DHS
Oregon Department of Human Services

OREGON STATE HOSPITAL

AUGUST 3, 2007: BASELINE ASSESSMENT - PSYCHOLOGY

The purpose of this report is to provide pertinent information about the patient's cognitive functioning, learning achievement, developmental history, personality characteristics, and other issues applicable to psychiatric diagnosis, treatment, and rehabilitation at the Oregon State Hospital. This assessment is supplemental to an assessment written in 2006 and identified below. Findings from that assessment will be incorporated into this Psychology Baseline Assessment.

ASSESSMENT TOOLS USED:

The Montreal Cognitive Assessment
Repeatable Battery for the Assessment of Neuropsychological Status
Personality Assessment Inventory
Adult Attention Deficit Disorder Evaluation Scale – Home Version
Adult Attention Deficit Disorder Evaluation Scale – Self-Report Version

Additional clinical interview and review of the patient's files were used for collaborative information. Of note is a Psychological Assessment conducted by Lisa Ilaria, MS, a Psychological Trainee, and signed by Elena Balduzzi, PsyD, dated May 6, 2006, the results of administrations of Millon Clinical Multiaxial Inventory - III Revision, and a Rorschach Inkblot Test performed the basis for the personality section herein. Of note is an invalid administration of the Minnesota Multiphasic Personality Inventory – Second Edition was in the patient's assess file that administration was invalid due to an F Score greater than 109.

IDENTIFYING INFORMATION: The patient is a 22-year-old non-Hispanic Caucasian never-married male who is under the jurisdiction of the Psychiatric Security Review Board for five years until June 18, 2009, after the result of being found guilty except for insanity of charges of Unlawful Use of a Weapon. His most recent diagnosis includes major depressive disorder, recurrent, severe, with psychotic features, and posttraumatic stress disorder on Axis I and borderline personality disorder on Axis II.

PATIENT BEHAVIOR: The patient alternated between being taciturn and interested in participating in the assessment process. He noted that he had been treated with medications for attention deficit disorder when he was young and had hoped to be able to start medication in his current setting. Of note is that on several occasions the patient left well written notes for this writer regarding his reluctance about participating in testing.

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The Montreal Cognitive Assessment is a brief measure of cognitive functioning aimed at determining presence of neuropsychological deficits. The results of administration of this instrument on May 22, 2007, suggested some cognitive dysfunction with deficits in productive language and memory.

COGNITIVE FUNCTIONING: The Repeatable Battery for the Assessment of Neuropsychological Status is a brief neuropsychological functioning screening device as such is used to determine where more in-depth investigation is necessary to determine the degree and specifics regarding deficits in functioning. It provides measures of five areas of functioning. These include immediate memory, delayed memory, visuospatial/constructional, language, and attention. The patient performed in the average range in visuospatial/constructional skills, in the borderline range in language skills, and in the extremely low range in attention, immediate memory, and delayed memory. These findings are consistent with the findings in the Montreal Cognitive Assessment.

No measure of intelligence was used as the patient noted he had left school in the sixth grade as well as the above noted deficits in neuropsychological function. Observations on the ward as well as report from other staff suggest some relative intellectual strength in the areas of performance Intelligence Quotient and some relative challenges in the areas of verbal Intelligence Quotient skills based on his fund of knowledge as well as his language deficits.

The Adult Attention Deficit Disorder Evaluation Scale – Home Version and Self-Report Version are self-report and other report check lists and are standardized forms used for diagnosis of attention related disorders and that subscale suggesting whether an indicative disorder is of the inattentive or hyperactive impulsive type of attention deficit hyperactivity disorder. These ratings were completed in May 2007, and suggest attention deficit hyperactivity disorder mixed type. The patient's self-report indicated more problems than the reports generated by ward staff.

The results of cognitive and mental status testing suggest deficits in attention as well as difficulties in functioning suggesting a cognitive disorder such as attention deficit hyperactivity disorder, mixed type.

PSYCHOSEXUAL BACKGROUND: The patient's notes that he had a difficult childhood having been abandoned by his mother to his father's care when he was young. He noted that he spent time under his mother's, father's, and paternal grandparent's care.

He reports as well, as records support, abuse and neglect sufficient to significantly impact normal development and adult interpersonal functioning. Reports of sexual and physical abuse are sufficient to met criteria for a posttraumatic stress disorder.

PERSONALITY/CHARACTER TRAITS: The Psychological Assessment dated February 9, 2006, reports on findings of administration of the Million Clinical Multiaxial Inventory – III, and the Rorschach Inkblot Test, that assessment concludes that the subject exhibits

> "...negative self-perceptions, unstable sense of self, poor interpersonal relationships, and depressed affect which may at times interfere with his perceptual abilities and cognitive processes. Mr. Giffen exhibits borderline personality features of instability and unpredictability of mood and behavior. He waivers between feeling dejected, euphoric, intensely angry, irritable, and self-destructive. He elicits his own rejections, but strongly reacts to fear of abandonment. He intermittently idolizes and devalues people, leading to relationships that are characterized by ambivalence, instability, and intensity. Underlying these behaviors are extremely, poorly developed sense of identity, which is the core of his disillusions of his control. His poorly defined sense of self might eventually give way to feelings of emptiness into his disorganized thought. Under stress he may have transient psychotic episodes. Mr. Giffen also appears to possess a narcissistic sense of entitlement and a tendency to externalize blame and responsibility. This contributes to problematic interpersonal relationships with others as well as unrealistic perspectives on success and failure. This tendency towards narcissisms does not constitute a pervasive personality character; rather it may serve as a defense against his substantial self-doubt regarding his self-worth which, in turn, contributes to extreme fluctuations in mood."

This report does provide a more extensive examination of personality and the reader is referred to that report. This report, observations on the ward, as well as conversations and interactions with the patient suggest that the patient does exhibit characteristic of both narcissistic as well as borderline personality disorders. Including a stance of entitlement and interpersonal lability respectively. Review of the client history does not suggest he fully meets the criteria, completely for either at this time.

DIAGNOSTIC AND TREATMENT CONSIDERATIONS: These current findings in combination with the findings of the previous psychological evaluation support, the patient's current diagnosis as well as an additional diagnosis of cognitive disorder on Axis I. The patient's cognitive deficits in the area of attention and memory as well as observations on the ward are supportive of a diagnosis of attention deficit hyperactivity disorder, mixed type, comorbid with a mood disorder, and an anxiety disorder such as posttraumatic stress disorder.

The patient presents a complex combination of cognitive mood/anxiety, and personality disorders. Recently the patient started treatment for attention deficit hyperactivity disorder using a stimulant, shortly thereafter became emotionally and behavior labile and was subsequently transferred from his previous ward to ~~the~~ a maximum security ward. While the connection is not at all clear, it does seem that the patient, when stable, is not optimally functioning. Treatment in different areas of functioning should proceed cautiously to increase personal coping skills and trust as change in mental status is observed. Emotional coping skill development such as that encouraged by Dialectical Behavior Therapy treatment should be encouraged as the patient proceeds through his psychiatric care at Oregon State Hospital. Emotional stability may be more important than optimal cognitive functioning for successful psychiatric treatment.

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D. 08/03/07
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cc: PSRB