MAASTRICHT UNIVERSITY

Clinical Activities Report

Stichting Moria

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The Dutch (mental) healthcare

In the Netherlands, four types of healthcare are distinguished: the so called zero line care, first line care, secondary line care, and tertiary line care (Van de Burgt, Van Mechelen-Gevers & Te Lintel Hekkert, 2006). The zero line care consists of consultation clinics and the GGD (*Gemeenschappelijke/Gemeentelijke gezondheidsdienst;* a governmental health organization) which provides with advice or health care even before people report having health problems (e.g. providing vaccination). In the first line care, you can find experts who are broadly trained, for example, general practitioners (GPs), dentists, paramedics, or psychologists. These offer care that is close to the patient's home. The care is offered without need for admission to a clinic, which is referred to as "extramural care" (*extramurale zorg*). Most health care in the first line care can be obtained without a referral by the GP (Van de Burgt, Van Mechelen-Gevers & Te Lintel Hekkert, 2006).

If more specialized health care is needed, one can turn to the secondary line care, where professionals who are specialized in a specific area are found, for example, an ophthalmologist, a dermatologist, or a mental health psychologist. If this specialized health care is needed, a patient must be referred to it by the GP (Van de Burgt, Van Mechelen-Gevers & Te Lintel Hekkert, 2006). In secondary health care, people can be admitted into a clinic to receive treatment, which is referred to as "intramural care" (*intramurale zorg*). The tertiary line care consists of academic centers that offer prominent clinical care. These academic centers usually carry out scientific research next to treating patients (Van de Burgt, Van Mechelen-Gevers & Te Lintel Hekkert, 2006).

The Dutch mental healthcare sector

The Dutch mental healthcare sector (*geestelijke gezondheidszorg; GGZ*) offers assistance to everyone who is suffering from psychological/psychiatric problems or disorders (e.g. burn out, depression, anxiety disorder, addiction, personality disorder, or schizophrenia). Someone who needs help can get it through different sources: an institution connected to the GGZ, or an

independent psychologist or psychiatrist. Because of the different types of disorders (different onset, cause, and expression), different kinds of institutions exist for mental health care (Geestelijke gezondheidszorg Nederland [GGZ Nederland], 2012a).

The GGZ has four main goals/domains: prevention of the onset of psychological disorders, treating and curing psychological disorders, aiding persons with a chronic mental disorder so they can take part in society as best as possible, and providing (unsolicited) help to people who are seriously confused/disordered and/or addicted and who do not seek help themselves (GGZ Nederland, 2012b).

Within these four domains, a distinction can be made based on the severity of the care/treatment. The so-called first line care (*eerstelijnszorg*), can be provided by the general practitioner (GP), a social worker, or the "first line psychologist" (GGZ Nederland, 2012b). This first line care is broad, quick, and easily accessible. The GP refers the patient to a social worker or psychologist in the first line care. If more specialized care/treatment is needed, then the patient is referred by the GP to the so-called secondary line care (*tweedelijnszorg*), the specialized mental healthcare (GGZ Nederland, 2012b). Patients with a rare or extremely complex mental health condition (e.g. depression, eating disorder, personality disorders, or addiction) can also go to a limited number of specialized institutions.

GGZ institutions often have different, specialized departments/sections for children, youth, adults (18-65 years old), and the elderly. There are also special care facilities for forensic mental health care, which are specifically for those who receive treatment mandated by a judge. According to GGZ Nederland (2012b), almost 90% of the patients are treated on an outpatient basis, which means that the patient keeps living at home. If more care is needed, someone can receive part time or day-treatment, which means that he/she goes to the GGZ institution for a couple of days a week (GGZ Nederland, 2012b). Yet another option is the so-called residential treatment, which entails that the patient lives in the clinic or in a protected environment (GGZ Nederland, 2012b).

An important duty of the GGZ is providing acute or urgent help, also known as "crisis care" (*crisisopvang*), where patients can register themselves voluntarily to be admitted to a hospital, or they can be involuntarily admitted (GGZ Nederland, 2012b).

Services for persons with disabilities

Special health care exists for persons with intellectual disabilities. Low intelligence is necessary but not sufficient for the diagnosis of an intellectual disability, and the disability has to be present since youth (Van de Burgt, Van Mechelen-Gevers & Te Lintel Hekkert). Someone is diagnosed with an intellectual disability if the intellectual functioning is clearly below average and if it is paired with disabilities in at least two of the following domains: communication, self-care, the ability to live independently, social and relational skills, making use of community facilities, being able to make decisions independently, health and safety, functional intellectual skills, the ability to fill in leisure time, and work (Van de Burgt, Van Mechelen-Gevers & Te Lintel Hekkert). A distinction is made between mentally retarded (IQ 70-85) and mentally disabled (IQ < 70) persons.

People with an intellectual disability often have other health problems, such as, motor disorders, sensory disorders, epilepsy, and mental disorders. Furthermore, some patients with an intellectual disability also suffer from behavioral disorders/problems (e.g. self-harm, aggression, and/or hyperactivity). Disorders in the autistic spectrum are common as well. These additional disorders/problems determine to a great degree the amount of health care that is needed to treat a patient (Van de Burgt, Van Mechelen-Gevers & Te Lintel Hekkert, 2006).

The health care offered to persons with a disability is gradually built up. If possible, health care is offered on an outpatient basis or at home. If necessary, however, clients will be treated at a specialized facility (Van de Burgt, et al., 2006).

Parents of a child with an intellectual disability receive support and advice during and after the process of diagnosis of their child. This helps them raise and care for their child. Next to health care, additional attention is given to education, work and housing. The amount of care offered depends more on the coexisting disabilities mentioned above, than on the intellectual functioning alone (Van de Burgt, et al., 2006).

Several adults with an intellectual disability live in protected housing where they receive help to live as independently as possible (Van de Burgt, et al., 2006). Housing is usually arranged for them where they receive help from (mental) health practitioners. One can often find different residencies together, housing four to six persons in each residency, close to a major health care institution. Persons living in these residencies are relatively independent; they care for themselves and their home and solve problems on their own or with other residents. Guidance

and support is offered to them a couple of hours per week (e.g., with financial issues). This guidance and support is offered by nurses, psychologists, pedagogues, and social workers; it is directed at increasing independence. Residents have a day job or some other daytime activities. Furthermore, facilities are available for short stay solutions (e.g., weekend or vacation stay), or emergencies (Van de Burgt, Van Mechelen-Gevers & Te Lintel Hekkert, et al., 2006).

Persons staying/living at an institution are usually the ones who have the most severe intellectual disability or coexisting behavior disorder (Van de Burgt, Van Mechelen-Gevers & Te Lintel Hekkert, yearet al., 2006). The institution offers helps with personal hygiene and nursing care, guidance, and treatment. Professionals from different specializations work at such facilities: doctors, doctors specialized in intellectual disabilities, nurses, psychologists, psychiatrists, and social workers. Sometimes patients have daytime activities at the institution itself, and sometimes they go elsewhere to spend their day (Van de Burgt, et al., 2006).

Services for youth

At Youth Care services (*Bureau* Jeugdzorg), it is usually the parents who seek help for their children. Professionals in the first line care have the responsibility of referring the family to Youth Care (GGZ Nederland, 2011). The main tasks of Youth Care can be described as: assessment, treatment and guidance, providing with advice and consultation, and prevention (GGZ Nederland, 2011). Treatment starts with an individual assessment of the patient's symptoms. Interviews are held in which the parents and the child are asked about the nature, severity, and course of the symptoms. The (medical) history of the family and the child are discussed, as well as somatic problems and medication use. Previous assessments (if any) are taken into account and additional psychodiagnostic or somatic assessment is carried out if necessary. Based on these data, the assessor comes to a diagnosis and determines what the best type and amount of treatment should be; a treatment agreement is then made (GGZ Nederland, 2011).

