Psychology Research & Training Clinic

W.J. Brogden Building, Room 351
Department of Psychology
1202 West Johnson Street
Madison, WI 53706
Phone: 608.262.5925 Fax: 608.262.5796

PSYCHODIAGNOSTIC AND PERSONALITY ASSESSMENT

Pseudonym: Mark Ferreira
Age: 17
Sex: Male

Supervisor: Christopher J. Gioia, PhD
Examiner's Name: Stephanie B. Ward, MS

REASON FOR REFERRAL

Mark Ferreira is a 17-year-old, cisgender man referred to the clinic by his therapist for a psychodiagnostic and personality assessment to evaluate for traits consistent with antisocial personality disorder (ASPD). Mark described the reason for referral and his motivation for seeking an assessment in terms of self-reported "irregularities" that he identified as consistent with, and possibly indicative of, ASPD. Thus, the goal was differential diagnosis, and based on the results, to help Mark, his parents, and his therapist better understand his personality profile and identify the most appropriate therapeutic strategies for his course of treatment.

HISTORY OF PRESENTING PROBLEM

Specifically, Mark reported "doing things I should not" such as "stealing." Mark wanted to understand these self-identified irregularities and decided that he "wanted a professional opinion." When asked how he felt before, during, and after engaging in behaviors such as stealing, Mark emphasized that "curiosity" was the primary factor, in addition to "maybe a little bit of a power trip." Other irregularities reported as potentially relevant included a limited emotional response to the death of his abuelo, whose passing was preceded by a sudden hospitalization and gradual deterioration of his condition. Mark's parents did not identify any irregularities consistent with ASPD, and cited their son's peace of mind as the primary reason for the referral.

PROCEDURES

Semi-structured clinical interviews
Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV)
Conners Continuous Performance Test-Third Edition (CPT-3)
Conners Adult ADHD Rating Scales-Self Report: Long Version (CAARS-S:L), self- and observer-reports
Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)
Rotter Incomplete Sentences Blank (RISB)
Validity Index Profile (VIP)

BACKGROUND INFORMATION

Clinician conducted extensive clinical interviews to inform differential diagnosis. Thus, for purposes of brevity and clarity, only the background information most relevant to this evaluation is presented below.

Developmental and Medical History

Mark was the first of four children born to Mr. and Mrs. Ferreira. Mark's mother (Ms. Ferreira) reported Mark was the product of a full-term pregnancy and that he was delivered without complications. Mark was slightly above average weight at birth (9 lbs, 8 ounces). When asked about developmental milestones, Ms. Ferreira reported Mark reached all major milestones within projected timeframes (e.g., walking at 9 months and 2 weeks). Mark and Ms. Ferreira reported that Mark has no significant history of chronic physical illness and that he has never taken psychotropic medication, nor is he taking any medication at present beyond allergy medication as-needed. Mark wears glasses for nearsightedness and reported maintaining regular sleep cycles (i.e., typically sleeps from approximately 11:00pm-6:30am).

Family History
Mark was born in the Midwest. He has three siblings (Lyn: 16 years old, Kenneth: 12 years old, and Luke: 11 years old). Ms. Ferreira shared that she was raised Catholic, and that Mark and Lyn attended catholic school until the church failed to support a family matter, at which point the family formally left the religion and the children changed schools. Mark has moved twice in his life and spent the vast majority of his 17 years in Wisconsin. Mark reported that his mother is currently working in an administrative role and that his father works in insurance.

Academic History
Some of Mark's most salient presenting concerns pertained to school and included: low motivation, procrastination, difficulty getting started on nearly all school assignments (despite the content of such assignments almost never presenting a challenge), and repeatedly failing to submit assignments before their deadlines even when he's completed them well before their due dates. Mark reported detesting group projects, falling asleep during class, and conducting behavioral experiments in an effort to better understand his difficulties with getting started and meeting deadlines. Mark also reported multiple instances where teachers expressed concerns that he was not "applying himself" and/or that he was squandering his potential.

