf, balance, archery, bowling).

Entertainment/Activities

Every afternoon, as well as several mornings a week, the entertainers organise a variety of activities for the residents. These activities are varied and include bingo, pet therapy, music therapy, newspaper reading, baking, gymnastics, memory workshops, shared meals, virtual visits, manual workshops and discussion groups.

These activities are designed to encourage socialisation, stimulate cognitive abilities, maintain physical health, provide pleasure and allow residents to express their creativity and personal interests. In this way, they help to improve their overall quality of life.

Personalised care

Personalised care plays a crucial role in EHPAD, guaranteeing the general well-being of residents, preserving their independence and quality of life, preventing health problems and meeting the specific needs of each elderly resident. Residents can benefit from a range of personalised services, including consultations with a psychologist, physiotherapy, psychomotor therapy, occupational therapy, speech therapy, chiropody and even hairdressing.

Description of the three establishments

First Establishment

We worked in the establishment on Mondays and Tuesday afternoons. 71 residents, including 21 in protected units. On Mondays at 11am, an interdisciplinary meeting involving the entire multidisciplinary team takes place. This meeting, often referred to as a "staff meeting", is of vital importance and has a number of objectives, such as sharing information, coordinating care, drawing up and adjusting the care plan and managing any problems encountered. The EHPAD has a protected unit. Protected units in EHPAD are areas specially designed to accommodate and care for residents with advanced cognitive disorders, such as Alzheimer's disease or other forms of dementia. These units are organised to provide a secure environment that is adapted and structured to meet the specific needs of these residents. Residents admitted to the

protected units require special attention due to a number of conditions, including a diagnosis of advanced dementia, cognitive dependency, behavioural problems, a safety risk and an inability to live independently. At EHPAD, 21 residents live in the UP located on the 3rd floor. UP residents have access to organised activities and to the PASA. In addition, the housekeeper offers activities specifically reserved for residents of the UP.

Second Establishment

Services are provided on Tuesday and Wednesday mornings. The EHPAD has a total of 88 residents, including 17 day residents and 18 in the disability sector. To ensure effective coordination of care and services, a staff meeting is scheduled every Tuesday at 10.45am.

Third Establishment

Visits are scheduled for Wednesday afternoons and Thursdays. The EHPAD has a total of 84 residents, 21 of whom live in the protected unit. This protected unit is divided into two distinct areas, named Mas and Oustaoui, and is located on the ground floor of the establishment. The two areas are linked by a garden, giving residents the opportunity to enjoy this outdoor space.

In the protected unit, a variety of activities are offered to residents to stimulate their well-being and self-fulfilment. These activities include gardening, cooking, reading, walks, art therapy, gentle gymnastics, balance exercises, karaoke, emotional expression and bingo sessions. These activities are carefully selected to meet the needs and

interests of the residents of the protected unit, encouraging their involvement and participation.

It should be noted that there is no staff meeting at this facility on Wednesdays or Thursdays, as this meeting takes place on Friday mornings. Despite this, care and services are still coordinated through planning and communication between team members throughout the week.

Evaluation of establishments

Periodic evaluation of retirement home facilities is an essential process for planning and effectively allocating the resources needed to care for residents over the coming years. This process is based on a number of clinical and functional assessments to build up a complete picture of each resident and determine their load in terms of care and service needs. A number of concepts and assessments are used to evaluate residents as a whole, with the aim of understanding their medical, functional, cognitive, psychological and social situation: (a) Mini-Mental State Examination (MMS) - an assessment tool designed to evaluate residents' cognitive functions; (b) Tinetti Performance-Oriented Mobility Assessment - a tool for assessing balance and mobility; (c) Mini Geriatric Depression Scale (Mini-GDS) - an assessment tool designed to screen for depressive symptoms; (d) Neuropsychiatry Inventory for Care Team (NPI-ES) - a tool designed to assess behavioural problems; (e) PATHOS - a multidimensional assessment tool designed to provide a comprehensive evaluation of residents' needs and situation; (f) Groupe Iso-Ressources - an assessment tool designed to evaluate residents' independence in activities of daily living.

As part of this evaluation, our task was to carry out a cognitive assessment of each resident in the three establishments, a total of 144 residents, using the MMS and

the Mini-GDS. In addition, we also carried out the NPI-ES scale in collaboration with the team for each resident.

