C. Scaffolding and Assignment Design

Assignments for Abnormal Psychology
Winter 2011, Dawson College

Worth: 30% total

Keep one folder for this assignment. Each time you submit a part, submit all prior parts in the same folder.

Part 1: Diagnostic information and research notes 4%
Part 2: Clinical Interview and Assessment form 3%
Part 3: Treatment approaches 3%
Part 4: Psychological Report 20%

Parts 1-3 will make writing Part 4 much easier. For Parts 1-3: late assignments (without a valid reason) will be given a grade of 0. For Part 4, 2 marks (10%) will be taken off per day late

Goal: Pretend you are a psychologist and write a Psychological Report on an individual who you have determined is suffering from a specific mental disorder from the DSM-IV[1]. Your job is to research this person sufficiently so you can provide a specific diagnosis and treatment plan and write a Psychological Report on this person. Pretend you are this "client's" clinical psychologist. As examples, in your course pack are two student papers on John Nash from *A Beautiful Mind.* (note: you cannot use John Nash as your client!).

Part 1: Finding your "client" and diagnostic criteria 4%

Step 1. Decide who will be your "client".
This person can be fictional or non-fictional; from a movie, tv show or book. I have provided a list of clients from which you can choose. For confidentiality reasons, it cannot be someone you know. If you still want to find your own "client", you must talk to me first and have it approved. If you want to use a movie or book not on this list, see me; sometimes the Hollywood portrayal is inaccurate/ or not enough material is provided on the character with the mental illness.
Some of these movies may have some disturbing content (especially those with *). Viewer discretion is advised. It is your responsibility to find the movie or book of your choice.

Addictions- Trainspotting*; The Basketball Diaries; Leaving; Las Vegas*; The Lost Weekend; Clean and Sober; Requiem for a Dream*
Alzheimers- Iris, Still Alice (a novel), Away from Her
Amnesia: Memento
Antisocial personality disorder- American Psycho*; We need to talk about Kevin* (a novel)
Autism or Aspergers- Rainman, The Curious Incident of the Dog in the Night-Time (a novel), Ben X
Bipolar- Mr. Jones;
Borderline Personality Disorder- Fatal Attraction; Girl Interrupted
Traumatic Brain Injury- Regarding Henry
Depression: American Splendor; The House of Sand and Fog; Ordinary People
Dissociative Identity Disorder –Three Faces of Eve

[1] For ideas, check out: www.behavenet.com/capsules/disorders/dsm4TRclassification.htm or http://www.psychologynet.org/dsm.html

Gender Identity Disorder- Ma Vie en Rose, Boys Don't Cry;
Mental retardation: The Other Sister; I Am Sam
Obsessive Compulsive Disorder- As Good As It Gets; The Aviator
Paraphilias- Ed Wood;
Pedophilia- Happiness*;
Post Traumatic Stress Disorder- First Blood- Rambo 1; Coming Home; The Deer Hunter*'
Schizophrenia - Benny and Joon; Clean, Shaven; Donnie Darko

Step 2: Find the diagnostic criteria from the DSMIVTR (2 points)
To get the diagnostic criteria, your best source is the DSM-IV from the library. I recommend you also photocopy most of the chapter – the DSM is full of lots of useful information. The diagnostic criteria can also be found on these websites: www.behavenet.com/capsules/disorders/dsm4TRclassification.htm or http://www.psychologynet.org/dsm.html. At the end of this section, highlight the name(s) of other disorders you will need to rule out before confidently making a diagnosis (sometimes called differential diagnoses- fans of *House, MD* may be familiar with the mechanics of a differential diagnosis).

Step 3: Research the disorder (2 points)

You will need to become knowledgeable about your client's disorder (wouldn't want to misdiagnose your client, now would you?). Start by reading the entire chapter in your abnormal psychology textbook in which your client's disorder appears. Focus your notes on your disorder. Write at least three pages of notes using your own words. You can make an outline of the chapter, include flowcharts or a diagram, or simply take careful notes. The purpose of this note taking is to help you understand as fully as possible the structure and details of this chapter and as evidence that you are doing the preliminary reading on your road to becoming an expert on this type of disorder.

Submit notes on what information you will need to do a proper assessment of your client. In many cases, the textbook does not go into great detail. I suggest you find a few more sources on the disorder (e.g., find scholarly articles on online databases; read reputable websites).

Submit to me the following information (stapled, please):

- The name of your client. Include the name of the movie/ book/ show and the suspected diagnosis
- (2 points) Provide ALL the DSM-IV diagnostic criteria for the disorder plus highlight the disorders to rule out (differential diagnosis)
- (2 points) Personal notes (3 pages, handwritten (2 pages if you prefer to type); grammar/ spelling do not matter) you have taken while researching the disorder.

Part 2. Complete and submit the Clinical interview(s) and Assessment form 3%

Just write n/a if something is not applicable to your client- e.g., client is a child, therefore married = n/a)
Handwritten or typed. This information will be very helpful when you begin to write you formal report.

CLINICAL INTERVIEW AND ASSESSMENT FORM

Psychologist's Name:

Client's Name:

Age:

Sources consulted (e.g., interviews with client, family, friends, medical-, prison-, or school records, other?):

A. THE CLINICAL INTERVIEW

Reason for referral / *main concern(s) this patient wants addressed* (why is person being seen at *this* time? who referred him- self, spouse, court ordered, other professionals?)[2]:

When did problems first begin?

Any precipitating factors, (i.e..other stresses at time)?

Past treatments? Successful? Why or why not?

Relevant medical history. Medications? Other illnesses? Note possibility of drug or alcohol problems.

