CESPU
INSTITUTO UNIVERSITÁRIO
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INTERNSHIP REPORT

Internship Report

Audrey Paulette Alice Labernardie

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

—

Gandra, **July de 2024**

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Work carried out under the Guidance of
Jose Carlos Rocha

DECLARATION OF INTEGRITY

I, the person identified above, 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.

List of abbreviations

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INTERNSHIP REPORT

Introduction

This internship report is part of the second year of the Masters in Health Psychology and Neuropsychology at the Instituto Universitário de Ciências da Saúde (IUCS) at Cooperativa de Ensino Superior Politécnico E Universitário, Gandra University and its main objective is to present all the activities and learnings achieved during the internship. It took place at the Villa ORYGEN, part of the psychiatry department of the Centre Hospitalier Universitaire Carémeau in Nîmes, under the supervision of Julie Jourdan, neuropsychologist, and Professor Jose Carlos Rocha, lecturer at the IUCS. The internship began on 5th February 2024 and ended on 21st June 2024, totalling 500 hours. This end-of-study internship is of vital importance for the completion of the academic course, as it marks the student's first contact with clinical practice. It allows students not only to apply but also to deepen and consolidate the knowledge they have acquired throughout their studies. It also provides an opportunity to gain practical professional experience and the scientific skills that are essential for future employment.

This work internship report is divided into 4 parts. The first part is devoted to a description of the internship. The second part explores the role of neuropsychology in psychiatry. The third part focuses on the activities carried out during my internship, divided between the observation period and the intervention period. Finally, this report will include an elaborate clinical case, providing a concrete illustration of the skills and knowledge acquired during the internship.

INTERNSHIP REPORT

1. Characteristics of the institution

1. CHU Carrémeau Nîmes description

The CHU Carrémeau is divided into two buildings: Carrémeau Sud and Carrémeau Nord. The Carrémeau North hospital, inaugurated in 1986, has been completely restructured, while the Carrémeau South hospital, inaugurated in 2003, is a new building integrated into the site (CHU Nîmes, 2023). In 2022, the hospital staff represented 5879 agents and had a capacity of 2083 beds, places and posts. 297 beds, places and workstations were available for day hospitalisation and 1933 beds, places and workstations for full hospitalisation (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).

2. Description of the location of the internship

The internship took place in the psychiatric department. It took place outside the CHU at Villa ORYGEN, an early intervention and rehabilitation centre for young people aged 16 to

30. ORYGEN is an acronym that stands for "Optimistic and Psychosocial Rehabilitation Care in Psychiatry for the Youth Generation". The concept comes from Professor Patric McGorry's Orygen early intervention centre in Melbourne (SanteMentale, 2020). The team consists of two psychiatrists, six case managers including 4 nurses and 2 care assistants, a psychologist specialising in neuropsychology, a psychologist, a social worker and a job coach (CHU Nîmes, 2023).

The various objectives are multiple: to raise awareness among the general population, and young adults in particular, of the importance of mental health, and to combat the stigmatisation of mental disorders and recourse to psychiatric care. The aim is also to facilitate access to psychiatric care for young adults, and to provide early treatment for emerging psychotic and thymic disorders in order to minimise the impact on daily life. In addition, the establishment of personalised care plans is essential to promote patients' medical and personal recovery. In addition, the aim is to enable young adults to become aware of their personal resources, and to strengthen their skills, autonomy and self-esteem. Support for users' families is also an important part of this approach (Centre ressource réhabilitation, 2023).

The patients concerned are generally aged between 16 and 30, with emerging psychotic or thymic disorders, with initial psychic symptoms or a duration of illness of less than 10 years. However, care criteria are not strictly limited to specific diagnoses or ages, but are adapted to the needs and demands of users in terms of rehabilitation and recovery (Centre ressource réhabilitation, 2023).

The Villa ORYGEN has developed the PsyTRUCK 3.0 project, offering mobile psychiatric consultations in mobile vans in and around Nîmes for young people aged between 15 and 30. The main aim is to change the image of psychiatric care by reaching out to users and facilitating access. The assessment consultations, open on a walk-in basis at pre-defined times and places, will enable young people to be referred to the appropriate follow-up structures. PsyTRUCK 3.0 will also organise information and awareness-raising campaigns for the general public on mental health and psychological disorders (CHU Nîmes, 2023).

3. PEPSY Research Project

The PEPSY platform is the result of a public-private collaboration between three multidisciplinary institutions with experience in the field of mental health: the Centre Hospitalier Gérard Marchant, the Centre Hospitalier Universitaire de Purpan and the Clinique Aufréry. The main aim of this initiative is to improve access to care for young people aged between 16 and 30 suffering from a first episode of psychosis (PEP). This will be achieved by simplifying administrative procedures through the creation of a centralised platform. In addition, PEPSY aims to coordinate care provision in the Occitanie region by bringing together two complementary care facilities, PEPSY 31 (Centre Hospitalier Gérard Marchant & Centre Hospitalier Universitaire de Purpan) and REPEPS (Clinique Aufréry). Finally, the platform plays a crucial role in raising awareness among health and youth professionals of the issues surrounding first episodes of psychosis (Centre Hospitalier Gérard Marchant, n.d.). The PEPSY platform model is based on collaboration between a psychiatrist and a nurse case manager. The role of the case manager is crucial, as he or she must establish a relationship of trust with the user by adopting a proactive, mobile approach that involves going out to the

patient. This means intervening directly in the patient's environment, meeting the patient's family and working with all the professionals involved in the patient's care. The nurse case manager can also receive users within the care structure and assist them with various procedures, such as training, schooling, job-seeking or housing. This co-ordination function maximises the chances of recovery for the user, reduces the risk of fragmentation of their care pathway and avoids breaks in the continuity of care (Centre Hospitalier Gérard Marchant, n.d.). Case managers work to meet patient needs through assessment, coordination, and planning, by evaluating the available options and services. Their involvement helps patients and caregivers make the best choices to manage the complex world of healthcare (Armold, 2019). To achieve these objectives, strategies are put in place such as therapeutic workshops focusing on self-esteem, assertiveness and emotion management, as well as psycho-education, cognitive remediation and social skills training. In addition, efforts are being made to provide day-to-day and social rehabilitation, including job coaching to encourage integration into the workforce and support in accessing housing (Centre ressource réhabilitation, 2023).

All of these interventions are designed to offer comprehensive support tailored to the specific needs of each patient. Working closely with all the partners in the area is essential if we are to offer genuinely tailored care and support (Parriaud-Martin et al., 2020). This approach aims not only to improve patients' quality of life, but also to facilitate their social and professional integration, by taking all their needs into account.