9. Health psychology and the role of the health psychologist

According to Bruchon-Schweitzer and Siksou (2008), health psychology seeks to understand the mechanisms that influence the development of physical and mental illness by integrating various disciplines such as medicine, psychiatry and epidemiology. It explores the biological, psychological and social factors that influence health, challenging the traditional biomedical model. This field focuses on the interactions between individuals and their environment, as well as on psychological processes such as stress, perceived control and social support, which can modulate the impact of risk factors on health. Health psychology takes a holistic approach, examining the classic determinants of illness without privileging any one of them, and highlighting the mediating processes that mitigate or amplify their impact. This rigorous, empirical approach aims to improve the quality of life and well-being of individuals by providing evidence-based knowledge and intervention tools (Bruchon-Schweitzer & Siksou, 2008).

10. Tasks carried out during the internship period

The role of the psychologist in a retirement home is multifaceted and involves a number of key responsibilities to ensure the emotional and psychological well-being of residents. Residents are offered a range of options.

Welcome interview

During the welcome interview with a new resident in the establishment, a benevolent and personalised approach is adopted. This first interview is scheduled

around a week after admission, to give the resident time to acclimatise to their new environment. The primary objective is to create a bond of trust with the resident. Ideally, before meeting the new resident at the EHPAD intake interview, the psychologist will take note of the information previously gathered by the care team, through reports or staff meetings. This feedback from the team enables the psychologist to find out the resident's first impressions of his or her arrival and adaptation to the establishment, and to discuss the resident's specific needs in terms of care and support. For example, if the resident is visually or hearing impaired, it is important to adapt the means of communication during the interview by using visual aids or giving priority to clear, articulate verbal communication.

During this interview, the psychologist introduces himself and explains his role within the establishment, creating a climate of security and confidentiality conducive to communication. The psychologist then takes the time to gather detailed information about the resident's life history. This includes aspects such as their previous place of residence, their parents' occupations, their family environment, their education and career history, and any significant events in their life. This exploration provides a better understanding of the resident's living environment and enables us to adapt our interventions accordingly.

As well as exploring their life history, the psychologist gathers information about the resident's integration into the establishment. He or she asks about the resident's general feelings regarding the welcome he or she received, his or her appreciation of the pace of life in the home, and his or her opinion of the services offered, both in terms of care and accommodation. The psychologist also assesses the resident's perception of the social life and activities on offer in the establishment.

Finally, the psychologist explores the resident's wishes and expectations in terms of care, to ensure that their specific needs are taken into account in their day-to-day care.

To sum up, the EHPAD welcome interview is a crucial stage in the new resident's adaptation to their living environment. It gives the psychologist the opportunity to gather information about the resident's situation, and to make recommendations.

Interview

Individual interviews in retirement homes can be initiated in response to complex situations or specific requests from care staff, information transmissions, or at the direct request of a resident. These interviews may be triggered when a member of staff notices a significant change in a resident's behaviour or emotional state, or when a situation requires special intervention or mediation. For example, a member of staff may request the intervention of the psychologist in the event of conflict between residents, refusal of care, or signs of emotional distress in a resident. In other cases, a resident may directly express the need to speak to a mental health professional, which may be the starting point for an interview with the psychologist. It is also common for some residents to receive more regular follow-up than others, depending on their psychological and emotional needs. These follow-ups may be scheduled periodically or triggered in response to particular events in the resident's life. The main aim of these interviews is to provide a safe and confidential space where residents can express their concerns, emotions and needs, while receiving tailored support from the psychologist. These interventions aim to promote the emotional and psychological well-being of residents, to resolve their problems and to improve their quality of life. Working closely with the nursing staff, the psychologist helps to ensure comprehensive, personalised care for residents, responding to their psychological needs and promoting their quality

of life. When retirement home staff ask the psychologist to meet with a resident following a complicated situation, a number of challenges can arise, particularly in relation to the resident's cognitive impairment. These problems may affect the resident's ability to remember the incident accurately or to communicate coherently about it. In addition, the resident may feel distrustful or anxious about the idea of the team talking about them in their absence, which could compromise trust between the resident and the care staff.

