

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



Pseudonym: Allen Hathaway, MFA
Age: 39
Sex: Male

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

Psychodiagnostic & Personality Assessment

REASON FOR REFERRAL

Mr. Allen Hathaway contacted the training clinic seeking a diagnostic assessment because of a long-term history of depression and concerns about whether the lack of treatment response stems from a muddled diagnostic picture. Allen reported that, in addition to symptoms of depression, he struggled with anxiety in social contexts and thus had concerns about avoidant personality disorder. Allen expressed great frustration with an overwhelming inability to make himself do what he needs to do, both personally and professionally, despite these often being tasks he enjoys and has no desire to avoid. Thus, the purpose of the evaluation was for Mr. Hathaway to receive more comprehensive information about the nature of his symptoms and to inform how he may best engage with therapy and subsequently achieve a better outcome.

PROCEDURES

Wechsler Abbreviated Scale of Intelligence—Second Edition (WASI-II)
Structured Clinical Interview for DSM-5 Clinician Version (SCID-5-CV)
Structured Clinical Interview for DSM-5 Screening Personality Questionnaire (SCID-5-SPQ)
Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD)
Personality Assessment Inventory (PAI)
Alcohol Use Disorders Identification Test (AUDIT)
Drug Abuse Screening Test (DAST)
Patient Health Questionnaire-9 (PHQ-9)
Generalized Anxiety Disorder-7 (GAD-7)

RELEVANT BACKGROUND INFORMATION

Client provided an extensive history and medical record for review. Thus, for purposes of brevity, only background information relevant to this psychological evaluation is presented here.

Developmental and Medical History

Allen has an extensive medical history including numerous hernias and a birth defect in his right foot that required major reconstructive surgery. After receiving his undergraduate degree, client endured five years of debilitating health problems (e.g., chronic fevers) until he finally received a proper diagnosis of PFAPA (periodic fever, aphthous stomatitis, pharyngitis, adenitis).

Family, Social, and Psychiatric History

Mr. Hathaway reported a series of complex traumas that began early in his development and extended into adulthood. Client shared that his father struggled with severe alcoholism and an explosive temper, the combined effects of which resulted in chronic psychological abuse, including verbal attacks and threats of serious injury. Allen provided examples of this maltreatment dating back to early childhood (e.g., his father angrily grabbing his toy without warning and destroying it by forcibly throwing it against a wall, causing it to explode). Client's father

also raced cars and pressured Allen to do the same, which lead to terrifying experiences both as a driver and unwilling passenger (e.g., his intoxicated father driving at dangerously high speeds with Allen in the bed of his truck as a form of punishment). These experiences culminated in the client's current fear of driving.

Allen reported a close relationship with his brother, who lives in the same area as Allen. Client noted that his brother struggles with alcoholism and depression, as well as disability and mobility restrictions. Allen reported that his mother has a significant history of depression and anxiety, for which she has received at least a decade of therapy. Client described his mother taking a very hands-off approach to parenting following her divorce, often leaving Allen and his brother alone for weeks at a time during their adolescence.

Premature independence in the broader context of neglect, trauma, and exposure to substance misuse likely lead Allen to experiment with illicit drugs as he tried to build social connections and manage his mental health. Client became involved with a group of troubled teenagers and went on to encounter a range of difficult interpersonal experiences during adolescence and emerging adulthood.

Academic & Work History

Mr. Hathaway reported enjoying and excelling in school, ultimately achieving the Master of Fine Arts (MFA) degree. Client shared that he is the author of a poetry book and founding editor of a literary magazine, describing an extended history of editorial service. Allen currently administers and teaches creative writing in the MFA program at a large public university. He explained that, as academic staff, he supervises master's students and post-docs but faculty are his superiors. While Allen enjoys teaching and editing, he expressed discontent with his professional status, feeling stuck and underappreciated or disrespected by colleagues.