The PEPSY platform is also involved in the PEPsy-CM research project led by Dr Schandrin, who works at the Villa ORYGEN and is based at the CHU in Nîmes. The PEPsy-CM project (Program for Early Psychosis based on case Management) is a randomised

controlled trial designed to assess the effectiveness of the intervention of case managers in psychiatric sectors with patients aged between 16 and 30 who have presented with PEP. The primary objective is to evaluate the impact of PEPsy-CM on relapse rates, defined as the re-emergence of positive psychotic symptoms or hospitalisation in a psychiatric unit. As secondary objectives, the team will assess its impact on clinical and functional outcome, quality of life, adherence to care and the therapeutic alliance, as well as insight (Institut de Psychiatrie, 2021).

2. The role of the neuropsychologist in psychiatry

Neuropsychology is situated at the intersection of the brain and behaviour. This distinctive position gives it a unique opportunity to provide information on the pathophysiological mechanisms underlying certain physical and mental disorders that have plagued human society for centuries (Zhou & Wang, 2021). The neuropsychologist implements cognitive rehabilitation programmes aimed at increasing patients' autonomy and quality of life. They also take part in the psycho-education of patients and their families, explaining the disorders they are experiencing and providing strategies for managing them on a day-to-day basis. Working closely with other mental health professionals, they help to formulate integrated treatment plans and provide comprehensive support for patients. In addition, neuropsychologists are often involved in clinical research projects. They also assist clinical decision-making by providing detailed assessments and specific recommendations, which is essential for adjusting treatments and assessing patients' capacity to consent to treatment (Babinet & Cannarsa, 2020).

3. Activities carried out during the internship

3.1. Observation period

The observation period enabled me to familiarise myself with the ORYGEN environment and how it works, including patients, families and other healthcare professionals. This immersion is essential for understanding clinical practices, care protocols and the specific roles of each member of the team. Observation without direct intervention also offers the opportunity to focus on acquiring practical knowledge, by observing interview techniques, intervention strategies and therapeutic interactions. Observation also aims to identify clinical signs, symptoms and diagnostic processes. In addition, this phase provides an opportunity to become familiar with the assessment and intervention tools used by healthcare professionals (Fernandez, 2021). This period is an essential transitional stage that facilitates the trainee's gradual integration into clinical practice.

To promote the therapeutic alliance and encourage positive developments in patient care, the Villa ORYGEN team sets up various activities adapted to the specific needs of patients. As a trainee, I had the opportunity to take part in these activities, organised by the multidisciplinary team, and to lead some of them. Here is a presentation of the main activities.

3.1.1. Individual therapeutic project

At Villa ORYGEN, the Individual Therapeutic Project (ITP) is generally carried out in the presence of the psychiatrist, neuropsychologist, case manager and job coach. A family member or someone close to the patient may also be present. The ITP is drawn up at the start of the treatment and re-evaluated every 6 months to assess the patient's objectives and progress. Properly completed, the ITP is a liaison tool that enables the patient's history,

progress and prospects to be followed in a concise and targeted manner. It helps to maintain continuity of care and avoid disruptions in care. In addition, the ITP strengthens the patient's place and role in his or her own care, enabling them to play as active a role as possible in their own lives by drawing on their psychological, family, social, friendship and professional resources. This work helps patients to better know, understand and accept their illness. This therapeutic approach helps patients to build a life plan that takes into account the reality of their illness. It also strengthens the therapeutic alliance with all the healthcare professionals who follow them (Haute Autorité de la Santé, 2016).

The ITP has various objectives: it consists of reconstructing the patient's history in collaboration with the patient, his family and the healthcare team, while assessing his current clinical condition. It aims to establish patient-specific therapeutic objectives, which are progressive and prioritised according to the clinical situation. It also helps patients to recognise their illness, identify its symptoms and the suffering it causes. It helps to identify the patient's resources and skills, as well as their difficulties, so that they can build on their strengths and work on their weaknesses during treatment. Understanding and actively participating in the proposed interventions is crucial to strengthening the therapeutic alliance, encouraging compliance and increasing patient autonomy. Finally, the ITP aims to support patients in building a personalised 'life project', aligned with their needs, aspirations and resources, in collaboration with their carers where possible. This includes work on empowerment and social, family and professional integration (Haute Autorité de la Santé, 2016).

3.1.2. First psychological interview

Patients are admitted to the Villa ORYGEN either following a referral from another establishment or on admission to the Carrémeau University Hospital. In general, the case manager is the first point of contact with the patient. During this initial interaction, the case manager introduces the institution and asks initial questions to better understand the patient's childhood, education, daily life, hobbies, substance use and other aspects of his or her life. The patient then meets the psychiatrist. The patient then completes an Individual Therapeutic Plan (ITP), which marks the start of personalised care. The first psychological interview is an important stage in the therapeutic process. This is the first meeting between the psychologist and the patient, during which several objectives are pursued: the first interview enables a relationship of trust to be established between the patient and the psychologist. This relationship is fundamental to the success of any therapeutic intervention. The psychologist gathers detailed information about the patient, including his or her personal history, symptoms, medical and psychological history, and expectations of the therapy. The psychologist and patient discuss the objectives of the therapy and mutual expectations. This helps to guide the therapeutic process in a clear and structured way (Bernard-Tanguy & Reniers, 2021).

3. Cognitive behavioral therapies

Cognitive behavioral therapies (CBTs) have different principles to adhere to, which are: they require a strong therapeutic relationship; they are culturally appropriate and tailor treatment to the individual; they emphasize the positive as well as collaboration and active participation; CBTs are educational, structured, present-based; and they teach patients to cope

with their dysfunctional cognitions (Beck, 2020). They can be used with children, adolescents, adults, couples, or families (Dobson & Dozois, 2021). Cognitions occur at 3 levels. First, we have the automatic thoughts which are at the most superficial level, then the intermediate beliefs and finally, at the deepest level we have the fundamental beliefs. For a lasting change in the patient, it is necessary that the therapist works on all three levels (Beck, 2020). Psychotherapists use different psychic and relational techniques such as interviews, combining understanding and active listening, empathy, reminders, reformulation, the contribution of an outside view and interpretation. There are also behavioral methods which aim to progressively expose oneself to the object of one's fear using techniques such as exhibitions, role-playing, experimentation with new behaviors, cognitive methods which aim to identify the patient's automatic thoughts and to change them by alternative thoughts so that the patient can make a realistic and more constructive judgement using techniques such as Beck's columns and cognitive restructuring, and emotional methods which aim to change the subject's relationship to their emotions and cognitions and reduce their negative impact using techniques such as relaxation, mindfulness, exposure and emotional acceptance. Techniques such as hypnotherapy can be added (Bouvet, 2020). The results of CBT depend on the patient. Overall, there are changes in behavior and cognition, and minimal changes in the emotional and physiological (Dobson & Dozois, 2021).

