

Confidential Psychological Report

Patient: [redacted]
Date of Birth: [redacted]
Date of Report: [redacted]
Testing Clinician: Jordan Hazzard, Psy.D.
Registered Psychological Associate
License #: PSB94026408

[redacted]

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Licensed Clinical Psychologist
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Referral Information

[redacted] was self-referred for psychological testing and assessment services. During the initial consultation, [redacted] explained that she experiences both cognitive and emotional difficulties. Namely, [redacted] reported that she experiences frequent rumination, racing thoughts, lapses in attention, impaired short-term memory, difficulty recalling childhood experiences, panic attacks, anxiety, and depression. [redacted] expressed that she is pursuing psychological testing and assessment services at this time in order to (1) clarify diagnoses that would appropriately explain her presenting concerns and (2) receive recommendations for treatment or other psychological services.

Evaluation Procedures

- 1. Semi-Structured Clinical Interview
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]
6. [redacted]
7. [redacted]
8. [redacted]
9. [redacted]
10. [redacted]
11. [redacted]
12. [redacted]

Mental Status

state of mild conflict throughout her childhood years, which eventually resulted in separation and divorce.

When [REDACTED] reached the age of [REDACTED], her parents separated. She and her brother relocated with their mother to [REDACTED], where they would reside for the remainder of her childhood while visiting their father in [REDACTED] once per year. [REDACTED] described the separation of her parents as “traumatic”, as the separation itself occurred suddenly and without discussion within the family. Additionally, [REDACTED] recalled that she found the cultural and social adjustment to life in [REDACTED] to be especially challenging for her.

[REDACTED] explained that she felt overly concerned with her mother’s apparent emotional distress following she and her father’s separation; in order to avoid contributing to further emotional distress in her mother, [REDACTED] reported that she learned to compartmentalize her negative emotions. As [REDACTED] began to approach adolescence, she began to experience heightened levels of anxiety and feelings of panic, which occasionally manifested in panic attacks.

[REDACTED] reported that she experienced frequent bullying throughout her elementary, middle, and high school years. She stated that she was primarily bullied for her manner of speaking, which was often faster than her peers, as well as her appearance and shyness. She explained that bullying was often treated as normal behavior by adults in her community, and so she didn’t receive assistance or guidance from adults in protecting herself from being bullied. Additionally, she felt unentitled to seek help from teachers or parental figures because she didn’t want to contribute to the distress she observed in the adults in her family and community.

When asked about her feelings of depression, [REDACTED] reported that she has felt depressed for as long as she can recall. However, throughout her developmental years, she suppressed her feelings of sadness in an attempt to manage them. [REDACTED] began to change this pattern in [REDACTED], when she sought therapy for depression. [REDACTED] reported that she found therapy to be helpful to her in alleviating depressive symptoms, making sense of past experiences, and improving her overall quality of life.

Although [REDACTED] had to discontinue working with her therapist at that time due to relocating to another state in which her therapist was unlicensed to practice, she reported that she continued to reflect on the experience and maintain the positive impact it had on her life. Further exploration of her presenting concerns indicated that the positive experience she had in therapy contributed to her decision to pursue the present course of psychological testing and appropriate treatment recommendations.

In [REDACTED] of [REDACTED], [REDACTED] and her husband began to experience marital difficulties, which led them to engage in frequent verbal arguments. [REDACTED] reported that she felt as though she was being verbally abused by her husband at the time. These conflicts led her husband to pursue therapy, which resulted in an improvement in both his apparent emotional and psychological functioning, and in the relationship overall. [REDACTED] reported that she now feels satisfied in her relationship, but added that she still feels negatively affected by the high level of conflict that occurred between she and her husband. [REDACTED] added that she experienced approximately three panic attacks during this period of marital conflict.

Academic History

█ was recognized as intellectually gifted by her teachers from a young age. She completed an IQ test during elementary school upon recommendation from her teachers, and received a score suggestive of intellectual giftedness.