Psychological History

Client's father asphyxiated on his own vomit as a result of suspected alcohol poisoning, depriving his brain of oxygen and resulting in brain death. As his father's medical proxy, Allen was responsible for authorizing his father's removal from life support, and he was forced to do so within a very narrow time frame. Mr. Hathaway developed Post-Traumatic Stress Disorder (PTSD), as a result of this experience for which he later received treatment (i.e., EMDR; Eye Movement Desensitization and Reprocessing).

BEHAVIORAL OBSERVATIONS & MENTAL STATUS

The client was oriented to person, time, and place. His mood was euthymic and he showed a range of affect appropriate to the situation (e.g., expressing frustration when tasks were difficult). While Mr. Hathaway has recounted others' experiencing him as detached and unemotional, this clinician did not experience him as such. He seemed gracious and considerate, sometimes laughing nervously and fidgeting in his seat, both of which are to be expected during a lengthy and invasive psychological assessment. Allen denied homicidal ideation and non-suicidal self-injury. He endorsed a history of intermittent, passive suicidal ideation, but denied consideration of means, plan, or intent to kill himself at present. Across all sessions, Allen's thought content appeared logical and linear and gross memory appeared intact. Based on observations of his 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.

ASSESSMENT RESULTS

Cognitive Abilities

Allen was administered the ***Wechsler Abbreviated Scale of Intelligence—Second Edition (WASI-II)*** in order to assess his intellectual functioning. Intellectual functioning refers to a person's ability to problem solve, reason, and learn. The WASI-II provides composite scores that estimate intellectual functioning in two areas: The *Verbal Comprehension Index* (VCI) measures verbal reasoning, verbal conceptualizations, and crystallized knowledge, while the *Perceptual Reasoning Index* (PRI) measures perceptual reasoning, spatial processing, and visual-motor integration. The WASI-II also provides a composite score that estimates general intellectual ability (i.e., *Full-Scale*

IQ-4 Subtests [FSIQ-4]). The WASI-II is an abridged version of the *Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV)* and comprises four subtests: Block Design and Matrix Reasoning (comprise the PRI), and Vocabulary and Similarities (comprise the VCI). These subtests are similar in format to their WAIS-IV counterparts and are the subtests most strongly linked to general intellectual functioning. Administration of all four subtests is a means of quickly estimating an individual's verbal, nonverbal, and general cognitive ability.

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 confidence interval indicates there is a 95% likelihood that a score representing Allen's true ability lays within that range. The FSIQ and index scores are standard scores and can be compared to each other. Individual subtest scores have a mean of 50, with a standard deviation of 10. Average scores range from 40 to 60. Subtest scores are standard scores and can be compared to each other, but not to index scores.

Index and Subtest Scores from the Wechsler Abbreviated Scale of Intelligence- Second Edition (WASI-II)

| <i>Verbal Comprehension Index = 119</i> | | <i>Perceptual Reasoning Index = 127</i> | |
|--|----|--|----|
| Similarities | 60 | Block Design | 69 |
| Vocabulary | 65 | Matrix Reasoning | 62 |

Allen's performance on the WASI-II revealed a *Full-Scale IQ-4 Subtests* in the ***Superior*** range (***FSIQ-4 = 126, Percentile Rank = 96, 95% CI = 120 – 130***). Overall, the results of this assessment suggest that Allen's general cognitive ability is above average relative to his same-aged peers.

Diagnostic Interviews

The ***Structured Clinical Interview for DSM-5 Clinician Version (SCID-5-CV)*** is a semi-structured diagnostic interview to assess current presence and history of DSM-5 disorders and symptoms. Allen completed interview modules assessing for mood episodes and disorders, psychotic symptoms and disorders, alcohol and substance use disorders, anxiety disorders, obsessive-compulsive disorder, PTSD, and attention deficit/hyperactivity disorder (ADHD).

Allen currently meets DSM-5 criteria for *Persistent Depressive Disorder (PDD), Early Onset, Moderate* (F34.1). He reported depressed mood for most of the day, more days than not, over the past two years, accompanied by fatigue, difficulty making decisions, feelings of hopelessness, and low self-esteem.