4. Family intervention

Relatives often play a crucial role in the lives of people with schizophrenia and other severe mental disorders, given that between 30% and 65% of affected adults live with their families (Haute Autorité de la Santé, 2013). According to the definition in the WHO-Europe

report published in 1996, therapeutic education is defined as helping patients, their families and those around them to "understand the illness and treatments, collaborate in care, take charge of their state of health and maintain and/or improve quality of life" (Haute Autorité de la Santé, 2013). Family psychoeducation is a well-established and effective psychosocial treatment for schizophrenia and bipolar disorder. Numerous controlled studies indicate that patient relapse rates are generally halved during active family psychoeducation interventions. These programmes have also been shown to have an impact on other important clinical outcomes, such as levels of positive and negative symptoms, as well as psychosocial aspects such as employment rates and social functioning. These interventions thus represent an essential pillar of comprehensive, evidence-based care for people with schizophrenia and other severe mental disorders (Murray-Swank & Dixon, 2004). These results clearly demonstrate the importance of family psychoeducation, and show the relevance of the projects carried out by Villa Orygen.

5. BREF programme

BREF is a free psycho-education programme for carers of people living with a mental disorder, with or without a diagnosis. It is based on participatory research and was designed by CLAP (Centre Lyonnais des Aidants en Psychiatrie) with national support from UNAFAM. UNAFAM is an association that fights on a daily basis against the prejudice and stigmatisation associated with mental illness and disability, and also supports research and innovation in care and support practices, in conjunction with public decision-makers.

The programme is available to all relatives of people suffering from psychiatric illnesses (thymic and psychotic disorders), whether they are experiencing the illness for the first time or being monitored on a regular basis (inpatient or outpatient monitoring). The aim is to provide priority information for the family or friends, to take the pressure off the situation, to relieve carers of their guilt, to develop the therapeutic alliance, to motivate participants to seek help and find out about support systems, and to support carers in their role as "helped" carers by encouraging them to contact UNAFAM. The programme consists of 3 sessions of around 1 hour. Each family is seen individually, in the absence of the relative, by a care team (psychologist, nurse, carer) not directly involved in the care of the ill relative. At the 3rd appointment, a volunteer from the UNAFAM association joins the healthcare professionals. Then, about three months after the last meeting, a member of the team calls the participants back to take stock of what has happened since the last meeting, to answer any new questions, to evaluate the programme, and to motivate the participants to contact family associations and not to remain alone (UNAFAM, n.d.).

The first session is used to identify the priority issues and problems faced by the family member being cared for. Participants are asked to choose an image from the "carer" pile and an image from the "sick person" pile that they feel is most appropriate to their situation. The second session involves processing the image in the "sick person" pile, i.e. working on the clinical signs, the current hospitalisation and the difficulties encountered by the sick relative. Finally, the third session involves processing the image of the "carer" pile, i.e. working on the feelings experienced by the carer around the illness, hospitalisation and family difficulties. The UNAFAM volunteer will also give details of all the resources available to carers. 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 programme, 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.

Recent international recommendations state that psychoeducational interventions for carers are effective care and should be offered early and systematically to all carers in psychiatry (Galletly et al., 2016). To this end, a free one-day training course has been set up, which is offered to healthcare institutions wishing to implement the BREF programme. The data collected prior to participation in the BREF programme shows the negative impact of being a carer on psychological health and confirms the value of offering early interventions to carers, from the first year of support. In fact, 67% of the carers benefiting from the BREF programme were suffering from depression requiring care or follow-up (Rey et al., 2020). Nevertheless, participation in the BREF programme was associated with a significant reduction in carers' depressive symptoms in the immediate aftermath of the programme. At the 3-month mark, 94% of participants were satisfied/very satisfied with the BREF programme and gave an average score of 9.3/10 to the usefulness of the BREF programme (Rey et al., 2020).

6. *Study PEPsy-Identity*

As part of Julie Jourdan's thesis, I was able to attend and take part in patient assessments. Her research focuses on narrative identity and its link with multidimensional

subjective well-being in First Episode Psychosis (FEP). Narrative identity is made up of several dimensions and represents our personal identity. What makes us us is our ability to tell the stories we have experienced.

The study population is made up of three groups: 1) a group of subjects aged between 16 and 30 who have had a first psychotic episode (PEP group); 2) a group of controlled subjects aged between 16 and 30 who are representative of the general French population (control group); 3) a group of subjects aged between 16 and 30 who have been diagnosed with a psychotic disorder or bipolar disorder (chronic group).

The protocol is divided into several parts and lasts about 2 hours. First, the participant was asked to complete a life history task. This task consisted of describing five specific memories as precisely as possible (date, place, emotions): one memory relating to his traumatic or highly stressful memories; one memory relating to his memories of transgression (a time when he broke a rule or norm and felt guilty and ashamed); one memory relating to his memories of low points (memories during which he may have felt extremely negative emotions); one memory relating to his defining memories (memories that define him); and one memory relating to his memories in connection with "turning points" in his life (episodes during which he experienced a major change). Secondly, the participant was asked to complete a number of cognitive tests. These tests included: verbal fluency measuring verbal fluency and cognitive flexibility; CVLT-II (California Verbael Learning Test-II), this verbal memory test helps to assess participants' learning and recall capacity; Matrix and similarities, sub-tests of the WAIS-IV. Finally, participants were asked to complete a series of psychological questionnaires: the PANSS (Positive and Negative Syndrome Scale), which assesses the symptoms of schizophrenia, both positive and negative, and general symptoms;

STORI, which measures recovery trajectories; PERMA-Profiler, which assesses well-being along five dimensions: positive emotions, commitment, relationships, meaning and fulfilment; BFI-10 (Big Five Inventory-10), a measure of personality traits based on the Big Five model; CTQ (Childhood Trauma Questionnaire), an assessment of childhood trauma; PSP (Personal and Social Perfomance Scale), a measure of personal and social performance; WHOQoL-Bref, an assessment of quality of life; TALE-15 (Thinking About Life Experiences), an assessment of autobiographical thinking processes; BIS (Barratt Impulsiveness Scale), a measure of impulsivity; EQ-5D-5L, a measure of health-related quality of life; HADS (Hospital Anxiety and Depression Scale), an assessment of anxiety and depression; and MARS (Medication Adherence Rating Scale), a measure of medication adherence.

