SAMPLE PSYCHOLOGICAL EVALUATION

Client:	**AB**
Age:	50 years
Education:	Master's degree
Birth Date:	XXXXXX
Date of Evaluation:	04/01/2017
Examiner:	Dr. Laurie Cestnick

Reason for referral:
AB reached out for testing given her personal belief that she is being harassed in her town, and her husband's contrary belief that she is imagining concerns that don't exist. Her husband has insisted that she be evaluated and is very concerned over recent delusional thinking as well as evident paranoia and reported olfactory hallucinations or hypersensitivities. No prior diagnoses or concerns were reported by AB nor by her husband; symptoms have said to have existed for approximately 18-24 months. Psychological testing was completed and results are presented herein.

TESTS

Interview with client and phone interview with her husband; background history; MMPI-2; MIPS; BAI (Beck Anxiety Inventory); MBMD; Rorschach Ink Blot Personality Test; D-KEFS: Twenty Questions, Proverbs, TOWER; WAIS-IV: Working Memory tasks.

BACKGROUND HISTORY

AB lives at home with her husband (XX) and their daughter. English is spoken in the home. AB is an only child and she has always spent a great deal of time with her husband's family and siblings. Everyone has always got along. Regarding AB's early development, all prenatal (AB's mother reportedly did not consumer alcohol or drugs during pregnancy), birth and early development were reported as free from complications with normal attainment of developmental milestones such as walking, talking, and potty-training. AB is an only child. Her medical history consists of chicken pox and hay-fever as a child with hay-fever persisting throughout life (and presently), and no asthma, head injuries, headaches, seizures, or hospitalizations/surgeries throughout her life. As an adult she did have a C-section when birthing her daughter, lost hearing in her left ear (cause unknown and reported as idiopathic), and breast cancer surgery (4x) in the fall last year (2016 when she was 52), and also allegedly experiences intensely bad olfactory sensations particularly with respect to her own body odor (olfactory hallucinations and/or hypersensitivities). Her thinking has been delusional (seeing random acts from strangers as passive-aggressiveness toward her, e.g. believing cars are parked with license numbers to frighten her, and that people in her town are colluding against her. She is allegedly cancer free at this time as treatments were successful. The following were reported on her family line: alcoholism (father), cancer (mother and father), and diabetes (father). AB's husband reported possible delusional thinking on AB's maternal side (mother) given reports of her believing the government was watching/tracking her for many years. No additional mental health or neurological concerns were reported on family lines. AB reported experiencing occasional concentration concerns, but no inattention, learning/academic, memory or cognitive concerns

were reported as present at any time during her life. No nightmares or nervous habits were reported. A specific and recent fear of being harassed was reported (discussed further in this report). AB has been seeing a counselor approximately once per month for the past few months, but has not at any other point during her life. AB states she enjoys sports, tennis, skiing, and doing activities with her family such as traveling and being outdoors.

SUMMARY

Delusions, paranoia, and olfactory hallucinations and/or hypersensitivity (contact Dr. Cestnick for facts behind symptomatology), are all present with an onset that appears to coincide with the onset of breast cancer and treatments (radiation). No history for these symptoms was present prior to the timing in/around the onset of cancer and cancer treatments. There may be some mild delusional thinking on the maternal side (patient's mother) as reported by AB's husband who stated AB's mother used to believe that the government was tracking/watching her, but he has not witnessed delusions or paranoia in AB for all of the years they have been married, until the past 18-24 months (when the cancer was discovered/ treated). An MRI of the brain and full medical evaluation are necessary to rule out medical causes for recent symptoms (delusions, paranoia, olfactory sensations). Should no medical causes be found for recent symptomatology, this would warrant a probable diagnosis of PTSD with psychotic features. Psychological testing indicated the possibility of a personality disorder and/or strong personality features that would exacerbate symptoms, such as a passive-aggressive and/or paranoid personality, although it is first necessary to rule out a psychotic disorder with a medical basis before assigning Axis II diagnoses with certainty. It is the case that a passive-aggressive personality style has contributed to the nature of her delusional thinking (believing others are acting very passive-aggressively toward her -- even total strangers). Ruminative thinking (delusional in nature), anxiety, and a negative self-image are exacerbating problems as well.

DSM-V diagnoses and recommendations are given on the next and subsequent pages.

DSM-V DIAGNOSES:

Axis I

293.81 and 293.82

Rule out Psychotic Disorder due to a medical condition
(symptoms: delusions, paranoia and olfactory hypersensitivity possibly olfactory hallucinations)
(medical: onset of above psychotic symptom coincide with onset of breast cancer and cancer treatments – largely corticosteroids and radiation; rule out psychoses from corticosteroids, brain cancer, temporal or parietal lobe insults/seizures, etc.)

309.81

Rule Out PTSD with delusional/paranoid features
(If no medical condition/steroid is causing psychotic symptomatology, PTSD with psychotic features is probable diagnosis; PTSD secondary to breast cancer scares/anxiety re. death)

Axis II

Passive-aggressive Personality features (strong)
(paranoia is also significant but with possible recent onset as opposed to developmental)

Axis III	Breast cancer remission Olfactory hypersensitivity or hallucinations (Rule out temporal, parietal or any other brain insult)
Axis IV	Marriage and interpersonal relationships (withdrawing from others; conflict over behavioral/cognitive/personality changes) Lack of support system (paranoia keeps her at bay from allowing support at this time)
Axis V	40 GAF

RECOMMENDATIONS

Medical

1. Rule out drugs/medical concerns contributing to paranoid/delusional testing, e.g. **brain MRI and medical evaluations**.

2. Completion of a **neuropsychological evaluation** to examine cognition and monitor these skills over time.

3. **Anti-anxiety medication at least for the short-term** (at least a few months) – but first rule in/out medical etiologies before deciding upon medications.

Counseling

4. Counselor should try to **establish as great of a trusting rapport** with AB as possible (essential to progress given high levels of paranoia and delusional thinking).

5. Counselor should **meet with AB's husband and/or additional family members for additional information** to assist AB, her marriage, and the family unit.

6. **After obtaining more medical information (e.g. MRI) and developmental history, update diagnoses** and take steps to inform AB and significant others of diagnoses and recommendations designed to assist AB, her marriage and the family unit as a whole.

7. **Insight, cognitive-behavioral, and behavioral therapies for AB to help improve conflict resolution and coping skills without resorting to passive-aggressiveness**. Insight and reality-testing therapies regarding the impact of her passive-aggressiveness and its contribution to how she has interpreted events and actions of others.

8. Counselor can work on **reality-testing strategies and accepting the presence of delusional thinking, paranoia, and possible olfactory hallucinations**.

9. Additional recommendations, e.g. for anxiety-reduction, will follow after additional medical and neuropsychological evaluations have taken place to help isolate diagnostics (and hence recommendations) more accurately.

Please schedule a brain MRI and appointment with a neurologist to discuss temporarily stopping steroid treatments and to monitor potential changes in psychotic symptoms thereafter. Consider scheduling a neuropsychological evaluation to rule out and monitor possible cognitive anomalies. Let's revisit recommendations once this additional information has been obtained.

Sincerely,

Dr. Laurie Cestnick