Allen also meets DSM-5 criteria for *Alcohol Use Disorder, Mild* (F10.10). He reported cravings (i.e., urges to use) and continued use despite knowledge of a persistent physical problem that was likely exacerbated by alcohol.

Finally, Allen currently meets DSM-5 criteria for *Social Anxiety Disorder* (SAD; F40.10). He endorsed elevated anxiety when faced with situations that might expose him to possible scrutiny by others and reported examples of social interactions across contexts that consistently provoke fear of negative evaluation. Allen reported avoiding these situations whenever possible and otherwise enduring them with intense discomfort accompanied by fears of rejection and concerns about maintaining important relationships and professional status.

The client endorsed experiences consistent with panic attacks but did not report concern with or steps taken to avoid future attacks, and thus did not meet diagnostic criteria for Panic Disorder. While Allen presented to the training clinic with a past diagnosis of PTSD, he did not meet diagnostic criteria for it at this time.

Allen denied experiences consistent with mania or psychosis. While he reported struggling with indecisiveness and maintaining attention, he did not endorse enough symptoms to meet diagnostic criteria for ADHD. Moreover, his symptoms of inattention and indecisiveness are better accounted for by his symptoms of PDD and social anxiety. Finally, Allen did not meet diagnostic criteria for the following disorders: Agoraphobia, Obsessive-

Compulsive Disorder, Generalized Anxiety Disorder, or Cannabis Use Disorder.

The **Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD)** is a semi-structured diagnostic interview for assessing the 10 DSM-5 Personality Disorders. A self-report personality questionnaire associated with the SCID-5-PD (SCID-5-SPQ) was utilized as a screening tool to shorten the time that it takes to administer the SCID-5-PD. Mr. Hathaway responded yes or no to 106 questions on the SCID-5-SPQ that map onto items in the SCID-5-PD. Only items where Mr. Hathaway responded yes were further assessed during the formal SCID-5-PD, as it is assumed that no responses on the SCID-5-SPQ would also be no responses if the item was asked aloud by the interviewer. Questioning during the SCID-5-PD was utilized to gather enough information to determine the appropriate rating for that criterion (0, 1, or 2), based on severity, persistence, and pervasiveness. A rating of 0 reflects that the pattern of inner experience or behavior described in the criterion is clearly absent; a rating of 1 reflects that the pattern of inner experience or behavior covered in the criterion is present but below diagnostic threshold ("subthreshold") in terms of severity, persistence, and pervasiveness; and a rating of 2 reflects a pattern of inner experience or behavior at a threshold of pathological level of severity ("threshold"). The SCID-5-PD can be used to make Personality Disorder diagnoses, either categorically (present or absent) or dimensionally (summing the ratings [0, 1, or 2] for each diagnosis and treating these sums as dimensions).

The results from Mr. Hathaway's SCID-5-PD do not support the diagnosis of a DSM-5 Personality Disorder. Dimensionality scores suggest that avoidant (9/14) and obsessive-compulsive (10/16) personality features are most common to Mr. Hathaway's personality. Avoidant features are characterized by a pattern of social inhibition and hypersensitivity to negative evaluation, whereas obsessive-compulsive features manifest in a pattern of perfectionism and preoccupation with mental and interpersonal control, often at the expense of flexibility, openness, and efficiency. However, the totality, severity, persistence, and pervasiveness of these features fall below the diagnostic threshold for pathology within each domain. Overall, these results provide insight into unique aspects of Allen's personality but do not suggest the presence of a DSM-5 Personality Disorder.

Self-Report Measures of Personality & Psychopathology

The **Personality Assessment Inventory (PAI)** is a self-report, objective test of personality and psychopathology designed to provide information on critical aspects of adult clients. Scales yield T-scores with a mean of 50 and a standard deviation of 10. Scale scores greater than 70 are unusual in the general population and likely indicate problems of clinical significance. PAI scales do not, on their own, provide adequate evidence for specific diagnoses. Rather the symptoms and behaviors documented by the PAI can support diagnostic conclusions in the context of additional information.