7. *Therapeutic Apartment*

Therapeutic flats are temporary accommodation facilities, taking in one or more residents, on medical indication, and funded by health appropriations (Mnasm, 2007). These flats are managed by psychiatric teams and enable residents to live independently while being monitored for treatment and, more often than not, for the management of daily life. Villa Orygen works in collaboration with the local psychosocial rehabilitation centre "Le Peyron", which offers accommodation in therapeutic flats and day hospitals for adults with mental health problems. To be admitted to the therapeutic flats, you not only need to have the right profile, but also to have a referring psychiatrist who considers this option and maintains regular and cordial relations with the flat team, and finally to show that you are willing to comply with the proposed framework. This system forms part of the transition between hospitalisation and reintegration, and is organised on a gradation that goes from the most all-

encompassing and possibly restrictive form of care, i.e. hospitalisation, to the most limited form, i.e. regular consultation with a psychiatrist, who only intervenes to control the illness through treatment, via the patient (Velpry, 2008). Staying in a therapeutic flat means agreeing to take part in what is known as psychiatric work, which involves establishing cooperation between patients and carers. This cooperation may be minimal, but it is based on the shared objectives of controlling the illness and managing daily life. Home visits are made on a regular basis to deal with day-to-day problems, particularly home maintenance, and to monitor the resident's condition (Velpry, 2008).

2. Intervention period

The intervention period enabled me to apply the theoretical knowledge I had acquired during my studies in a practical way, while at the same time developing essential practical skills. By interacting directly with patients, I had the opportunity to observe a variety of psychiatric disorders and gain a better understanding of their clinical manifestations. This experience has also enabled me to develop my interpersonal and communication skills, which are essential for establishing a relationship of trust with patients. I now feel more competent and confident in my role as a future psychologist thanks to this immersion in the reality of working in psychiatry. Here's a presentation of the different activities I was able to carry out during my internship.

3.2.1 Initial Interview

During my internship, I was able to construct a structured framework for the first psychological interview. This was used as a guide to ensure that all relevant information was gathered and that the interview was conducted in a coherent and effective manner. The outline

for my first interview (see appendix 1) is structured into several key sections, each with specific objectives: gathering socio-demographic information to provide a context for the patient's living conditions, e.g. questions such as "How old are you? This can be done by asking, for example, "How old are you?" or "Why do you think you need counselling?"; assessing the patient's general mood, for example by asking "How are you feeling at the moment? Collect information about the patient's medical and psychological history "Have you ever been hospitalised? If so, for what reasons and for how long? ; assess the use of psychoactive substances, including alcohol, drugs and tobacco, examples of questions "Do you use drugs? If so, which ones? Understand the patient's current work situation and its impact on his or her mental health, e.g. "How do you feel in your work environment"; obtain information about the patient's educational background and any difficulties, e.g. "What was school like for you? "Exploring childhood experiences and their influence on the patient's psychological development, e.g. "Do you have any significant memories of this period? Whether positive or negative"; understanding the patient's current relationships with their family and friends, e.g. the question "How are your relationships with your parents and family? "Finally, we summarise the key points of the interview, answer the patient's questions and plan the next steps. For example, we might ask "Is there anything else you'd like to add that I haven't thought of?

Once I had drawn up this form, I used it systematically during my first interviews with patients. However, it should be used flexibly to adapt to the specific needs of each patient; it is simply a guide to the interview process. After each interview, I took the time to reflect on what had worked well and what could be improved, which enabled me to refine the grid and improve my clinical skills.

Conducting initial interviews enabled me to hone essential skills in communication, active listening and clinical observation. In my opinion, these skills are fundamental to establishing a trusting and effective therapeutic relationship. I was also able to learn how to draw up treatment plans, including defining therapeutic objectives and implementing treatment strategies tailored to each patient.

2. CBT

During my internship at Villa Orygen, I was able to apply various exercises from CBT with my patients, which my internship tutor passed on to me: 1) the daily activity log, in which patients record their daily activities and evaluate them in terms of enjoyment and achievement; this technique helps to raise patients' awareness of the impact of their activities on their mood and to encourage them to engage in beneficial activities; 2) the sleep diary, in which patients keep a sleep diary, recording the times they go to bed, get up and the quality of their sleep; this technique helps to address the sleep disorders that are often present in psychiatric patients; 3) activity planning, in which patients plan pleasant and meaningful activities in advance. This helps to structure patients' time and reduce inaction and procrastination; 4) exposure, in which patients are gradually exposed to anxiety-provoking situations in a controlled environment; 5) working on qualities: patients identify their personal qualities and find concrete situations in which they have used these qualities. This technique helps patients to recognise and value their strengths, which can be very beneficial for their personal development and increasing their self-confidence.

3. *PEPsy-identity*

During my internship, I had the opportunity to administer the assessments to patients who met the study criteria. I therefore administered various scales: (a) Life Story Task; (b) Verbal Fluency; (c) California Verbal Learning Test; (d) Matrices; (e) Similitudes; (f) PANSS.

Once the assessment has been carried out, it's time to mark the various tests. Scoring tests requires great attention to detail and methodological rigour. Each response must be evaluated precisely to ensure that the results are reliable and valid. This experience has enabled me to develop an attention to detail in checking and double-checking scores to minimise errors and also a methodical approach in following standardised procedures for each test, which guarantees the consistency and comparability of results. Scoring various psychological and cognitive tests has enabled me to acquire specific technical skills. I have mastered assessment tools and developed skills in processing and interpreting psychometric data. What's more, scoring tests independently involves a great deal of responsibility. I learnt to manage my tasks independently, by planning my work and meeting deadlines. I've also learnt to adapt my method of scoring and interpreting tests to suit the particularities of each patient. This experience taught me to deal with the unexpected and to adjust my techniques according to patients' reactions and behaviour during the tests

