Critical Analysis: M. Myers

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Demographics

- 10 year old
- White
- Male
- Enrolled in the fifth grade
- Remains in the custody of biological mother while residing with maternal grandparents

- M. Myers was referred by his mother for psychological testing to assist in diagnostic clarification and treatment planning
- M. Myers' grandmother, Mary, described her grandson as "oppositional-defiant a lot"
- Noted he has exhibited behavioral outbursts and aggression since early childhood
- Long history of animal cruelty, torture, and killing
- Mother, Janice, added, "And he'll just be sitting there and when I walk past he'll start growling and tell me to leave him alone and throws things at me."
- Exhibits conduct problems across settings, including the requirement of special academic accommodations for his emotional and behavioral disturbances which limits his time at school.

Referral Question/ Summary of Presenting Problem

- No developmental history consistent with ASD. Previous diagnosis of ADHD.
- Expressed pica since infancy including eating dog food, shrubs, flower bulbs, feces, and "sucking pus out of sores"
- Parents not involved in relationship at time of birth
- Family is of lower SES and comes from a close-knit culture of keeping problems "in-house" rather than involving external resources. Highly suspicious of authority.
- One maternal half-brother: tumultuous relationship including regular violence and Hx of sexual abuse directed at client

Biopsychosocial History/Diversity Components

- Typically excluded from social interactions due to behavioral outbursts and odd mannerisms
- Immature in presentation
- Regular aggression toward peers and adults including hitting, kicking, and biting
- Unable to articulate details regarding peer interactions
- Difficulties recognizing emotions in others
- Attends school for two hours each day due to accommodations to manage behavioral and emotional disruptions. Delays in achievement. Previous education evaluation resulted in FSIQ= 68.

Biopsychosocial History

- No history of childhood illness or medical hospitalization
- Admitted for inpatient psychiatric treatment Jan. to March 2017 due to SI/HI threats
- Outpatient psychotherapy “off and on for the last couple years”
- Currently prescribed Guanfacine, Haldol, Prozac, Concerta

Biopsychosocial History

Biopsychosocial History

- Routine SI/HI threats when angry including one instance of holding a knife to his own throat
- No true attempts at intentional self-harm
- Exceptionally labile mood, sometimes without provocation
- Substantial impulsivity, excessive energy, recklessness since early childhood
- Problems with focus and easily distracted

Biopsychosocial History

- Visual and auditory hallucinations, such as seeing “ghosts,” accounts of being violated by entities, and command hallucinations to harm himself and others
- Intense episodes of near-panic with no recognizable triggers

Biopsychosocial History

- Extensive History of cruelty to animals including:
  - Throwing baby chicks
  - Placing his fingers/hands into chickens' rectums and pulling out intestines while alive
  - Pulling off the talons of chickens
  - Skewering live frogs and placing them into campfires before they have died
  - Fondling the genitalia of the family dog
- Stated, "It's funny. Their butt is funny. I pulled their guts outside of their booties. I squeeze them too tight because it's funny." He denied genuine remorse for his actions and stated it is "only not funny because I get in trouble."

History of Abuse

- Sexually assaulted by classmate in school bathroom approximately two years ago
- Half-brother has attempted to sexually molest him on numerous occasions including regularly asking M. Myers to urinate on and in him
- Sexually molested by lower functioning maternal uncle while in his care which may have continued for years
- Biological father?

- Clinical Interview
- Collateral Interview: mother and grandmother
- Behavioral Observations
- Rorschach Performance Assessment System (R-PAS)
- Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV)
- Woodcock-Johnson Tests of Achievement-Third Edition: Brief Reading Subtests (WJ-III)
- Adaptive Behavior Assessment System- Third Edition (ABAS-III)
- Asperger's Syndrome Diagnostic Scale (ASDS)
- Conners-3: Parent Rating Form (Janice: mother)
- Conners-3: Parent Rating Form (Mary: grandmother)

Testing Procedures

- Required near constant redirection back to the task at hand
- All objects needed to be removed from reach
- Regressed into immature grammar as well as feral-like growls when boundaries enforced
- Quickly ate two Kleen-ex before restrained by mother
- Family was asked to leave the office lobby due to conscious attempts to break objects and interrupt other clients

Behavioral Observations

WISC-IV				
SCALE	COMPOSITE SCORE	PERCENTILE RANK	CONFIDENCE INTERVAL (95%)	QUALITATIVE DESCRIPTION
Verbal Comprehension	59	0.3	55-68	Extremely Low
Perceptual Reasoning	77	6	71-86	Borderline
Working Memory	65	1	60-75	Extremely Low
Processing Speed	50	<0.1	47-65	Extremely Low
FULL SCALE IQ	56	0.2	52-62	Extremely Low

WISC-IV

- Previous FSIQ= 68
- Effort?
- Other psychological factors?

WISC-IV

Behavioral/Neurodevelopmental Rating Scales

- Conners-3
- ABAS-III
- ASDS

Rationale for Rorschach

- Typically reduced utility with lower functioning clients
- MANUAL
- But what about psychosis?

Hurley, A.D., O'Brien, M., Chadwick, K., & Svenson,S. (1996). The use of the Rorschach and Thematic Apperception Test in persons with mental retardation. *Seminars in Clinical Neuropsychiatry*, *1*, 94-104.

Rationale for the Rorschach

- 45 of 55 produced valid profiles
- Mean number of responses was lower
- Lower complexity scores
- Less adept at estimating affective and stress tolerance
- However, identifiers for cognitive slippage and thought distortion were intact, providing insight into psychosis
- Additional findings showed utility in identifying predispositions for aggression and predatory sexual behaviors in this population

Rationale for the Rorschach

Rorschach Data

- What sticks out?
- Possible diagnostic picture?

Differentiating Trauma and Psychosis

Shevlin, M., Dorahy, M.J., & Adamson, G. (2007). Trauma and psychosis: an analysis of the National Comorbidity Survey. *The American Journal of Psychiatry, 164, 166-169.*

Differentiating Trauma and Psychosis

- Childhood physical abuse found to have strong predictive ability for psychosis
- Significant gender-by-rape interaction was observed
  - Rape having higher predictive value for psychosis in male subjects

Diagnostic Impression

Diagnostic Impressions
The following impressions are phrased in terms of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5).

- **F28** Other Specified Psychotic Disorder
- **F43.12** Posttraumatic Stress Disorder, Chronic
- **F91.1** Conduct Disorder, Childhood-Onset Type, Severe
- **F70** Intellectual Disability, Mild
- **F98.3** Pica in Children
- **Z62.810** Personal History of Sexual Abuse in Childhood

Treatment Recommendations

- Necessity for highly supervised environment with restrictions from means of harm, animals, vulnerable populations, and sexual perpetrators
- Residential treatment if this cannot be achieved in the home
- Individual, group, and family therapy with emphasis on addressing trauma-related disorder and behavioral modification
- Regular appointments with psychiatrist for medication management
- Upon stabilization, education evaluation to better estimate cognitive functioning and identify any underlying learning disorders

Application to Private Practice

- Great example of a somewhat benign presenting problem often referred to private practice which turns out to be a combination of evaluation, psychoeducation, and case management
- Must be well versed as a generalist to attend to each of these areas

Questions??