Parents are the ones who are primarily responsible for the upbringing of their child. However, they can receive help and guidance from the Dutch municipalities and health care services. Help is offered through consultation clinics (available from 0 to 4 years old), youth health care services (available from 5 to 19 years old), and the care system at schools (GGZ Nederland, 2011).

Dutch municipalities are also responsible for selective health care prevention services. This selective prevention is meant for groups that, based on a particular predisposition or their (family) surroundings (e.g., having parents with addiction problems), are at risk of developing mental disorders. Children and youth receive courses and training to acquire skills that help them ameliorate their psychological wellbeing (GGZ Nederland, 2011).

Children with less complicated psychological problems can turn to their GP or a psychologist in the first line care. Some GP's also receive the support of mental health care practitioners in order to provide the best mental health care possible (GGZ Nederland, 2011).

In the secondary line health care, Youth Care is offered by nine institutions specialized in child and youth psychiatry and by 32 youth departments at regular health care institutions, offering help to all age groups (GGZ Nederland, 2011). Additionally, there are other (commercial and noncommercial) institutions that offer help to specific groups, in an ambulant manner. Both individual and group treatment takes place. Family therapy has been growing in the last years and recently, so called e-health interventions have been introduced to the secondary line in youth health care.

Admission to a clinic only takes place in extreme cases and is limited to the shortest time possible. One of the goals within Youth Care is to bring down the number of admissions and increase the number of outpatient interventions instead (GGZ Nederland, 2011). Furthermore, there are 23 institutions for sheltered housing (*Regionale Instelling voor Beschermd Wonen; RIBW*) in The Netherlands. These provide sheltered housing for youth up to 17 years old. There are also special institutions that provide help to youth with addiction problems. These different institutions (including sheltered housing) are also available for youth who have previously had contact with the police. Moreover, there are institutions for acute health care in the child and youth psychiatry which provide help 24 hours a day, 7 days a week. This help is meant for emergency situations (GGZ Nederland, 2011).

Judicial and ethical aspects of healthcare services

Act on professions in individual healthcare

In The Netherlands, there is an Act on professions in individual healthcare, called *Wet-BIG* (*Wet op de beroepen in de individuele gezondheidszorg*). This act is intended to promote and ensure the quality of practice of all professionals working in the healthcare sector. All psychiatrists, psychologists, and psychotherapists who wish to work as a mental healthcare practitioner, should register with the BIG (in their own professional register). In doing so, they can prove, if necessary (e.g., to the patient), that they are qualified professionals (Wet BIG, 1993; art. 3). Psychiatrists, psychologists, and psychotherapists can only register with Wet BIG if they have the necessary training and qualifications (Wet BIG, 1993; art. 18, 24, and 26). If a (mental) health practitioner does not act in accordance with his profession, or if he puts his patient/client in danger, he will be subjected to disciplinary proceedings (Wet BIG, 1993; art. 47).

The code of conduct of the Dutch Institute of psychologists

The Dutch Institute of Psychologists (*Nederlands Instituut van Psychologen; NIP*) has a code of professional conduct which all registered psychologists should abide by. This code serves as a guideline to carry out the occupation as a psychologist as professionally as possible (NIP, 2007). If a psychologist finds himself in a situation in which two separate clauses of the code are in conflict with each other (and therefore one clause cannot be followed without disobeying the other clause), he has to consider the consequences when following each clause, without following the other (NIP, 2007). Furthermore, in such a situation, he should consider consulting colleagues in order to make the best decision. When obeying a clause is in conflict with a specific law, psychologists are obliged to follow the law and disobey the clause. In this case, the psychologist should strive to obey the remaining clauses of the code of conduct as well as possible (NIP, 2007).

Four basic ethical principles can be found in the code of conduct: responsibility, integrity, respect, and expertise. These four basic principles form the basis of the clauses within the code of conduct. Psychologists must follow these principles in order to carry out legally responsible and ethical practice.

Responsibility. The principle of responsibility entails that psychologists recognize their professional and scientific responsibility towards the persons involved, their surroundings, and to society in general. Professional and ethical standards should always be followed. Psychologists are responsible for their behavior while practicing their profession. Furthermore, they should always prevent and limit any damage to the persons involved. Psychologists also have the task to do everything in their power to prevent the use of reports for any other purpose than the original purpose it was created for. The purpose of a psychological report should always be mentioned in a report, as well as the fact that a report is confidential. Moreover, a psychologist has the responsibility of maintaining records of his professional activities and taking accountability of these activities (i.e. being responsible for his own professional activities). After ending the relationship with a client, the psychologist has to keep the client's file for a year (or whatever period is necessary or legally established); it should never be kept longer than the agreed upon period (NIP, 2007). According to the law regarding medical treatment agreement (*Wet op de geneeskundige behandelingsovereemkomst; WGBO*), the psychologist has to keep the client's file for the duration of 15 years in criminal cases (*Nederlandse Vereniging voor Psychiatrie* [NVVP], 2009). If a complaint is filed against a psychologist, he will do everything in his power to cooperate and will answer questions posed as best as possible (NIP, 2007).

Integrity. With the principle of integrity is meant that psychologists are honest towards those involved (i.e., do not mislead or give unrealistic hope regarding the results of the treatment) and treat everyone equally. Furthermore, psychologists have to be clear about the role they fulfill in the relationship with those involved and they should keep to that role. Psychologists have to recognize the difficulties that can arise when fulfilling different simultaneous or consecutive professional roles with respect to one or more persons involved. Such a situation should be avoided, if possible. Professionals in the field of psychology should refrain from any sexual behavior towards or with a client. Psychologists should only commence and continue a relationship with their client if it can be accounted for in a professional and ethical manner. As soon as there is no reason to continue the professional relationship, the psychologist should end the relationship and communicate this clearly to the client, making sure there are no ambiguities regarding the relationship.

Respect. The principle of respect entails that all psychologists respect the fundamental rights and dignity of those involved, independent of the client's sex, race, political affiliation, or

sexual orientation. Psychologists should not invade the client's personal life, any more than is strictly necessary for the purpose of the professional relationship with the client. They should respect the right to privacy and confidentiality. They should also respect and promote their client's self-determination (i.e., their right to start, continue, and terminate the professional relationship) and autonomy; as long as it is compatible with other professional obligations and with the law. If the client's self-determination is limited (e.g., due to age, psychological development, a client undergoing court-mandated treatment), the psychologist should respect the client's self-determination as best as possible. If the client wishes to see or to receive a copy of his/her file, the psychologist has to concede and give any necessary explanation regarding the psychological file. If a psychologist has to report to a third party (e.g., court), the client has the right to see the report before the court does and to receive a copy of it. If the client notices any factual mistakes in the report, the psychologist has to amend these or make a note of it within the report; this is not the case for results or conclusions the psychologist reports; these will not be amended. Furthermore, psychologists should treat all information they receive from a client as confidential information. This confidentiality may be broken if the psychologist believes that it is the only way (and last resort) to prevent acute danger to the client or to others. Confidentiality may also be broken if the law stipulates it or if a court decision has been made forcing the psychologist to break it.

Expertise. This principle entails that psychologists strive towards acquiring and maintaining a high degree of expertise in their professional conduct. They are aware of the limits of their expertise and of their experience. Furthermore, psychologists only offer those services for which they are qualified and sufficiently trained.

Involuntary admission to a clinic

In the Netherlands, the Compulsory Admissions Act (*Wet bijzondere opnemingen in psychiatrische ziekenhuizen; Bopz*) contains information regarding compulsory admission to a psychiatric hospital. The most important objective of this act is to protect the rights of those who are committed to a hospital against their own will. According to the Compulsory Admissions Act, one may be admitted to a psychiatric hospital against his will if that person is suffering from a mental disorder that constitutes a danger to the person, and the danger can only be averted inside a psychiatric hospital (Ministerie van Volksgezondheid, Welzijn en Sport [VWS], 2000,

p.5). In order to admit someone to a hospital, an authorization must be issued by a court, based on the requirements above. Such an authorization is needed if the person in question is not willing to be admitted (or is not willing to prolong admission) and if he is older than 12 years. It is also required if parents/guardians refuse to admit their child to a clinic or if the parents have different opinions about it (VWS, 2000).