Psychosocial History
Mark and Ms. Ferreira both described Mark as a sociable individual with a tight-knit core friend group and no issues making friends more broadly. Social idiosyncrasies included a disinterest in social media and relative distaste for texting. Mark attributed the latter aversion to the ambiguity inherent to conversations held via text, where tone of voice, facial expression, and/or context clues cannot be used to inform interpretations of messages received. Mark stated that when he's talking to someone he likes or about something he personally finds interesting, he can talk for hours, but described small talk as one of many infuriating exasperations that increase his irritability over the course of a school day and can cause him to explode once he gets home.

In terms of pleasurable hobbies, interests, and activities, Mark and Ms. Ferreira both reported that swinging (on a swing set) was one of Mark's most preferred activities. Another more recently acquired hobby involves the high-precision painting of mini figurines, a detail-oriented activity that Mark will happily engage in for hours and walk away from with a final product that he can share with pride. Although Mark described time spent swinging, painting, playing video games, and spending time with friends or family as relatively enjoyable, he endorsed pervasive boredom and irritability across contexts. Mark described himself as unmotivated even when an activity is fun and reported difficulty getting himself to engage in social activities. He stated feeling the "least bored when doing stuff" but consistently overwhelmed by task demands, such that he finds everything he needs to do burdensome and ends up making excuses to get out of doing things that would have alleviated his boredom, perpetuating a feedback loop.

MENTAL STATUS & BEHAVIORAL OBSERVATIONS
The procedures outlined in this report were the result of in-person testing sessions. Client was oriented to person, time, and place. He appeared nervous at the beginning of the assessment intake (e.g., more formal, guarded posture) but his body language and response style seemed to relax relatively early in the first 2-hour appointment. Mark exhibited spontaneous, seemingly organic, emotive facial expressions in response to session content (e.g., smiling when clinician reflected what Mark deemed to be an accurate understanding of what he was trying to communicate). At times, particularly when the instructions or rationale for a test were ambiguous, there were signs of irritability and impatience, which aligned with Mark's self-report that he is an irritable person with a short temper. Given the patient's presenting concerns about antisocial personality disorder, it is important to note that Mark seemed gracious and considerate, and maintained a positive, respectful attitude toward the interviewer throughout the evaluation process, even when frustrated. As the process progressed, Mark's affective expression and responses to interview questions appeared to grow less restricted and guarded, respectively. Across all sessions, his thought content appeared logical and linear and gross memory appeared intact.

Based on observations of Mark's behavior as well as the pattern of test scores, the current results appear to be a reliable and valid estimate of his current psychological functioning.

Suicidal Ideation
Patient endorsed passive suicidal ideation but denied current plan or intent. During the evaluation process, Mark stated that the probability of him acting on any suicidal thoughts before his assessment feedback session was 0%. However, Mark did report previously engaging in some consideration of the means by which he would kill himself (e.g., "car").

When he shared his thoughts about suicide with this clinician, they seemed to be the product of a systematic cost-benefit analysis, reflecting Mark's thoughtful contemplation of what he deemed to be risk and protective factors associated with the decision to take his own life. According to Mark, risk factors included having no more negative experiences and ending the tedious monotony of day-to-day living whereas protective factors included the positive experiences he would miss out on in life and the pain suicide would cause his family. Of note, Mark reported calling a crisis hotline once (which he found "annoying" and "not helpful") and thereafter shared his mental health concerns with his parents.

