Clinical Neuropsychological Interviewing & Feedback

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Thanks to Evelyn Miccio for her summary of *Feedback that Sticks*

Origin of this talk

- The NP interviewing talk was developed as the 2nd talk in our new post-doc training didactic program.
- It reviews the basics of interviewing and patient feedback in a neuropsychological context.
- Ultimately your primary supervisor will be the person who approves how you are doing your interviews, information gathering, testing, and feedback.

Neuropsychology

"Neuropsychology is total psychology. Everything you have ever learned about child development, family therapy, psychopathology, testing, evaluation, communication skills, and life in general. There is nothing you have learned in your entire life that won't be important, and you will use it all at once. This is the coolest and most complicated thing you will ever do." –- - Byron Rourke

Being a Post-Doc: Its okay to say “I don’t know.”

- It is ok to be ignorant in some area
- You just need to let us know what you actually do not know
- Remember this is a learning experience and is for training

Neuropsychological Testing Domains

- Who needs neuropsychological testing?

- Anyone with a problem in one of the following neuropsychologically related domains:

- Intellectual Ability
- Attention
- Language
- Memory
- Visual Spatial Ability
- Executive Functioning
- Personality

Current Referral Reasons in KP NP service

- Competency Assessment/Capacity Declaration
- Memory problems
- Neurocognitive Disorders (Alzheimer, Vascular, Frontal, Lewy Body, Parkinson's, etc.)
- Amnestic Disorder
- Aphasia
- CVA
- Multiple Sclerosis
- Brain Tumors
- TBI
- Pre-surgery evaluation for epilepsy

Current Referral Reasons 2

- HIV
- Alcohol Abuse
- Toxic Exposure
- Psychotic rule-out
- Depression/Bipolar
- PTSD
- Somatization
- Paranoia
- Schizophrenia/Schizoaffective

Typical Neuropsychological Assessment

What is done in a typical neuropsychological evaluation?

- Neuropsychological Questionnaire
- Clinical Interview (Education, Occupation, CD Hx, Personality)
- Testing by Psychometrist or PostDoc (2-6 hours)
- Personality Testing if needed
- Feedback Session within 30 days of the final testing appointment (check your state ‘s requirement)
- Test Report: Diagnosis, Treatment recommendations

Neuropsychological Tests

- Most commonly used on typical Neuropsychology Services

Neuropsychological Screening Tests

Brief:

- Cognistat
- MOCA
- IFS: INECO Frontal Screening

Longer:

- NAB Screening Module
- RBANS

Effort/Symptom Validity Testing

- Word Memory Test: WMT
- NVWMT: NonVerbal WMT
- Dot Counting Test
- b Test
- 15 Item Test
- Rey Word Recognition
- ROCF Recognition
- Warrington Recognition
- TOMM

Intellectual Ability

- Wechsler Intelligence Scales:
  - WAIS IV
  - WASI - II
- Woodcock Johnson III
- Bateria III

Attention

- WAIS: Working Memory Measures
  - Digit Span
  - Number-Letter
  - Arithmetic
- Trail Making A/B
- IVA CPT – Sustained Attention
- PASAT – Divided Attention

Memory

- California Verbal Learning Test 2
- Wechsler Memory Scale IV
- NAB Memory Module: Shape Learning
- Rey Complex Figure

Language

- Boston Naming Test
- COWAT Fluency
- Animal Naming
- NAB Language Battery
- Action Fluency
- Boston Diagnostic Aphasia Exam (BDAE)

Sensory/Motor

- Finger Tapping Test
- Grip Strength
- Tactual Performance Test
- Grooved Pegboard
- Dean-Woodcock Neuropsychological Battery (ages 4 yo-adult)

Visual Spatial

- WAIS Block Design & Visual Puzzles
- Clock Drawing
- Rey Complex Figure
- NAB Spatial Module
- Benton-Visual Retention
- Benson-
- VMI
- Hooper Visual Integration
- Judgment Line Orientation

Executive Functioning

- Trail Making B
- Wisconsin Card Sorting Test
- Category Test
- Iowa Gambling Task
- Delis Kaplan Executive Function System (DKEFS) (Tower of Hanoi, 20 Questions)
- NAB Executive Module (Categories, Mazes, Judgment, Fluency)
- NIH Examiner

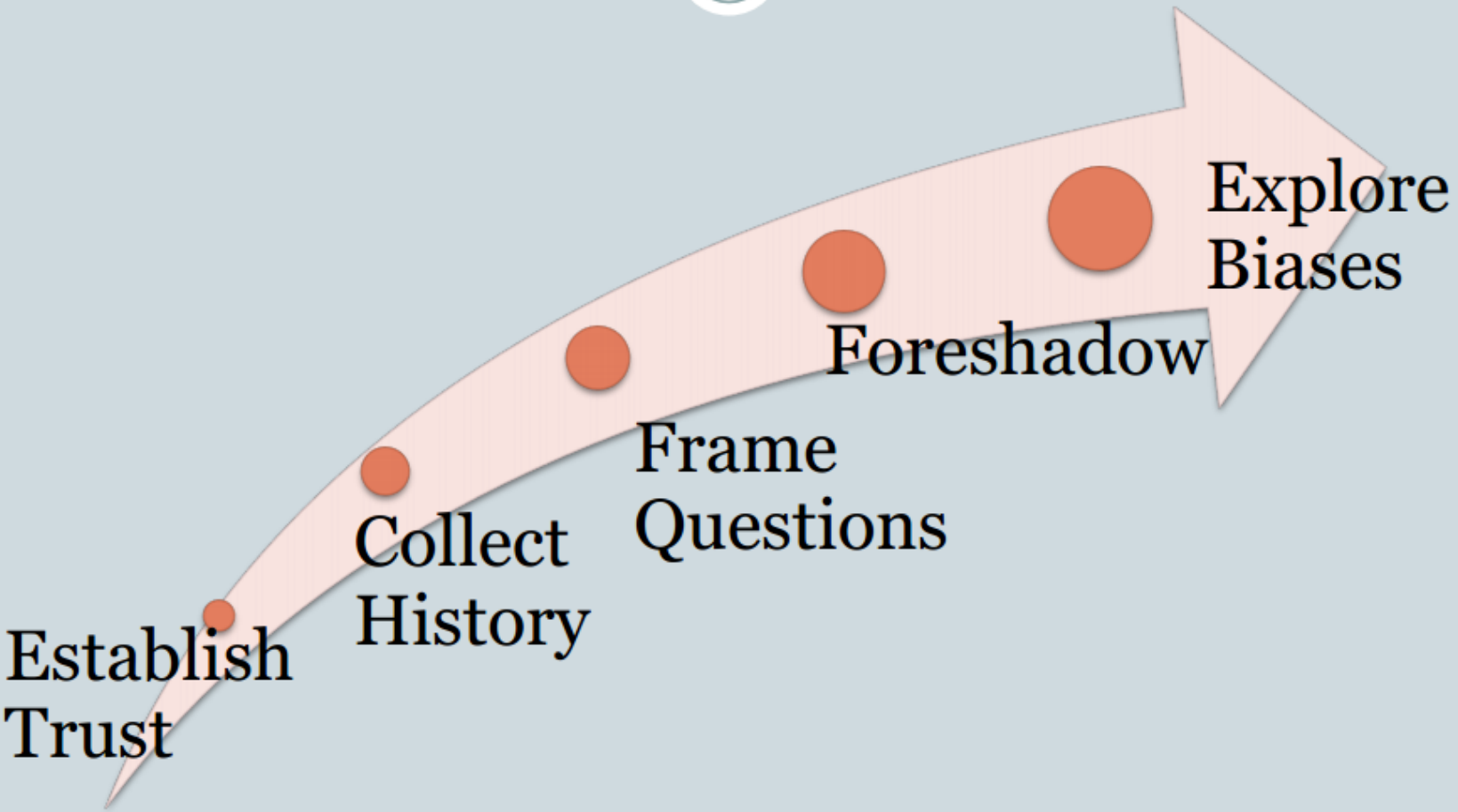
Daily Living

- NAB Judgment Test
- NAB Bill Paying Test
- Activities of Daily Living
- IADLS

Personality

- PHQ9
- GDS
- MCMI-3
- MMPI-2-RF
- PAI
- Rorschach Performance Assessment System® (R-PAS®)
- NEO-PI-R

Feedback begins at the initial interview



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Practice at SF Neuropsychology Service

- In person feedback session required.
- If memory impaired or Major NCD must have collateral person present for interview and feedback sessions.