A request for such an authorization of admittance can be made to the court by the spouse, the parent(s)/guardian, or by any adult blood relative. This request must be accompanied by a declaration written out by a psychiatrist who has recently examined the individual for this purpose, but who has not otherwise been involved in his treatment (VWS, 2000). If admittance has to be prolonged, such a request is accompanied by a declaration by the medical director of the hospital where the patient is held (VWS, 2000).

A different, quicker procedure exists for urgent situations. If a person constitutes an immediate danger, and there is no time to await the authorization of the judge, the mayor can order a provisional admission to a psychiatric hospital. Additional conditions must be met, however: there has to be reason to believe that a mental disorder is causing the person to be dangerous and that the danger cannot be averted by the intervention of persons or institutions outside a psychiatric hospital (VWS, 2000). The mayor shall not order provisional detention without a declaration of a psychiatrist or a physician stating that there indeed is immediate danger. The mayor shall inform the public prosecutor of the provisional detention he ordered, as soon as possible (VWS, 2000). If the public prosecutor considers that there is indeed reason to admit the person to a hospital, he shall then apply to the court to grant an authorization extending the provisional detention. This order extending provisional detention shall remain in force for three weeks following the date of issue (VWS, 2000).

The Netherlands makes a distinction (in law) between compulsory admission and compulsory treatment. One is not allowed to give compulsory treatment solely because one is admitted to a psychiatric hospital; other criteria are required for compulsory treatment (VWS, 2000). One of the reasons for making a distinction is to be in accordance with human rights legislation.

Once a person is admitted to a psychiatric hospital, the person responsible for his treatment shall draw up a treatment plan, in consultation with the patient (VWS, 2000). If, prior to his admission, the patient was treated elsewhere, the person responsible for his treatment shall

consult the institution or psychiatrist who treated or counseled the patient. The GP should be consulted as well. If the person responsible for treating the patient should decide that on the grounds of the mental disorder, the patient is not capable of determining his own will with regard to the proposed treatment, the person responsible shall discuss the matter with the legal representative of the patient, with any person possessing written authorization from the patient for this purpose, with the patient's spouse or blood relative (VWS, 2000). If the consultation regarding the treatment plan has not led to agreement or if the patient objects to it, no treatment of the patient may be instituted (VWS, 2000). Notwithstanding the previous two sentences, a proposed or agreed treatment plan may be instituted in so far as this is absolutely necessary to avert grave danger to the patient or others arising from the patient's mental disorder (VWS, 2000). Furthermore, any necessary treatment may be implemented even without consultation if there is an emergency situation caused by the patient. The means and methods of such treatment shall be designated through an order in council. The order shall lay down maximum periods of time during which the said methods of treatment may be undertaken (VWS, 2000).

If the danger arising from the mental disorder of a patient admitted to a psychiatric hospital has decreased to such an extent that his temporary return to the community is justified, the medial director shall, in so far as this is in the best interests of the patient, grant him leave to depart from the hospital for a stated period of time (VWS, 2000). Leave for a continuous period of more than 60 hours may not be granted more than twice per year, and for not more than two weeks on each occasion.

As soon as it is no longer necessary to admit a patient against his will (the patient is no longer dangerous or the danger arising from the disorder can be averted by an intervention outside of the psychiatric hospital), the medical director shall grant discharge from the hospital (VWS, 2000). Someone will also be discharged if the authorization to admit him expired, unless a new authorization has been submitted (VWS, 2000).

Admittance to a psychiatric clinic in the forensic setting

Some persons are admitted to a psychiatric clinic against their will on the grounds of a judgment handed down by a criminal court. Dutch law states that if, due to a mental disorder, a person bears no or diminished responsibility for the crime he committed, he can be admitted to a maximum security psychiatric clinic (Article 37a, section 1 of the Dutch Criminal Code [DCD]).

Another requirement for such a decision is that the person constitutes a danger to society because of his disorder, and to protect society, is therefore admitted to a clinic (Article 37a, section 2 of the DCD). This can be done through the so called TBS (*Ter Beschikking Stelling*) measure. The TBS measure can only be imposed if the person involved committed a crime for which the prison sentence would usually be 4 years or more. TBS can be combined with a prison sentence, which is imposed for the part of the crime for which the offender does bear responsibility (Van Marle, 2002). The length of stay in a TBS facility is two years; after which the court evaluates whether the TBS measure should be prolonged (Van Marle, 2002). Therefore, a person stays in TBS as long as he is considered dangerous.

Note that, as in the "regular" compulsory admissions Act (Bopz), TBS patients can be admitted to the clinic against their own will but cannot be treated against their will. Compulsory treatment may only be imposed if a patient constitutes a danger to himself or to others around him (Van Marle, 2002).

Another measure, the "conditional TBS", makes it possible to impose TBS without having to admit a person to a maximum security hospital, rather offering ambulantory treatment (Van Marle, 2002). It is important for a conditional TBS that the perpetrator is motivated to undergo treatment. It is the probation officer's responsibility to monitor adherence to treatment and potential risks of recidivism (Van Marle, 2002). If someone stops going to treatment while under conditional TBS, it counts as a violation of his conditional sentence.

Description of the internship setting

Organization and structure of the institution

Stichting Moria was founded by the Sisters of Julie Postel and the Marist Brothers in 1994 and these congregations are now still in the Board of Directors. The Brothers of Utrecht are also part of the Board of Directors of Moria, since 2005 (Stichting Moria, n.d., b). Stichting Moria is an assisted living project for the social reintegration of (ex) young male prisoners (ages 18-30). It is Moria's mission to work together with the client towards a new future; looking at each individual client and his needs (Stichting Moria, n.d., c).

The Board of Directors broadly sets the policy of Moria and advices the managing director with regard to his task of the everyday management of Moria. The Board of Advice

gives advice to the Board of Directors regarding policy making and implementation (Stichting Moria, n.d., d). For more information about the organization of Stichting Moria, see Figure 1.

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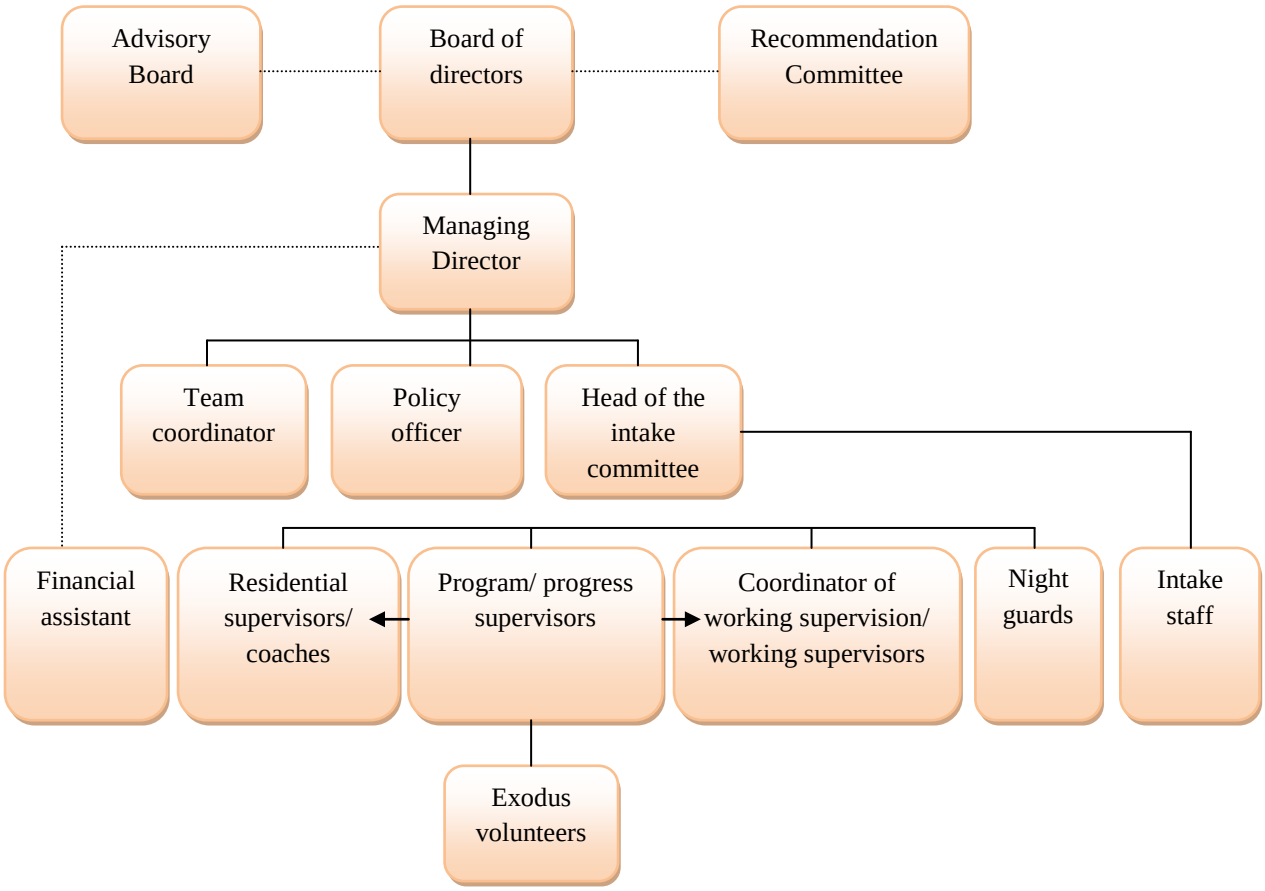