Married status:

Children:

Currently lives with:

Social supports:

[2] State at what point in the client's life is he or she coming to see you, and for what purpose. Many students find they need to pretend they have been asked to see the client early on in the movie's plot line; other students pretend to be doing a reassessment of an already-diagnosed person; while others find it appropriate to having been court appointed. This is an assessment of your client, not a movie review; you do not have to stick to the plot line of the movie 100%.

Religion:

Education:

Job history:

Financial status:

Bereavement or losses

Social activities, Hobbies and other interests

Other relevant background information?

B. BEHAVIOURAL OBSERVATIONS (SEE THIS SECTION OF THE ACTUAL PSYCHOLOGICAL REPORT FOR IDEAS)

appearance-behaviour

thought processes

mood, affect

intellectual functioning

orientation

C. PSYCHOLOGICAL TESTING- indicate which test(s) you are considering using and explain why.

Intelligence testing (e.g., WAIS-R)

Achievement tests

Neuropsychological tests

Projective tests (e.g., Rorschach ink blots, TAT)

Personality inventories (e.g., MMPI, parent, teacher checklists)

D. PHYSICAL EXAM REFERRALS- indicate which test(s) you are considering using and explain why.

Vision or hearing,

toxicity,

thyroid,

neurological like EEGs or brain scans

Part 3. Appropriate treatment approaches (3%):

Find at least 3 treatment suggestions for your client. Given what you know about your client and how your client's problem affects those people close to him, what are some of the treatment approaches you would put in place?

Point form (typed) is fine for this exercise. Don't just make up these ideas; you must also back up the suggestion with a reference from an academic source (scientific journal article, reputable website, textbook, etc). The treatment must be tailored to the individual and to the disorder. For example, some disorders primarily respond to medication (be specific), and treatment is enhanced with supportive individual therapy and vocational counseling. People with other disorders might need education, couple's therapy, and assertiveness training. While others will start with cognitive behavioural training, medication, relaxation training and group therapy. There are many types of treatments - I have named but a few. (1 point for each appropriate approach backup up by the literature)

Part 4. Psychological Report (20%)

Now you must submit a formal Psychological Report on your client. **Length**: Should not be less than 4 pages or more than 10 pages, not including cover page (typed, double-spaced, one inch margins, no extra line spaces between paragraphs).

Imagine this report will likely be read by other professionals.

Have a plan or general outline in mind when you start writing. Know where you're going; what conclusions you're building toward. If you start writing with the idea that you'll figure out some conclusions when you get to the end of the report, you'll need to do extensive rewriting to make the report flow smoothly and to remove the unnecessary details. For example:

- Know your diagnostic criteria well (along with diagnoses you may need to rule out!) so you will know what evidence you will need to include in your report.

- While re-watching the movie, keep the list of diagnostic criteria handy- write down examples that support your diagnosis or disconfirms other competing diagnoses
- Know in advance if there are certain people you will interview who know your client well.

You want the report to flow smoothly, so that minimal effort is required of the reader to organize the data. Help the readers assimilate the information by giving them an efficient structure. Let them concentrate on understanding the patient, rather than being distracted by trying to "put the pieces together." Excessive, unnecessary details will distract the reader from the case you are trying to build in support of your conclusions.

1. You will need to use my Psychological Report template (attached to this document).
2. Organize each section of the report with paragraphs and use good paragraph structure. The first sentence of the paragraph tells what the whole paragraph is about. The last sentence sums up the paragraph. Good paragraphing - often missing in cegep students' papers- helps the reader understand the logical flow of your paper and helps to digest the information in manageable chunks.
3. Within each topic, it usually is helpful if you follow a chronological order. You don't want the reader to have to stop and figure out which admission came first or which symptoms appeared last, etc.
4. Students often find it easier to write the report in the past tense, as if you actually had conducted an assessment and was writing about it, with some exceptions (e.g., treatment plan will likely be written in the future tense).
5. Try to keep information under the appropriate subheading; try not to be repetitive. If paragraph one stated that the patient has been repeatedly fired from jobs, don't repeat this in paragraph four as part of the "social issues" paragraph. Find a way to convey all the information and only say it once. Exceptions to this rule include repetition for emphasis and limited repetition in the summary.
6. Show awareness of when you are making inferences and providing concrete observations to back up your speculations (a mistake many students make is guessing what's going on inside someone's head, rather than providing information that is based on more solid evidence; This is what it means to provide *empirical* evidence). If you do not have certain pieces of information about this person in order to complete a section, note where you are speculating or simply note in the report that this information is missing from your evaluation.
7. When referring to yourself in a report there is no clear consensus whether you should use personal pronouns or refer to yourself as "the examiner." Many psychologists feel that referring to yourself in the third person makes the report sound more objective and formal. Others feel that it makes the report sound awkward and stilted. One option is to find ways to avoid references to yourself. For example,

(WEAK)	(BETTER)
The patient was angry with me for interrupting his scheduled activities on the ward.	The patient voiced frustration and hostility over disruption of scheduled ward activities.

Evaluation: You will be evaluated on the following criteria:

1. How well you have angled the report so that the reason for referral is ultimately addressed.
2. How well you have shown that the diagnostic criteria of a particular mental disorder relates to your client. Use the DSM-IV for criteria. Also research criteria for differential diagnosis (i.e., did you rule out other, competing diagnostic criteria?)
3. How well you have provided the relevant information a mental health professional should include in a report.
4. How logical your treatment plan seems to be (do proper research on this, so your plan is good).
5. How well written your paper is (e.g., clear sentence structure, proper spelling, logical flow of ideas, not repetitive).

6. At the end of the report, on a separate page, include a reference section of sources you have consulted. No need, however, to include in-text citations throughout the report.

See me if you have any questions.

Please remove from my template anything in italics from your report. Keep all information in bold in your report, in that order.