Norm Book and Tests

- KP Norm book contains everything we think new Post Docs need for reference (general norms, IQ stats, etc.)
- Get to know your Norm book
- Familiarize yourself with new tests; shadow a psychometrist; schedule tutorial of tests, scoring, & testing rooms with psychometrist
- Never have a patient be your first test administration of a test
- Take the test yourself

Health Connect (KP computerized medical chart) and NP

- Put full initial NP intake note in chart within 48 hours of intake appt. Must include MSE write up.
- Place summary of report in visible notes if there is a significant cognitive issue, whenever the referring provider is outside of psychiatry
- Omit substance use information for ALL visible notes. (Following federal legal requirements that SA has higher privacy than Psych).

HC and Substance abuse

- No information concerning alcohol/substance use is included in Visible Notes
- No CD diagnosis in HC diagnosis (which visible to all MDs); only in mental health narrative area (only Psych & CDRP access)
- Can use "Mild NCD due to another medical condition" for diagnosis if cognitive issues.
- Ok in full report in HC or paper version
- Can always talk to PCP by phone or send paper report

Interviews in Clinical Assessment

- Interviews are commonly used in conjunction with other forms of assessment.
- Interviews may be structured, semi-structured or unstructured.

Structured Interviews

- Structured interviews have increased in use since the development of the DSM-IV-TR, esp. in research settings

- Common structured interviews include:
  - Anxiety Disorders Interview Schedule for the DSM-IV (ADIS-IV)
  - Composite International Diagnostic Interview (CIDI)
  - Diagnostic Interview Schedule (DIS)
  - Diagnostic Interview Schedule for Children (DISC-IV)
  - Substance Use Disorders Diagnostic Schedule (SUDDS-IV)

Structured Interview for Schizophrenia Diagnosis

Structure Clinical Interview for DSM-IV (SCID)
WHO Composite International Diagnostic Interview (CIDI)
Brief Psychiatric Rating Scale (BPRS)

Positive & Negative Symptom Scale for the

Assessment of Positive Symptoms (PANSS)

Scale for the Assessment of Negative Symptoms (SANS)

Semi-Structured Interviews

- Semi-structured interviews provide greater flexibility than structured interviews, but provide greater reliability than unstructured interviews.

- Some semi-structured interviews include:
  - Diagnostic Interview for Children and Adolescents (DICA-IV)
  - Schedule for Affective Disorders and Schizophrenia (SADS)
  - Semistructured Clinical Interview for Children and Adolescents (SCICA)
  - Research Version of the SCID-5
  - Structured Clinical Interview for DSM-IV Axis-II Disorders (SCID-II)

Unstructured Interviews

- Despite the increasing use of structured interviews, unstructured interviews are the most common style of interviews used in clinical settings.
- Unstructured interviews often focus on core domains relating to the client issue and general functioning.

Unstructured Interviews

Includes assessing client's presenting problem in three main areas:

- **Onset/Course:** When did the problems begin? Was there a time when the client felt worse or better? Was there any particular pattern?
- **Severity:** Do the problems interfere with the client's life and/or lead to suffering or distress?
- **Stressor:** Does the client believe that some external event brought on the problems? Are any stressful life events associated with the problem?

The Interview

- Biosocial history: 95% of diagnosis is history (Adolf Meyer, 1915)
- But:
  - Getting an adequate history is full of problems
  - Focus of history is based on interviewer experience and/or idiosyncrasies (timidity, biases, lack of cultural awareness, etc.)
  - Interviewee may be accurate, not accurate, memory impaired (neuro or psych), out for secondary gain, etc.

Mental Status Exam (MSE)

- The MSE is a structured assessment modeled after physician medial exams.
- Focuses on core areas of psychiatric functioning.
- Commonly used in medical and psychiatric settings.
- You are informally doing it automatically anytime you interview a patient

Common MSE Categories

- Appearance
- Behavior/Psychomotor Activity
- Attitude toward Examiner
- Affect and Mood
- Speech
- Perceptual Disturbances
- Thought
- Orientation
- Memory
- Concentration and Attention
- Intelligence
- Judgment and Insight
- Reliability

Anything out of the ordinary in the above domains should be noted. These in-office observations are important, but remember that office is an artificial setting—symptoms of concern may not be observed.

Observation and Clinical Assessment

- Observation can be used for many purposes in clinical settings:
  - to help determine a diagnosis
  - to target specific patterns of behavior
  - to provide behavioral baseline data
  - to identify effective treatment approaches

Neuropsychological Assessment

- *Neuropsychological assessment* involves assessing :
  - attention
  - concentration
  - learning and memory
  - sensory-perceptual abilities
  - speech and language abilities
  - visuospatial skills
  - overall intelligence
  - executive functions
  - assessment of symptom exaggeration (SVT) & effort

The Neuropsychological examination

- The neuropsychologist is trying to understand why this patient is having this profile of problems at this particular time.

- So, it is crucial to know about both the current status and its history, and the neuropsychologist should approach the examination in a spirit of cautious scepticism, and drawing upon, and integrating multiple sources of information

The Neuropsychological Exam

- The neuropsychologist should:
  - Beware of the post hoc ergo propter hoc trap: "Since event Y *followed* event X, event Y must have been *caused* by event X."
  - Be aware of the frequency of apparent neuropsychological complaints in ordinary people in daily life (esp. in mTBI)

Sources of information

- What you read in reports, records, and witness statements
- What you observe in the patient
- What you are told spontaneously by the patient and others, particularly family members
- What you elicit from the patient and others
- Formal mental status and neuropsychological assessment

Sources of Information

- Medical records and patients are not always accurate
- What you are looking for may be hidden in the nursing or therapy notes
- Patients and family members do not always tell the truth, even if not malingering
- Patients may present a false picture on neuropsychological assessment by underperforming– you'll only identify this if you look for it (effort measures)

Components of the Neuropsychological examination

- An interview, taking a detailed history from the patient and others
- Scrutiny of pre-injury medical, social, educational, psychiatric, and vocational records
- Questionnaires dealing with NP symptoms, emotion and behavior
- Formal neuropsychological examination
- Formal assessment (SVT) of effort or symptom exaggeration using measures of high sensitivity and specificity

Purposes of Initial NP Interview

- The purposes of NP interviewing are
  - to answer the referral question
  - to understand the possible neuropsychological origins of the current behavioral issues
  - to come up with a clear diagnosis
  - and to do this in 1 hour !

Neuropsychological interviewing

- Purpose of NP interviewing is to get enough information to arrive at accurate diagnosis and recommendation.
- NP interview is not psychotherapy
- Need to be significantly more directive in questioning
- NP is more like oncology than psychotherapy
- It does depend on having learned how to do a solid clinical interview.
- Patient has the right to accurate information even if news is negative
- Note the way patients originally describe their symptoms. Use their own self descriptions in feedback

The interview

- Clinical interview – Unless very experienced, use a prepared list of areas to cover (a proforma), to make sure you don't miss anything.
- Look for evidence of cognitive status, spontaneity, initiation, self-monitoring, mood, social behavior, as well as engagement in the examination
- Detailed history of physical, cognitive, emotional, social changes related to NP question
- Report from significant other (Be careful about their info; may have biases)

Collaterals

- The more neurologically impaired someone is, the more definite the requirement of bringing a collateral or family member to the initial appt.
- If they live alone, is there an APS worker who can come?
- All patients should be asked to bring a list of their current medications.
- Ask all patients to bring their reading glasses or hearing aides if they use them. We have hearing amplification device at front desk.

Collaterals Required

- If a collateral person is present, ask them to remain silent for the first part of the interview.
- They are not to VERBALLY respond to any questions asked by the patient (offer them a notepad and pen for any information they want to provide). CV's Neck Turning Sign
- After interviewing the patient, interview the collateral person.
- Compare the info; patient lack of awareness of deficit can be revealed

Cultural Considerations in Clinical Assessment

- Assessors should be sensitive to cultural differences when performing clinical assessments.
- Actively exploring and being open to differences is essential to working with all clients.
- We should take care not to confuse cultural differences for psychopathology, i.e. Latino torture victims, African American "paranoia" about white motivations, etc.
- Always note the effect of educational level on NP results; Ardilla on parental educational effects

NP Intake

- Basic requirements
  - Consent to treatment: do not see if won't sign on day of appt.
  - Separate confidentiality form (a total of two forms signed by patient)
  - Signed notice of being evaluated by postdoctoral resident
  - Signed/dated

Patient reassurance

- This is not Psychiatry; this is the Neuropsychology Service.
- We are not here to decide whether you are crazy or not.
- We are here to discuss the possibility that your brain is causing you some problems.
- Ask about personal strengths:
  - Hobbies
  - Personal, Skill and Cognitive Strengths

Internet exposure to tests

- Ask if patient is familiar with any NP tests or games similar to our tests on internet
- Rorschach, Stroop, WCST are out there.