█ reported that she earned grades in the A and B ranges during elementary school, but her grades fell to the B and C ranges as her emotional distress increased in middle and high school. Specifically, █ reported that she felt increasingly high levels of anxiety and depression as she entered adolescence. Additionally, bullying became more severe, and she often felt alienated from her peers and community members. She recalled that her teachers often stated that she needed to “apply herself more”, which █ experienced as frustrating because she didn’t understand how to make use of the feedback, as she was doing her best to apply herself in spite of bullying and rejection from her peers.

Although █ recalled that she experienced a high level of interpersonally aversive relationships in general during her developmental years, she explained that she maintained close and supportive friendships with a small number of trusted peers, just as she does at the time of the present evaluation in her adulthood. █ also remained active in multiple creative and arts-based extracurricular activities, including contributing to her school newspaper and becoming involved in her student government. Although she enjoyed some aspects of these activities, she reported that she felt overwhelmed by the high number of activities she was involved in.

During her later years in high school, █ reported that she experienced a high level of difficulty in her coursework. She was often unable to focus on course material, and frequently felt lost in her classes. She attributed her academic difficulties during her high school years to a combination of a high level of emotional distress, chronic anxiety and depression, lack of interest, and feelings of alienation from her peers and teachers.

Occupational History

█ has held multiple and varied jobs throughout her adulthood. For the past █ years, █ has worked in a variety of roles within the banking industry. She reported that she often experienced difficulty in her previous jobs due to feelings of anxiety and difficulty sustaining attention and focus. However, she stated that she enjoys the work that she has done within the banking industry. Although █ has previously experienced occupational difficulties associated with inattention, she has been successful in her work within the banking industry, which requires a high level of attention to detail. In her current role, █ enjoys using her intellectual and analytical skills to solve complex problems within the workplace.

Psychiatric History

█ has attended counseling multiple times in her life. She stated that she found counseling to be helpful. However, she had a notably positive experience while working with a therapist in

█ She stated that she found the insight-oriented nature of her work with this therapist to be helpful to her in making sense of how she has been impacted by past experiences.

█ has taken multiple psychiatric medications in her lifetime, including █, and █. She recalled that she experienced multiple negative reactions to █ and █.

█ reported that she has experienced approximately two panic attacks per year since adolescence. She added that she experiences mild elevations in acute anxiety that resemble panic attacks on a more frequent basis.

Medical History

█ had a grand mal seizure at age █. This led her to pursue evaluation and treatment from multiple different neurologists. Eventually, it was discovered that she had an arachnoid cyst on her right hippocampus, which has been successfully treated.

Legal History

█ does not have a history of noteworthy legal difficulties.

Substance Use History

At the time of the present psychological evaluation, █ uses cannabis on an approximately daily basis.

At approximately age █, █ experimented with cocaine for approximately █ months. █ also took psychedelics, including LSD and psilocybin mushrooms during her teenage years. She discontinued using psychedelics after taking too many and having a negative experience.

Test Results

The present psychological assessment battery was organized to clarify the possible impact of anxiety and depression on █'s functioning; to identify other possible psychiatric disorders or psychological factors that may be affecting █'s functioning; and to attempt to explain █'s self-reported difficulties with inattention and memory. The data gathered during the semi-structured clinical interview indicated that █ may have an attention-deficit disorder; therefore, screening for ADHD was incorporated into the present psychological assessment battery.

Emotional and General Psychological Functioning

█

The █ is a self-report screening measure designed to screen for the presence of anxiety or symptoms associated with an anxiety disorder. The █ produces T-scores ($m=50$; $sd=10$), which allow for comparison with a normative sample. █ received a T-score of █, which is associated

with a moderate level of anxiety. Scores in this range are suggestive of the presence of anxiety at a level of severity that is sufficient to interfere with information-processing functions when an individual is faced with environmental pressures. [REDACTED] diagnostic ranges are based on a clinical reference group of outpatients; moderate levels of symptomology may be experienced subjectively as significant within the general population. A moderate range of anxiety as represented in [REDACTED] diagnostic ranges may be experienced subjectively by [REDACTED] as highly distressing.