4. *Therapeutic Appartment*

During my internship, I had the opportunity to intervene with the residents of Le Peyron in order to carry out the evaluation of the PEPsy-Identity study, described above. The participants selected had to belong to the 'chronic' group. In addition to administering the

assessment, I was able to work with a new team of healthcare professionals consisting of a psychologist and a nurse. I had to make direct contact with the residents and plan and manage appointments independently, which strengthened my organisational skills and my ability to work independently. After each assessment session, I held a debriefing with the nurse or psychologist present. This was essential for several reasons. Firstly, these discussions enabled me to obtain additional information about the patients, insights into certain situations, and sometimes perspectives that differed from those of the patients themselves. The nurse and/or psychologist provided important details about the patients' daily lives, their behaviour and their specific needs. For example, she could clarify aspects of the medical history or behaviours observed during interviews, group activities or in the therapeutic flats. This information was crucial for completing the clinical picture and fully understanding the context of each patient. Also, an important aspect of the debriefs was to compare the patients' accounts with the professionals' observations. For example, one resident told me that he had no difficulty carrying out his daily tasks independently and that he was socially active, whereas the nurse revealed that he was in fact isolated and needed daily help with basic tasks such as showering, dressing and housework. This discrepancy between what patients say and what professionals observe is particularly important to take into account when scoring tests. Psychological and cognitive assessments are largely based on patients' self-reports. However, relying solely on these statements can lead to inaccurate conclusions. Debriefing allows information to be cross-checked and scores to be nuanced, ensuring a more accurate and faithful assessment of patients' reality.

This experience at Peyron, as part of the PEPsy-Identity study, has been extremely enriching for my training as a psychologist. It enabled me to develop practical skills, increase

my autonomy and understand the importance of interdisciplinary collaboration in order to achieve optimal patient assessment and management. The central point I would take away from this experience is that comparing patients' self-reports with the observations of healthcare professionals gives a more complete and accurate picture of the clinical situation.

5. BREF

During my internship, I had the opportunity to run several BREF sessions for families, which was an enriching experience on several levels. Firstly, I strengthened my ability to communicate empathetically and effectively with carers. This included not only imparting knowledge about psychiatric disorders, but also actively listening to the concerns and challenges faced by families in their role as carers. By running the BREF sessions, I learned to work with a multi-disciplinary team, including nurses and voluntary workers. I also gained an in-depth understanding of family dynamics specific to psychiatric disorders, as well as practical strategies to help families cope with day-to-day challenges. Overall, this experience has been instrumental in my learning as a psychologist, providing me with an in-depth perspective on the needs and resources of families in their journey with psychiatric disorders.

4. Clinical case

1. Anamnesis

Name: F.

Age: 27

Main diagnosis : Anxiety disorder with agoraphobia.

Other diagnoses: ADHD (attention deficit hyperactivity disorder).

It's important to point out that I don't have F.'s full medical history, as she began attending the Villa ORYGEN several years ago. I did not conduct his first interview.

F is a 27-year-old man with anxiety disorders marked by agoraphobia and a lack of self-confidence. He lives with his mother, who has been diagnosed as bipolar. His parents are separated, but F. has maintained a good relationship with his father, who has been diagnosed as schizophrenic. This complex family situation probably contributed to F.'s fragile emotional stability. F. childhood was marked by hyperactivity, tachycardia and intense stress manifested by tremors and tingling in the face. He was diagnosed with ADHD during childhood. During his school years, F. was also subjected to bullying, which considerably affected his social and emotional development. The experiences of rejection and social isolation probably reinforced his current social anxiety. This school bullying contributed to a persistent feeling of insecurity and lack of self-confidence.

F. currently has severe social anxiety, a lack of self-confidence and recurrent dark thoughts. F. has great difficulty leaving her home. F. has difficulty recognising his own qualities and skills. His self-perception is often negative and he sees himself as inferior to others. He finds it hard to value himself and appreciate his achievements, however small they may be. This low self-esteem is fuelled by past experiences of rejection and a tendency to compare themselves unfavourably with others. As a result, the idea of going out and facing the outside world causes him intense anxiety, often leading him to stay indoors. This reluctance to leave the house is exacerbated by his fear of meeting and interacting with strangers. F. finds it extremely difficult to talk to new people. Every social interaction is perceived as a potentially anxiety-provoking situation, which leads him to avoid social

contact as much as possible. When he is forced to talk to someone, he feels very awkward and his mind is filled with anxious, critical thoughts. He is also very withdrawn and isolated. Social interaction, even with acquaintances, is rare and difficult. F. has few friends. F. is also deeply marked by an omnipresent fear of being judged by others. Every social interaction is accompanied by intense anxiety linked to the fear of being criticised, negatively evaluated or rejected. This fear of judgement is rooted in his past experiences of bullying at school, where he was often mocked and excluded by his classmates. These experiences have shaped his perception of himself and his interactions with others, making him sensitive to all forms of criticism. F.'s lack of self-confidence also manifests itself in his fear of interacting with others. He is constantly preoccupied with the idea of not being up to scratch in conversations, of saying something awkward or inappropriate. This fear leads them to avoid social situations where they might have to talk to new people. This social avoidance feeds a vicious circle: the more he avoids interactions, the less opportunity he has to build up his confidence in his social skills. Relationships are also a particularly intense source of stress for F. He is terrified of being rejected or of not being good enough for someoneThis fear is exacerbated by her lack of experience in this field, which reinforces her feeling of inadequacy. F. fears not knowing how to behave, making mistakes or not being able to maintain a relationship. These fears prevent him from getting close to girls and exploring potential relationships, limiting his opportunities for emotional intimacy and emotional support. The absence of siblings has also contributed to his social isolation, depriving him of the family support that could have fostered more frequent and less stressful interactions. F. has an irrational fear of using public transport. For him, buses, trains and other forms of public transport are unpredictable environments where he fears losing control or being confronted with embarrassing situations.

This fear also extends to driving. F. is afraid to take his driving test for fear of an accident. This anxiety is linked to a general fear of accidents and of the potential dangers he might encounter outside his home. Because of his fears, F. prefers to stay at home, an environment where he feels safe. This voluntary isolation has a negative impact on his daily life. F. does not work and is not involved in any training, which limits his opportunities for social interaction and personal development. The absence of professional or educational activity also contributes to his feeling of stagnation and lack of perspective. In addition, his sleep problems manifest themselves in frequent night-time awakenings and nightmares, accompanied by hypervigilance. He takes a number of medications, including mirtazapine, temestra and abilify, which cause significant side-effects, including weight gain and sleep disturbance. Despite his difficulties, F. aspires to a degree of independence. Eventually, he would like to have his own flat so that he can live independently. For him, this goal is a symbol of personal fulfilment and independence.