CONFIDENTIAL-PSYCHOLOGY REPORT

Name of consulting clinician:
Date of Report:
Name of "client":
Where was this client found? *(e.g., which movie or book?)*
Suspected Diagnosis:

Reason for referral:

Use this section to briefly introduce the patient and the problem. Begin with a concise "demographic picture" of the patient. (eg., "Mr. X is a ____-year-old, Caucasian male who presented to this clinic with a history of sad feelings" or "This is the third inpatient admission for this 32 year old, single, white female, who claims to hear voices telling her to kill herself.") In most cases, you will not know at the time of referral what the patient's diagnosis is. That's expected- most of you are here to diagnose your client. Just describe why this individual has come to see you. e.g., "Mr. X was referred to this clinic by so and so for an assessment of his current level of functioning and to determine an appropriate plan of treatment….etc…"

Background Information

*Provide relevant information from the clinical interview regarding: History of the present illness, Past treatment(s), Relevant medical history, and Psychosocial Information. You will likely find this section will flow better if you present the information in **CHRONOLOGICAL ORDER**.*

Behavioural observations

Focus on YOUR observations and impressions. "An initial interview found Mr. X to be..." Here is where you describe relevant aspects about your client's presentation (e.g., appearance-behaviour, speech, thought content and form, attention, mood, emotional expression, intellectual functioning, orientation). Write what you observe, and if you wish to infer what this evidence implies, fine, but make sure you make it clear you are speculating (e.g., She spoke slowly and minimally. Combined with her poor hygiene, body posture and comments she made, she seems to be experiencing some feelings of depression). Do not create subsections for this section (e.g., 1. Appearance. 2 Orientation…); rather, write flowing paragraphs highlighting only the essential qualities that will help further your diagnosis. Two common mistakse: a) Not imposing some sort of order to this section and simply throwing at the reader a bunch of disconnected observations.; b) using terminology you do not understand.

Example: A typical mental status examination for a 'normal' patient might read: Results of mental status examination revealed an alert, attentive individual who showed no evidence of excessive distractibility and tracked conversation well. The patient was casually dressed and groomed. Orientation was intact for person, time and place. Eye contact was appropriate. There was no abnormality of gait, posture or deportment. Speech functions were appropriate for rate, volume, prosody, and fluency, with no evidence of paraphasic errors. Vocabulary and grammar skills were suggestive of intellectual functioning within the average range. The patient's attitude was open and cooperative. His mood was euthymic. Affect was appropriate to verbal content and showed broad range. Memory functions were grossly intact with respect to immediate and remote recall of events and factual information. His thought process was intact, goal oriented, and well organized. Thought content revealed no evidence of delusions, paranoia, or suicidal/homicidal ideation. There was no evidence of perceptual disorder. His level of personal insight appeared to be good, as evidenced by ability to state his current diagnosis and by ability to identify specific stressors with precipitated the current exacerbation. Social judgment appeared good, as evidenced by appropriate interactions with staff and other patients on the ward and by cooperative efforts to achieve treatment goals required for discharge.

If the patient is too psychotic, disorganized, or uncooperative to be evaluated, then be specific about why you were unable to complete the evaluation and what efforts you took to try to motivate cooperation. Be sure your reader understands that you put forth appropriate effort. Even in cases like this, you can still write a report. Your description of the type of uncooperativeness encountered is important (e.g., Repeated efforts to conduct psychological evaluation were unsuccessful. The patient refused to answer most questions and became hostile

when encouraged to participate. Efforts to establish rapport were impaired by extreme paranoid ideation exhibited during the sessions.)

Some more ideas for this section (remember: don't use any terms you don't know what they mean):
appearance: appropriate and unremarkable dress, grooming/ hygiene, carriage, facial expression (blank),asymmetry, maintained good eye contact, mannerisms, motor stability, gait, restless activity, normal movement and posture. *physical problems: bodily concerns include:-decreased (R) arm and (L) leg strength and ability (paralysis/ pain)-prosthetic device:-gait/ balance, dizziness:-tremor: resting/ intentional-motor retardation:-visual:-hearing:-headaches*

orientation: disorientation for / appreciation of time/ place/ person:involvement with environment(seeming indifference), Forgets what cues mean or what the instructions were (test for this: a)hearing ok? b) attending ok? c) follow 1 step ok? d) do a,b,c, with 2 steps etc)

emotional state: mood (prevailing emotional tone) e.g.,(the patient seemed to be under a great emotional strain, which manifested itself more by...)/ (He was at times tearful, but exhibited a good range of affect): unremarkable, friendly,easy going relaxed, cheerful, elated, optimistic, euphoric, tearful, cautious, restrained,, inhibited, defensive, negativistic, pessimistic: shy, serious, fearful, aggressive, hostile, tense, depressed

affect (range and appropriateness of emotional response): contradictory:anxiety: labile: tense: blunted: apprehensive, restricted: panic state

Speech a) delivery: rate, tone, quality, concise expression, articulation, phrasing smoothness and ease of delivery, spontaneity (initially spontaneous speech was limited, though he answered all the questions posed to him.)During conversation his speech was fluent and grammatical (limited)
oral expression: stuttering:, halting: labored: dysarthric: accent:-His speech was clear but lacking in prosody.
b) content: misuse or confusion of words, (his sentences were often incomplete) grammatical or syntactical errors, perseveration, dysnomia, and other deficits in word production and organization,
concrete / abstract: The content of his speech was limited to concrete observations. paraphasic: word substitutions jargon: word finding problems:

