

**[PLACE] PSYCHIATRIC CENTER
PSYCHOLOGICAL ASSESSMENT**

**DATE OF TESTING: 9/23/02, 9/26/02,
10/7/02, 10/21/02, 10/31/02**

NAME: Mr. X

C#: xxxxxxx

DOA: x/x/02

DOB: x/x /1955

DATE OF REPORT: 11/14/02

MANHATTAN PSYCHIATRIC CENTER

WARD/UNIT: D5B

Reason for Referral:

Mr. X was referred for psychological testing by the treatment team to assess his cognitive strengths and deficits. Knowing more about his cognitive functioning is particularly important for involvement in the STAIR (Service for the Treatment and Abatement of Interpersonal Risk) unit. The treatment team is interested in gaining a clearer diagnostic sense of the patient's personality as well as his dangerousness and risks of violent behaviors for treatment planning purposes.

1. HISTORY OF PSYCHOLOGICAL PROBLEMS, PRIOR PSYCHIATRIC TREATMENT & HOSPITALIZATIONS & PSYCHOTHERAPY:

Mr. X is a forty-six year old, single, Latino male who was transferred to [Place] Psychiatric Center on x/x/02 from Psychiatric Center after having been admitted to [place] Medical Center due to auditory hallucinations. Mr. X's first hallucination began possibly as early as age 7, but by 1975 were unremitting, and caused him to attempt suicide by hanging when he was in the Marine Corps. He reported that after that episode he self-medicated with street drugs for 10 years before he finally sought hospital treatment at [city] Hospital in 1985 (where he was also hospitalized in 1989 and 1990). He has a total of 70 arrests and 26 convictions for a variety of crimes including burglary, possession of burglary tools, as well as felonies. He has been aggressive towards staff in several institutions, including at [State] Correctional Facility, where he threatened to kill police officers. He has one parole violation.

The patient was born in New York City and lived there until age 10, when his family decided to move to Puerto Rico. He returned without his family at age 13 and lived with his grandfather for 1 year. Thereafter, he lived with an uncle from age 14 until his 30s. He reports that his parents never married ("that was how it was done then"). His father left the family when the patient was two years old. Mr. X still remains in contact with both parents. He has one brother. There is some evidence of mental illness in the family, including possibly his mother, as well as three of his paternal uncles, yet specific diagnoses are unclear.

His history of substance abuse includes heroine, PCP, LSD, cannabis, and crack. He began using drugs at age 13. As a teenager, he used LSD for 3 years. He allegedly abused PCP daily for 5 years in his 20s. He struggled with heroin dependence and went through at least one detoxification program, after which he was drug-free for six years.

Mr. X can read and write in both English and Spanish. However, he reports not having much formal education. He stopped school after the eighth grade at the Y School, a school for emotionally-disturbed boys. He did not specify what caused him to be sent there except to allude to having done some "bad things." The patient has a limited work history. He stated that he spent about five years dealing drugs. He proudly pointed out that he's never been homeless. He denies any physical or sexual abuse. The patient has never been married and has no children.

2. DIRECT OBSERVATIONS & BEHAVIORAL APPRAISAL:

Mr. X is a slightly below average-height, 46 year-old Hispanic male. He wears glasses and looks his stated age. He was adequately groomed with good hygiene. The patient did not demonstrate overt signs of psychosis during the testing sessions, and denied experiencing auditory hallucinations. He did show some aggression toward the tester by demanding the tester address him in a certain way by using the term “absolutely” instead of “OK.”

The patient was tested over a several week period with individual meetings lasting roughly an hour each. Between sessions, the patient had several angry encounters with staff, which caused him to be transferred to the high-security ward. Despite the circumstances around his transfer, Mr. X appeared cheerful and his affect was surprisingly positive during sessions. He did not mention any details, but was able to discuss it when asked about it. Mr. X denied any present suicidal ideation, intent or plan. His speech was normal in pitch and volume. Throughout the testing, Mr. X was mostly cooperative and compliant with examiner’s requests, however he did not put forth a great deal of effort to complete the tasks. Often he would give an answer, and if asked for more information, he would refuse to expand upon his original answer.