Figure 1. Organization Stichting Moria

Population group

The population group at Stichting Moria consists of (ex) detained men between the ages of 18 and 30 years. Motivation to participate is an important condition to take part in the program. The presence of a current, serious addiction problem will be a reason to reject someone who wants to join Moria. However, Moria is currently accepting more clients with addiction problems. Furthermore, conviction of a severe (aggressive) crime or of a sex offence will be reason for rejection as well (Stichting Moria, n.d., d). A client can sign up with Moria on a completely voluntary basis, or he can join on the basis of a judicial title (Stichting Moria, n.d., h).

Referrals

If a client wishes to sign up with Stichting Moria, it is best if he is referred by someone else, for example his probation officer or a social worker. Three forms should be sent to Moria (Stichting Moria, n.d., e), one sign-up form filled out by the referrer, one sign-up sheet filled out by the client, and a form in which the client states that he does not object to:

- providing information about himself, his (family) history, and his past living conditions;
- Moria collecting this information at the Dutch Probation Office (*Stichting Reclassering Nederland*);
- Moria requesting psychological/psychiatric reports from the court or previous mental health providers, if necessary.

After Moria has received these three forms, the intake committee at Moria assesses whether the client is eligible for a first interview, which preferably takes place at Moria. After the first interview, the intake committee reviews whether a second interview is needed. If, after the second interview, the decision is made to accept the client into the program, Moria contacts the referral source regarding the steps that need to be taken in order to transfer the client to Moria (Stichting Moria, n.d., e).

The intake committee consists of three employees: a clinical psychologist, who makes sure that the right approach is being taken during the interviews and who is responsible for the decisions that are ultimately made; and two interviewers that are responsible for holding one of the two interviews each (Stichting Moria, n.d. e).

Types of problems being treated

Stichting Moria offers each client individual and intensive guidance. With the help of a program/progress supervisor, each client learns how to cope with problems in different life domains, such as:

- Living
- Working
- Social skills

- Friends and family
- Debts and learning how to deal with money
- Filling of leisure time
- Continuity of (mental) healthcare

Stichting Moria also works with different institutions (such as forensic mental health clinics) to offer and achieve the best help within the re-socialization program for each client (Stichting Moria, n.d., a).

Methods and procedures used for diagnosis

Until recently, Stichting Moria used no structured instruments for diagnosing the clients. Rather, the procedure consisted only of formulating an Individual Work Plan (IWP) for each client. This IWP is set up with the client in order to offer each client a "tailored" program that fits his individual needs (Stichting Moria, n.d., f). The information used for the IWP is gathered during the two interviews of the intake phase and during the first four weeks of the client's stay at Moria (Stichting Moria, n.d., f).

In September 2011, Stichting Moria introduced a procedure of assessment for every new client coming in to participate in the program. The psychological assessment is now carried out by a Master's student in Forensic Psychology from Maastricht University, under supervision of Prof. Dr. Corine de Ruiter, licensed clinical psychologist BIG. The assessment procedure consists of a structured interview with the client (interview belonging to the *Psycopathy Checklist-Revised*; PCL-R), the administration of a personality inventory (the *Minnesota Multiphasic Personality Inventory 2*; MMPI-2), and risk assessment based on scientific tools for risk assessment (the HCR-20 and SAPROF). If, based on the interview and the MMPI-2, additional tests are required (e.g., an intelligence test such as the WAIS-III), these will be administered as well. A report is then written and advice regarding treatment and supervision is provided. (For more detailed information regarding the procedure, see section "Own clinical activities during the internship").

Treatment

Until September 2011, treatment/guidance was solely based on the IWP, in which the client sets his own goals and thinks about the steps he needs to take to achieve those goals. Different kinds of training are offered to clients (e.g., social skills training, budget training, professional skills training), depending on what type of training they need (Stichting Moria, n.d. f). These trainings are especially given internally but can be external if needed.

Guidance and supervision at Moria is intensive and is characterized by an individual approach; the focus of attention during a program at Moria is the client himself (Stichting Moria, n.d., f). At Moria, clients can expect to have guidance from the coaches on a day-to-day basis. The approach Stichting Moria takes for the treatment/guidance of their clients is based on the notion that criminal behavior is not caused by a single factor, but by different factors that interact with each other (Stichting Moria, n.d., f). Therefore, their approach is a "total approach" concentrating on different life domains as mentioned above.

Phases of treatment

The program at Moria consists of three phases in which the client gradually works towards reintegration into society. The three phases consist of the exploratory phase, the internal phase, and the external phase.

Exploratory phase. Moria's property consists of a grand villa where the clients reside during the internal phase of their program. The first phase is the exploratory phase which constitutes the first four weeks after the client is (conditionally) admitted to the program (Stichting Moria, n.d., g). In this phase, an assessment is made of the client's needs and problems he has to confront. Attention is also paid to the problems the client thinks he is going to face when going back to living in society. This is the phase in which the IWP is set up for the rest of the program. A possibility exists that Moria decides in this phase that the client will not be able to receive necessary guidance/training at Moria. If this is the case, the client will no longer participate in the program (Stichting Moria, n.d., g).

Internal phase. During the internal phase, the client stays in the villa of Moria in Nijmegen and with intensive guidance/training learns how to independently run a household and works towards his goals (Stichting Moria, n.d., g).

Clients at Stichting Moria are stimulated in different ways to think about their future. Work plays an important role in this. Moria tries to get the client to familiarize with different sorts of occupations so he can get the chance to discover what his specific interests and qualities are (Stichting Moria, n.d., g). Once he has an occupation in mind, the working supervisors help the client search for adequate training required to be qualified for the specific occupation or help him get in contact with an employer. Moria has a wide network of institutes who offer training and a network of employers who know Moria (Stichting Moria, n.d., g). For training and work, motivation of the client is essential.

Many of the clients who start the program at Moria have existing debts which they need to repay. Moria helps them to achieve a future without debts and therefore pays a lot of attention to this through, for example, budget training (Stichting Moria, n.d., g).

The circle of the client's friends and family is analyzed together with the client. A discussion is held regarding the positive or negative influence of certain friends or family members. The clients are then taught how to start and maintain healthy relationships (Stichting Moria, n.d., g).