Thought processes: (aside from speech, not always easy to distinguish, esp with patients with aphasias, verbal dyspraxias, depression, motor slowness)
(occasionally necessary to have him clarify/ elaborate his thoughts)
He failed to account for the need of the listener for coherence. This poor pragmatic skill affected the intelligibility of his discourse; incoherence; quality and appropriateness of associations; logic clarity, difficulty organizing information that he wanted to convey. Very essential information was omitted.
rate of thought production, (the content of her thoughts was superficial and did not reveal a lot of information. Lack of abstraction); blocking, confabulation, circumstantiality, rationalization,
(with confabulation, patient may change answer when confronted "do you really see little green men?" This "insight" does not rule out confab - it just shows patient awareness of social cues):
there appears to be some difficulty in the initiation and execution of plans; slower thought processes; problem understanding new instructions; problem in scheduling daily activities; difficulty reading; greater decision making difficulty; impaired judgment

comprehension-good, functional -impaired as a result of language difference -primary (auditory) comprehension deficit - impaired comprehension of complex demands -cannot follow conversational speech -needed time to process incoming information. If it was presented too fast, he missed some information

insight: patients does not fully appreciate the extent of his difficulties, and appears to resent the implication that he has problems. As such, his expectations are slightly/ grossly, unrealistic, response to deficits -Able to see limitations and consequences related to his problem

Results from Formal Testing

Only include this section if you administered some standardized tests (e.g., Intelligence or Achievement tests, Behaviour Checklists , MMPI, TAT or CAT, Rorshach Ink Blot Test) , present findings here.

a) Test Taking Behaviour:

Testing was completed in X sessions...from (date) to (date)
-Most test sessions were limited to one hour as X became(fatigued/ complained of increasing neck pain/ her confusion increased)

***assets**:-the patient was friendly and related easily to the examiner.-Good sense of humour-He responded with obvious comfort (confidence)to the structure of the testing situation and worked meticulously and methodically on all tasks.-appeared to be highly cooperative and motivated to perform well. (absorbed in task)-endurance, persisted, even when the tasks were difficult-displayed a willingness to guess when unsure of his answers*

***hindrances**:-uncooperative-unmotivated, bored, lack of concern about his performance, unresponsive -his responses were given slowly and hesitantly, as though each one required a great deal of effort and concentration on his part.-he continued to respond cautiously, but showed signs of trying when encouraged-After discussions with Mr X regarding the nature of the testing and what was expected of him, he became more cooperative-he seemed overly anxious to please the examiner-needed a lot of encouragement (reactions to failure and praise)-his anxiety about his illness exacerbated the difficulty he had orienting himself to tasks and maintaining attention-self deprecating/ overly critical-low fatigue threshold - low frustration tolerance/ irritable/ antagonistic-his inability to tolerate failure interfered with his performance-appeared frustrated with himself when progress was not immediately forthcoming and expressed some distress at realizing his areas of deficit during the examination.-distractible Sustaining attention was difficult; he frequently had to be reoriented to the task at hand. If he repeated instructions aloud, this seemed to aid his comprehension.- impulsive, though tended to correct his own mistakes. -....and when brought to his attention X could acknowledge them (his errors) but would not alter his response style--he tended to answer questions impulsively, without considering all pertinent elements, and he had difficulty considering alternatives.-approach generally methodical with the more simple tasks, though tended to become increasingly disorganized as the tasks became more complex-reliant on trial and error-perplexed -hurried, hyperactive-malingering compulsive-often failed to indicate, either verbally or non-verbally, when he did not understand something. - Directions needed to be repeated.-Whether tasks were self-paced or externally paced he was highly impulsive and poorly vigilant. He had clear difficulty regulating his own responding and occasionally forgot the test rules. To his credit he was able to use repeated and ongoing feedback to significantly modify his response rate over time, but without such input his attention and self-control were more likely to deteriorate. It will be this area of deficit which will be most problematic behaviourally and academically.*

b) <u>Results of the testing</u>

<u>Diagnosis:</u>

(e.g., "Based on the information provided, a diagnosis of ___ is offered." Write out the entire DSM diagnositic criteria for your client's disorder, then show how your client meets enough criteria to offer a diagnosis. A deeper paper might show how you have ruled out other competing diagnoses (differential diagnosis) or how you might be considering another diagnosis.

<u>Summary and Recommendations</u>

Begin by specifically answering the questions you posed under "Reason for Referral." Then elaborate as much as needed to present your conceptualization of the case. What type of therapy(s) would be best for the person? Why is this approach recommended? If you have any concerns for this person's safety (e.g., suicide risk) what would you recommend? What is the likelihood this patient will get "better" (this is your prognosis)?

e.g., Results of psychological evaluation reveal an extended history of alcohol abuse and a psychotic disorder characterized primarily by disturbance of thought content, with relative integrity of thought process and no clear indication of perceptual disturbance. The current clinical presentation appears to represent an acute exacerbation of a chronic psychotic disturbance which had its onset approximately 8 years ago. Currently, Mr. Jones appears to remain extremely distressed, anxious, paranoid, and delusional, despite self-reports to the contrary. He lacks sufficient capacity/ motivation to rely on external supports and lacks sufficient personal insight to cope independently at present. The patient appears to be attempting to cope with his illness using extreme guardedness and withdrawal. During recent months he has shown no signs of aggressive ideation and is not believed to be a physical risk to himself or others at present. It is recommended that efforts to establish a trusting relationship with this patient be continued, in order to help him cultivate a more adaptive coping/defensive pattern. Individual therapy will be more productive than group interventions. Once his guardedness has been relaxed, it will likely be beneficial to explore psychosocial issues present at the time Mr. Jones lost his job, as these appear to have partially precipitated the current psychotic exacerbation. Additionally, the patient will benefit from encouragement to explore the social and adaptive significance of his substance abuse history.

Please do not hesitate to contact me if any additional information is needed concerning the results of this evaluation.