Description of Testing Experience

- You will be asked to do a variety of things.
- We will assess your memory, attention, problem solving, etc.
- The one thing we need is your best effort (explain internal validity checks). If you fail these, test results will be considered unreliable and invalid.
- Everyone experiences some failure during testing, and this allows us to understand your cognitive strengths and weaknesses better.

Description of Testing Experience 2

- Please bring your glasses or hearing aides to every appointment, if you use them.
- Be rested on day of testing. Ask how many hours of sleep on night before testing. Less than 6 hours is a problem.

Testing

- We need your brain as natural as we can get it (so no alcohol or drugs (MJ etc.) for the duration of the evaluation process). No pain meds if possible
- Require minimum of 3 weeks/30 days clean and sober before testing
- No stimulants on day of ADHD testing
- Complete Pre-Test Information sheet, write patient's name, date, and medical record number on every document in the testing chart.

Personality Tests

- Use both PAI and MCMI3
- Personality Tests are **never to leave the clinic**

Importance of being specific in questioning

- Before California mandated sexual abuse training, therapists rarely asked about history of abuse.
- The lesson: If you don't ask about certain topics, patients won't reveal info. If you ask, they often will.

Why Here?

- Introduce yourself.
- If the patient requested testing:
  - What is it you hoping to learn from this evaluation?
- If the patient did not request it:
  - Who requested it?
  - Do you know why you were referred for testing? If yes, why?
  - If no, explain why.
- Have you ever been tested before?
  - If yes, get the details/Release of information for report
  - If no, explain what testing will entail.
  - Are you familiar with neuropsychological tests?

Why Here? 2

- Have you noticed any problems with yourself, your thinking abilities? (Possibility of anosognosia/lack of awareness – need for collaterals)
- If no, try to make the question more concrete: “Like memory, attention, problem solving?”
- Are other people/family concerned about you?
- Ask patient if s/he has any questions before we get started.
- Are any aids needed for hearing, vision, reading?

Self Estimates of Cognitive Ability

- In initial interview:

- Self Estimate (percentage):
  - IQ
  - Memory
  - Attention
  - Visual Spatial
  - Problem Solving
  - Depression # of 10
  - Anxiety # of 10

- Procrastination
- OCD symptoms
- Organizational Ability

Make sure you review all the standard NP domains;

- History of Academic Achievement – Manley on AA education & overdx of NCD
- IQ
- Attention
- Memory
- Language
- Visual Spatial
- Motor
- Executive Function
- Mood/Personality/Psychosis

NP Intake 2

- Psychiatric Section:

Psych Sxs reported

History of sxs (time lines, dates, meds tried), Trauma, Psychosis & diagnoses

Inpatient treatment

Suicidal ideation/attempts or hospitalization (statement about all three)

Family psych history

Suicide Risk Assessment

- Assessing suicidality involves evaluating client **risk factors** and **warning sites**.
- **Risk factors** are ongoing client characteristics that increase suicide risk, i.e. male, lethal method availability
- **Warning signs** are client behaviors that warn of imminent suicide risk, i.e. anxious distress

NP Intake 3

- Medical Section – Do chart review prior to first interview
- Major medical conditions
- Diagnostic Neuroimaging
- Medications
- Dates/History of surgeries

- TBI/LOC/MVA/Seizure history (if yes elaborate; see later sections)

NP Intake 4

- Substance Use Section

History of substance use; how serious

Family history of use/addiction

Current use (cigarettes, alcohol, marijuana, prescription meds, etc.)

Substance Abuse problem? Refer to Chemical Dependency Recovery Program

Must ask about smoking and document advisement to quit if appropriate.

NP Intake 5

- **Psychosocial Section**

Developmental History: Born and raised, family environment, trauma (neglect, physical, emotional, sexual abuse)

Birth order/intact family

Ethnicity/Religion/Primary language in the home

Academic History

Vocational History

Social History (Relationships)

Legal History

NP Intake 6

- MSE: "**JOIMMMATT**"
- Appearance
- Age
- Ethnicity
- Speech
- **J**udgment
- **O**rientation
- **I**nsight
- **M**emory

Movement/Gait
Mood
Affect
Thought Process
Thought content

Behavioral Observations

- 1. EFFORT: give your own estimate, but rely on effort measures
- 2. ANXIETY
- 3. AFFECT/PERSONALITY:
  - DEPRESSED
  - HOSTILE
  - PERFECTIONIST/DETAIL-ORIENTED
  - IMPULSIVE

NP Intake 7

- Risk Statement
  - History and current: SI/HI/Hx of violence
  - Weapon ownership/availability of means
  - Arrest history
- Self report measure of depression: PHQ-9 score, range, item #11 (suicide)?

What about Consent for Googling Patients?

- Keely Kolmes and Daniel Taube conducted an online survey of 227 clinicians (see *Professional Psychology*; October, 2013)

• Asked, among other things, how often and under what circumstances clinicians searched for client information on the internet

• Were also asked who informed clients ahead of time, or discussed it with their clients

•

Taken from Dr. Daniel Taube's presentation to KP in October 2013 regarding Supervision Ethics

Googling patients

- 49% of sample purposefully searched for client information on the Web

- Very few informed clients of such searches

- Only about 8% searched due to an emergency

- Mostly it was curiosity; not clear clinical need

What about Consent for Googling Patients?

Other studies found:

- up to 27% of psychology graduate students reported seeking online information about clients (Lehavot, Barnett, & Powers, 2010).

- 22% of 193 clinical psychology graduate students googled their clients (Martin, 2010).

• Lal and Asay found that *22%* of 193 clinical psychology graduate students had Googled their clients (Martin, 2010).

• DeLillo and Gale (2011) surveyed 854 doctoral students in psychology and *97.8%* had reported using social networking sites to find client information.

What about Consent for Googling Patients?

Keely Kolmes, PsyD created this list of questions about ethical concerns:

- Is it okay to look up information on patients?
- Under what circumstances?
- How might you communicate this to patients?
- It may be a legal, ethical, or personal breach of trust.
- As oneself--what are my motives: Is it personal curiosity or is it in service to clinical care?
- Do I do it routinely?
- Do I do it in crisis situations?
- Do I document it? (note that all professional activities should be documented)
- Do your clients know you are doing this? (Is it a part of the treatment agreement?)

Justified googling?

-
- *Duty to re-contact/warn patient of possible harm
- *Evidence of doctor shopping
- *Evasive responses to logical clinical questions
- *Claims in a patient's personal or family history that seem improbable
- *Discrepancies between a patient's verbal history and clinical documentation
- *Levels of urgency/aggressiveness are not justified by clinical assessment
- *Receipt of discrediting information from other reliable health professionals that calls the patient's story into question
- *Inconsistent statements by the patient, or between a patient and their family members
- *Suspicions regarding physical and/or substance abuse
- *Concerns regarding suicide risk

- "Under certain circumstances -- when carefully thought out -- it may be appropriate to Google a patient. Need guidelines.

First Intake Note

- State the Referral Question
- Reported Symptoms
- Collateral Reports
- History of presenting problem
- Identifying information:
  - Name, relationship status, ethnicity, education, profession, language (acculturation)

The frontal lobe paradox: think outside clinic

- A patient may perform well on mental testing
- They may present well in the clinic
- But in daily life they may continually make poor decisions, and be like a ship with an engine, but lacking both a pilot and rudder
- Legally a person may be considered to have capacity to manage money, or litigate, despite being extremely vulnerable, impulsive, and easily influenced

- For the neuropsychologist it is crucial to think “outside the clinic”

Quick Review of NP Domains

- Ask specifically about any area that the patient does not spontaneously mention, including:

- Memory:

  Forget conversations?
  Movies you've seen or books you've read?
  Forget appointments?
  Who was your HS history teacher. What did you have for breakfast

Memory

- Memory
  - What are you having trouble remembering? (Names, routes, written information, oral information, object locations)
  - When does it happen?
  - How often do you forget this information?
  - Is it more difficult at certain times? (When stressed, just after panic attack, when around certain objects, places, etc.)

Quick Review of Domains 2

- Language/Word-finding
  - When you're talking, do you sometimes find that you can't think of the word you want?
  - Difficulty with names?
  - Do you have difficulty understanding what people say to you?

- Arithmetic (mental calculation and written); tip calculation

- Visual Spatial problems (Map reading? Directions? Difficulty judging heights, depth, distance? Car accidents?)

Language

- Was English your first language?
  - If No, first Language?
  - Do you consider yourself fluent in English?
  - If non-native, assess level of acculturation for example: (Radio stations, news, TV programs, food, language in home, on phone, is your voicemail set up? computer experience?)
  - Have you had any ESL classes.

Major Neurocognitive Disorder

- In the elderly: if issue of significant memory problem becomes manifest in first interview
- Review Instrumental activities of Daily Living (IADL) Performance (medications, meal preparation, transportation, bill pay, laundry)
- Need collateral if available

Neurocognitive Disorder 2

- How long has s/he been experiencing memory problems? Personality changes?
- What medications are you taking? How often are you supposed to take them? Do you remember to take them? How do you remember to take them?
- Get lost in familiar places?
- Lose track of what you're saying?