EVALUATION RESULTS

Cognitive Abilities

Mark was administered the ***Wechsler Adult Intelligence Scale-Fourth Edition*** **(WAIS-IV)** in order to assess his cognitive abilities. Cognitive ability refers to a person's ability to problem solve, reason, and learn. The WAIS-IV provides a general measure of cognitive ability and intellectual functioning (FSIQ), which is generated from four index scores described below. The *Verbal Comprehension Index* (VCI) measures verbal reasoning, verbal conceptualizations, and crystallized knowledge. The *Perceptual Reasoning Index* (PRI) measures perceptual reasoning, spatial processing, and visual-motor integration. The *Working Memory Index* (WMI) measures attention, concentration, and mental control. Lastly, the *Processing Speed Index* (PSI) measures the speed of mental and graphomotor processing. In addition, the *General Ability Index* (GAI) is a composite score generated from the three core Verbal Comprehension subtests (Similarities, Vocabulary, Information) and the three core Perceptual Reasoning subtests (Block Design, Matrix Reasoning, Visual Puzzles) and provides a measure of cognitive ability that is less sensitive to the working memory and processing speed components of the FSIQ.

The FSIQ, GAI, and index scores (VCI, PRI, WMI, PSI) are based on a mean of 100, with a standard deviation of 15. Average scores range from 85 to 115. The FSIQ and index scores are standard scores and can be compared to each other. Individual subtest scores have a mean of 10, with a standard deviation of 3. Average scores range from 7 to 13. Subtest scores are standard scores and can be compared to each other, but not to index scores.

Verbal Comprehension Index = 132		***Perceptual Reasoning Index = 105***	
Similarities	17	Block Design	13
Vocabulary	13	Matrix Reasoning	11
Information	16	Visual Puzzles	9
Working Memory Index = 97		***Processing Speed Index = 100***	
Digit Span	9	Coding	11
Arithmetic	10	Symbol Search	9

Mark's performance on the WAIS-IV revealed a *Full-Scale IQ* in the ***High Average*** range (FSIQ = 112, Percentile Rank = 79, 95% CI = 108-116) and a *General Ability Index* in the ***Superior*** range (GAI = 121, Percentile Rank = 92, 95% CI = 115-125). The 9-point difference between the FSIQ and GAI is statistically significant at the .05 level (and obtained by 3.6% of individuals in the standardization sample).

It is important to note that Mark's set of thinking and reasoning abilities makes his overall intellectual functioning difficult to accurately summarize using a single score (such as the FSIQ). The main reason for this was because of a 35-point difference between his VCI and WMI scores (statistically significant at the .05 level), which occurs very rarely (obtained by only 0.50% of individuals in the WAIS-IV standardization sample). Instead, his global intelligence is best understood by collectively examining Mark's GAI and performance within each index (i.e., VCI, PRI, WMI, PSI).

Mark attained a *Verbal Comprehension Index* (VCI) of 132, a score considered to be in the ***Very Superior*** *range* and above that of approximately 98% of his peers (VCI = 132; 95% confidence interval = 125-136). The VCI is

designed to measure verbal reasoning and concept formation. Mark's performance on the subtests contributing to the VCI suggests a diverse set of verbal abilities.

Mark earned a *Perceptual Reasoning Index* (PRI) score of 105, placing him in the ***Average*** range (Percentile Rank = 63). The PRI is designed to measure fluid reasoning in the perceptual domain with tasks that assess nonverbal concept formation, visual perception and organization, visual-motor coordination, learning, and the ability to separate figure and ground in visual stimuli. Mark presented with a diverse set of nonverbal abilities, performing much better on some nonverbal tasks than others. For example, Visual Puzzles emerged as a weakness relative to Mark's overall Perceptual Reasoning mean score (11) across the three subtests (Critical Value = 1.99, $p < 0.05$). This subtest is designed to measure nonverbal reasoning and the ability to analyze and synthesize abstract visual stimuli within a specified time limit. Performance on this task also may be influenced by visual perception, broad visual intelligence, fluid intelligence, and simultaneous processing.