It is therefore essential for the psychologist to show sensitivity and empathy during these interviews. He or she can use communication techniques adapted to cognitive disorders, such as validation and orientation towards positive memories, to facilitate the resident's understanding and enable him or her to express him or herself more easily. In addition, the psychologist must establish a climate of trust with the resident, assuring them that he or she is there to help and to understand their perspective on the situation.

By working closely with care staff and adopting an approach focused on the resident's specific needs, the psychologist can help resolve complex situations and strengthen the relationship of trust between the resident and the care team. This not only promotes the resident's emotional wellbeing, but also helps to foster a sense of trust between them and the care team.

Evaluation

Assessments are carried out on residents as soon as the care team identifies possible cognitive impairment or a decline in mood. These assessments are of crucial importance in identifying the psychological and emotional needs of residents and guiding appropriate interventions. For example, if the doctor observes signs of

depression in a resident, she may request an assessment of mood by the psychologist, with a view to possibly adjusting the drug treatment to specifically target depressive symptoms. In the case of cognitive loss, these assessments help to determine the degree of deterioration in cognitive functions and to adapt support strategies accordingly. They also provide an opportunity to identify needs in terms of cognitive stimulation and psychological support to help the resident maintain an optimal quality of life despite the challenges associated with dementia or other cognitive disorders.

When I arrived for my placement, the establishment was responsible for reassessing each resident within three months, as part of an institutional evaluation, as previously mentioned. Our task was therefore to reassess each resident.

Mini-Mental State Examination (MMS)

The MMS is a standardised tool that measures various cognitive functions, such as temporal and spatial orientation, memory, attention, language and calculation capacity. By assessing these different aspects, the MMS provides an overview of the resident's cognitive state, enabling care staff and healthcare professionals to detect any cognitive problems and implement early interventions if necessary.

During my experience, I had the opportunity to carry out several MMS tests. This experience raised a number of questions about the adaptation of the test and its usefulness with residents.

Firstly, with regard to adaptation, I had to adapt to different test-taking situations. Some residents were assessed in the communal lounge, while others were assessed in their bedrooms, sometimes even when they were in bed. This diversity of

settings required me to be very flexible in order to guarantee the comfort and respect of each resident.

With regard to the perceived usefulness of the MMS, I met residents who, despite our explanations of the purpose of the assessment, did not see any value in it. Some openly expressed their disinterest in the test, questioning its relevance to them. In addition, I was also confronted with refusals from certain residents who did not agree to take the MMS. These refusals required a delicate and respectful approach to deal with the situation and find alternative solutions. Each MMS was unique. Some were quick, lasting just 10 minutes, with an exclusive focus on taking the test, while others evolved into more in-depth interviews, drawing on memories of the person's life history, their experiences in care and their morale.

Despite the challenges encountered, this experience gave me the opportunity to meet many residents and establish links with them. It also enabled me to develop regular follow-ups with some residents who, although initially reluctant, eventually agreed to more in-depth support. This diversity of encounters and situations has enriched my professional experience and strengthened my ability to adapt to the individual needs of retirement home residents.

Mini Geriatric Depression Scale (Mini-GDS)

The Mini-GDS is a standardised tool for the rapid detection of depressive symptoms in the elderly. It consists of four simple questions about mood and feelings. By completing this questionnaire, residents showing signs of depression can be identified and referred for appropriate treatment, whether this involves psychological intervention, medication or a combination of the two.

During my experience, I had the opportunity to complete several rounds of the Mini-GDS. This experience raised a number of questions about the administration method and the perceived usefulness of this tool.

Firstly, in terms of adapting the administration, I had to adjust to different settings. Unlike a simple series of questions, I decided to conduct the Mini-GDS more in the form of an exchange, which requires a more interactive and empathetic approach. This adaptability was necessary to ensure the comfort and understanding of each resident. The usefulness of the test also raised questions. Although some residents were in good spirits, the collective nature of the assessment could lead to misunderstandings about its relevance. Residents may express surprise at these questions, even if they are feeling emotionally well. Each interview was unique. Some were very brief, lasting only three minutes, due to the resident's unwillingness to talk. Other sessions evolved into more in-depth interviews, where I was able to explore the resident's life memories, residential experiences and expression of emotions. One positive aspect of this experience was that it enabled me to establish regular follow-ups with residents who didn't seem to be showing any obvious depressive symptoms to the care teams. These exchanges enabled the residents to free their thoughts and emotions, which led to greater emotional well-being and strengthened their bond of trust with the staff at the facility.