Neurocognitive Disorder 3

- Ever leave the stove on and forget about it until you smelled something burning.
  - Any changes in the types of things you cook?
  - Any changes in taste of food?
- What is the living situation? Is there supervision? Any trip hazards?
- Who cooks? Shops? Who does laundry?
- Who does the finances? (checkbook*, any late or double payments?)
- Driving/Car accidents?

ADHD

- Easily distracted? Easily bored?
- Hx of being identified with symptoms in elementary or high schools.
- Difficulty being organized or prioritizing?
- Begin lots of tasks, but don’t finish them?
- Act first and think later; do things impulsively?

ADHD 2

- Run up credit card debt?
- What do you like to do for fun? (assessing for high risk behaviors)
- Trouble controlling your temper.
- Use the **ADHD Diagnostic Guide (aka "Golden Rod" at KP SFO)**
- Family history of ADHD (parents or children)

Mood Assessment

- General ?: How would you describe your mood lately? Have you been depressed?
- Specific ?: Have you been feeling sad or down?
- Crying more than usual? Feel like things are out of your control?
- Feel helpless? Don’t care about things anymore or like you used to?
- How does your future look to you?

Mood Assessment

- How is your self-esteem?
- Do you constantly criticize yourself a lot?
- How is your appetite? Sleep?
- Ever think about hurting yourself or killing yourself?
  - If yes, Have you thought about how you would do it?
  - If yes, how?
  - Have you ever attempted suicide?
  - Do you have access to: gun, pills, etc.
  - Do you think you would really do it?

Mania

- Any periods of high energy (activity, sex, spending, drugs)
- Rapid speech, racing thoughts, decreased need for sleep, hypersexuality, euphoria, impulsiveness, grandiosity
- Hypomania vs full mania
- Check intake form for quantity of writing

Anxiety

- Do you tend to worry?
- Are you tense?
- Are you anxious?
- Have you ever had a panic attack?
- Screen specifically for OCD Symptoms
  - Any unwanted repeated behaviors or thoughts?
  - List: Hair pulling, skin picking, nail biting, re-reading, repeating, counting, checking, cleaning, touching, tapping, symmetry, etc.,
- Do you collect things or have clutter?
- Are you afraid of anything?

Psychiatric Treatment History

- Have you been in psychotherapy? For what?
- Have you ever gone to the ER for a psychiatric reason? An emotional reason?
- Have you ever been psychiatrically hospitalized?
- Have you ever done anything to hurt yourself?
- Any history of suicidal ideation or attempts? Or family history of suicide?
- Any family history of mental illness? Learning disabilities? ADHD?

Psychosis

- Ever hear things no one else could hear?
- See things no one else could see?
- Are you hypersensitive to sounds, smells?
- Feel like someone is out to get you?
- Feel like there’s a plot against you?

Personality Changes

- Go through the DSM-5 Symptoms
  - Any interpersonal problems ?
- Do you think your personality has changed
  - Lately?
  - Since accident, stroke, etc.?
  - Are you less or more reactive emotionally?
  - Are you more impulsive?
  - Do you get angry more often?
  - Are you less spontaneous or more apathetic?
  - Have you ever been told you have a personality disorder?

Psychosocial History

- Development: Any issues with mother's pregnancy, birth complications, developmental milestones.

- Family of Origin:
  - Who raised you?
  - Siblings?
  - How were feelings dealt with? Anger?
  - Any weapons in the home?

Psychosocial History 2

- What was home like?
  - Any fatal flaws?
    - Alcoholism
    - Abuse -- verbal/physical/sexual, neglect
    - Lack of intimacy
    - How was anger handled

ACES: 9 Adverse Childhood Experiences

- Growing up, did you experience any of the following:
- 1 Emotional abuse or neglect
- 2 Physical abuse or neglect
- 3 Sexual abuse
- 4 Witnessed domestic violence
- 5 Parental separation or divorce
- 6 Grow up with drug-abusing parent
- 7 Grow up with mentally ill parent
- 8 Grow up with suicidal parent
- 9 Having household members who was a criminal or in jail
- Criteria met: 4 or more, equals increased chance lifelong medical and psychiatric illnesses (Felletti ACE Adverse Childhood Experiences studies, 1998, 2001, 2004).

Academic History

- Tell me how you did in school, beginning with grade school.
- # of years of school completed.
- Grades, GPA in HS, SAT scores
- College major and GPA, GRE scores
- Skipped or repeated grades
- How well did you get along with other students?
- Ask them to bring in any school records they have (report cards, SATs, GREs)

ADHD 2: Academic history

- Any difficulty learning how to read? Learning arithmetic?
- Least favorite class?
- How did you perform in PE? or organized sports? (motor coordination; “fail hall”)
- Any classes failed?
- Special education classes?
- Tutoring?
- Trouble with organizing term papers, dissertation?

Vocational History

- History of jobs.
- Ever laid off or fired?
- Problems with supervisors or coworkers?
- Quit due to boredom?

Relationship History

- Intimate or romantic relationships
- Do you live with anyone.
- # of Marriages, divorces (why?)
- Friendships
- What was longest relationship
- Ask why relationships ended.
- Any abuse or chemical dependency in partners.
- Any violence
- Has a partner ever told you that you have CD problem?

Legal and Disability

- Any legal history- Have you ever been arrested?
- Any time in jail or prison
- Current litigation or a law suit
- Are you seeking or on disability? Why?

Substance Abuse

- Tell me your experience with alcohol and drugs from 1st use (It is important to ask how the substances make them feel, for example, stimulants can be relaxing for individuals with ADHD).

- If they stopped, why?

- Marijuana, Cocaine, Speed, IV, Party drugs, prescription medications for recreational purposes?
- Blackouts?
- DUIs?
- Any TX for substance abuse?

Substance Abuse 2

- Do you think alcohol was ever a problem for you?
- How much use in last six months.
- Cigarettes? Stop!! Recommend Smoking Cessation program at 415 833-3450, through Health Education
- Coffee, if anxiety or insomnia

Exercise

- Do you do any regular exercise?
- If not, recommend 150 minutes per week.
- Exercise is most powerful method for improving brain, heart, and psychiatric conditions
- Always include exercise as a standard recommendation in your test report.

Traumatic Brain Injury/Concussion

- Have you ever had a head injury/concussion?
- Ever lost consciousness for any reason? If so, for how long?
- Ask about seizures.
- Do you get frequent or severe headaches?
- Ask about PTA:
  - describe accident
  - gaps in their memory before, during, or after
  - What's last thing s/he remembers before the event? That you actually remember, not what you were told
  - First thing s/he remembers after the event?
  - Confirm with collateral!

Medical Conditions

- Any historical or current medical problems?
- What medications are you now on?
- Is there a history of psychiatric illness in your family? Substance abuse?
- What is your method of remembering to take medications

Medical Conditions 2

- Is there a history of neurological disease in your family (Alzheimer, Parkinson's, Huntington's, Tics, Memory problems?).

Seizure History

- Have you ever had a seizure?
- If yes, what type (tonic-clonic, complex partial, absences?)
- Have you experienced any noxic smells?
- Have your seizures ever been witnessed?
- Are you on anti-epileptic medications?
- Who is your neurologist?
- Has your driver's license taken away?