Another important domain to which Moria pays attention, is filling of leisure time, so clients have something to do when they feel bored (instead of committing a crime). Clients learn to carry through with positive leisure activities, especially during hard times. They also learn which ways are best to relax, for example working out, playing music, or carrying out another hobby (Stichting Moria, n.d., g).

External phase. If the personal goals for the internal phase (stated in the IWP) are achieved, clients transfer to the external phase, where they move into their own house in the city and live independently (Stichting Moria, n.d., g). During the external phase, the guidance/training of the clients is gradually reduced until they reach the point where they can live independently (i.e., without the help of Moria staff). The external phase also lasts a maximum of one year. Once the client receives no more help from Moria, he gets the opportunity to sign a lease for his home with his own name and finishes the Moria program (Stichting Moria, n.d., g).

Professional disciplines at Stichting Moria

There are four professional disciplines at Stichting Moria: residential supervisor/coach, program/progress supervisor, working supervisor, and intake interviewer. In every discipline, different activities are performed.

Residential supervisor/coach.

The residential supervisor/coach takes responsibility for the daily activities at the Moria villa (for example, making coffee and cleaning up after meals). A residential supervisor/coach is required to make sure that clients are adequately carrying out their household activities, such as cleaning. He/she also helps clients do their groceries and helps them cooking. Whenever possible and necessary, a residential supervisor/coach will have conversations with clients and give them advice.

Residential supervisors/coaches also take the role of mentor for the clients. Each client has a mentor with whom weekly conversations are held. Clients can turn to their mentor whenever they need (emotional) help with something.

Program/progress supervisor.

A program/progress supervisor is responsible for monitoring the progress a client makes during his program. Also, an important domain a program/progress supervisor helps the client with, is finances and debts. If necessary, he/she will give the client budget training so he can learn how to deal with money.

Working supervisor.

A working supervisor at Moria has the responsibility of making sure the client has daytime activities to fill every day of his week (Monday through Friday). He will teach the client skills, such as carpenter skills, gardening skills, and welding. It is also the working supervisor who puts the client into contact with a potential employer or with training needed for the occupation the client wishes to fulfill.

Intake interviewer.

The intake interviewer has the responsibility of gaining as much (relevant) information as possible during the first or second interview. Furthermore, the intake interviewer has the task of making an overview of the problems the client may or may not have (e.g. aggression, addiction, debts). He/she will then use this information to decide whether a client can be admitted or not.

The role and function of a psychologist at Stichting Moria

There is one clinical psychologist working at Stichting Moria, who is the head of the intake committee. She makes sure that the right approach is being taken during the intake interviews and is responsible for the decisions that are ultimately made with regard to admitting a new client or not.

At present, there are no other psychologists working at Moria. However, the activities performed during the internship, are activities that may perhaps later be performed by a psychologist.

Own clinical activities during the internship

My clinical activities during the internship consisted of the following:

- Administering/scoring assessment tools
    - Interviewing clients using the interview belonging to the Psychopathy Checklist-Revised (PCL-R). On average, each client was interviewed twice, each session lasting approximately two hours.
    - Scoring the PCL-R
    - Scoring risk assessment tools (HCR-20 and SAPROF)
    - Administering, scoring, and interpreting the MMPI-2
    - Administering, scoring, and interpreting the SCID-II
    - Administering, scoring, and interpreting an intelligence test (Wechsler Adult Intelligence Scale-III; WAIS-III)

    - Administering, scoring, and interpreting a projective test (Thematic Apperception Test; TAT)
    - Administering, scoring, and interpreting a neuropsychological test (*De Vijftien Woorden Test;* 15WT, or 15 words test)
- Interviewing employees regarding the (behavior of the) client who is being assessed
- Making a diagnosis and a risk assessment based on the interviews (both with the client and the employees) and the results of the assessment tools
- Giving treatment advice based on the results of the assessment tools
- Writing a comprehensive report (for Stichting Moria and the client) incorporating all of the above
- Summarizing the results of the assessment tools and the treatment advice
- Returning the report to the client, answering any questions he may have about the report and explaining any ambiguities
- Presenting the report to the team of employees at Stichting Moria

In total, I interviewed, assessed and wrote reports on five clients. The SCID-II, the WAIS-III, the TAT, and the 15WT were each only used with one client (different clients for each instrument); all remaining instruments were used with all clients. Furthermore, for each client, I interviewed three employees, namely, the mentor, the program/progress supervisor, and the working supervisor of that particular client.

The clinical activities at Stichting Moria were performed under the clinical supervision of Prof. Dr. Corine de Ruiter. Supervision was provided during a meeting at Maastricht University once every two weeks. Furthermore, I also received advice and feedback through e-mail. Since my clinical supervisor was not present at Stichting Moria itself, I had another supervisor working at Stichting Moria. She is the only clinical psychologist present at Moria.

Learning goals

Learning goals at the beginning of the internship

1. I have good interviewing skills.
   - I can interrupt an interviewee in a subtle manner.
   - I know when it is necessary to ask secondary questions and when it is not.
   - I know how to motivate the interviewee to be as open and complete as possible.
   - I know how to deal with short and vague answers and I can stimulate the interviewee to be more detailed/descriptive.
   - I can smoothly change from one subject to another.
   - I can respond properly to what an interviewee tells me.

2. I have the skills to score/interpret the different psychological instruments adequately.
   - I can score/interpret the instruments accurately.
   - I can score/interpret the instruments within an appropriate amount of time.
   - I am able to independently decide if and which psychological instruments should additionally be used (next to the standard test battery).

3. I have the skills to translate the results of the psychological tests into an adequate treatment advice.
   - I can construct a clear advice that can be deduced from the results of the instruments.
   - I can present the advice to the (group of) coworkers at Stichting Moria.

4. I am able to present the results of the psychological instruments.
   - I can write a comprehensive report, understandable for the client as well as the co-workers at Stichting Moria.
   - I can present the results of the instruments in a manner that is understandable for the client.
   - I can present the results of the instruments in a manner that is understandable for the co-workers at Stichting Moria.

5. I can work in a well-structured/organized manner.
    - I can make a fairly accurate estimate of how much time it will take to complete a test battery (including interpretation).
    - I can make a fairly accurate estimate of how much time it will take to complete a report.
    - I can work efficiently.

Evaluation of the learning goals at the end of the internship

1. I have good interviewing skills.

During the first interview I conducted, I was not able to interrupt an interviewee in a subtle manner. I did not know when to interrupt and I felt uncomfortable doing it. As a result, the interviewee took charge of the interview and kept on talking and repeating things he had already mentioned. This led to the interview lasting almost 8 hours, instead of the desired 3 hours. Although I still felt somewhat uncomfortable interrupting during the last interview, I could manage it in a better way. For example, if the interviewee repeated something he had already said, I would let him know I understood what he was saying and asked the next question. Or, if he went off topic after already having answered my question, I interrupted, paraphrasing him, and asked the next question.

At the beginning of the internship, I was not able to decide whether or not it was necessary to ask secondary questions. Later on, as I held more interviews, I started to understand which information was important and when I should ask more questions. This I learned when scoring/interpreting the different instruments and when writing the reports (I remembered what information was crucial). After the first interview, I still had many unanswered questions that I had to ask the interviewee again, at a later time. For the second interview, I only had 4 unanswered questions and for the last interview, I was only left with one. However, after receiving feedback from my supervisor, I found out that there was still missing information in every report. I think that experience in the future will help me to better know when to ask questions and which questions to ask.

Furthermore, I had difficulty motivating the interviewee to be as open and complete as possible. I found it hard knowing how to deal with short and vague answers and stimulating the

interviewee to be more descriptive. During the first interview, I was satisfied with very short answers or with, for example, the following answer: "I do not want to talk about that". I would just leave it for what it was and go on with the next question. My supervisor at Stichting Moria gave me some advice on how to handle this. She said I could ask why he did not want to talk about something and stress that the information he gave me was confidential, reassuring him it would not leave Stichting Moria. During the next interviews, I did this and the result was that the interviewee felt more comfortable providing more (detailed) information. However, not all interviewees reacted this way and some still refused to give more information. It would be good to practice this skill more in the future.