[REDACTED] endorsed the following items, which may be relevant to providers as they engage in treatment planning:

- Unable to relax. (moderate)
- Fear of the worst happening. (moderate)
- Nervous. (severe)
- Fear of dying. (mild)
- Scared. (mild)
- Numbness or tingling. (mild)
- Feeling hot. (mild)
- Dizzy or lightheaded. (mild)
- Unsteady. (mild)
- Hands trembling. (mild)
- Shaky. (mild)
- Indigestion or discomfort in abdomen. (mild)
- Faint. (mild)
- Face flushed. (mild)
- Sweating (not due to heart). (mild)

In addition to exploratory, insight-oriented, and/or supportive interventions, [REDACTED] scores in the moderate range are often indicative of the need for anxiety-reduction strategies in order to reduce acute distress.

[REDACTED] [REDACTED]

The [REDACTED] is a self-report screening measure designed to screen for the presence of depression or symptoms associated with a depressive disorder. The [REDACTED] produces T-scores ($m=50$; $sd=10$), which allow for comparison within a normative sample. [REDACTED] received a T-score of [REDACTED], which is associated with a severe level of depression. Scores in this range are suggestive of a high likelihood of a depressive disorder. Although [REDACTED] denied suicidal ideation and intent both in her [REDACTED] responses and in the semi-structured clinical interview, mental health providers are encouraged to attend to feelings of hopelessness, low self-esteem or worthlessness, and passive suicidal ideation or fantasies. As [REDACTED] is a reliable narrator with good insight and judgment, clinicians are encouraged to focus on establishing a positive working alliance with her and, within that context, to collaborate with her in attending to concerns associated with suicide risk. The focus on a collaborative, supportive clinical stance is to be emphasized. [REDACTED] presented as an exceptionally socially skilled individual; this is one of her strengths, which was reflected both in the collaborative stance that she adopted as a patient in psychological testing, and in her ability

to sustain long-term friendships. A strength of this kind bodes well for the treatment of a depressive disorder in psychotherapy, and is encouraged to be supported within a positive therapeutic alliance.

█ endorsed the following items, which may be relevant to providers as they engage in treatment planning:

- I am so restless or agitated that I have to keep moving or doing something.
- It's hard to get interested in anything.
- I don't have enough energy to do anything.
- I have no appetite at all.
- I find I can't concentrate on anything.
- I am sad all the time.
- As I look back, I see a lot of failures.
- I have much greater difficulty in making decisions than I used to.
- I feel more discouraged about my future than I used to be.
- I don't enjoy things as much as I used to.
- I feel guilty over many things I have done or should have done.
- I have lost confidence in myself.
- I am more critical of myself than I used to be.
- I cry more than I used to.
- I don't consider myself as worthwhile and useful as I used to.
- I sleep somewhat less than usual.
- I am more irritable than usual.
- I get more tired or fatigued more easily than usual.

█ is a comprehensive, objective measure of adult personality and psychopathology. It is frequently administered in a broad range of psychological assessment and treatment settings. The fourth edition of the █ is correlated with the fifth edition of The Diagnostic and Statistical Manual of mental Disorders (DSM-5), and may be of support in the accurate diagnosis of DSM-5 syndromes.

█'s █ protocol portrayed an overall healthy individual at the level of personality functioning. Her scores were consistent with the data gathered in the present assessment battery, indicating a high level of depressive and anxious symptomology. Notably, █'s █ protocol also suggested that feelings of feelings of worthlessness may be triggered by both perceived and overt rejection in interpersonal settings. This finding is both consistent with the possible impact of bullying on █'s self-esteem, as reported during the clinical interview, and supportive of the value of a collaborative working alliance in mental health treatment settings. Providers may also find benefit in exploring associations between perceived rejection and the severity of anxious symptoms.