_____ _____

Provide your signature here **Date of Report**

On the next page, provide a Reference page of all the scientific sources you consulted

Appendix A: Include the "notes" you took for the Clinical Interview

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Dawson College

CONFIDENTIAL-PSYCHOLOGY REPORT #1

Consulting clinician: **Olivia Jerebic**
Date of report: May 9, 2009
Name of Client: John Nash
Suspected Diagnosis:Schizophrenia – Paranoid Type
Where was the client found? John Nash is the main character in the movie *A Beautiful Mind*.

Reason for referral:

Mr. John Nash was referred to this clinic by his wife, Alicia Nash, who was concerned with some of her husband's occasionally bizarre and erratic behaviour. Mrs. Nash did not know how to deal with her husband's unorthodox behaviour and concluded that a psychological or psychiatric evaluation might be necessary.

Background Information:

Mr. Nash is a 30-year-old Caucasian male who presented to this clinic with what appear to be visual and auditory hallucinations. Furthermore, he seems to have periods of delusional thinking, paranoia, confusion, as well as agitation.

It was revealed during an interview with Mr. Richard Sol, a former college classmate and current work colleague of the client, that Mr. Nash began portraying some of these symptoms approximately 8 years ago, at a time when they were both still graduate students in mathematics at Princeton University. Mr. Sol claimed that he, as well as many other students, viewed Nash as being a very strange, solitary and erratic individual. He stressed that Mr. Nash had been socially withdrawn during his years at Princeton, and often sat aside from everyone else in class. On the rare occasions when Mr. Nash did participate in certain social activities, Sol mentioned that he usually appeared uncomfortable and even made certain inappropriate or irrational comments. Richard Sol did admit to believing that Mr. Nash acted strange. However, he claimed to have viewed the client's behaviour as being part of his personality and not as a potential mental illness.

During a recent interview with Alicia Nash, the client's wife, she described her husband as having excessive paranoia and believing that people, which he referred to as Russian spies, where following him and trying to harm him. She also mentioned that she had caught her husband conversing with what appeared to be himself or someone who was not physically present. Mrs. Nash admitted that she grew particularly anxious when her husband's strange behaviour did not subside and began to affect his ability to work, as well as his social interactions. She claimed to have never witnessed her husband act in such a strange way prior to getting married and claims that her husband's abnormal behaviour has begun to take a toll on their marriage.

Mr. Nash has never received any form of psychological or psychiatric treatment in the past and has therefore never been diagnosed with a mental illness or been hospitalized. He also claimed that there is no history of mental disease in his family and that he was currently not taking any sort of medication. Furthermore, Mr. Nash denied any history of excessive drug use or alcohol use. He did, however, admit to drinking occasionally, but claimed that his intake was moderate.

Psychosocial Information John Nash graduated from Princeton University with a Ph.D. in mathematics approximately 5 years ago. He is obviously very gifted at mathematical and scientific reasoning and is a well-known professional in his field. Mr. Nash has worked at MIT as a calculus professor and a researcher in the science and mathematics field for 3 years. However, his ability to properly perform his job on a daily basis has been hindered due to his current condition. He does not enjoy socializing with people, appears to have limited social skills and mostly enjoys spending his time doing research and working in his office. His social network consists of mainly his wife, as well as two work colleagues with whom he conducts research. He has been married for two years and he and his wife are expecting their first child in a few months. He and Mrs. Nash are in a stable financial situation and

live comfortably off of their earnings. Mr. Nash states reading, spending time with his wife, as well as stargazing in her company as some of his favourite activities.

Behavioural Observations

During an initial interview, Mr. Nash appeared extremely tense and confused as to where he was being taken to. He was clothed with garments that did not match, had not shaved himself and had not combed his hair. As he entered the room, he did not make eye contact and kept his head down. His bad posture became prominent as he walked, and a shuffle gait did become apparent. When confronted about the tasks he performs on a daily basis at work, he became extremely cautious and stated that he was not in a position to discuss the matter, since "they", who he referred to as Russian spies, were watching his every move and would overhear what he was saying. He did claim however to be working on something "top-secret" for the Pentagon. Also, he often lost focus during the interview and occasionally shouted-out something incoherent and irrelevant, as if he were speaking to someone standing right beside him. When asked who he was speaking to, he did not answer immediately, as he remained concentrated on something beside him. It later became apparent that he was referring to someone named Charles, who he claimed was present in the room and trying to convince him that he did not need any treatment.

During conversation, Mr. Nash spoke very quietly and slowly, as if he feared that someone would overhear what he was saying. Nevertheless, his speech was rather fluid and he did express himself in a relatively normal tone. Mr. Nash did stutter on several occasions; however his speech was grammatically and syntactically correct as he answered questions slowly and hesitantly. Mr. Nash did not appear to have any insight into the nature of his disorder, since he constantly stated that he was not sick and did not need to see a psychologist.

Mr. Nash was administered a toxicity test, which came back negative, therefore confirming that he had not been using drugs or drinking excessively. A hearing exam and a vision exam were also performed on Mr. Nash. The results for both tests did not portray any abnormalities in the client's auditory and visual abilities. Mr. Nash was also administered an MMPI as part of the testing process and results did indicate a high paranoid scale. The client was also required to take a general medical exam, but nothing abnormal about the client's physical health was implied in the physician's medical report. While being administered the tests, Mr. Nash was very difficult to work with and did not want to collaborate with staff members. He was also extremely tense, aggravated and fearful, repeatedly shouting-out that he was deliberately being harmed and that he did not need any medical attention.

[note: At the time of this report, the Results from Formal testing section wasn't required]

Diagnosis:

Based on the information provided, a diagnosis of paranoid schizophrenia is offered. Below are the diagnostic criteria, along with commentary.