To sum up, taking the Mini-GDS was an enriching experience, marked by challenges but also by moments of deep connection with the residents. It gave me a better understanding of the importance of empathic communication and active listening in assessing the emotional well-being of elderly people in retirement homes.

Neuropsychiatry Inventory for Care Team (NPI-ES)

Administering the NPI-ES in retirement homes is of considerable interest for assessing neuropsychiatric symptoms in elderly residents. The main aim of this assessment is to detect and characterise common neuropsychiatric disorders, such as agitation, anxiety, depression, disruptive behaviour, hallucinations and sleep disorders, in elderly people living in institutions. The NPI-ES provides an overview of behavioural disorders, enabling care staff and health professionals to detect potential problems and implement early interventions if necessary. I had the opportunity to carry out several NPI-ES assessments in collaboration with the establishment's care team. This experience led me to reflect on several essential aspects of this practice.

Firstly, adapting to the time constraints and availability of the care assistants proved to be a major challenge. Finding a time slot compatible with their busy schedules while respecting their daily tasks was crucial so as not to disrupt the smooth running of the establishment. This often required meticulous planning and effective coordination with the care team. In addition, I found that taking the NPI-ES also provided a valuable opportunity to take time out with the care assistants to discuss in depth the complex situations they might encounter in their day-to-day practice. This not only provided essential information about the residents, but also strengthened communication and collaboration within the team. Another important aspect was each carer's individual feel and approach to the residents. Each member of the team had a unique relationship with the residents, which could influence their responses to the assessment. This variability underlined the importance of a collaborative, multidisciplinary approach to get a complete picture of each resident's situation.

Despite the challenges I encountered, this experience brought me many benefits. It allowed me to interact with members of the care team, to understand their perspectives and concerns, and to bring a different perspective to the residents and the operation of the facility.

Interviews with families

Interviews with families are of crucial importance in the context of retirement homes and can be organised for a variety of reasons. When a resident arrives with pronounced cognitive problems, accompanied by incoherent or confused speech, it is often necessary to schedule a meeting with their family. The main aim of this meeting is to gather detailed information about the resident's life history, particularly if he or she has previously resided in other establishments, so that the care provided can be adapted as effectively as possible. These discussions also provide an opportunity to explore the resident's tricks of the trade and areas of interest, thereby facilitating their integration and well-being within the facility. Similarly, when the care of a resident is complex, involving delicate medical, social or psychological aspects, it is a good idea to involve the family. The aim is to share crucial information about the resident's situation and to solicit the expertise of relatives, who can provide valuable insights into their loved one's needs and preferences. These exchanges encourage a more holistic and personalised approach to care, while strengthening collaboration between the care team and the family. However, relations with families can sometimes become strained or even conflictual. After certain admissions, the family may express their dissatisfaction or behave in a derogatory manner towards the care team. In such situations, when this tension becomes difficult for the team to manage, a psychologist may be called in. The aim is to reduce conflict, provide the family with a different perspective and create a

space where they can talk and listen to each other, thereby improving the general well-being of all those involved. Ultimately, these meetings help to maintain a harmonious working environment focused on the well-being of the residents within the retirement home.

11. Case study

I decided to undertake a case study focusing on psychological follow-up, including an assessment of the cognitive sphere using MMS.

During my meeting with Mr A, which was part of the process of updating the assessments of all the residents, I first examined his medical file in order to gather relevant information about his situation. Mr A was adapting well to the establishment and was generally in a positive mood. As far as his cognitive abilities are concerned, he shows remarkable autonomy in administrative and financial management, regularly using a computer for this purpose. He is also autonomous in most of his daily activities, such as personal care. However, his asthma limits his physical activities, which means he has to have respiratory physiotherapy sessions. Socially, Mr A is very sociable at mealtimes in the company of other residents and maintains an active social network through regular use of his computer, which keeps him mentally stimulated. He is fully involved in the life of the home, taking an active part in events and sitting on the social life committee (CVS) as a resident representative.