Upon inspection of the validity scales, it appears that Allen's profile is valid. His clinical scale profile was elevated across several scales, including Depression (DEP, T-score = 86), Anxiety Related Disorders (ARD, T-score = 74), Anxiety (ANX, T-score = 73), and Somatic Concerns (SOM, T-score = 72). This clinical profile is indicative of an individual who exhibits discomforting levels of tension, unhappiness, and social withdrawal. Various stressors—both past and present—have adversely affected Allen's self-esteem and he may feel stuck with respect to changing the direction of his life. An array of lived experiences has left him uncertain about his purpose and generally pessimistic about what the future may hold, which, when considered in tandem with the hopelessness, anxiety, and stress apparent in these scores, may begin to explain why he has found limited success in past treatment efforts. Collectively then, this constellation of symptoms impairs Allen's ability to enjoy and participate fully in life. A more in-depth interpretation for the elevated clinical scales follows:

The client reported a number of difficulties consistent with a significant depressive experience. He endorsed physiological and affective signs of depression including low energy levels, indecisiveness, trouble concentrating, disrupted sleep patterns, a lack of interest in or motivation for activities of daily living, and a loss of pleasure derived from things he previously enjoyed. Consistent with Allen's presenting concerns, the responses observed here indicate he is quite distressed and acutely aware of his need for help.

The elevated ANX and ARD clinical scales suggest that Allen experiences a great deal of fatigue due to the general stress of trying to manage and make sense of his thoughts and emotions, as well as specific symptoms that correspond to different categories of anxiety disorders (i.e., SAD and PTSD; refer to the SCID-5-CV). It appears as though Allen has trouble regulating his nervousness and negative expectancies regarding issues and events over which he has no control, plagued by worry to such a degree that his ability to direct and maintain attention is significantly compromised. Affectively, he struggles to relax and experiences incredible tension resulting from high perceived stress. In contrast to these cognitive and affective signs of anxiety, physical symptoms (e.g., sweaty palms, trembling hands) do not appear to be a major feature of the clinical picture.

Finally, the SOM clinical scale was elevated as Allen endorsed a heightened degree of worry about physical health matters and relative impairment arising from somatic symptoms. He reported numerous times when his daily functioning has been compromised by complex medical problems, which aligns with his medical history. The level of concern with his health status is thus reasonable and proportionate to the problems endured, while still contributing to his overall distress and likely exacerbating symptoms of anxiety and depression.

Allen's PAI responses depict him as a socially isolated individual with few relationships that could be described as close and warm. He may have difficulty interpreting the normal nuances of interpersonal behavior that provide the meaning to personal relationships, while his social isolation may serve to decrease the sense of discomfort that interpersonal contact fosters. Allen may be dissatisfied with his important relationships and uncertain about major life goals, describing himself as more cautious and sensitive in relationship contexts than the average adult.

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item self-report screening tool designed to assess alcohol consumption, drinking behaviors, and alcohol-related problems in the past year. Scores range from 0 to 40, with a score of 8 or higher suggestive of an alcohol problem. Client's AUDIT score was an 11, suggesting that he may be at increased risk of encountering negative consequences from his alcohol use.

The Drug Abuse Screening Test (DAST) is a 10-item self-report screening tool designed to assess drug consequences and problem severity over the past year. Scores range from 0 to 10, with a score of 3 or higher suggestive of a drug problem. Client's DAST score was a 2, indicating a low likelihood of encountering negative consequences from his drug use.

The **Patient Health Questionnaire-9 (PHQ-9)** is a 9-item, reliable and valid metric utilized to assess current depressive symptom severity. Mr. Hathaway's responses are summed, which associate with minimal (1-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe (20+) depressive symptomatology. Mr. Hathaway was administered the PHQ-9 on two different occasions, with scores falling in the moderate (12) and moderately severe (16) ranges.