A. Characteristic Symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) Delusions

(2) Hallucinations

(3) Disorganized speech (e.g., frequent derailment or incoherence)

(4) Grossly disorganized or catatonic behaviour

(5) Negative symptoms, i.e., affective flattening, alogia, or avolition

Symptoms specific to Paranoid Schizophrenia:

1. Preoccupation with one or more delusions or frequent auditory hallucinations.

2. None of the following is prominent: disorganized speech, disorganized or catatonic behaviour, or flat or inappropriate affect.

There are indications that Mr. Nash is preoccupied with an organized system of delusions. He did show symptoms of delusions of persecution, which are the most common in Schizophrenia, as well as delusions of grandeur, since he claimed to be working on an important classified project for the Pentagon and being constantly hounded by Russian spies who analyse his every move. He also clearly suffers from auditory hallucinations, which were manifested as he conversed with an individual that he referred to as Charles. There were also indications that Mr. Nash has visual hallucinations, which are uncommon, and not present in many cases of Schizophrenia. There was evidence suggesting that Charles is not only an auditory hallucination, but also a visual one, since Mr. Nash did refer to him as if here was physically present in the room during the interview.

There was no indication of perseveration or neologisms in Mr. Nash's speech content. He did not portray any signs of apathy or avolution, since he did not appear unmotivated or as if he were lacking energy. There was no sign of alogia, as Mr. Nash spoke rather fluently and responded to questions in mostly full and comprehensible sentences without making any loose associations. Furthermore, Mr. Nash's motor skills were fairly intact, except for a minor shuffle gait. Therefore, because there was no indication of majorly disrupted speech/ behaviour and no severe psychomotor disturbances, Disorganized Schizophrenia, as well as Catatonic Schizophrenia can be ruled out as potential diagnoses for the client.

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

Many areas of Mr. Nash's life have been negatively affected by his condition. He has developed very poor social skills and has distanced himself from any sort of social activity. He has been struggling with his job, since he is constantly responding to unreal stimuli, which are brought on by his delusions. He is also having marital problems, as he and he wife are having difficulty communicating. Furthermore, Mr. Nash's personal hygiene did appear to be affected by his current condition.

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

Mr. Nash's disturbance has persisted for a period greater than 6 months and symptoms have been present throughout those whole 6 months. Therefore, Brief Psychotic Disorder and Schizophreniform Disorder are ruled-out as a potential diagnosis for the client, as they require duration of less than 6 months. During this period, Mr. Nash did not receive any form of treatment for his condition. Thus, because he has not yet been provided with any medical attention, it is not possible at this point in time to discuss the presence of residual symptoms. However, prodromal symptoms, such as hallucinations and delusions did manifest themselves significantly. During this 6 month period, Mr. Nash did not show signs of negative symptoms, which are mostly not characteristic of Paranoid Schizophrenia.

Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

There have been no signs of Major Depressive, Manic, or Mixed Episodes concurring with the symptoms of Schizophrenia portrayed by Mr. Nash. He did not show significant signs of mood swings or an irregular display of inappropriate emotions. Therefore, Schizoaffective Disorder and Mood Disorder can also be excluded as potential diagnoses for Mr. Nash.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

It was revealed by the toxicity test performed on the client that he is not in a state of psychosis due to medication or abuse of illicit substances. Mr. Nash was also administered a general medical exam by a physician; however the client did not show signs of having any kind of medical problem. Therefore, Mr. Nash's disturbance is not due to substance abuse or an untreated medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Mr. Nash does not have a history of Autistic Disorder or any other Pervasive Development Disorder. Thus, these disorders do not have an effect on his diagnosis.

Treatment Plan and Prognosis:

In order to treat Mr. Nash, prescribing a conventional neuroleptic drug, such as Loxapine or Pimozide would be recommended in order to reduce excessive amounts of the neurotransmitter dopamine in the patient's brain. These types of antipsychotic drugs are very effective in reducing positive symptoms, such as delusions and hallucinations, which are Mr. Nash's main schizophrenic symptoms. In concordance with the antipsychotic drugs, psychotherapy, especially insight therapy, would also be extremely useful in helping Mr. Nash learn more about his disorder. It could potentially help him think more clearly, distance himself from his delusions and eventually change his own behaviour. Marriage counselling should also be an important part of Mr. Nash's treatment plan, since Mr. Nash's disorder has greatly affected his marriage. Because Mr. Nash is a Paranoid Schizophrenic, social therapy would also be important in order to ensure that he is taking his medication and following his treatment plan. Often, Paranoid Schizophrenics stop taking their medication because their delusions and paranoia convince them that they do not need to be treated, or that they are being harmed. Furthermore, social therapy will also help Mr. Nash re-establish himself in his workplace and also help him develop his social skills.

If Mr. Nash follows through with this treatment plan, his positive symptoms should begin to subside within a timeframe of 6 months. Furthermore, he should also begin acquiring new social skills, enabling him and his wife to communicate better, which would improve their marriage. This treatment plan is also designed to provide Mr. Nash with skills to help him remain focused on the tasks he is required to perform at work, as well as to help him establish new goals for his career.

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Psychologist's Name Date of report

CONFIDENTIAL- PSYCHOLOGY REPORT #2

Consulting clinician: **Adam Caplan**
Date of report: April 20, 2009
Name of "client": John Forbes Nash
Suspected Diagnosis: Paranoid Schizophrenia
Where was this client found? This client was found in the movie "A Beautiful Mind", playing the role of a renowned genius mathematician battling paranoid schizophrenia.