Mark attained a *Working Memory Index* (WMI) score of 97 (Percentile Rank = 42, ***Average*** range), suggesting his immediate memory, auditory processing of verbal stimuli, and ability to use rehearsal strategies all fall within normal limits. It should be reiterated that the 35-point difference between WMI and VCI was statistically significant at the .05 level (and obtained by only 0.50% of individuals in the WAIS-IV standardization sample). Thus, Mark's abilities to sustain attention, concentrate, and exert mental control were a weakness relative to his verbal reasoning abilities. A relative weakness in mental control may make the processing of complex information more time-consuming for Mark, draining his mental energies more quickly compared to others at his level of ability. Additionally, Mark's score on the Arithmetic subtest was higher than his score on Digit Span; this discrepancy may indicate specific strengths in arithmetic computational skills rather than a general proficiency in working memory.

Finally, Mark's *Processing Speed Index* (PSI = 100) was in the ***Average*** range, which suggests Mark's efficiency in processing visual material is better than approximately 50% of his peers. Mark's ability to quickly process visual material emerged as a weakness relative to his verbal reasoning abilities (Difference Score = 32, Critical Value = 12.47, $p < 0.05$). Of note, processing speed is merely an indication of the rapidity with which Mark can mentally process simple or routine information without making errors. Individuals with superior reasoning ability often tend to perform less well, although still adequately, on processing speed tasks.

Overall, the results of this assessment suggest that Mark possesses variable cognitive abilities, though all of them fall within average or above average ranges.

Neuropsychological Measures

Mark was administered the ***Conners Continuous Performance Test-Third Edition*** **(CPT-3)*,*** an assessment tool that can reveal important information about an individual's functional inattentiveness, impulsivity reaction time, perseveration, and sustained attention. During the CPT-3, the examinee is asked to press the space bar in response to letters flashing on the computer screen, except when the letter is "X," in which case he must refrain from pressing the space bar. For this administration, the self-diagnostic check of the accuracy of the timing of each CPT-3 administration revealed no indication of timing difficulties or respondent non-compliance. Thus, the current administration should be considered valid. A summary of information about Mark's scores, what scales and indices are elevated, and how he compares to the normative group is presented below.

Conners Continuous Performance Test-Third Edition (CPT-3) Scores

	Raw Score	T-Score	Percentile	Description
Omissions	6%	60	88th	Elevated
Commissions	72%	64	89th	Elevated
Hit Reaction Time (HRT)	348.24	44	30th	A Little Fast
HRT Standard Deviation	230.89 (0.302)	57	81st	High Average
Variability	176.66 (0.117)	64	90th	Elevated
Detectability	-0.89	64	91st	Elevated
HRT Block Change	-0.12 (-0.001)	47	35th	Average
HRT ISI Change	33.50 (0.065)	52	59th	Average
Perseverations	1%	56	84th	High Average

Mark's performance on the CPT 3 suggested a balanced style of responding that was sensitive to both speed and accuracy (T-score = 47). Mark's detectability (*d'*) score was ***Elevated*** (T-score = 64), which indicates he encountered difficulty differentiating targets (letters other than "X") from non-targets ("X"). Considered in tandem with the high number of omission errors (failure to respond to target letters; T-score = 60, ***Elevated*** range), high response speed variability throughout the administration (T-score = 64, ***Elevated*** range), and slightly less consistent response speed relative to his same-aged peers (T-score = 57, ***High Average*** range), Mark's scores on this measure suggest he may have problems with inattentiveness, and that his information processing efficiency fluctuated across the different segments of the test.

The number of commission errors (responses to non-targets; T-score = 64, ***Elevated*** range), number of perseverative errors (repetitive or anticipatory responses; T-score = 56, ***High Average*** range), and slightly fast hit rate reaction time observed in relation to others his age (HRT; T-score = 44, ***A Little Fast***) collectively suggest Mark may have problems with impulsivity. Finally, Mark's CPT-3 performance indicated an ***Average*** reduction in response speed during later segments of the test (HRT Block Change; T-score = 47) and an ***Average*** change in response speed at longer inter-stimulus intervals (HRT ISI Change; T-score = 52).