2. Problem conceptualisation

According to the DSM-V, anxiety disorder with agoraphobia is characterized by marked fear or anxiety about two (or more) of the following situations:

1. Using public transport (e.g. cars, buses, trains, boats, planes).
2. Being in open spaces (e.g. car parks, markets, bridges).
3. Being in enclosed spaces (e.g. shops, theatres, cinemas).
4. Queuing or in a crowd.
5. Being alone outside the home in other situations.

Individuals fear or avoid these situations because they think it may be difficult to escape or that help may not be available if panic symptoms or other disabling or embarrassing symptoms (such as fear of falling, incontinence, or inability to escape) occur.

To diagnose anxiety disorder with agoraphobia according to the DSM-V, the following criteria must also be met:

- Agoraphobic situations almost always provoke immediate fear or anxiety.
- Agoraphobic situations are actively avoided, require the presence of a companion or are endured with intense fear or anxiety.
- La peur ou l'anxiété est disproportionnée par rapport au danger réel posé par les situations agoraphobiques et au contexte socioculturel.
- La peur, l'anxiété ou l'évitement est persistant, typiquement pendant 6 mois ou plus.
- The fear, anxiety or avoidance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- If another medical condition (e.g. inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety or avoidance is clearly excessive.
- The fear, anxiety or avoidance is not best explained by symptoms of another mental disorder, such as specific phobia, obsessive-compulsive disorder, body dysmorphic disorder, post-traumatic stress disorder or separation anxiety disorder.

In F.'s case, we can ask what therapeutic strategies might be most effective in alleviating her current symptoms and improving her quality of life? Cognitive-behavioural therapies, including exposure, could be beneficial in F.'s case. The most common treatment for social anxiety disorder is CBT, which aims to modify maladaptive behaviours and

cognitions by administering behavioural and cognitive strategies (Hoffman & Smits, 2008). To do this, the process can begin with graded exposures, where F. is gradually exposed to simple social interactions before increasing the complexity of the situations. The use of video recordings of these interactions could be beneficial, as it would allow F. to analyse and understand his behaviours and reactions in real time. This can help to identify anxiety-provoking patterns and to see the progress she is making, thus boosting her confidence in her social skills. Also, CBT teaches deep breathing which may help to reduce F.'s physical symptoms of anxiety such as palpitations and tremors. Encouraging F. to take part in group activities is another important strategy. These activities can improve social skills and reduce her avoidance behaviour. F's problems are complex and multidimensional, requiring an integrated therapeutic approach. This must take into account her past experiences as well as current environmental factors. By combining strategies from exposure therapy, CBT and psychosocial support, it is possible to create a treatment plan tailored to F. This plan would help F. to manage her anxiety, boost her self-confidence and improve her overall quality of life.

3. Consultations

09 April 2024

F expressed a strong desire to be more active and to overcome his anxiety, marked by frequent anxiety attacks. In response, a number of interventions were put in place:

- Positive thoughts notebook: F. is asked to write down positive affirmations and read them regularly to improve his self-esteem. These affirmations can include statements about personal qualities, past successes and future aspirations. This practice has

multiple benefits for patients suffering from anxiety. Firstly, it helps to improve self-esteem. By focusing on the positive aspects of their life and personality, patients can gradually develop a better self-image. Secondly, the positive thoughts notebook helps to reduce negative thoughts, which are often omnipresent in anxious people. By writing down positive thoughts, the patient counterbalances the negative ones and creates a more optimistic mental space.

- Relaxation techniques: introduction to square breathing, a breathing technique for managing anxiety. Square breathing is a deep breathing technique involving a four-step breathing rhythm: inhale for four seconds, hold for four seconds, exhale for four seconds, and hold again for four seconds. Square breathing immediately reduces stress by calming the nervous system and reducing the physical symptoms of anxiety, such as an increased heart rate. It also improves concentration. By focusing on the breathing rhythm, the patient's attention is diverted from anxious thoughts, which helps to calm the mind. By mastering this technique, patients also acquire a portable and discreet tool that they can use in any stressful situation, which is particularly valuable in the day-to-day management of anxiety.
- Activities: online role-playing games, used as a means of improving social skills in a safe virtual environment. Online role-playing games are games in which participants embody characters in virtual worlds, often involving social interaction, collaborative quests and group problem-solving. For a patient suffering from social anxiety, these games offer a controlled and less intimidating environment in which to practise social interaction. This practice can actually improve social skills. By interacting positively with other players, patients gain confidence in their social and decision-making

abilities, thereby increasing their self-confidence. Online role-playing games also serve as a constructive distraction. They allow patients to relax and enjoy themselves, reducing the time spent dwelling on anxious thoughts. By combining entertainment and social interaction, these games offer an engaging way to work on anxiety.

23 April 2024

F. is making progress in managing his social anxiety. He has started to walk more regularly, which shows an improvement in his physical and mental well-being. He is also actively using his positive thought diary. F's social anxiety was assessed using the Liebowitz Social Anxiety Scale, a recognised tool for measuring the extent of anxiety in various social situations.

F identified and prioritised the social situations that caused him the most anxiety. This made it possible to structure gradual exposure interventions. Here are the specific stages identified by F. in descending order of anxiety:

1. Trying to meet someone for the purpose of a romantic or sexual relationship: this situation is the most anxiety-provoking for F, requiring a delicate and gradual approach so that he feels comfortable with the idea of meeting someone with romantic or sexual intentions.
2. Organising a party: the idea of taking charge of organising a party generates anxiety in F. because of the social responsibilities and the fear of judgement.
3. Taking part in small group activities: this remains a significant source of anxiety for F. because of the contact with several strangers.

4. Going to a party: attending a party, even without the responsibility of organising it, causes considerable social anxiety because of the interaction with a large number of people.
5. Talking face-to-face with someone you don't know very well: this situation makes F. feel uncomfortable, but it's essential for improving his communication skills and self-confidence.
6. Meeting strangers: meeting people he doesn't know is an intermediate stage in his exposure programme, designed to reduce his fear of initial interactions.
7. Being the centre of attention: the fact that everyone can look at him and judge him makes him very anxious.
8. Speaking at a meeting without preparation: spontaneous public speaking is too stressful for F.
9. Looking into the eyes of someone you don't know very well: F. feels uncomfortable when he looks into someone's eyes and prefers to avoid the gaze.

7 may 2024

Sleep disturbances persist, with frequent awakenings and general tiredness, but F's mood is rated at 7/10 (0 being the lowest possible mood, 10 being the highest possible mood).