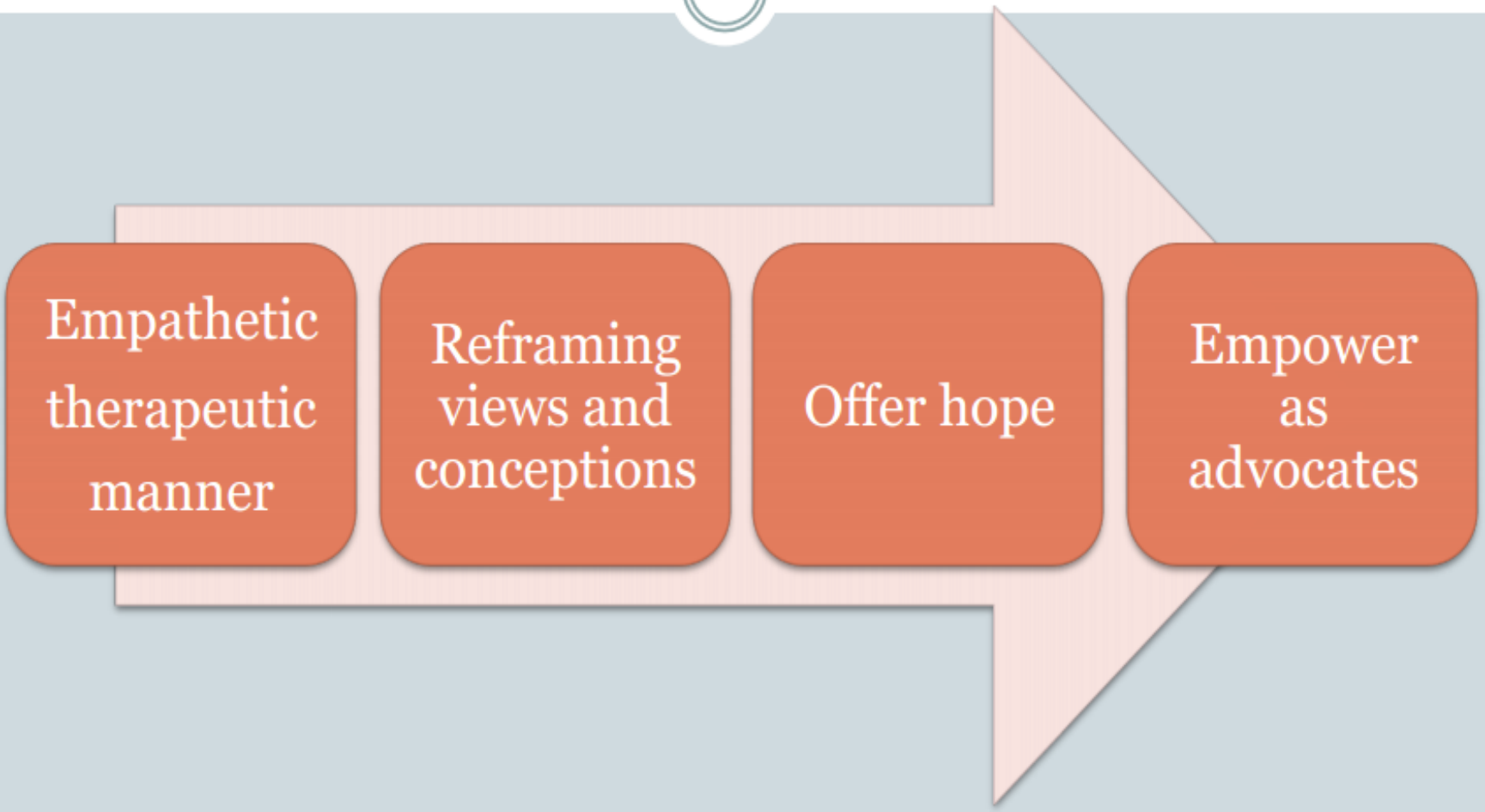
Report Writing and Written Communication

- The written report is the primary means of communicating the results.
- Timing of the report distribution: before/during/after the FB appointment.
- Types of handouts for patients:
  - Bullet point format
  - 2 paragraph summary
  - Discreet domains
  - Length of the report as a liability-some won't read or ultimately refer bc the report is too dense, and not user friendly.

Report Writing and Written Communication

- Importance of knowing your audience
- Consumer oriented reports comment:
  - “Patients are entitled to a copy of the report. What they are not entitled to is a neuropsychology lesson. Having a chest X-ray does not buy you an explanation of the physics of photons from the radiologist who read the film. The neuropsychological report is an archival record intended for medical use (p270-271).”
- Prompt reports (within a week) include:
  - Brief history
  - Report data
  - Interpretation
  - Diagnosis
- Cut to the chase!
- Don’t forget the power of the written word: how patient’s might experience the information laid out in writing can make it more “real” and/or painful.
- Focus on the problem oriented evaluation.

Feedback goals



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Patient Recommendations

- Have a standard model of patient recommendations on clinic computer
- Medications, i.e. antidepressants, Aricept
- Therapy (individual, Group, Classes)
- Chemical dependency recovery programs
- Exercise (150 minutes per week)
- Mindfulness
- Sleep hygiene

The report

- **Your qualifications**
- **Background**
- **Sources of information**
- **The accident or event**
- **Clinical picture**
- **Neuropsychological assessment**
- **Formal assessment of symptom exaggeration**
- **Questionnaire data**
- **Formulation**

In depth interviews with 85 neuropsychologists who practice

- across the lifespan
- with diverse clinical populations
- in hospitals, private practice, and universities

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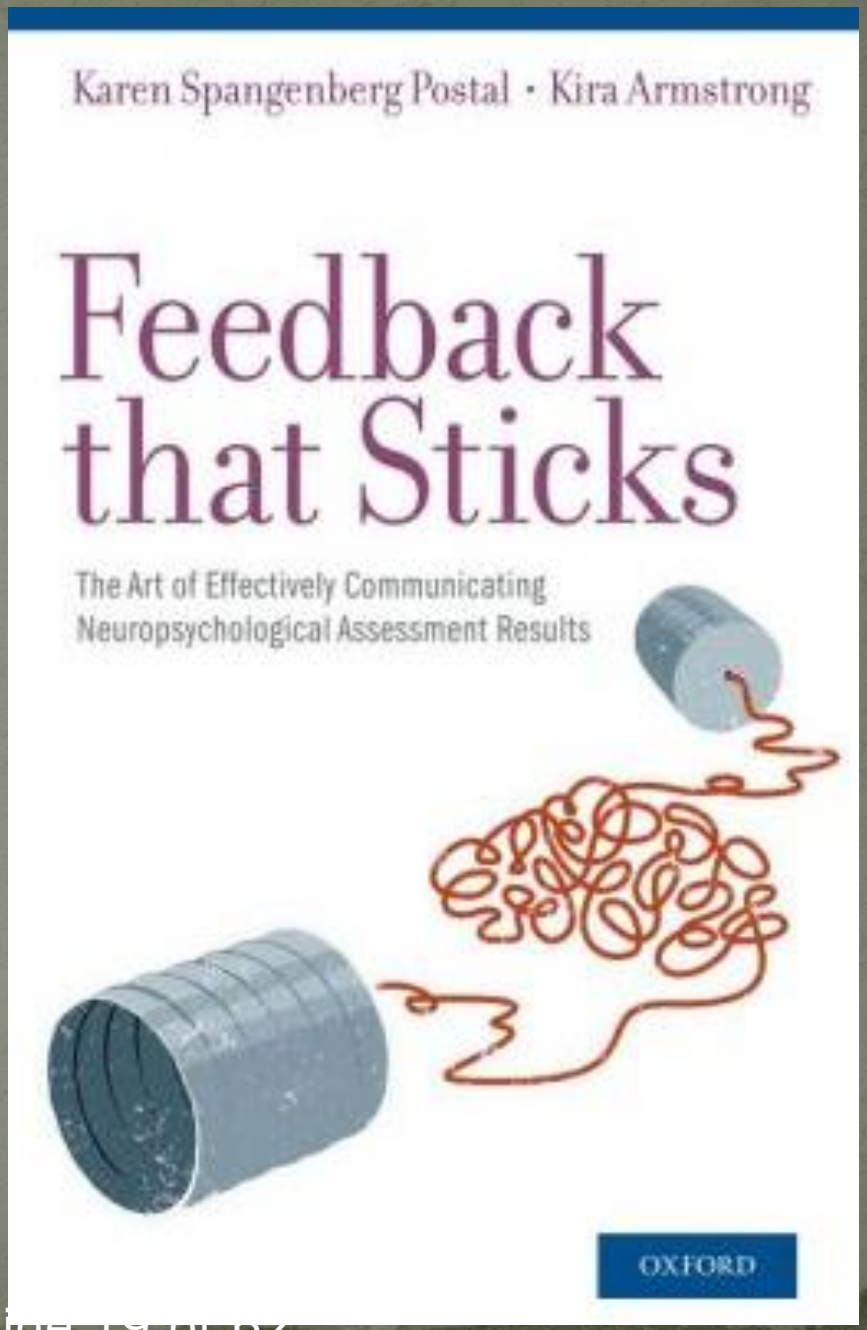