3. RESULTS OF INTELLECTUAL, COGNITIVE, NEUROPSYCHOLOGICAL, MEMORY, ACHIEVEMENT, VISUAL/MOTOR, MATURITY, OR OTHER EVALUATIONS:

Tests administered: Bender-Gestalt Test, Wechsler Adult Intelligence Scale – Third Edition (WAIS-III), Figure Drawings, Thematic Apperception Test, Rorschach

Cognitive Functioning

Mr. X obtained a Full Scale IQ score of 74, placing him in the Borderline Range of overall intelligence. His Verbal IQ of 71 also falls in the Borderline Range, however his Performance IQ of 90 is in the Average Range. The nineteen-point difference between his Verbal and Performance scores is significant. This may be the result of his lack of formal education which seemed to interfere with his performance on tasks emphasizing verbal, language-based abilities. It should be noted that his scores might not be indicative of his intellectual functioning since he did not seem particularly motivated to understand the tasks.

WAIS- III Results:

<u>Verbal Subtest</u>	<u>Scaled Score</u>	<u>Performance Subtest</u>	<u>Scaled Score</u>
Vocabulary	4	Picture Completion	10
Similarities	4	Digit Symbol-Coding	8
Arithmetic	4	Block Design	9
Digit Span	5	Matrix Reasoning	6
Information	8	Picture Arrangement	10
Comprehension	7		

Mr. X demonstrated a strong knowledge of social rules and is able to articulate the “right” responses to interpersonal situations. At the same time, he may not act accordingly in real-life situations. Subsequently, he expressed an egocentric tendency in his responses, such as explaining the use of taxes as “taxes help people like me, prisoners, they spread around and you can fall back on that money

as you get older.” In addition, he has a strong fund of academic knowledge about the world, which appears to have been attained through his own exploration rather than through formal education.

It should be noted that although Mr. X has a relatively poor fund of vocabulary, it often seemed that Mr. X knew what the words meant or could use them in context, yet did not know how to define them without using the word. For example, remorse was defined as “people that do something very bad and have no remorse.” His score may not reflect his knowledge of word meanings and may be partially a result of his lack of formal education. In addition, Mr. X has problems with verbal reasoning. He seemed to struggle with understanding the process by which to arrive at answers regardless of whether the tasks called for concrete or abstract reasoning. Finally, he has difficulty remaining focused on tasks, particularly when he does not find them interesting. As such, it is important to ensure that he is focusing by assessing his level of engagement in tasks he finds interesting and worthwhile.

In the performance domain, he performed well on tasks that required attention to detail, and demonstrated an ability to organize information logically and chronologically. On a task which asked him to organize and construct objects in space, Mr. X was surprisingly methodical and deliberate while taking the tests, demonstrating sustained concentration and persistence. He has relatively strong visuo-spatial organization and good visual scanning abilities. This means Mr. X has an ability to pay attention to nuances and subtleties of his surrounding and to be quite alert to what is happening around him.

Mr. X had a more difficult time when required to identify patterns. In addition, he has trouble with timed tasks. He appears not to perform to his potential when required to work quickly. Staff should give him time to process information to ensure that he will perform to his potential.

On the Bender-Gestalt, a neuropsychological screening assessment in which he was asked to copy several figures, Mr. X's figures were simplistic. He drew loops instead of dots, demonstrated closure failures, and primitive reproductions. As was the case throughout the testing, the patient appeared compliant yet not very motivated to do well on the tests. Nonetheless, no obvious neurological involvement was noted.

4. RESULTS OF PERSONALITY, EMOTIONAL, PROJECTIVE OR OTHER EVALUATIONS:

Mr. X demonstrates profound anger and disturbed sense of interpersonal relations. Most notable was his repeated image of a “father” who he reported to be absent or unavailable in several scenes. One striking aspect of this missing father figure was that he had not left any reliable information or legacy, repeatedly leaving the young son alone, helplessly awaiting support. It seems that the loss of his father has left Mr. X feeling alone and abandoned. A sense of longing for a masculine figure to rely on figured prominently in his responses. Mr. X appears to have responded to this deep loss by overcompensating and presenting himself as a macho tough-guy.