The first session took place on 13 February 2024 and lasted an hour and a half. From the outset, I was greeted by a warm and smiling Mr A. After a few initial exchanges, I suggested we start with the assessment of cognitive functions (MMS), but Mr A preferred to begin with his history so that I could get to know him better.

During this history, Mr A gave me details of his life. He was born in Saint-Étienne on 20 August 1936 and grew up with his parents in the Cantal and Puy-de-Dôme regions of France. His education led him to attend a technical high school, after which he worked as a labourer in a metal framework factory, a site chemist and a worker for Electricité de France in Clermont-Ferrand from 1957. It was also during this period that he met his wife, of Spanish origin, an event he describes as important and positive.

He told me all about how they met, their first contact and their first dates. They married in 1958 and had four children, including twins. Mr A then did 24 months' military service in the air force in 1959, while his wife looked after the children in Clermont-Ferrand. On his return, he took internal competitive examinations at Electricité de France and became an engineer. The family moved several times for professional reasons, before settling in Montferrier-sur-Lez to be closer to their sons, then in the Résidence Roma in Nîmes. Mr A emphasised the importance of his wife's support in his professional success throughout his career with Electricité de France. He also spoke of their move to a retirement home, where he came to accompany his wife, who will die in December 2021.

At the second session, on 20 February 2024, which lasted about an hour, we concentrated on the MMS. However, during this assessment, I noticed that Mr A found it difficult to stay focused and tended to digress on other subjects. Despite this, he obtained a perfect score of 30/30 on the MMS. After the MMS, Mr A shared with me his role as representative of the CVS. He stressed the importance of this role, explaining that it reminded him of the responsibilities he had in his previous professional roles. He drew a parallel between his current commitment and his past experience, which gave him a sense of continuity and appreciation of his previous skills. In addition, Mr A said

that his role as CVS representative gives him a concrete objective and keeps him active and present within the establishment. It also gives him the opportunity to actively contribute to improving social life and the activities offered to residents, which gives him personal satisfaction and a feeling of usefulness.

At the third session, on 27 February 2024, which lasted about an hour, Mr A raised a number of issues, including the death of a care assistant at the home. He expressed his sadness and shock at the news, stressing the emotional impact it had had on him and the other residents. During this session, Mr A also spoke about a sensitive situation he had faced as a residents' representative. He shared that an anonymous letter had been sent to the management of the establishment, denouncing the harassment to which the deceased care assistant had been subjected during her working hours. The letter also mentioned that the harassment was continuing for other members of staff. In this context, a care assistant asked Mr A to intervene as a representative of the residents. She felt it was her role to make the residents' voices heard in this situation. However, during our discussion, we were able to clarify Mr A's role as CVS representative. We discussed the need for him to position himself appropriately in this delicate situation, reminding him that he was not directly involved in managing internal staff conflicts. This discussion enabled Mr A to better understand his responsibilities as a residents' representative and to clarify the limits of his role in this type of situation.

The fourth session, which took place on 11 March 2024 and lasted approximately one hour, began with a discussion of planned appointments with his cardiologist, pulmonologist and rheumatologist with a view to adapting his medical treatment. Mr A expressed positive feelings, particularly after returning to his son's home to celebrate a birthday, where his great-grandson recognised him, and learning

that a member of his family is expecting a child. However, he also reported sleep disturbances, attributed to physical pain and ruminations. To remedy this, he has implemented strategies such as reading in his armchair when he can't fall asleep. During the session, Mr A also spoke about his experience at the clinic and went back over the situation for which he had previously been asked. He expressed his concerns and emotions about the event, underlining his personal connection with the deceased care assistant's illness, which was similar to the one his wife had suffered from years before, but from which she had recovered. Mr A shared his perception of his own current period of life, describing it as a time of reflection and positive assessment. He expressed his desire to maintain this positive dynamic, stressing the importance of his role as a representative in the establishment and of family ties. He also shared his views on various subjects such as immigration, social networks, religions and human evolution, shedding light on his thoughts and personal values.

The final session, which took place on 19 March 2024 and lasted an hour, was marked by the announcement of the end of our collaboration. When I told him it was our last session together, Mr A asked me what my plans were for the future. Referring to a planned trip to South America, he shared with me his own travel experiences, in particular the various cruises he had taken with his wife, 18 in all. These travel memories evoked emotions and anecdotes that he was happy to share, making for a warm and nostalgic moment of exchange.