In addition to highlighting areas of satisfaction and dissatisfaction in specific domains of life, the [REDACTED] also provides an estimate of a patient’s overall subjective sense of their quality of life. [REDACTED]’s [REDACTED] protocol indicated that she is experiencing an overall very low quality of life at this time. [REDACTED] is encouraged to focus on prioritizing areas of health, money, work, learning, creativity, helping, and children, as these domains were associated with a subjective experience of lower quality of life. In contrast, [REDACTED] is encouraged to continue to focus on supporting her self-esteem, goals and values, leisure activities, romantic relationship, friendships, familial relationships, home life, and engagement with her neighborhood and overall community. These domains may be revisited in a counseling or supportive psychotherapy setting and incorporated into the overall treatment plan.

Cognitive Functioning and ADHD Screening

[REDACTED]

The [REDACTED] is a self-report screening measure that is frequently used in the diagnosis of adult ADHD. In the present assessment, the testing clinician read the items to [REDACTED] and recorded her responses, taking time to discuss those items that required additional attention to nuance. The measure consists of 18 items, which are rated in order of severity. The first 6 items are correlated with the diagnostic criteria of ADHD, and the remaining 12 items are included to assist in specifying presentation type and severity level. Respondents who report experiencing 4 or more of the first 6 items at a high level of frequency (“often” or “very often”) are expected to meet diagnostic criteria for ADHD.

[REDACTED] rated 4 of the first 6 items at a high level of frequency. Her responses were suggestive of difficulties primarily associated with inattention. However, discussion of specific items suggested that a majority of the highly rated items may be associated with anxious mood, either in addition or as opposed to an attention-deficit disorder.

[REDACTED]

The [REDACTED] is an empirically validated self-report measure consisting of a collection of rating scales that are used to detect and evaluate impairment in executive functions associated with ADHD. The measure can be administered to individuals aged 3 or older; adults complete a self-report measure comprised of 58 items. Completed protocols produce T-scores (m=50; sd=10) for the following scales: [REDACTED] (organization, prioritizing, activating to work); Focus (focusing, sustaining and shifting attention to tasks); [REDACTED] (regulating alertness, sustaining effort, and adjusting processing speed); [REDACTED] (managing frustration, modulating emotions); [REDACTED] (utilizing working memory and accessing recall); and [REDACTED] (monitoring and self-regulating action).

Summary of Scores

Scale	T-score (%ile at 90% confidence interval)
[REDACTED]	[REDACTED]

[REDACTED]'s protocol indicates that she experiences high levels of difficulty in all areas of executive functioning outlined in the [REDACTED]. T-scores above 70 are typically associated with significant challenges in daily functioning. Her lowest score was associated with managing frustration and modulating emotions, which may suggest that her otherwise high levels of executive dysfunction are associated primarily with an attention-deficit disorder or other cognitive impairment, rather than an anxiety or mood disorder.

[REDACTED] endorsed the following items, which may be relevant to psychiatric providers or psychotherapists in preparing pharmacological or behavioral interventions:

Cluster 1. [REDACTED]

- I have trouble getting started on projects, assignments, or other tasks.
- It's difficult for me to wake up, get myself out of bed, and get started in the morning.
- I have trouble organizing my work and doing the most important things first without wasting time.
- I tend to be disorganized and forget due dates for projects, assignments, or bills.
- I wait until the last minute to do things.
- I have excessive difficulty starting tasks I should do, like running errands and paying bills, unless the task is interesting.

Cluster 2. [REDACTED]

- I need to be reminded to keep working or to pay attention.

- I am easily distracted by background noises or other things going on around me.
- I find it hard to focus on one thing for a long time unless it's something I'm really interested in.
- I lose focus easily when I have to listen to or read something that isn't very interesting.
- Because I speak too quickly or keep changing topics while talking, others have trouble understanding me.
- When I'm reading something that isn't very interesting, I have to read it more than once to remember it.

Cluster 3. 

- Unless I'm doing something I enjoy, I feel sleepy or tired during the day, even after a full night of sleep.
- I have trouble getting to sleep at night because I can't stop thinking about different things.
- I need to be reminded to get started or to keep working on tasks that need to be done.
- It's hard for me to focus on a task unless it's interesting or I'm working with someone else.
- I have trouble finishing routine tasks that don't interest me.
- Soon after starting a project or assignment, I get bored and don't want to finish it.