Overall, Mark's style of responding provides some evidence for a disorder characterized by significant difficulties in attention or impulsivity, such as Attention Deficit/Hyperactivity Disorder (ADHD).

Self and Other Reports of ADHD Symptoms, Personality, and Psychopathology

The ***Minnesota Multiphasic Personality Inventory-Adolescent*** **(MMPI-A)** is an empirically-based, widely-used test designed to measure characteristics of personality and psychopathology among adolescents. It is considered a self-report and objective measure. Scales yield T-scores with a mean of 50 and a standard deviation of 10. Scale scores greater than 65 are likely to indicate problems of clinical significance. MMPI-A scales do not, on their own, provide adequate evidence for specific diagnoses. Rather, the symptoms and behaviors documented by the MMPI-A can support diagnostic conclusions in the context of additional information.

It is well-known in the research literature (Finger & Ones, 1999; Forbey & Ben-Porath, 2007; Menton et al., 2019; Roper, Ben-Porath, & Butcher, 1995) that MMPI test scores are reliable and valid when the test is administered by computer or tablet. Thus, the MMPI-A was administered by remote on-screen administration through the Q-global system. Mark was sent the invitation to complete the MMPI-A initially on 02/28/2024; it was resent on 03/20/2024 and Mark completed the measure on 03/21/2024. No in-person or on-screen (via audio, video, or audio and video) supervision or monitoring of the administration occurred.

Upon inspection of the validity scales, Mark's MMPI-A profile appears to be valid and his clinical scales are within normal limits. However, Mark's content scale profile was elevated on A-Dep (Depression, T-score = 66) and A-Lse (Low Self-Esteem, T-score = 66). Upon further examination of the subscales it was found that scales A-Dep$_1$ (Dysphoria, T-score = 78), A-Dep$_4$ (Suicidal Ideation, T-score = 64), and A-Lse (Self-Doubt, T-score = 73) were elevated, indicating clinically significant levels of adolescent depression and low self-esteem.

While not elevated, Mark's T-score (64) on Adolescent Conduct Problems (A-Con) is worth mentioning. Further exploration of the subscales for A-Con (Acting-Out Behaviors, T-score = 65; Antisocial Attitude, T-score = 63) suggests the incidence of relevant adolescent conduct problems (i.e., stealing). More broadly, Mark's pattern of responses suggest he tends to view the world in a negative manner and may develop a worst-case scenario mindset with respect to events affecting him. His self-critical nature may, at times, prevent him from viewing relationships in a positive manner. Finally, Mark reported several symptoms of anxiety, including excessive worry and feeling overwhelmed by his circumstances.

The ***Conners' Adult ADHD Rating Scales-Self Report: Long Version*** **(CAARS-S:L)** is a set of multi-informant questionnaires designed to assess a wide range of behavioral, emotional, social, and academic/occupational concerns in adults. It is particularly useful for assessing ADHD-related problems. The system includes observer and self-reports. The resulting T-scores (mean= 50, standard deviation= 10) are standardized estimates of symptom severity; scores above 60 are considered elevated.

Upon review of Mark's completed CAARS-S:L, he received an ***Elevated*** score on the *Inconsistency Index,* meaning that he engaged in some inconsistent responding across the measure. As such, it is suggested that his results be interpreted with caution. Mark's T- scores on the CAARS-S:L are presented below:

Scale	T-score	Range
Inattention/Executive Dysfunction	53	Average
Hyperactivity	51	Average
Impulsivity	42	Average
Emotional Dysregulation	84	Very Elevated
Depressed Mood	67	Elevated
Anxious Thoughts	60	Slightly Elevated
Schoolwork	61	Slightly Elevated
Peer Interactions	42	Average
Family Life	46	Average
ADHD Inattentive Symptoms	49	Average
ADHD Hyperactive-Impulsive Symptoms	47	Average
ADHD Symptoms Total	48	Average
Oppositional Defiant Disorder Symptoms	65	Elevated
Conduct Disorder Symptoms	62	Slightly Elevated