Comments on the case study

Mr. A initially appeared not to require regular follow-up based on the team's information and transmissions. However, over the course of sessions, he expressed that these meetings were beneficial to him and helped him calm his rumination. This

observation highlights the importance of not assuming residents' needs and remaining attentive to their evolution, even if they do not initially seem to request psychological follow-up. Each individual has their own needs and reactions to life events, and it is essential to consider them to ensure their well-being and psychological comfort.

This reflection also underscores the challenge of managing time and resources in a facility like this. It is crucial to strike a balance between residents' needs and organizational constraints to ensure everyone has equitable access to psychological support services. This requires careful planning and effective communication within the multidisciplinary team to ensure each resident receives attention and care tailored to their individual needs.

In summary, Mr. A's case study highlights the importance of flexibility and attentive listening in the practice of psychology in nursing homes, as well as the need for proactive resource management to address the varied and changing needs of residents.

12. Personal Reflection

This end-of-year internship experience during my Master's degree in Health Psychology and Neuropsychology has been a pivotal moment in my training. At the beginning of my first placement, I faced numerous personal doubts regarding my legitimacy as a future psychologist. I experienced a mix of apprehension and uncertainty about my ability to adapt in this demanding field. At times, I found myself struggling, which reinforced my feelings of insecurity and doubt. However, the second placement was a real turning point for me. Over the weeks, I gained confidence in my practice and skills. I began to feel comfortable in my role as a future psychologist specialised in neuropsychology. This placement provided me with the opportunity to

apply the knowledge gained during my studies, but more importantly, to develop my own professional identity. I learned to handle complex situations with assurance and to implement interventions tailored to the specific needs of each patient.

Ultimately, this internship experience has been a significant personal and professional learning curve. It enabled me to overcome my initial doubts and fears to fully embrace my future career as a psychologist specialised in neuropsychology. I am now more confident in my abilities and ready to face the challenges that lie ahead in my future career.

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Appendix

PSYCHOMETRIC EVALUATION

Last name : X

First name : X

Evaluation date : 21/11/2023 et 13/12/2023

Date of birth : 12/01/2007

Age : 16 years old

Marital Status: Single, no children

Education level : CM2

Professional status : No activity

This report is based on information gathered directly from Mr. X during two interviews.

Reason for consultation

Mr. X is seen for an intelligence quotient assessment to justify a request to the Maison Départementale des Personnes Handicapées (MDPH).

Observation and interview behavior

Mr. X was interviewed twice, alone in the afternoon, for 45 minutes in the first session (13:45 to 14:30) and 30 minutes in the second (15:00 to 15:30). The first session ended after 4 tests. He preferred to stop because he felt tired, although he had expressed interest in the tests. At the end of the second session, having completed all 6 tests, he reported no fatigue and still found the tests interesting. Hygiene and physical presentation are adequate. Social etiquette is respected. Monsieur X is motivated and cooperative. If he has difficulty with a question, he doesn't hesitate to point out that he doesn't know. The instructions have been well integrated. Spontaneous speech is fluent. There is no lack of words.

Anamnesis and lifestyle

With regard to his personal medical history, Mr. X reports having been treated from the age of 12 to 15 at the Hôpital de Jour de Montfavet (84).

He has now decided to stop taking his medication. His decision stems from his conviction that treatment is not the appropriate solution, preferring instead to cope with his illness in other ways.

Mr. X reports no substance abuse.

As far as his family is concerned, Mr. X lives with his mother and grandmother. He no longer has contact with his father, expressing that his father was never there for him, an experience he describes as traumatic.

During his childhood, Mr. X sees himself as having often been lonely, with a feeling of unease. He also describes himself as sensitive. Mr. X also describes being bullied by his cousins.

At school, he dropped out at the age of 11/12 following an altercation with his teacher.

Mr. X is not employed.

As far as sleep is concerned, Mr X goes to bed late, usually between 4 and 6 in the morning, waking up around 11. Lately, he's been trying to gradually bring his alarm clock forward to get up earlier. He particularly likes the night-time hours, which he finds more peaceful. He sometimes has nightmares, but these don't seem to affect his daily routine.

His hobbies include walking and watching YouTube videos. He would like to create his own videos. He would also like to take up sports such as jogging.