Cluster 4. 

- I feel excessively stressed or anxious in situations that should be manageable for me.
- I get overly sensitive or defensive when someone teases or criticizes me.
- I spend too much time on little details trying to make my work perfect.
- I feel sad or depressed and think that things may never get better.

Cluster 5. 

- I have a hard time following instructions, especially when I have more than one thing to do at the same time.
- I tend to forget or to bring – or often misplace – things that I need, such as phone, keys, wallet, or purse.
- When writing or talking, it's easy for me to wander off on some detail and forget the main thing I am trying to say.
- I tend to forget a lot of what I have just heard in conversations.
- When writing, I put in – or leave out – letters or words without meaning to.
- I have trouble memorizing things like names and dates.
- I have a hard time understanding and remembering directions or instructions.
- I plan to do things but forget about them (like running errands or paying bills).

Cluster 6. 

- I get restless and fidgety when I have to sit still or wait in line.

administered by computer, and is preceded by a pre-test interview and concluded with a post-test interview.

The [REDACTED] presents the patient with a situation that tests his or her capacity to sustain attention and focus while engaged in a mundane task. Within an administration period of 20 minutes, the patient is presented with a series of different shapes of varying colors. The patient is instructed to press the spacebar each time the visual stimuli (shape and color) is repeated consecutively. A web camera tracks the patient’s motor activity throughout the duration of the administration period.

The test produces a composite score, which is referred to as the [REDACTED]. The [REDACTED] is representative of the overall likelihood that the patient has ADHD. [REDACTED] attained a [REDACTED] of [REDACTED]. Scores above 50, on a range of 0 to 100, represent a high likelihood of having ADHD-like symptoms. Approximately 7% of the general population are estimated to display a similar level of ADHD-like symptoms.

The [REDACTED] is a composite score that is comprised of five scale scores: [REDACTED] (representative of movement detected by the webcam); [REDACTED] (representative of the frequency with which the patient pressed the spacebar when not prompted to do so); [REDACTED] (representative of the frequency with which the patient failed to press the spacebar when prompted to do so); [REDACTED] (representative of the overall speed with which the patient pressed the spacebar); and [REDACTED] (representative of the overall consistency or variability in the patient’s reaction time throughout the test administration period). Q-scores (m=0; sd=0.5) are generated for each scale score, allowing for comparison with individuals of a similar age and gender.

Scale	Q-score (%ile)
[REDACTED]	

[REDACTED]’s results on the [REDACTED] are indicative of a primarily hyperactive-impulsive presentation. Specifically, the web camera observed a markedly high level of fidgeting behaviors, which remained consistent throughout the test administration period. An activity graph clarified that these behaviors were confined to a relatively restricted range of movement, and were limited to moving slightly back and forth and from side to side, as well as movements of [REDACTED]’s arms and shoulders.

In addition to a high level of motor activity, [REDACTED] also attained a markedly high number of commission errors. Errors of these kind occur when a patient presses the spacebar at the inappropriate time. During the post-test interview, [REDACTED] clarified that her commission errors were associated with multiple factors, including anxious mood, anxiety about taking the test, feeling pressured by the environmental constraints associated with the test, and pressing the spacebar as

a form of erring on the side of caution as she frequently forgot the shape or color of a preceding visual prompt. The final factor is notable in its consistency with other test results in the present evaluation that highlighted a pervasive difficulty with short-term storage and recall of information.

Notably, however, [REDACTED] attained scores in the average range on all measures associated with inattention on the [REDACTED]. Although she attained a high number of commission errors, her [REDACTED] scale score was remarkably average, and her reaction time remained stable and slightly faster than average throughout the administration period. [REDACTED] did attain two delayed scores, both of which were commission errors, but these scores were delayed due to deliberation following having forgotten the shape or color of the preceding visual prompt and, furthermore, were not sufficient to push her [REDACTED] score outside of the normal range.