Reason for referral:

Mr. Nash was referred to this clinic by his wife, Alicia Nash, for an assessment of his current level of functioning and to determine an appropriate plan of treatment. Mrs. Nash believed it was necessary for him to be reevaluated for his condition. He had already been assessed at the McArthur's Psychiatric Hospital upon which a treatment was put into practice that at this time Mrs. Nash feels is inappropriate and ineffective. After Mr. Nash had become aggressive and violent for the first time, Mrs. Nash felt it was important for her husband to be reassessed and to have a new treatment program implemented. Mrs. Nash's main concerns are that her husband can no longer be trusted to take care of his child and can no longer support his family under his current prescribed treatment.

Background Information:

History of the present illness: Mr. Nash is a 42-year-old, Caucasian male who presented to this clinic with a history of delusions and hallucinations. As previously assessed at the McArthur's Psychiatric Hospital ten years ago, signs of a mental disorder including delusions and hallucinations begun upon entry to the Carnegie Institute of Technology at the age of 17-years-old. Since Mr. Nash's entry to C.I.T., he has continuously been having a number of delusions and hallucinations. The recurring delusion that Mr. Nash encounters is of a man named William Parcher who heads a CIA corporation attempting to use Mr. Nash to decode Russian messages. Mr. Nash has been overly obsessed with decoding what he believes to be Russian messages. To add to this delusion, Mr. Nash was convinced that the Russians were pursuing him in an attempt to shut down his operation. Mr. Nash became very anxious and worried about all black cars, men in suits and loud noises, which brought upon extreme paranoia and stress. As well, it was noted in his previous assessment that Mr. Nash has been experiencing visual hallucinations of multiple individuals since beginning his stay at C.I.T. The hallucinations included his roommate named Charles, Charles's niece named Marcy and the head of the CIA group named William Parcher.

Past treatment and outcomes: Mr. Nash has previously been treated by the McArthur's Psychiatric Hospital at the age of 32-years-old. McArthur's Psychiatric Hospital quickly diagnosed Mr. Nash with paranoid schizophrenia. They began a treatment including injection of insulin shocks five times per week, for a total of two weeks. After completion of the two-week period, the hospital proscribed Mr. Nash a high dosage of anti-psychotic medication to be taken daily to control his symptoms of delusions and hallucinations. Mr. Nash's body and mind did not react well to this designated treatment. Symptoms from the medication included affective flattening, social withdrawal, and an extreme case of apathy, as the client felt so restricted while taking his medication that he no longer had any energy, interest or motivation to stay active. While taking the medication Mr. Nash could no longer perform simple mathematic problems, something he had always been able to do as a recognized genius of mathematics. Mr. Nash began to smoke cigarettes after his treatment.

Relevant medical history: Prior to his onset of symptoms at the age of 17-years-old, Mr. Nash has no record of previous medical illness. Records from his childhood cannot be found, however, Mr. Nash assures that he never felt as though he had a mental problem before entering the Carnegie Institute of Technology. Mr. Nash was taking anti-psychotic medication proscribed by his previous doctor at the McArthur's Psychiatric Hospital until he unadvisedly discontinued his medication. Mr. Nash has no history of drug abuse as he was constantly focused on his work and studies. Mr. Nash was never consuming alcohol consistently but claims to have turned to alcohol at several stressful times during his days at school.

Psychosocial Information- Functional Assessment: Mr. Nash is 42-years-old. He has been married to his wife Alicia López-Harrison de Lardé for 13 years. Mr. Nash has a son named John Charles Martin Nash. Mr. Nash lives at home with his wife and son. Information on Mr. Nash's schooling is missing prior to his enrollment to Carnegie Institute of Technology at the age of 17-years-old. Mr. Nash graduated with both a bachelor's degree and a master's degree from C.I.T. Mr. Nash did not work while at school and began his first job as a professor at Princeton University upon graduating from C.I.T. This was his last job before being treated by the McArthur's

Psychiatric Hospital and he now remains unemployed. While only speculation, it seems as though Mr. Nash's financial status is relatively comfortable from his previous job, however without employment perhaps his family will need support. There is no evidence of bereavement as no one close to him has passed away as of late. Mr. Nash was never an abusive husband or father until the one event prior to his referral when he hit his wife. Mr. Nash doesn't engage in social events; he spends most of his time with his work and studies. Evidently, any of Mr. Nash's hobbies relate to mathematics. Mr. Nash recently took on the habit of smoking cigarettes after his previous treatment began. Prior to his treatment, Mr. Nash's strengths all revolved around the use of his mind and brain as he was recognized as a mathematics and engineering genius.

Behavioral observations/ mental status examination:

An initial interview found Mr. Nash to be very uncomfortable being back at a hospital. His hygiene didn't seem to be under control, smelling of odor and cigarettes while his clothes looked dirty as if he hadn't changed in a few days. Mr. Nash was very fidgety while being interviewed; he was constantly moving around. He never made good eye contact, another sign that he was uncomfortable being in my office. Whenever Mr. Nash was asked a question that made him uncomfortable he would consistently scratch his head with his right index finger. However, He still answered most questions, albeit his answers were usually short. When the interview swayed towards questions about his family, Mr. Nash's tone began to sound rather sad and emotional and he became at times tearful. When asked to describe how he feels about his situation at home with his wife and son, Mr. Nash's emotional strain was apparent while explaining how it saddens and hurts him that he can no longer be trusted with his own son or to protect his wife. It was the first time since the beginning of the interview that he began to open up and talk, which made it clear that he wishes to change and become responsible at home.