I also found it hard to smoothly change from one subject to another. It felt uncomfortable to change the subject and this led to me saying "uhhhh" and/or pausing for a long time between subjects. This made the interview go slow and I think I lost interest and motivation from the interviewee when doing that. Every time before conducting an interview I tried to remind myself to paraphrase the interviewee to make the change of subject smoother. Unfortunately, I did not succeed in this. Therefore, I still have to work on this in the future.

Finally, I was not able to respond properly to what an interviewee was telling me, especially when the topic was emotional, especially during the first interview. When the interviewee told me about a traumatic event in his life, I did not know how to respond and therefore only said, "that must have been hard on you". Afterwards, I realized I should have asked more questions and should have asked what the consequences were for him and his family. Most importantly, I should have asked how he coped with the traumatic event. During the fourth interview, I did ask more questions, while still showing empathy. The result was that I got a better understanding of the event and its consequences for the individual. For example, I learned how the interviewee felt about the event and how he coped with it.

Overall, I think I have learned much about interviewing a client; I gained better interviewing skills. However, there is still much for me to learn. I think the most important thing for me to learn is to let the interview flow easily, so it comes across "natural" to the interviewee. Furthermore, the ability of asking good secondary questions that render crucial information is a skill I can especially learn by experience.

2. I have the skills to score/interpret the different psychological instruments adequately.
After receiving feedback on the scoring of the PCL-R, HCR-20 and SAPROF, I found that I had performed better than I expected. I was prepared for many comments provided by my supervisor at Maastricht University and thought there would be many corrections of the scores. However, these were less than expected. I found the interpretation of the MMPI-2 more difficult and this was recognizable in the feedback I received. I especially had difficulty phrasing sentences and selecting important information that fit the MMPI-2 profile, but also fit the respondent. When interpreting the MMPI-2 profile of the first candidate, I only looked at the whole profile, ignoring the scores on specific items/subscales and ignoring what I knew about the candidate. In later cases, I did take this into account. Nevertheless, I still find it difficult phrasing the sentences of the interpretation of the MMPI-2.

The scoring of the first PCL-R took me at least 16 hours. This is because I watched back almost all of the video recordings. I had not typed anything the interviewee told me during the interview itself so I could not remember all of the information he gave me. However, afterwards, I realized that there was no reason to watch back everything. I found it hard to pick out the most important information. During the next interviews, I did type most of the information and this made watching back the recordings less tedious. I first scored the PCL-R, and if I found I was still missing information, I tried to only watch back those parts of the interview that provided the missing information. However, I still found myself watching back too much after the second and the third interview. When watching the recordings, I was sometimes afraid of stopping it and going to the next part. I was afraid that I would be missing critical information after all. After the two last interviews I only watched those parts of the recordings that provided the missing information and I felt confident that I had enough information. The scoring of the last PCL-R only took me 4 hours.

The scoring of the HCR-20 and the SAPROF for the first case, took me around 6 hours each. I still had to get used to the SAPROF, because I had never used it before. After doing it a couple of times, I became more accustomed to the instrument and I could score it faster. The last scoring of the HCR-20 and the SAPROF took me 2 hours each. I needed around 10 hours to write the interpretation of the first MMPI-2 profile. I found myself putting too much time into the interpretation of the validity scales (4 hours); I was wondering where my time had gone. For the interpretation I used a book written in English. I found it hard to both summarize and

translate the information in the book. Therefore, I started translating the whole text and then summarizing it. Afterwards, I realized this was a waste of time and that I had to find a different way to do this. For the interpretation of the second MMPI-2, I wrote down keywords in English and then put it together into a whole text in Dutch. Although this was a lot faster than in the first case, I still found it difficult to translate the keywords. For the interpretation of the last MMPI-2 profile, I needed 4 hours. Especially the interpretation of the validity scales went a lot faster. I think this is because I got used to the way I had to interpret them.

My last learning goal was: "I am able to decide if and which psychological instruments should additionally be used." During my internship, I have used four additional psychological instruments. The first one (SCID-II) was advised by my supervisor, and I used the instrument in order to diagnose a personality disorder. I used the WAIS-III because the candidate asked for it. The remaining two (TAT and 15WT) were advised by my supervisor as well. Therefore, I must conclude that I was not able to decide if and which psychological instruments should have additionally been used.

3. I have the skills to translate the results of the psychological tests into an adequate treatment advice.

For the first case, I found it extremely difficult to write a treatment advice. I felt I had no idea what an adequate treatment would be. My supervisor told me which treatments would help the candidate and therefore I did not come up with the treatment advice myself. For the second report, I could use similar treatment advice as in the first report, which made writing the advice fairly easy. In the next reports, I could give treatment advice that fit the candidate and my supervisor provided me with additional ideas. According to my supervisor, the advice I gave in the last case, was excellent and showed improvement compared to the first. Therefore, I think I have reached this goal.

When presenting the advice to the team at Stichting Moria, I received the feedback that the advice was clear and that they could deduce it from the results. However, they found it difficult to translate the advice into concrete plans for the client. For example, it was unclear what kind of role playing could help someone increase his empathy. Questions that came up were: "Should a professional carry out the role playing? Or is the team at Stichting Moria capable of doing it?" Perhaps I could make the advice more concrete in the future.

4. I am able to present the results of the psychological instruments.

According to the co-workers at Stichting Moria, my first report was clear and provided them with some information about the candidate that was not yet known to them. Furthermore, the presentation of the results to the team was clear as well. However, the co-workers proposed that, for a better presentation, I should try not to use specific terminology, or if I use it, that I should explain more clearly what the terminology means.

5. I can work in a well-structured/organized manner.

At the beginning of the internship, I did not work with a schedule and "just" started working instead. The result was that I took a lot of time to score/interpret the instruments and to write the report. A lot of time was also spent reading the case file and making notes. I spent days working, without really knowing how much work I was doing in how much time. After about two months, I started working with a schedule, trying to estimate how much time every part of the report would take me. I somewhat overestimated how much work I could do in a specific time slot at first. I therefore started writing down how much time every section took me. This helped me to estimate the needed time for the next reports. At the end of the internship, I still overestimated myself, but I was able to make a more realistic estimate.

To test whether I am able to work efficiently, I started writing down how much work I could do in how much time. I wrote down the "net time" to see how much time I spent doing other things. It turned out that this was quite a lot, about one third. By also scheduling in breaks, I managed to lower this to $1/4^{th}$ – $1/5^{th}$ of the total time.

Case description (psychological assessment)

Client details

Name Mr. A

Sex Male

Age 23

Interviewing sessions

Life course

Mr. A and his 4 year older stepbrother were raised by his mother and his stepfather. Later on during the assessment period, it became clear that Mr. A also has a sister. However, he never mentions her in any of the interviewing sessions. His parents' occupation when he was growing up is unknown. Mr. A indicates during the interviews that he rather not talk about his family because he wants to leave them out of it; he says he is willing to talk as long as necessary about himself. According to Mr. A, there was a lot of violence going on in the neighborhood where he grew up. At the age of 12, his mother and stepfather separated. He then first went on to live with his mother. However, he was sent to a boarding-school because of his behavior (at age 13). He says he did not like it at boarding-school because they were too strict. Two months after having lived there, his stepfather decided to go get him and took Mr. A to live with him. Mr. A says that he did not see his mother for two years after that; because he did not want to (he blamed her for "everything"). Regarding the relationship with his brother, he says that he could get along with him but that he did not have any real bonding with him because his brother was a junkie. At the moment, he does not have any contact with his brother, who is currently in prison in the United Kingdom. As a child, Mr. A enjoyed causing mischief in his neighborhood; he enjoyed to damage (other people's) property. From the age of ten, he started showing criminal behavior. It started with stealing; escalating into several instances of breaking and entering, the stealing of cars, drug trafficking, and robbery.