A successful exposure took place where F. chatted with a new trainee nurse, which was filmed for later self-analysis. Exposure therapy is an essential technique for helping patients to overcome their fears and anxieties by gradually and systematically confronting them with anxiety-provoking situations. The basic principle is that avoidance of these situations maintains and reinforces anxiety. By exposing themselves to the feared situations in a

controlled and repeated manner, patients can gradually reduce their anxiety response. This desensitises the person to their fears, shows them that the feared consequences are often exaggerated or irrational, and gives them the skills to manage their anxiety more effectively. In this case, where social anxiety is predominant, F often fears being judged, humiliated or rejected. Exposure can therefore reduce avoidance and modify erroneous beliefs about social interactions by providing positive or neutral experiences. This exposure did not cause any anticipated stress and F. showed a degree of confidence.

For the next appointment I prepared new exposure situations (making a request, paying a compliment, exposing oneself to ridicule) (see appendix).

21 May 2024

F's mood has improved to 8/10, with no dark thoughts and a low level of stress. He has renewed contact with an old friend and is able to leave his house every day. While watching the video of his interaction with the trainee nurse, F. was able to observe his behaviour and reactions objectively. He noticed several positive aspects of the interaction that enabled him to better understand and evaluate his social performance. Firstly, F. was pleasantly surprised to see that he was able to ask questions naturally and spontaneously. He also found that he answered the nurse's questions with ease, which reinforced his perception of his communication skills. Another striking feature was his ability to maintain eye contact; he was able to look his interlocutor in the eye, which is a sign of self-confidence and sincerity in communication. In addition, the fact that he was able to laugh and share light-hearted moments with the nurse was particularly revealing. It showed him that he could not only manage social interaction, but also enjoy it.

During the viewing, F. felt a wave of satisfaction and relief. He had expected to see signs of intense anxiety, such as nervous gestures or marked hesitation in his answers. Instead, he observed a slight shyness, which he recognised as being much less paralysing than he had feared. This distinction between shyness and anxiety was crucial. F. realised that the embarrassment he felt was not insurmountable and that it was part of a normal human reaction to new social situations.

Watching the film had a very positive effect on his self-esteem. By seeing that he could manage an interaction with a stranger without major difficulty, F. became aware of his progress and his abilities.

In conclusion, watching the video was an eye-opening and rewarding experience for F. It not only identified his strengths and progress, but also dispelled some of his unfounded fears. Armed with this new self-perception, F. is now more motivated and confident to pursue his future therapeutic goals, such as participating in group activities and carrying out tasks involving social demands.

4 June 2024

Did not turn up for appointment.

18 June 2024

F reported a relapse by email, indicating an exacerbation of his anxiety, sleep disturbances and dark thoughts. He feels unable to leave his home, which he sees as a significant step backwards in his therapeutic journey.

4. Personal analysis

F. clinical clas has deepened my understanding of several crucial aspects of psychiatry, including the complexity of mental disorders, the fluid nature of recovery and the importance of a personalised approach. F's journey highlights the non-linear nature of recovery in psychiatry. Despite significant progress, relapses can occur, illustrating that recovery is not a linear process but rather a series of ups and downs. This has taught me not to regard relapses as failures, but as stages in the therapeutic process. Relapses provide an opportunity to reassess treatment strategies and reinforce the patient's coping mechanisms. In addition, the support provided to F. showed the importance of adapting interventions to the specific needs of each patient. The techniques used, such as the positive thoughts booklet, square breathing and online role-playing, were chosen according to F's preferences and abilities. This taught me the value of individualising care in psychiatry, where each patient requires a unique and adaptable treatment plan. Seeing F. regain his self-confidence inspired me to persevere and continue to encourage patients even during difficult times. The victory of talking to a stranger and the analysis of this interaction show that these small everyday successes can have a major impact on the patient's self-esteem and overall progress. In this case, despite regular monitoring, exposure and relaxation techniques, relapse was not prevented. What could I have done if I had continued with him? Firstly, it would have been necessary to identify the reasons for the relapse, perhaps there had been a triggering event? Secondly, I think it would have been appropriate to increase the frequency of CBT sessions to reinforce anxiety management techniques, and to introduce more advanced relaxation techniques such as mindfulness meditation. In addition, I could have encouraged F to take part in support groups for people suffering from anxiety disorders. These groups offer a safe space where participants can share

their experiences, challenges and successes. Feeling understood and knowing that he's not alone in his difficulties can strengthen his sense of belonging and emotional support. F. could find practical advice from others who have experienced or are experiencing similar situations, which could improve her ability to manage her symptoms on a daily basis. In addition, these social interactions could help to reinforce her social skills in an understanding and non-judgemental environment, thus helping to reduce her social anxiety. It would also have been beneficial to involve his family more closely in his treatment, in particular by offering psychoeducation sessions to his mother and father to improve family dynamics and support at home.

In conclusion, F.'s initial progress demonstrated the effectiveness of strategies tailored to her specific needs. The improvement in her mood and her ability to re-establish social contacts demonstrated the relevance of these interventions. However, the relapse in mid-June highlighted the continuing challenges and the need to continually adjust therapeutic approaches.

5. Personal Reflection

At the start of my internship as a trainee psychologist at Villa ORYGEN, I was faced with a number of personal challenges that made my integration a little complicated. It took me a while to find my place and feel comfortable. Working as a psychologist, especially at a relatively young age, is often accompanied by a lot of questioning and doubts about one's own abilities. Feeling legitimate in this role is a considerable challenge. In the beginning, I felt insecure about the complexity of clinical situations and the responsibility involved in therapeutic work. Every interaction I had with patients, every decision I made as part of their

care, made me question the relevance of my choices and my ability to really help. This period of adaptation was marked by moments of doubt, when I wondered whether I had enough knowledge and experience to provide effective support. The positive feedback from my tutor and the small victories over time gradually helped me to gain confidence. Accepting that learning and professional growth are ongoing processes enabled me to put these feelings of doubt into perspective and turn them into drivers for personal and professional development. Taking charge of the entire process at the Peyron centre was a turning point for me. This responsibility allowed me to project myself fully into the role of psychologist, by confronting me with the essential practical and decision-making aspects of the profession. Conducting clinical interviews alone also enabled me to develop fundamental skills that will be crucial to my future career as a psychologist. These skills include active listening and empathy, which are essential for establishing a relationship of trust with patients. They enable patients to feel understood and supported, which is vital for effective therapy. By conducting interviews, I learned to listen better without interrupting and to reflect patients' emotions, which strengthened my ability to understand their experiences and needs. I have also developed techniques for asking open-ended questions, rephrasing and summarising what the patient has said, and adapting the framework of my first interview according to the answers obtained. In addition, conducting interviews exposed me to a variety of emotionally charged situations, enabling me to develop strategies for managing my own stress and emotions while remaining professional. This internship has been a truly formative and rewarding experience that has contributed significantly to my professional development. It enabled me to develop essential clinical skills, increase my self-confidence and autonomy, and better understand and adapt to the diversity of patients.