Although [REDACTED] attained ADHD-like scores overall on the [REDACTED], her average scores associated with inattention is notable because these score suggest that [REDACTED] was capable of sustaining attention and focus throughout the administration period. A discrepancy in scores of this kind fails to clarify the extent to which [REDACTED]'s overall difficulties with inattention may be better attributed to an anxiety disorder in addition or as opposed to an attention-deficit disorder.

[REDACTED]

The [REDACTED] represents an increasingly popular approach to the assessment of cognitive functioning. Based on the Cattell-Horn-Carrol model of cognitive functioning, the [REDACTED] consists of six core subtests adapted for efficient use in time limited settings. The test yields T-scores, which allow for comparison of the examinee's scores with individuals of a similar age and gender. T-scores are calculated for both individual subtests and composite index scores.

The six subtests of the [REDACTED] include [REDACTED], in which examinees are presented with a series of questions, read by the examiner, and asked to provide their best answer based on prior learning and/or context; [REDACTED], in which examinees are presented with slides consisting of six or more images or symbols, and are asked to identify the image or symbol that doesn't belong within the group; [REDACTED], in which an examinee is asked to provide the correct answer to a series of similes; [REDACTED], in which an examinee is presented with a series of visual images, and asked to identify what may be missing in each image; [REDACTED], in which an examiner reads a collection of stories aloud to an examinee, after which the examinee is prompted to recite the story from memory to the best of his or her ability; and [REDACTED], in which an examinee is presented with a series of pairs of slides, one with a single image, and another with the same image alongside other similar images. The examinee is asked to identify the image that had been shown in the preceding slide. Additionally, the [REDACTED] includes four index scores, including the [REDACTED], which is an estimate of the patient's global intelligence; the [REDACTED], which is an estimate of the patient's verbal intelligence as reflected by verbal reasoning and crystallized intellectual functions; the [REDACTED], which is an estimate of the patient's nonverbal intelligence as reflected by nonverbal reasoning and fluid intellectual functions; and the [REDACTED], which is an estimate

of the patient’s broad memory skills as comprised by both verbal and nonverbal memory functions.

Summary of Scores

Index (m=100; sd=15)	Subtest (m=50; sd=10)	95% C.I.	T-score	%ile	Description
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

[REDACTED]’s overall performance on the [REDACTED] fell within the average range. Notably, she attained an above average [REDACTED] score, suggestive of strong verbal reasoning skills. Qualitatively, [REDACTED] exhibited a high level of creativity while engaging in the test, particularly when responding to test items that featured visual stimuli, such as symbolic imagery or stylized illustrations of real objects. She frequently commented on multiple and diverse ways of viewing such imagery in a manner that reflected an artistic sensibility.

[REDACTED] attained a notably low score on the [REDACTED] subtest, which brought her [REDACTED] composite score down to the below average range. In the [REDACTED] subtest, the clinician reads a short passage to the patient, and then the patient is prompted to recite the story from memory. [REDACTED] was unable to utilize her working memory in order to store words and phrases used in the composition of the passages for later recall and recitation within the testing situation. During the administration of the [REDACTED], [REDACTED] appeared to the clinician to be anxious. In a post-test interview, [REDACTED] confirmed that she felt anxious during the administration of the [REDACTED] subtest. She explained that she “froze up” and was unable to listen as the clinician read the passages aloud. [REDACTED]’s low [REDACTED] score should be interpreted alongside her [REDACTED] score, in which minimal face-to-face interaction with a testing clinician is required as the patient responds primarily to visual stimuli contained in a stimulus book. [REDACTED] attained an average score on the [REDACTED] subtest. The discrepancy of scores among the two subtests that comprise the [REDACTED] composite score suggest that [REDACTED]’s difficulties with short-term storage and recall of information may be due to anxious mood, rather than cognitive impairment or an attention-deficit disorder per se.