Mr. A attended five different primary schools. According to him, he was kicked out of school because of his bad behavior (e.g. getting into fights, stealing, and truancy). Furthermore, he recalls being put back a grade three or four times during primary school. He says his stepfather did not mind if he cut class, as long as he helped out at their "growshop" (a store where everything for marijuana cultivation can be found). Moreover, Mr. A attended one high school, which was a school for children with behavioral problems. He graduated with a certificate to work in construction. Mr. A remembers not liking school. He says the teachers could not handle him and that his stepfather "beat them up" several times. Starting at age 12, Mr. A. made it a habit to go to school under the influence of marijuana. As regarding to friends, he

says he did not have any at school. He did have a position of power, however. According to him, he could manipulate other children into doing anything he wanted them to.

Since he was twelve, Mr. A helped out his uncle as a road worker. After school he started working independently, as a road worker. He says he had two employees and that he enjoyed having control over others. According to Mr. A, he never worked as an employee for someone else because he does not like other to give him orders. Furthermore, he says he did work through several working agencies, but that he only did that to know where the safe was so he could empty it later. Mr. A does not want to make any statement regarding his finances. He does admit that he has some debts that he needs to pay back. He says that one of his goals, during his stay at Stichting Moria, is to be less materialistic.

Mr. A is in a relationship with the same woman since he was twelve. She is six years older than he is. When he was 16, Mr. A became father for the first time; his son is now five years old. He also has a daughter who is now 9 months old. The relationship with his girlfriend has never been very stable, according to Mr. A. Even though they never broke the relationship off, he did leave the house several times. He also lived with two other women with whom he had a relationship, while still in a relationship with his steady girlfriend. He says he always had relationships with other women on the side. Whenever he has free time, he goes to see his girlfriend and children.

Mr. A reports never having requested help from a psychologist or a psychiatrist, and he says he will never want to ask a professional for help in the future. However, he says that when in prison, he did request to speak to someone because he was feeling lonely (because he was in an isolation cell). During that time, he got the advice to take medicine (Seroquel) in order to calm down his aggression and fury. Moreover, Mr. A reports never having suffered from any physical problems.

According to Mr. A, he used alcohol since he was 12. He says he did not drink that much alcohol but he admits to engaging into fights as a consequence of drinking. He also says that he drove around on his scooter several times, while being intoxicated. Mr. A has also used marijuana starting age 12, around age 18, he used it twelve times per day. He says he stopped using drugs around two months before going to prison.

According to his file, Mr. A got convicted for maltreatment and for insulting an officer, before age 18. After turning 18, he was convicted twice, for public violence and for traffic

violations. Mr. A himself reports being arrested five to six times (for trading in counterfeit money and for drug trafficking).

Mr. A is not completely clear regarding his plans for the future. He says he wants to be a good father, that he wants a good future for his children. He says he wants a "normal" job as a road worker. He says he wants to learn more and that it is up to Stichting Moria if he does it or not. However, later on in the interview, Mr. A. says that he would only stop with his criminal behavior, if he could know for sure that his children would be safe.

Conversation regarding last offense

According to his case file, Mr. A portrayed himself on the internet as someone who was looking to selling laptops and mobile phones. Before the day of the actual sale was supposed to take place, he and the victims (2 men) had met. On the day of the sale, Mr. A and his accomplice threatened the victims with a pistol to give them 8000 euros, car keys, 2 mobile phones and a wallet. During the assessment interview, Mr. A states that that was not what actually took place. According to him, he and his accomplice kidnapped the two victims for two and a half days and forced them to hand over 150.000 euros (of drug money).

Psychological Assessment

DSM-IV-TR classification

Based on the results of the psychological assessment, the following DSM-IV-TR classification was made:

Axis I		No diagnosis
Axis II	301.7	Antisocial personality disorder
	301.81	Narcissistic personality disorder
As III		No peculiar details
As IV		Problems with primary support group: unstable relationship with partner
		Economic problems: debts and only income consisting of welfare
		Problems with the legal system: Re-integration into society after prison
As V		*Global Assessment of Functioning* = 61 (some problems with social functioning, but generally functioning pretty well, has some meaningful interpersonal relationships).

Integration and diagnostic conclusion

The MMPI-2 results, the interview with Mr. A, and the collateral information are not entirely congruent with each other. Based on the interview and the MMPI-2 results, Mr. A comes across as a sensation seeking, dodgy, rebellious, antisocial, and emotionally unstable young man, who was shaped by the criminal environment he grew up in. When he was only 2 months old, his biological father left his family. Pretty soon after that, his stepfather joined their family, becoming the only father figure Mr. A has ever had. His stepfather and the rest of his family have always been involved in criminal activities. From a young age, Mr. A witnessed his stepfather's aggressive behavior towards others. As he was his role model, Mr. A wanted to be exactly like him when he got older.

At school, Mr. A was a rebellious boy who committed truancy and stole a lot. He became involved in criminal activities from a young age. Because of his stepfather's positive attitude towards criminality, Mr. A never learned to live according to conventional norms and values. He has often used others (especially women) to get what he wanted. His good social skills and superficial charm have made it possible for him to manipulate others. Furthermore, he has always made a living through criminal activities. He likes to be perceived as special and wants others to do what he wants them to. If others do not follow his orders, he "explodes" and becomes (verbally) aggressive. Perhaps this is partially due to his intellectual abilities, which are below average; because of which he might have difficulty solving problems and coping with particular events/situations. However, when considering his childhood experiences, it is more likely that his environment shaped his behavior and personality.

Mr. A's file and the information provided by the employees at Stichting Moria deviate from the interview with Mr. A and from his MMPI-2 results at several points. In the case file, Mr. A comes across as a vulnerable young man who is easily influenced by others and as a result ends up in the wrong situations en makes the wrong choices. However, in the interview and the MMPI-2 results he came across as someone who consciously makes choices and who possesses antisocial attitudes that define his behavior. According to the employees at Moria, Mr. A is motivated to work hard on his goals and to live without committing any criminal activities. Based on the psychological assessment, his motivation remains doubtful.

Shortly put, it can be said that Mr. A's personality is characterized by aggression, irresponsibility, manipulation, and lack of empathy or remorse. Finally, it is striking that Mr. A portrays two different personalities (or masks).

Risk assessment

The risk assessment tools were used in the context of the internal phase in the Moria program. When combining Mr. A's risk factors (HCR-20) and protective factors (SAPROF), the recidivism risk has to be judged as moderate to high.

Treatment plan/advice

The following advice is given to decrease the risk factors as much as possible and to increase the protective factor as much as possible.

Mr. A is a young man who shows antisocial behavior and possesses antisocial attitudes. He is not empathic towards his partner or towards his victims. He says he knows that, as a result of his behavior, his victims suffered psychological damage especially. However, it is important for Mr. A to be aware of the consequences of his behavior on a conscious level and to empathize with others when they are hurting. Perhaps role playing and/or victim confrontation would be a good way for Mr. A to work on this.

Furthermore, Mr. A does not possess efficient coping skills. He plays down his problems and can get extremely verbally aggressive if something does not go the way he expected it to. It would be good if he could acquire coping skills with which he can test different possible solutions to problems so he can find a way to fix his own problems. The staff at Moria could help him acquire these skills and/or could support him if he follows such training.

Mr. A gets annoyed pretty quickly and reacts in an exaggerated manner, being verbally aggressive quickly. This is an important behavior/reaction which Mr. A could work on. The first step would be to follow anger management training.

Another point that becomes clear based on the psychological assessment is that Mr. A is not a "group" person but rather prefers to be on his own. His social network furthermore consists especially of people who are involved in criminal activities. It is

important for Mr. A to socialize with prosocial people. Perhaps signing up for a club (e.g. soccer club) would be a good starting point.

It is finally apparent that Mr. A is not sufficiently motivated for treatment. He says that he is only cooperating with Stichting Moria so he does not have to be in prison. It is important for Mr. A to become intrinsically motivated for treatment. Once the motivation is there, more intensive treatment, such as help from a psychologist, will be necessary. Perhaps he can ultimately be motivated to search for a more positive/prosocial network.