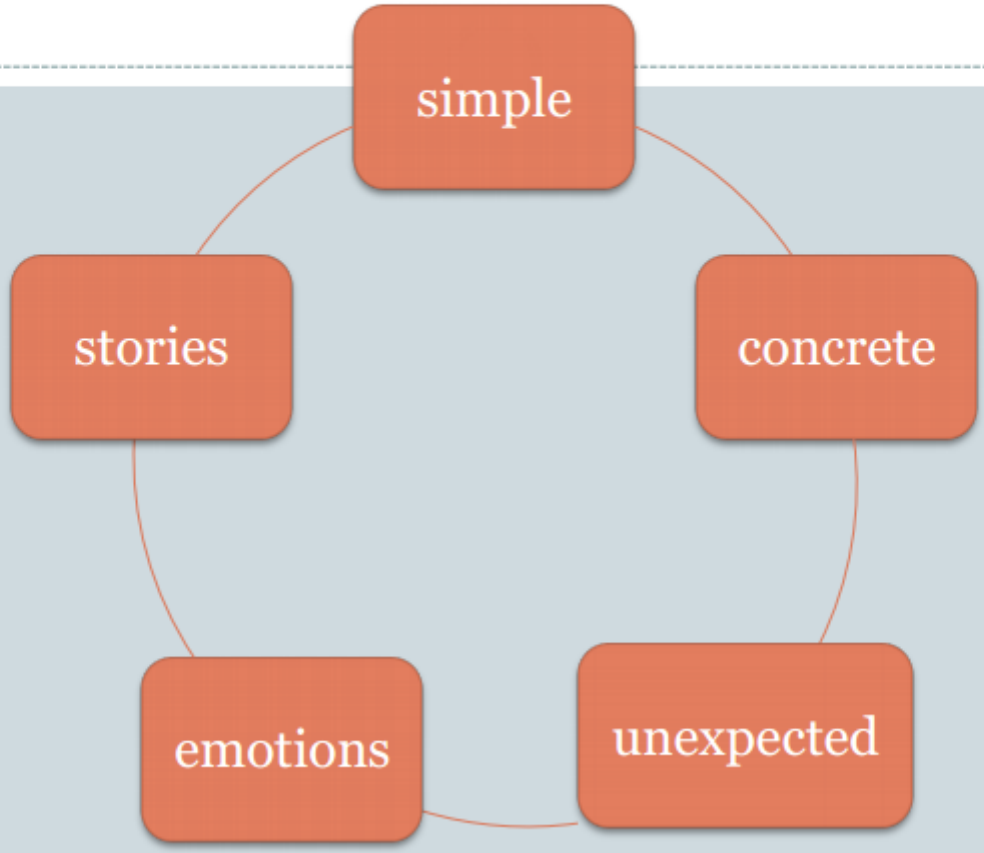
Feedback That Sticks: The Art of Communicating Neuropsychological Assessment Results.

- Most integrated thing we do
- 71 % neuropsychologists give feedback.

- Does the patient understand the findings?
  - The diagnosis?
  - The scores?
  - The expected prognosis ?

- How did *you* learn to give feedback?
  - Neuropsychologist's personality, family and regional background influences how feedback is offered.

6 principals for making an idea stick



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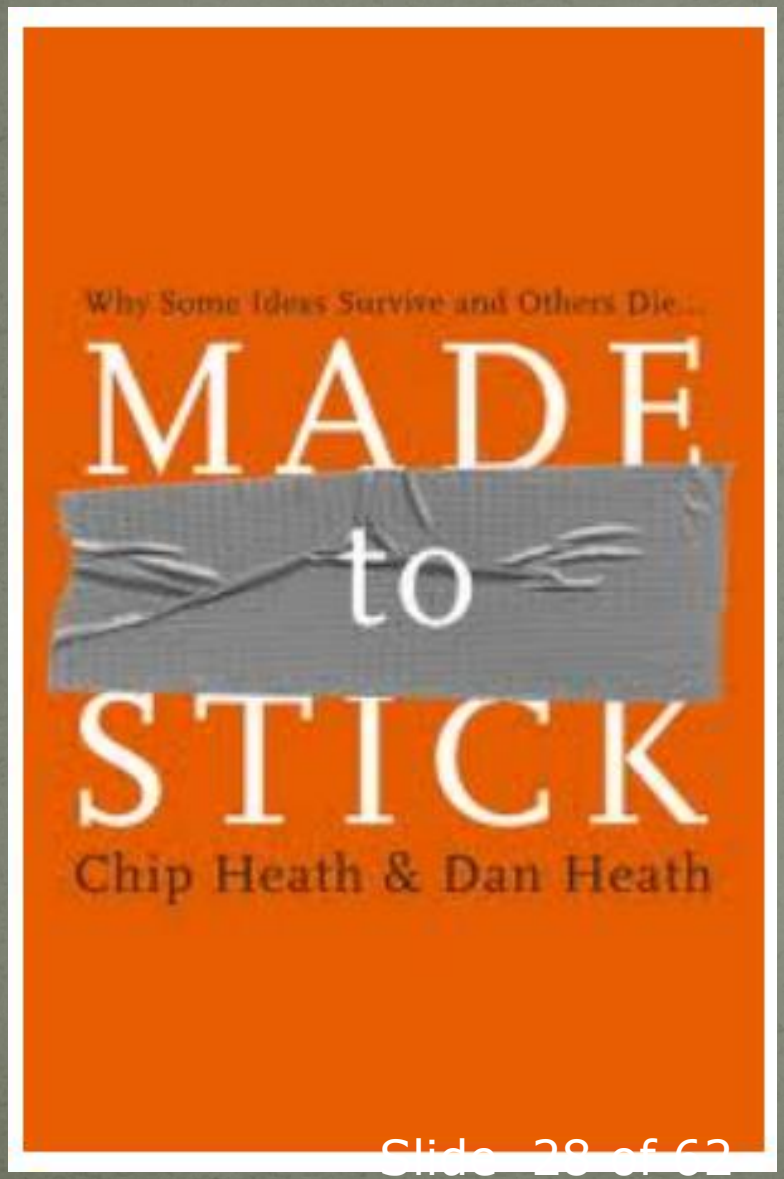
Pearls of Wisdom from Chapter Two
Why Some Feedback Sticks

- "Curse of Knowledge" or once we know something we have difficulties imagining not knowing something; resulting in abstract, impoverished stimuli from the perspective of the listener.
- Humans orient towards novelty-unexpected messages stick.
- Concrete message- what is the day to day impact of the NP test results?

Stanford organizational behaviorist and an educator offered their perspectives on what makes ideas stick in this 2008 book



Ideas stick when:

- We <u>understand</u> it.
- We <u>remember</u> it.
- We can <u>retell</u> it later.

Pearls of Wisdom from Chapter Three
Feedback Protocols and Theoretical Considerations

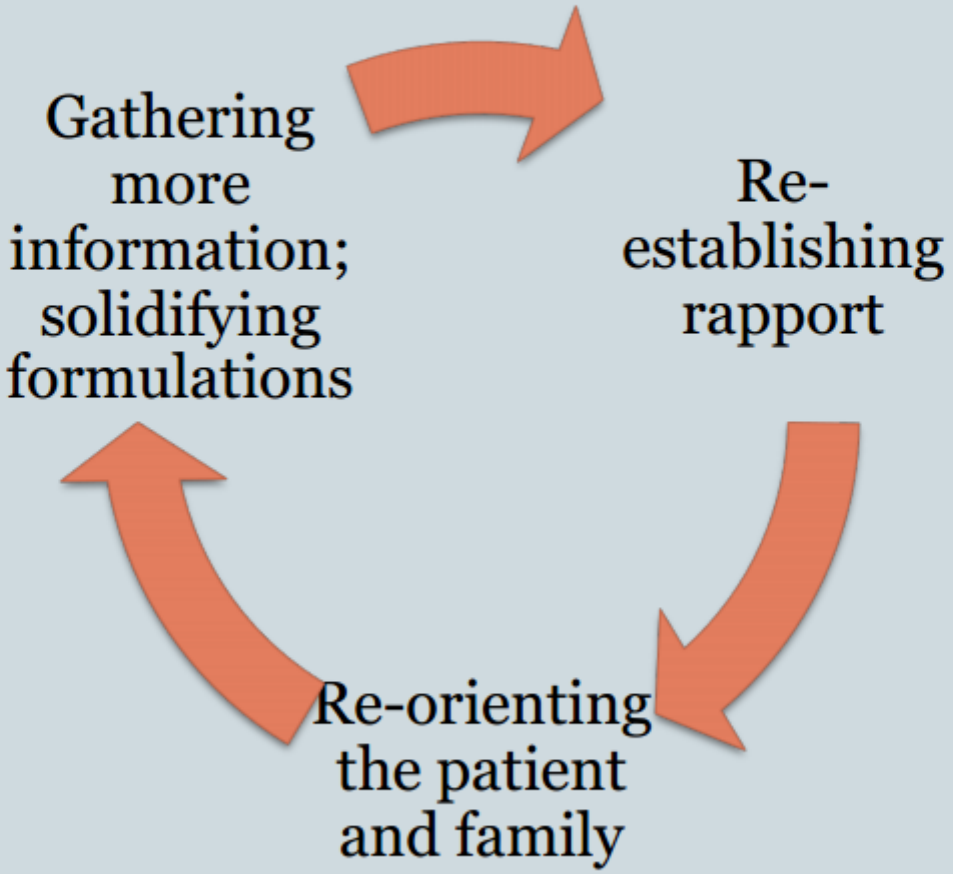
- Assist families in framing their questions and managing their expectations.