Mr. X's goal is to find a job and become independent.

Current complaints

Mr. X says he consumes too much Coca-Cola and would like to cut down.

In the cognitive sphere, Mr. X reports memory difficulties, particularly in remembering names or Internet codes.

Tests administered

Overall intellectual performance was assessed by administering all the compulsory subtests of the Wechsler Adult Intelligence Scale - 4th Edition (WAIS-IV). Differences were compared, and strengths and weaknesses were determined.

Lexical knowledge and verbal concept formation, general knowledge and factual knowledge were assessed by the *Information*, *Vocabulary* and *Similarity* subtests respectively. The *Verbal Comprehension* index was calculated.

The ability to analyze and synthesize abstract visual stimuli, visuo-spatial reasoning, visual perception and organization were assessed by the *Cubes* subtest; visuo-spatial intelligence was assessed by the *Matrices* subtest; non-verbal reasoning and the ability to analyze and synthesize abstract visual stimuli were assessed by the *Visual Puzzle* subtest. The *Perceptual Reasoning* index was calculated.

Information processing speed and selective visual attention were measured by the *Code and Symbols subtests*. The Processing Speed Index was calculated. This index provides a measure of the ability to quickly and correctly explore simple visual information, process it sequentially and discriminate it.

Working memory was assessed using the *Digit Memory* and *Arithmetic subtests*. This task involves temporarily storing auditory-verbal information in memory, performing certain mental operations on it and producing a result. Working memory involves attention, concentration, mental control and reasoning. The *Working Memory* Index has been calculated.

Results et interpretation

Mr X's overall intellectual performance is pathological, with a total intelligence quotient of 69 (Pc 2; CI 65-75). The result shows a mild intellectual disability. There was homogeneity between the different indices.

Results for the Perceptive Reasoning index (standard score = 24) are within the norm. Results for Verbal Comprehension (standard score = 17), Working Memory and Processing Speed (standard score = 5) are deficient. The Perceptive Reasoning index contrasts significantly with the Verbal Comprehension, Working Memory and Processing Speed indices.

The result for the Cube subtest (standard score = 9) is within the norm. The results for the Similitudes (standard score = 7), Matrices (standard score = 9), Visual Puzzles (standard score = 6), Number Memory (standard score = 5), Vocabulary (standard score = 5), Arithmetic (standard score = 5), Symbols (standard score = 3), Information (standard score = 5), and Code (standard score = 2) subtests are deficient.

On the verbal and communication levels, lexical knowledge, general and factual knowledge, and conceptualization skills are deficient.

On the gnosis and praxis levels, visuo-constructive skills, analysis and visual synthesis are deficient when manipulation is mental. Nevertheless, Mr. X manages to normalize his performance when the manipulation is motor and involves non-verbal reasoning skills, which represent a real strength within Mr. X's profile. In terms of memory, there is an impairment of working memory. He is unable to store information temporarily in order to carry out certain mental operations and produce a result, or to store it temporarily in order to repeat it in direct, inverse or ascending order.

With regard to processing speed, Mr. X's abilities are deficient.

Conclusion et recommendations

This psychometric evaluation is being carried out with a view to an IQ assessment to justify the application to the Maison Départementale des Personnes Handicapées (MDPH).

In conclusion, the psychometric table presented by Mr. Bélanger to date highlights a pathological overall cognitive performance, showing a mild intellectual disability (IQ = 69). Results on the Perceptive Reasoning index (standard score = 24) are within the norm. Verbal Comprehension (standard score = 17), Working Memory and Processing Speed (standard score = 5) were deficient. The Perceptive Reasoning

index contrasts significantly with the Verbal Comprehension, Working Memory and Processing Speed indices. Due to the homogeneity of the results, the overall IQ is interpretable. Perceptual Reasoning scores (standard score = 24) are within the norm. Results for Verbal Comprehension (standard score = 17), Working Memory and Processing Speed (standard score = 5) are deficient. The Perceptual Reasoning index contrasts significantly with the Verbal Comprehension, Working Memory and Processing Speed indices. Mr. EL BAKKALI's memory difficulties echo what we have observed to date. However, his difficulties do not hinder his day-to-day functioning.

Anaïs PRUNIER

Trainee psychologist specialized in neuropsychology