Collectively, the client's ratings suggest that he has greater difficulty regulating and managing emotions (Emotional Dysregulation scale) as well as more features of depressed mood (Depressed Mood scale) than are typically reported by 17- to 18-year-old men. Of note, Mark's ADHD Index score was in the Borderline range, which is similar to those produced by 17- to 18-year-olds, whether they are in the general population or have been diagnosed with ADHD. Finally, Mark reported more features of opposition, defiance, and disordered conduct than are typically reported by 17- to 18-year-old males (see the Oppositional Defiant Disorder Symptoms and Conduct Disorder Symptoms scales). These scales assess for symptoms related to angry/irritable mood, deceitfulness, argumentative/defiant behavior, vindictiveness, aggression, and theft.

Ms. Ferreira completed the ***Conners Adult ADHD Rating Scales- Observer Report*** to get a sense of her concerns with regard to Mark's behavioral, emotional, social, and academic functioning. Ms. Ferreira responded to all items and her responses were found to be valid. The only scale of concern – which was, albeit, slightly elevated – was the Anxious Thoughts scale, suggesting that Ms. Ferreira believes her son experiences slightly more anxiety than is typically reported by parents of 17- to 18-year-old males. She did not endorse any features of opposition, defiance, and disordered conduct (as compared to Mark).

Mark was administered the ***Rotter Incomplete Sentences Blank (RISB)***. The RISB is considered a semi-structured projective measure of personality adjustment. It consists of 40 stems (the first word or words of a sentence) and asks respondents to write a sentence for each stem provided. The RISB offers an objective scoring system for evaluating an individual's responses, which provides an overall level of adjustment. However, the instrument was also developed to yield data useful for diagnostic and treatment planning purposes. Thus, the latter purpose primarily guided the clinical interpretation of Mark's responses.

Mark's RISB responses revealed themes that generally aligned with information gleaned from clinical interviews and other assessments. Several of Mark's responses mapped onto previously reported symptoms consistent with dysthymia. He endorsed feelings of guilt ("My greatest fear is that I'll be properly punished for the things that I've done;" "Sometimes, I should really do what I'm supposed to"), pessimism ("The future is a little bleak"), and mental fatigue ("My mind is tired"). Discontent with respect to school and schoolwork was also apparent ("Reading is a chore;" "What annoys me is a lot of schoolwork;" "I would rather be here than school;" and "The only trouble at the moment is that I have Spanish today").

Of note, some of his responses were sarcastic ("I suffer the pain of working in my dairy department;" "I can't jump 5 feet in the air"). Many of them reflected a straightforward, literal interpretation of the question stem ("Men are tall;" "A mother has a child;" and "Nerves are part of the nervous system") and most were surface-level ("I want to know when my AP US History teacher will change the grades in the grade book"). Importantly, there were also themes that related to activities that Mark finds pleasurable ("I like to paint minis;" "The happiest time is usually when I'm outside swinging").

Performance & Effort

The ***Validity Indicator Profile*** **(VIP)** is a test to identity valid versus invalid responding. In other words, it is a test designed to assess one's performance and level of effort when administered other psychological tests concurrently. The VIP has two subtests (Nonverbal, 100 items; Verbal 78 items), from which a validity ranking and response style (e.g., compliant, inconsistent) can be obtained. Generally, when a respondent's approach on the VIP is classified as valid, the examiner can have reasonable confidence that the respondent intended to perform well. When the VIP indicates invalidity, the examiner should be aware that other concurrently administered tests might be an underestimate of the respondent's true abilities.

Mark's performance on the Nonverbal and Verbal subtests of the VIP suggests that the results were valid and probably a good representation of his ability. His response style for both subtests was compliant. Mark's performance curves and total scores (Nonverbal: 94 correct out of 100; Verbal: 61 correct out of 78) on both subtests indicate that he made an effort to answer the items correctly and intended to do well. As items became more difficult on the VIP, Mark transitioned from "knowing" the answers to "'guessing" them, and the reasonable conclusion for this switch in strategy is that item difficulty began to exceed his ability.