- Increase patient's sense of involvement in the evaluation by strategically asking the following, allowing the clinician to illicit:

  - Patient's theories of what is going on
  - Patient's fears
  - Patient's misconceptions
  - Patient's belief systems

- Feedback protocol is to:
  - Reestablish rapport,
  - Reorient by reiterating the referral question,
  - Provide a summary and
  - Direct towards resources and intervention options.
  - Empower the patient: Encourage hope.

Opening a Feedback session



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Feedback Session

- Patient has right to accurate information even if the news is negative
- Use their own self descriptions in feedback
- Identify symptoms that brought them in for assessment
- Summarize the clinical, work, and educational history; correct for accuracy

Addressing Effort

American Academy of Clinical Neuropsychology Consensus Conference Statement on the Neuropsychological Assessment of Effort, Response Bias and Malingering (Heilbronner et al., 2010) article referenced as industry standard.

- Timing of FB regarding effort is explored
- **"Inconsistencies"** in your results
- "Test results suggest you had a hard time applying yourself."
- Use of the term **"disengaged"** with the patient, then can write "we discussed and patient acknowledged that there are times when she was disengaged during the evaluation."
- **X-ray metaphor**: Don't move or the picture will come out fuzzy; "the data we have is blurry and impossible to read."

Feedback

- Discuss effort level: valid /reliable data or not
- Discuss possible sources of bias or error: educational, lack of appropriate norms, culture, language, etc.
- Describe both cognitive strengths and weaknesses.
- Don’t diagnosis “rule out…”; if you as a neuropsychologist cannot come up with appropriate diagnosis, there is a problem
- Write a good summary: most read part of NP report.

Feedback about NCD

- It can be very uncomfortable telling a patient that they have a Major NCD.
- If they have insight, they already know there is a problem.
- If they don't have insight, telling results won't improve their insight; they will not understand implications of their deficits.
- If amnestic, they will not remember 10 minutes later; feedback is for family, partner, or collateral.

Feedback about NCD 2

- If they are aware enough to know that they are impaired (or if there is a collateral person), discuss the NCD diagnosis.
- If same diagnosis after serial testing, then discuss progressive nature and fact that progressive NCDs are usually fatal (3-10 years).
- This is important because of need to plan for the future (legal, financial, assisted living).
- Issue of testamentary capacity; may need to discuss on initial interview.

Feedback with Collaterals

- If patient is so impaired that they do not understand results, imperative that collateral/caregiver be present for feedback.
- Patient should always be present. They have right to know results.
- May need to tailor feedback to caregiver's ability to understand it.
- May need to discuss level of care or supervision now and in future.

Feedback about NCD 3

- Alzheimer's: memory is most common first sx; dx by autopsy, but our test data is very relevant. Discuss Aricept, Namenda. (use and limits)
- Vascular: due to blood flow. Need for HTN, DM and hyperlipidemia meds. Exercise.
- Frontal: personality changes 1st; need for conservatorship or POA/DPOA to conserve finances, assist with medical and legal decision making
- In California, Capacity Declaration (capacity & supervision issues)

NCD

- Importance of educating patients and their families about the differences between normal effects of aging, MCI and various stages of NCDs.

- Talk up their strengths-given tendency to feel dumb with a dementia diagnosis.

- Metaphors:
  - Waiting room of memory-not sure what will happen next
  - Yellow-light situation: proceed with caution
  - Radar for MCI- blips on the radar-not sure where we are but need to track the blips
  - Left hand turn-and all that is involved in maneuvering this aspect of driving. Also mention insurance company clause:

    "**agree not to drive in an impaired condition**."

Sharing difficult results

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NCD: Caregivers

- The memory loss proceeds backwards. Forget the new, then the old.
- Slow down, say less.
- Need to Mirror moods
- Explore the utility of correcting patients memory mistakes.
- Caregiving is NOT a one person job: normalize need for support.
- Lack of insight/denial- patients and caregivers.

Feedback about Psychiatric Results

- If diagnosis is psychiatric, discuss diagnosis and treatment.

- If Personality Disorder diagnosis, discuss symptoms. Discuss in terms of early development of characterlogical ways of dealing with stress or for relating to others (“as the twig is bent, so goes the tree”). Role of early abuse.

Feedback about Psychiatric Results 2

- Never say “you are borderline, demented or a narcissist.” Always state that you “have a borderline personality condition (with relationship and anger problems), or have traits that make you very self focused or unempathic.” Use personality test results: “you are like individuals who exhibit unusual patterns of thinking; depression, etc.”

- Then discuss the need for psychotherapy and that some diagnoses require longer treatment.

- Recommend research based treatments: CBT, DBT informed, exposure, mindfulness training

Feedback about IQ level

- Use percentages, not IQ scores in feedback.
- During initial evaluation interview, if I get data that indicates possible low IQ, I ask them if they actually want to know their IQ if it turns out to be low. Many opt out of testing rather than find out.

Feedback about IQ level 2

- If they do get tested, and IQ is borderline to low average, most common discussion is about college completion ability or vocational alternatives.
- I discuss the fact that only 59% of those starting 4 year colleges, and less than 40% from low economic background, complete college; that college graduation often requires an IQ in the 75^{th} percentile range.
- Discuss self esteem issues related to IQ.

Feedback about results

- Review all cognitive results in all domains: IQ, attention, memory, language, visual spatial, executive function, personality

- Use percentages
- Note deficits and strengths
- Discuss diagnosis
- Discuss recommendations
- Tell them to do release of information (ROI) from the clinic when they want copy of report.

Feedback about Substance Abuse

- If cognitive deficits due to SA, discuss positive consequences of being clean and sober.
- Discuss long term consequences of SA: possibility of NCD, family consequences.
- Discourage getting sober alone; poor stats; need for Tx (CDRP, AA)
- AA as single most powerful treatment, refer them to www.aasf.org/meetings

Substance Abuse Positive

- Have a list of all your local SA services phone numbers and addresses.
- Substance Abuse problem?
  - Refer to Chemical Dependency Recovery Program at KP 415 833-9400
  - www.aasf.org for AA
  - www.sfna.org/meetings for Narcotics Anonymous
  - www.ma-sf.org for Marijuana Anonymous

- Smoker?
  - Advise to quit smoking through the Smoking Cessation Program at Kaiser Permanente
  - Health Education Classes at KP,

    415 833-3450.

Emotional Response to Test Results

- Given that most NP evaluations reveal significant deficits in testees, there is high probability that patients will have a strong reaction to feedback (whether they reveal it or not).
- Must respond to their reactions to the feedback.
- Discuss seeing you again if need to understand results or therapist if strong emotional reaction.

Need for therapy, care and assistance

- Does the person need any help at all
- If so,
  - how much,
  - of what type,
  - on what schedule,
  - and for how long?
- Help may include family care (paid or not), paid social care, nursing care, case management, and medical, psychological, and therapy input
- What's your evidence for this judgment?

Employability

- Does the person have the capacity to work at all?
- If so, is it paid employment?
- If paid employment, is it full time?
- Is the person likely to be able to find and keep a job – with or without help?
- If paid employment is not possible, would any further specialist rehabilitation help?
- If not, is sheltered or supported employment, or volunteer activity possible – with or without help?
- Need for disability application?

Employability

What will prevent return to work?

1. Unpredictable irritability
2. Poor social skills
3. Inconsistency, and inability or unwillingness to accept instruction and supervision
4. Poor cognitive skills
5. Fatigue

NP Intake 8

- Assessment:
  DSM-5
- Under Title 42, CFR 42, part 2; the legal statue for the highest protection for CD issues:
- Do not write chemical dependency DX in Visible note or Encounter Diagnosis
- Treatment and Follow up:
  Statement about plan: e.g.: testing to begin (date) to rule out (referral question).

NP Intake 9

- Contact PCP about the reason for referral, sxs, diagnosis, and treatment plan
- Offer the patient a list of the recommendations on final session.
- You should send a copy of HC note; write required information in note to PCP section only

Copy of Report Discussion

- Report is written for professionals
- Ultimately patient can request full report.
- Tell them to do release of information when they want copy of report.

Administrative Issues 2

- Gather paperwork and place in “CHARTS TO BE MADE”
- Order of final chart is:
  - Final Test report
  - Referral form
  - Signed consent forms
  - Intake paperwork
  - Intake note by provider
  - Tests (in alphabetical order)
- Once you have finished the case-put original copy of the report in the chart and return chart to the “to be filed” container

Follow-up

- Write Test Report, which is to be completed within 30 (thirty) days of the last testing date, per the BOP requirements
- Submit to supervisor for review.
- Contact PCP/psychotherapist/psychiatrist about the reason for referral, sxs, findings, diagnosis, and treatment plan
- Put Neuropsychological Summary Report in HC (visible and confidential sections) after supervisor has signed report. Do NOT put psychosocial or CD use in visible section of HC.