Nijmegen, 22 December, 2011

Evaluation of the internship

Own functioning in the setting

Overall, I think my performance during the clinical internship was good. I found it difficult to work efficiently at the beginning and I think this was especially due to my lack of planning. However, considering that I had to introduce a completely new procedure into the program at Moria, with no one there (at Stichting Moria itself) who could give me advice on how to do things, I think I did a good job. The first two months were somewhat of a struggle and we (my supervisor at Moria and I) had to figure out what the best procedure was. Furthermore, I found it very difficult to interview clients without being able to first observe how someone else conducts an interview. I also found it difficult to write a report without having an example of what it should look like.

Planning and working efficiently were my biggest pitfalls during my internship. If I would have planned better and if I would have worked more efficiently, I would not have had to finish four of the five reports in one month. It would have been better if I could have finished one report every four weeks. That way, I could have spread my workload (and my supervisor's workload) better. During the internship. I was able to put the knowledge and training I obtained during the theoretical part of the Forensic Psychology Master's program into practice. During the program, I received training about PCL-R rating and I got to use this during my internship. Although rating the PCL-R was more difficult during the internship than during the

program, I believe my training prepared me sufficiently. What made it more difficult during the internship is that I had to gather the information about the client myself and that there were more unknown facts than in the cases we received during training. I found it striking that, after an interview, without having scored the PCL-R yet, I could already make a relatively good guess regarding what the client's score would be (in terms of "high", "moderate", and "low"). I think the knowledge I gained during the Master's regarding psychopathy made it possible for me to do that. What I missed during the program, is training regarding the interview pertaining to the PCL-R. It would have been good to practice my interviewing skills and to know how the interview should go.

Another skill I could put into practice during the internship, was making use of risk assessment tools and the MMPI-2. Again, this was more difficult during the internship than during the training we received, but I still felt confident I was able to use the tools appropriately. Regarding the MMPI-2, I feel I have learned a lot during my internship. I think I have a better understanding of which profiles can come out of the test and of how they should be interpreted. During my training, I think I was still a little bit lost as to how the instrument was constructed and how a particular profile could come out of it. I found it interesting being able to recognize the profile in a particular client (how a profile "matched" a client).

Something I had not expected to learn, was constructing a treatment advice based on the psychological assessment. Before the start of the internship, I thought my supervisor would always have to tell me what kind of treatment should be given. However, I found that I learned to generate treatment advice myself. I still need to learn a lot regarding treatment advice, but I think I am better prepared now.

Overall, I think I learned a lot during my internship. Even though I think I am still not able to write a psychological report independently, without any supervision, I think my work has improved during the internship. Before starting the internship, I was convinced that in the future, I would especially want to pursue a career in research in forensic mental health. However, my experiences during my clinical internship made me change my mind and I am pretty sure I want to work both in the field as in research, if possible.

Reception and clinical supervision at institution

The staff and the clients at Stichting Moria were very welcoming. They also helped me whenever they could. However, since there is no one who is working there as a psychologist (with the exception of my supervisor), and since no one has any experience with psychological assessment, it was difficult to explain to everyone what my internship was about. They always saw me as a researcher and as someone who worked completely independently of them. This sometimes made it difficult to work there. The staff at Moria was a little bit confused about my role and I think they did not really understand what my tasks were. Therefore, they did not know what to expect of me and of my presence there. In a way, I did not feel as being part of the team of co-workers and other interns, because I was doing something no one else did. Nevertheless, they did include me whenever they could. I think that once the staff received the first report, they finally understood what I was there for. Since they are now familiar with the procedure of assessment, I think they will be able to receive the next intern in a better way.

My clinical supervisor at Stichting Moria could not supervise me as much as I think is usual at other (forensic) clinical internships. This is because I was introducing the psychological assessment and she did not have enough knowledge or training to be able to supervise me. My internship was new to everyone at Stichting Moria. However, my supervisor helped me whenever she could. She was also able to give some tips regarding interviewing tactics. Furthermore, she helped me a lot with my planning and gave me tips whenever she could.

Clinical supervision at Maastricht University

My clinical supervision I received at Maastricht University was excellent. The feedback I received on the rating of the instruments and on the reports helped me to improve my work. Furthermore, I also received some feedback on the interviews, which improved my interviewing skills. I think the quality of my supervision was a lot better than at many other internships. The advice and feedback I received from my supervisor at Maastricht University was extremely helpful and I learned a lot from it. However, it would have been nice to have had some guidance at Stichting Moria itself. Having clinical supervision at the university only once every two weeks sometimes made it difficult to work at Stichting Moria. Although, it helped that I could receive feedback and advice via email.

Suggestions for improving the internship

One thing that could improve at Stichting Moria is the acquisition of material for psychological assessment. I had to borrow instruments from Maastricht University and I think this might have slowed down the process of psychological assessment. For example, it would be good to be able to administer an intelligence test whenever necessary, without having to wait for the material.

Because the whole process of psychological assessment was new at Stichting Moria, there was not much supervision or support I could receive there. Guidance is one thing that could improve. I think that now that they have had the experience of having one intern, they are a lot better prepared to receive the next intern. They are now better familiarized with the whole procedure. They know what the tasks of the intern are and they know what to expect of a psychological assessment and the accompanying report. This knowledge will help them guide and support the next intern at Stichting Moria.

References

Burgt, M., van de, Mechelen-Gevers, E., van, Lintel Hekkert M., te (2006). *Introductie in de gezondheidszorg.* Houten: Bohn Stafleu van Loghum.

Geestelijke gezondheidszorg Nederland (2012a). *Wat is GGZ?* Retrieved January 23, 2012, from http://www.ggznederland.nl/de-ggz-sector/wat-is-ggz_.html

Geestelijke gezondheidszorg Nederland (2012b). *Het GGZ werkveld*. Retrieved January 23, 2012, from http://www.ggznederland.nl/de-ggz-sector/het-ggz-werkveld.html

Geestelijke gezondheidszorg Nederland (2011). *Jeugd-ggz: Investeren in de toekomst.*

Marle, H.J.C., van (2002). The Dutch entrustment act (TBS): Its principles and innovations. *International Journal of Forensic Mental Health, 1*, 83-92.

Ministerie van Volksgezondheid, Welzijn en Sport (2000). *Psychiatric hospital (compulsory admissions) act (Wet Bopz).* International Publication Series Health, Welfare and Sports.

Nederlands Instituut voor Psychologen (2007). *Beroepscode voor psychologen*.

Nederlandse Vereniging voor Psychiatrie (2009). *Conceptrichtlijn psychiatrisch onderzoek en rapportage in strafzaken ("pro Justitia").*

Stichting Moria (n.d., a). *Informatie voor verwijzers naar Stichting Moria*.

Stichting Moria (n.d. b). *Over Moria: geschiedenis.* Retrieved January 27, 2012, from http://www.stichtingmoria.nl/over-moria/geschiedenis.html

Stichting Moria (n.d. c). *Over Moria: missie.* Retrieved January 27, 21012, from http://www.stichtingmoria.nl/over-moria/missie.html

Stichting Moria (n.d. d). *Over Moria: organisatie*. Retrieved January 27, 21012, from http://www.stichtingmoria.nl/over-moria/organisatie/raad-van-advies.html

Stichting Moria (n.d., e). *Verwijzers: aanmelden.* Retrieved January 27, 21012, from http://www.stichtingmoria.nl/verwijzers/aanmelden/intakecommissie.html

Stichting Moria (n.d., f). *Verwijzers: aanpak werkwijze*. Retrieved January 27, 21012, from http://www.stichtingmoria.nl/verwijzers/aanpak-werkwijze.html

Stichting Moria (n.d., g). *Verwijzers: programma*. Retrieved January 27, 21012, from http://www.stichtingmoria.nl/verwijzers/programma.html

Stichting Moria (n.d., h). *Verwijzers: voorwaarden*. Retrieved January 27, 21012, from http://www.stichtingmoria.nl/verwijzers/voorwaarden/toelatingscriteria.html