SUMMARY & RECOMMENDATIONS

Mark presented for a diagnostic and personality assessment to provide clarity on his psychiatric symptoms, especially those he believed were consistent with ASPD. Based on the information gathered through objective psychological and neuropsychological measures and clinical interviews, several conclusions were made.

At present, Mark meets Diagnostic & Statistical Manual of Mental Disorders- Fifth Edition (DSM-5) diagnostic criteria for Persistent Depressive Disorder (PDD), Early Onset, Moderate (F34.1). He reported anhedonic mood for most of the day, more days than not, over the past several years, accompanied by difficulty making decisions, feelings of hopelessness, and low self-esteem. Further symptoms include sadness, pessimism, crying spells, suicidal ideation, and self-deprecatory thoughts, as well as feelings of uselessness and loneliness. He endorsed a number of very negative opinions about himself, including the perception that he has several faults and an inability to do anything well. Mark also expressed great frustration with an overwhelming inability to make himself do what he needs to do, despite these often being school-related tasks that would temporarily relieve the chronic boredom and guilt he is eager to escape. Collectively, Mark's constellation of symptoms limits his ability to find joy or meaning in life, and causes significant distress and impairment across multiple settings and domains, including school, work, family, and social functioning.

A hypothesis to the development of Mark's symptoms of depression is important to consider and is presented here. Briefly, brain cells are linked together by complex pathways and our brain uses information sent back and forth through these pathways to control how we think, feel, and behave. Sometimes, especially when the brain is still developing, its pathways undergo changes that disrupt the flow of information. These disruptions can affect how different parts of the brain communicate, which can lead to symptoms of depression (including little to no pleasure from day-to-day experiences, low motivation, and feelings of worthlessness, guilt, and low self-esteem). Over time, the combined effect of these symptoms can make it challenging to view life as worth living, culminating in hopelessness and contributing to the impression that dying by suicide is a viable alternative.

Second, the results from the assessment suggest that Mark does not meet DSM-5 diagnostic criteria for ASPD. Regardless of not meeting the criterion to be of age (18 years old), there must be evidence of conduct disorder with onset before age 15 years. Mark does not meet this criterion for ASPD as he denied almost all of the criteria necessary for conduct disorder [stealing while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery); forcing someone into sexual activity; deliberately engaging in fire setting with the intention of causing serious damage; deliberately destroying others' property; breaking into someone else's house, building, or car; staying out at night despite parental prohibitions; running away from home; frequently being truant from school; or directing aggressive behavior toward others while using a weapon that could cause serious physical harm].

Moreover, Mark's concerns about his behavior that he believed were consistent with ASPD likely fall within the scope of normative adolescent development (e.g., manipulating and physically fighting with his younger siblings) or are better explained by Mark's PDD (e.g., irritability, low motivation/executive dysfunction resulting in procrastination/failure to meet deadlines) and subsequent sensation-seeking. Sensation-seeking is a trait defined

by the search for feelings and experiences that are varied, novel, and complex, and by the willingness to take social, legal, and financial risks for the sake of such experiences. Mark's history of stealing appears to fall squarely in this category, as it represents one of the only means through which he currently knows how to disrupt the chronic boredom and apathy characteristic of dysthymic depression.

Finally, the results from the VIP suggested adequate levels of performance and effort, something that is not commonly associated with or observed in ASPD. Moreover, Mark's responses to both self-report measures and interview questions posed throughout the evaluation process made it abundantly clear that he holds himself and others to a specific moral code. His responses repeatedly illustrated loyalty to his family and ideals, awareness of and gratitude for the privileges afforded to him, and a vested interest in progressive politics, overall demonstrating an impressive passion for social justice, personal accountability, and civic engagement antithetical to the "pervasive disregard for and violation of the rights of others" characteristic of ASPD.