INTERNSHIP REPORT

This internhip gave me a valuable opportunity to feel ready and confident to start my career. The field of psychiatry interested me deeply and raised many questions. One of the themes that particularly challenged me was the boundary between religious beliefs and psychiatry. It's not always easy to distinguish between what is a pathological delusion and what is a sincere religious belief, especially when these beliefs are different from those of the medical staff. This consideration is essential because it directly affects our understanding and interpretation of patients' experiences. Where do we draw the line between a psychiatric disorder and a cultural or spiritual expression? This complex question has enabled me to develop a more balanced approach that respects the various dimensions of patients' lives, which will be crucial in my future practice.

In conclusion, this internship has not only provided me with technical and practical skills, but has also enriched my ethical and cultural reflection on the practice of psychology in psychiatric settings. This learning is invaluable and will guide me in my future career.

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ANNEXE

CESPU
INSTITUTO UNIVERSITÁRIO
DE CIÊNCIAS DA SAÚDE

INTERNSHIP REPORT

Exhibition F

Make a request :

- Go to the tourist office to ask for advice on visiting Nîmes
- Go to the post office to ask how to send registered post
- Going into a clothes shop and asking for advice on buying a garment
- Ask in a shop how to make a loyalty card
- Going into a library and asking how to borrow books
- Asking someone where they bought their shoes because you like them (request + compliment)
- Ask someone for directions, how to get to a particular shop or street

Paying a compliment :

- Tell someone you like their style / how they are dressed
- Tell someone you like their haircut
- Tell someone that you find them friendly, for example the person who gives you advice on visiting Nîmes
- Tell sb. that you find him/her to be a good listener, e.g. the person who advises you on a piece of clothing
- Telling someone that it's nice that he/she is smiling

Exposing yourself to ridicule :

- Asking in a bakery if they bake bread
- Asking passers-by the name of a street while standing right under the street name sign
- Ask where a particular shop is when you're standing right in front of it
- Go into a shop that sells phones and take a selfie with the phones on sale
- Take clothes to try on, go into the dressing room and then say you don't want to try them on any more
- Asking someone to take a photo of you and making faces as they do so
- Ask strangers for a selfie
- Go to a chemist and ask for condoms

Liebowitz Social Anxiety Scale (LSAS) is a questionnaire whose objective is to assess the range of social interaction and performance situations that individuals with social phobia may fear and/or avoid.
It is also a popular measurement tool used by researches to evaluate the efficiency of various social anxiety disorder treatments, including pharmacological trials.
A modified social anxiety scale exists for children and adolescents.

The questionnaire includes 24 items. Each item consists of a given situation, the rate of anxiety (0 to 3 = none, mild, moderate, severe) and the rate of avoidance (0 to 3 = never, occasionally, often, usually).

Situation	Fear	Avoidance
1. Telephoning in public	0	0
2. Participating in small groups	3	2
3. Eating in public places	0	0
4. Drinking with others in public places	0	0
5. Talking to people in authority	2	1
6. Acting, performing, or giving a talk in front of an audience	2	2
7. Going to a party	3	3
8. Working while being observed	0	0
9. Writing while being observed	0	0
10. Calling someone you don't know very well	0	0
11. Talking with people you don't know very well	3	3
12. Meeting strangers	3	3
13. Urinating in a public bathroom	0	0
14. Entering a room when others are already seated	1	3
15. Being the center of attention	3	3
16. Speaking up at a meeting	3	3
17. Taking a written test	0	0
18. Expressing appropriate disagreement or disapproval to people you don't know very well	2	1
19. Looking at people you don't know very well in the eyes	3	3
20. Giving a report to a group	2	2
21. Trying to pick up someone	3	3
2. Returning goods to a store where returns are normally accepted	0	0
23. Giving an average party	3	3
24. Resisting a high pressure sales person	0	0

FIRST INTERVIEW

Date:

SOCIO-DEMOGRAPHIC INFORMATION

Name/First name:

Date of birth:

Primary residence:

Was it your decision to see a psychologist, or did someone advise you to do so?

Why do you think you need psychological follow-up?

Do you have specific expectations from this follow-up?

GENERAL MOOD

How do you feel at the moment?

Suicidal thoughts?

Have you recently experienced periods of intense sadness?

CURRENT TREATMENT

Have you been diagnosed with any illness/disorders? If yes, which one?

Treatment? If yes, which one?

Side effects?

How would you describe your current health?

MEDICAL/PSYCHOLOGICAL HISTORY

Hospitalization/Reasons/Duration:

If yes, how was it experienced?

Family history:

SUBSTANCES

Do you smoke? If yes, frequency?

Do you drink alcohol? If yes, frequency?

Do you use drugs? If yes, which ones? Frequency?

Do you consider yourself to have an addiction? If yes, which one?

PROFESSIONAL LIFE

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INTERNSHIP REPORT

Current job:

How do you feel in your work environment? Relationship with colleagues?

What did you do before this job?

EDUCATION

Have you studied? Which field? For how long?

Did you enjoy it?

Since childhood, how has school been for you? Difficulties? Strengths?

How were your relationships with teachers?

How were your relationships with classmates?

CHILDHOOD

How were your relationships with your parents? Your family?

Social relationships?

Activities you enjoyed doing?

How would you describe your childhood?

Do you have any memories, positive or negative, that stand out?

CURRENTLY

How are your relationships with your parents and family today?

Do you have friends you can count on?

What do you enjoy doing daily? Passions? Hobbies?

Can you give me a schedule of a typical day?

Do you have any plans? Which ones?

SLEEP

On average, what time do you go to bed? Get up?

Do you have trouble falling asleep?

Do you sleep well? Nightmares? Frequent awakenings?

Are you tired when you wake up?

Do you take naps?

DIET

How is your diet? How many meals per day?

Do you cook for yourself?

Do you have difficulties with certain foods? Have you ever made yourself vomit? Used laxatives?

CONCLUSION

Is there anything you would like to add that I might not have thought of?

Do you have any questions?