The **Generalized Anxiety Disorder-7 (GAD-7)** is a 7-item, reliable and valid metric utilized to assess current anxiety symptom severity. Mr. Hathaway's responses are summed, which associate with no (0-5), mild (6-10), moderate (11-14), and severe (15+) anxiety symptomatology. Mr. Hathaway was administered the GAD-7 on two different occasions, with both scores falling in the mild (6-10) range.

SUMMARY & RECOMMENDATIONS

Based on information gathered through the clinical interview and psychological testing, it is determined that Allen meets diagnostic criteria for Persistent Depressive Disorder with early onset (PDD). Despite meeting formal diagnostic criteria for Social Anxiety Disorder (SAD) and Alcohol Use Disorder (AUD) via the SCID-5-CV, the results of this assessment do not warrant an additional diagnosis of SAD or immediate treatment for AUD. Reasoning for this interpretation is as follows:

First, the Hathaway family's psychiatric and behavioral history suggest that Allen might be vulnerable to harmful alcohol use, as he is genetically predisposed to alcohol dependence and hazardous use was modeled for him from an early age. That being said, Allen is aware of this heightened vulnerability and reported cognizance of alcohol's deleterious effects on his mental health. In response to his increased awareness and superior cognitive abilities, Allen may benefit from developing a substance use harm prevention plan to identify situations (triggers) in which he may be more likely to use alcohol or other drugs as a coping mechanism, and learn to replace these resources with other adaptive coping strategies or self-soothing techniques.

Mr. Hathaway endured maltreatment and complex trauma across his childhood, adolescence, and early adulthood. The nature of these experiences during such formative periods likely disrupted his cognitive and emotional development in the social-interpersonal arena. Considering the unpredictable environment in which he was raised (by parents who were both engrossed in their own mental illness), it is reasonable to conclude that Allen received scarce validation or unconditional positive regard. He likely had limited opportunities to form warm, secure attachments and may have difficulty perceiving the nuances of social behavior that provide a sense of closeness in personal relationships. Said another way, it is likely that Allen never received an appropriate understanding of social/interpersonal functioning as a child/adolescent, one in which he learned the reciprocal nature of interpersonal encounters. Perhaps more importantly, Allen may have a limited understanding of how his behavior "links" to his social/interpersonal environment and how consequences of his behavior can result in facilitative (helpful) ways.

In essence, his current social detachment may serve as a defense against future harms and a shield intended to decrease the discomfort interpersonal contact fosters, and is not in response to possible scrutiny or negative evaluation by others (as would be suggested by SAD). Moreover, the results of this assessment imply Allen possesses superior intellectual ability and thinking patterns that might be reflective of cognitive rigidity. The combined effects of his above-average intelligence, somewhat inflexible thinking, and social discomfort appears to culminate in an interpersonal style that negatively affects his relationships and overall experience in the workplace.

It's worth reiterating that Mr. Hathaway's depressive symptomatology is self-sustaining and deeply engrained. Although Allen reported a sharp uptick in his depressive experience approximately 10-12 years ago, there is evidence to suggest his dysthymia dates back to childhood. As such, this client would likely stand to benefit from engaging with a combination of the following evidence-based psychotherapeutic techniques and modalities.

- Dialectical Behavior Therapy (DBT) to build skills in the following areas: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.
- Acceptance & Commitment Therapy (ACT), with a particular emphasis on values-based work to clarify Allen's purpose and most personally meaningful path forward. He may also benefit from self-compassion work, devoted to acknowledging his value and worth as a person.
- The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) to cultivate an increased awareness and understanding of his role in social relationships, and how best to utilize his social skills to express needs/wants (desired outcomes) to others.

Overall, Mr. Hathaway appears to be an exceptionally resilient individual whose ability to empathize and critically consider the experience of those around him remains intact despite lifelong hardship. With time, a positive response to treatment is anticipated.

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

Stephanie B. Ward, MS
Graduate Clinician

Date

Christopher J. Gioia, PhD
Licensed Psychologist
WI License # 3236-57

Date