When asked if he had any pains, he responded no and that he felt fine. His bodily functions appeared to be under control and working fine. Following visual and hearing tests, it was evident that he could see and hear perfectly everything presented to. When asked whether his hallucinations were appearing during the interview, he responded that they were happening as we speak and that he can see his college roommate sitting next to him. Then, when asked whether he was aware that his college roommate was merely a form of hallucination he said yes, a sign of acknowledgement that this was not real but simply a hallucination. Mr. Nash was given a toxicity test to see whether he had been taking excessive amounts of drugs or alcohol, however the test came back negative proving that he had not been overdosing on any drugs. Next Mr. Nash was given a standardized intelligence test, to test whether his brain was functioning the same way as before his first treatment, now that he is off of his medication. Mr. Nash scored 160 on the test, a score 1 out of 10,000 people score on the test, indicating that while off of his medication his brain performs at the high rate it use to work at. When speaking there were no content errors in his speech, rather his delivery at times was spotty. At many times his speech was spontaneous due to the random thoughts that were flowing through his mind, though he still continued to answer all questions posed to him fluently and grammatically correct. Mr. Nash spoke in a low tone while often stuttering his words. For the most part he was focused in on the interview, although at certain random times you could see his eyes focusing on something else and at a low tone muttering something. For example, at one point when asked what he was doing, he answered that he was decoding the article that lay on the desk. It was clear that his intelligence, while not taking medication, was fully intact with his reading, mathematics and other skills functioning properly, though he did say that his hallucinations had reappeared. The patient understands that he has hallucinations and doesn't seem to resent the implication that he has problems, but rather he wishes to fix and change these issues.

Diagnosis:

Upon review of the information provided, a definite diagnosis of paranoid schizophrenia is offered and confirmed from his previous assessment. The following is the criteria for schizophrenia and furthermore the criteria for the paranoid type.

Diagnostic criteria for Schizophrenia (cautionary statement)

A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) delusions

(2) hallucinations

(3) disorganized speech (e.g., frequent derailment or incoherence)

(4) grossly disorganized or catatonic behavior

(5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

Mr. Nash's symptoms fall directly in place with the criteria above. The patient has been having both delusions and hallucinations, each present for a significant portion of time for greater than a 1-month period. Also, his delusions have been of a bizarre type and his hallucinations have at times consisted of two or more voices conversing with each other, as he mentioned his roommate Charles and Charles's niece Marcy talking to him.

B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

Since the onset of the disturbance, Mr. Nash's functioning at work as well as interpersonal relations have both been performed below the level prior to the onset. He has not been teaching due to his obsession with his delusions nor has he been keeping up with his relationships with his wife, son and friends like it was prior to the onset.

C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

Mr. Nash has had continuous signs of the disturbance persisting for greater than 6 months with greater than a 1-month period that included symptoms that meet Criterion A.

D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

Schizoaffective Disorder and Mood Disorder can be excluded as Mr. Nash's delusions and hallucinations were not concurrent with a Major Depressive Episode (which must include depressive mood), since the patient wasn't depressed while having his delusions and hallucinations.

E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Mr. Nash's disturbance is not due to the direct physiological effects of a substance or a general medical condition, as he has not been abusing drugs/medications nor does he have any other medical condition.

F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions

or hallucinations are also present for at least a month (or less if successfully treated).

This doesn't apply to the patient, as he has no history of Autistic Disorder or another Pervasive Developmental Disorder.

Diagnostic criteria for 295.30 (Schizophrenia) Paranoid Type (cautionary statement)

A type of Schizophrenia in which the following criteria are met:

A. Preoccupation with one or more delusions or frequent auditory hallucinations.

B. None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.

This concludes that Mr. Nash has a Paranoid type of schizophrenia, as he has had frequent hallucinations (his roommate and niece, head of CIA), auditory and visual, as well as one or more delusions (undercover decoding mission for CIA as well as being chased by the Russians). As well, Mr. Nash showed no signs of disorganized speech, catatonic behavior or flat affect.

Treatment plan and Prognosis:

When creating a proper treatment plan for Mr. Nash, his previous treatment and outcome was taken into account. Due to his reaction to the high dosage of anti-psychotic medication, a change in medication must be made. While ECT is well known for providing significant improvement in symptoms quickly, this doesn't bode well in Mr. Nash's case. His last doctor previously gave Mr. Nash insulin shocks and his body did not respond well to it. In his case, it is more important for him to be able to control his symptoms while keeping his mind in tact and functioning. The risks of ECT on his brain are not worth it as his wife referred him in an attempt for him to feel comfortable and be trustworthy while his symptoms remain under control. With the above being ruled out, the following treatment plan has been designed to help control Mr. Nash's symptoms without restraining his mind:

1) Medication- Mr. Nash will be started with a low-to-average dosage of second-generation atypical antipsychotics. These medications are well known for helping manage delusions and hallucinations. The main risk of these medications is tardive dyskenesia which is known to take many decades to develop, but in Mr. Nash's case as he grows into his later years this is less of a worry, as his wife desperately needs him now as their son grows up.

2) Individual therapy- Mr. Nash will attend individual therapy. Psychotherapy is recommended in order to improve skill deficits that have been created due to his condition and to help compliance in taking his medications, as Mr. Nash previously decided to stop taking his medication on his own. Individual therapy will also help improve communication, relation and social skills.

3) Employment support- Mr. Nash will receive help to get him back at work, not as a full time professor, but merely to get him socializing and ease him back into it. Perhaps sitting in on classes is a good way to slowly get back to what he loves doing.

4) Family therapy- Mr. Nash along with his wife will attend family therapy to improve the understanding of his condition, stressful situations to avoid relapses and help with the new treatment plan.

The prognosis for Mr. Nash is very optimistic. Though his symptoms of hallucinations and delusions will never go away, with the proper therapy, medication and support he can live a comfortable life with his wife and son and return to doing things he loves while his hallucinations and delusions remain under control. Mr. Nash is an intelligent man, with his mind he should have an easier time adapting and understanding what is reality and what he is imagining.

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Psychologist's name Date Of Report