[REDACTED]

The [REDACTED] is a self-report measure that is frequently used in the retrospective diagnosis of ADHD in adults who present with otherwise ambiguous psychopathology. When completing the measure, patients are presented with a collection of statements about childhood beliefs, emotional experiences, and behaviors that are commonly endorsed by adults who have ADHD. During the administration of the [REDACTED], the respondent is asked to rate the frequency with which he or she experienced the inventory items during his or her developmental years; the respondent’s responses are then compared to responses that were frequently endorsed by

individuals in a sample population. The response items that comprise the [REDACTED] were derived from interviews with individuals who presented with a range of diagnostic presentations, including predominantly individuals who had a depressive and/or anxiety disorder comorbid with ADHD. Therefore, the [REDACTED] is especially efficacious in assisting clinicians in identifying ADHD in adults who also have been diagnosed with a depressive or anxiety disorder.

[REDACTED] results may be interpreted by referring to a cutoff score, with a score at or above 46 indicating a high likelihood that the patient will receive a diagnosis of ADHD. [REDACTED] attained a score of [REDACTED], which is well below the cutoff score. A low score of this kind does not indicate that [REDACTED] experienced ADHD-like symptoms during her developmental years, thereby also failing to support a diagnosis of adult ADHD.

Summary, Interpretation, and Conclusions

[REDACTED] was self-referred for psychological testing and assessment services. During the initial consultation, [REDACTED] explained that she experiences both cognitive and emotional difficulties. Namely, [REDACTED] reported that she experiences frequent rumination, racing thoughts, lapses in attention, impaired short-term memory, difficulty recalling childhood experiences, panic attacks, anxiety, and depression. [REDACTED] expressed that she is pursuing psychological testing and assessment services at this time in order to (1) clarify diagnoses that would appropriately explain her presenting concerns and (2) receive recommendations for treatment or other psychological services.

The present psychological evaluation consisted of a semi-structured clinical interview; the administration of multiple objective inventories and self-report measures focused on emotional, personality, general psychological, and cognitive functioning; the administration of a continuous performance test; and the administration of an objective measure of intellectual ability. This psychological assessment battery was organized in order to assist in the identification of mood disorders, personality factors, and/or areas of cognitive impairment that may be contributing to her presenting concerns. Additionally, screening for ADHD was conducted after [REDACTED] reported several symptoms and experiences that are commonly indicative of the presence of an attention-deficit disorder.

[REDACTED]'s test results confirmed that [REDACTED] has both [REDACTED] Disorder and [REDACTED] Disorder. Although [REDACTED] tested positive for ADHD on a majority of relevant measures, her test results were inconclusive in the support of a diagnosis of ADHD. Specifically, although [REDACTED]'s test results suggest that [REDACTED] Disorder and [REDACTED] Disorder likely contribute to her difficulties with inattention, it remains unclear to what extent, if any, an attention-deficit disorder may also contribute to those difficulties. If [REDACTED]'s difficulties with inattention do not improve following successful treatment of [REDACTED] Disorder and [REDACTED] Disorder, further assessment of ADHD or the provision of an otherwise specified attention-deficit disorder and appropriate treatment may be warranted. Although [REDACTED]'s test results consistently suggested that she has ADHD-like symptoms of inattention, the present psychological assessment battery did not confirm the presence of those symptoms during her developmental years, nor is it clear that those symptoms are associated with impairment in multiple domains of functioning.

there is a good therapeutic alliance. The semi-structured clinical interview and results of the [REDACTED] indicated that [REDACTED] would benefit from insight-oriented therapy that includes exploration of past experiences and their impact on her current functioning.

2. [REDACTED] may benefit from a cognitive-behavioral approach to therapy, either as a primary or adjunctive treatment. A cognitive-behavioral approach is expected to provide [REDACTED] with faster relief of acute symptoms, and, additionally, may assist her in improving symptoms of inattention.
3. [REDACTED] is encouraged to pursue psychiatric care and medication management services. These services may assist her in managing symptoms of anxiety and depression. [REDACTED] may also choose to pursue psychiatric care for symptoms of inattention.

Recommended Resources

1. [REDACTED] is encouraged to learn relaxation and stress reduction techniques. *The Relaxation and Stress Reduction Workbook* by Matthew McKay, Martha Davis, and Elizabeth Robbins Eshelman is a popular workbook that [REDACTED] my find to be helpful in learning and practicing a variety of relaxation and stress reduction techniques.