RECOMMENDATIONS

Given Mark's unique presentation, below are a series of specific recommendations for consideration:

- Mark is encouraged to continue attending individual therapy on a regular basis. Therapy models that account for the unique complexities associated with high intelligence and emotional dysregulation may be helpful to him. For example, Mark may stand to benefit from:
    - Dialectical Behavior Therapy (DBT), with a particular emphasis on mindfulness of emotions and emotional regulation.
    - Acceptance & Commitment Therapy (ACT), with a particular emphasis on meaning-making and values-based work to reduce his anxiety related to his life purpose and self-identity and anxious thoughts surrounding time management.

  Regular risk assessments should be conducted during psychotherapy to evaluate the presence of current suicidal behaviors and monitor the frequency and intensity of suicidal thoughts. In the event that his level of risk for suicide persists or increases, Mark may benefit from the development of a safety plan.
- Mark may want to consider engaging in other interventions that aren't necessarily bound to psychotherapy, such as self-directed mindfulness training and/or meditation. Research has shown these practices can be helpful for enhancing emotional awareness and self-regulation (Mitchell et al., 2015).
- While symptoms consistent with ADHD were observed and are better accounted for by Mark's PDD, there is the possibility of comorbid disorders that contribute to the maintenance of his symptoms. As such, if Mark's depression responds to treatment but symptoms of ADHD persist (e.g., low motivation, procrastination, difficulty with task initiation, demand avoidance, emotional dysregulation), or his depression does not respond to treatment, he may stand to benefit from treatment that has been shown to be effective for symptoms consistent with ADHD.
- Mark's responses throughout the evaluation process indicated exceptional intelligence, a desire to succeed in life, and limited intellectual stimulation in his current academic environment. Thus, if the opportunity presents, Mark is encouraged to attend college/university. Attending an institution of higher education will likely challenge him intellectually while providing more flexibility for Mark to choose classes aligned with his interests and values. Moreover, the structure and content of his daily schedule would vary substantially on a daily, semesterly, and yearly basis, providing more avenues for novel and complex experiences to counteract his dysthymic depression.
- Both Mark and Ms. Ferreira gave some indication during clinical interviews that Mark is already aware of and implementing verbal processing as a tool for managing mental and emotional dysregulation. Mark is encouraged to continue pursuing opportunities to verbalize his thoughts and emotions, especially when used as an alternative to suppressing racing, intrusive, or overwhelming thoughts and emotions.
- Mark denied any previous alcohol or drug use and stated that he does not see the appeal of engaging in substance use behaviors. Mark is encouraged to maintain this outlook as he ages, as emotional dysregulation can be a risk factor for developing an unhealthy reliance on alcohol or other drugs. In addition, substance use can elevate the risk of attempting suicide among individuals experiencing depression.
- Behavioral activation and physical activity can both be excellent tools for combating symptoms of depression and ADHD. Mark is encouraged to seek out opportunities to engage in new experiences, activities that previously brought him joy (e.g., swinging), and forms of aerobic exercise (or other, less vigorous means of moving his body) that elevate his heart rate and increase blood flow.

- It is recommended that Mark develop a set of encoding strategies that help him to remember organized and related information that is presented verbally, both in the short- and long-term. Examples of encoding strategies include segmentation (chunking), mnemonic devices, and self-referencing.
- While Mark does not meet diagnostic criteria for ASPD at this time, he is encouraged to monitor any concerns raised as potentially relevant to ASPD to his support system as he gets older.

It was a pleasure to work with Mark. Please do not hesitate to call our clinic with any questions or to discuss these results and recommendations in greater detail.

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Stephanie B. Ward, MS Date
Graduate Clinician

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Christopher J. Gioia, PhD Date
Assistant Clinic Director
WI License # 3236-57

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