Mr. X appears to alternate between this defensive grandiosity and a more depleted sense of self. Several of his stories were full of images of sad little boys longing for help and success, which always remained out of their grasp. At other times he spoke of boys with fantasized success. At these times, Mr. X's self-image was clearly grandiose. On the ward, for example, Mr. X sees himself as an intellectual, somehow above the other patients; he often sits apart, reading the newspaper self-consciously with his eyeglasses low on his nose. This vacillation between grandiosity and depletion can also be seen in his interpersonal style on the ward. He can be very upbeat, saying hello to everyone

and shaking hands. Yet at times he apparently gets extremely threatening and violent, particularly at authority-figure staff. At either extreme, Mr. X suffers from a lack of self-efficacy such that he does not seem to believe he can or needs to make a difference in his life.

In addition to his intense anger at this sense of abandonment by his own father, Mr. X presented with a highly affectively-charged style. He seems to respond very strongly to affective stimuli to the point of being easily overwhelmed. He seems to be missing the ability to contain his feelings, such that he may “drown” in emotion. It is possible that because he seems unable to control his feelings cognitively, he may turn to drugs as a way to deal with the flooding. When describing how people feel, Mr. X mostly used simplistic terms such as “happy” or “sad” descriptive words, thus dulling down intense emotions. Along these lines, he appears to experience deep feelings of aggression and hostility that he attempts to bury and conceal.

5. PATIENT RISK FACTORS AND IMPLICATIONS: PROBLEMS, STRENGTHS, AND DISABILITIES:

Risks: Arrests for repeated assaults, burglary, felony. Patient displays little remorse for assaultive behaviors. He also has an extensive history of drug abuse. He can be manipulative of staff and other patients.

Strengths: Mr. X did not display any psychotic symptoms during this testing. He has developed social skills and has a good intellectual grasp of conventional social norms. He is perceptive and aware of what goes on around him.

Problems: Mr. X shows a lack of insight into his illness. He is vulnerable to assaultiveness when angry or psychotic. He demonstrates very little ability to contain emotions, and becomes angry and explosive when upset. Staff should be aware that he often tries to manipulate others.

Disabilities: Mr. X has a long history of criminal charges for assault; low cognitive functioning, including possible cognitive impairment due to substance abuse history; and lack of significant work history.

6. SUMMARY, DIAGNOSIS & FORMULATION

Mr. X was tested upon the request of the team to address his cognitive capacity. He is forty-six year old, single, Latino male who was transferred to [Place] Psychiatric Center on x/x/02 from Psychiatric Center due to auditory hallucinations. He currently denies having any hallucinations or delusions. Mr. X obtained a Full Scale IQ score of 74, placing him in the Borderline Range of overall intelligence. His Verbal IQ of 71 also falls in the Borderline Range, however his Performance IQ of 90 is in the Average Range. The nineteen-point difference between his Verbal and Performance scores is significant. This may be the result of his lack of formal education. Mr. X appears to be a good candidate for STAIR. He demonstrated strengths on tasks involving worldly knowledge, as well as performance-based tasks that required visual scanning and organizing and sequencing information. His weaknesses were on tasks of verbal reasoning and pattern recognition, as well as timed tasks. Mr. X is an emotionally volatile and angry man. He can be very controlling of his environment. Although he often presents as charming, he harbors a lot of covert hostility that often appears in subtle demands. Given his disowned rage and his history before and during the weeks of testing, he is a significant risk for violence. This is particularly the case because he engages in significant denial of his aggressive impulses, which interferes with his taking full advantage of his treatment.

AXIS I: Schizophrenia, Undifferentiated 295.90
Polysubstance Abuse 304.80
AXIS II: Antisocial Personality Disorder 301.7
AXIS III: Hepatitis C
PPD +
Deafness, left ear
AXIS IV: Legal problems
AXIS V: GAF: 45 (current), GAF: 35 (past year)

7. TREATMENT RECOMMENDATIONS:

1. Mr. X would benefit from continued participation in the treatment mall to increase his insight into his violent outbursts and to improve his impulse control. Anger management groups might be particularly useful.
2. Mr. X could benefit from a substance abuse group.
3. Mr. X needs to work on gaining insight into his anger and learning to engage with the limits of conventional reality as a way of gaining realistic self-esteem. Individual therapy could help him resolve some of his anger and sadness over early losses.
4. Group therapy could help Mr. X see how he manipulates and distances himself from others, as well as develop a more realistic self-appraisal. Because he has a tendency towards manipulation of others, before such a referral is made, it would be necessary to explore whether he is motivated to change his behaviors.

My Name, Psy.M.
Psychology Extern

Supervisor's Name, Ph.D.
Supervising Psychologist