Final Thoughts

- Be rigorous, honest, and consistent in your practice.
- Always assess symptom exaggeration.
- Be your own toughest critic and anticipate peer-review and possibility of legal cross examination.
- Be aware of your areas of expertise and review those that are unfamiliar.
- Don’t stray into areas where you are not expert.
- Seek and use peer supervision

In depth interviews with 85 neuropsychologists who practice

- across the lifespan
- with diverse clinical populations
- in hospitals, private practice, and universities

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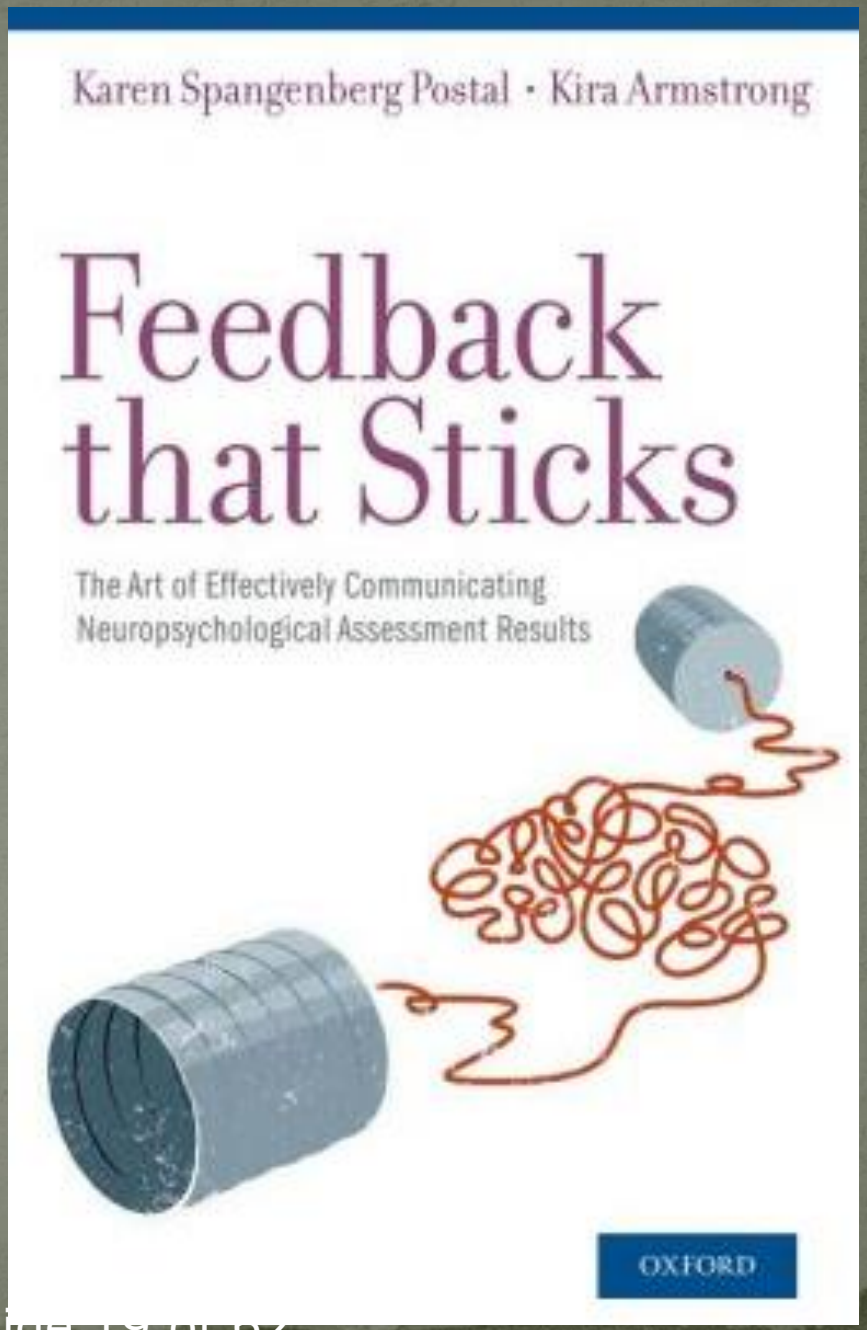


How Is Feedback Presented?

How the conversation is set up (word usage)

- Who is invited?
- How long will the conversation last ? (“one hit wonder” or follow up appointments)
- In person? Over the phone? Via Skype, Email? HIPPA compliant?
- Social pragmatics? (Tone of voice, pace of conversation with cultural considerations, honor family hierarchies, degree of authority, presumed confidence, physical appearance, body posture, facial expression)
- Repeat, rephrase, lament how challenging this must be.
- Verbal qualifiers, avoid use of psych jargon.

How Is Feedback Presented?

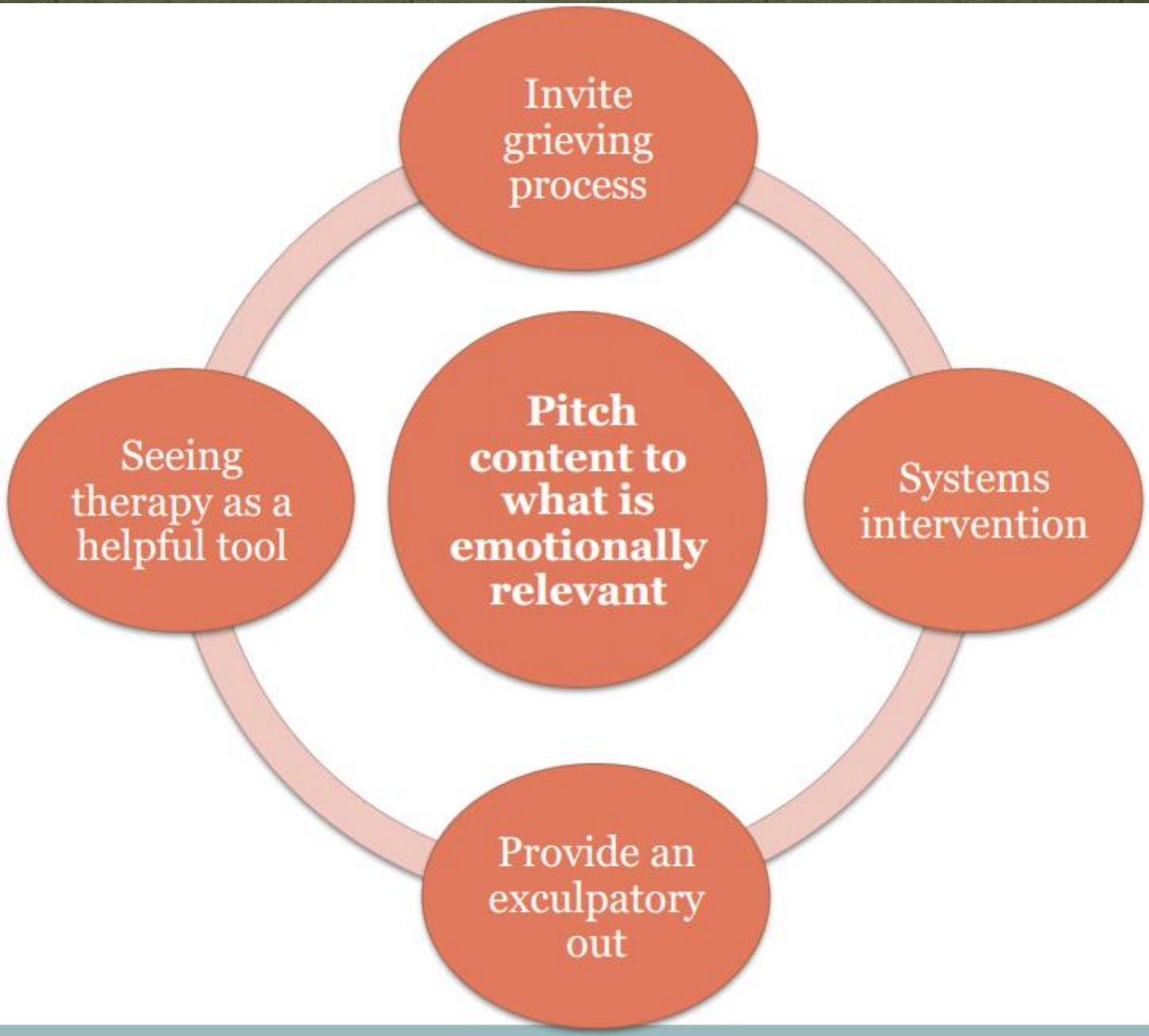
How the conversation is set up (word usage)

- Length of the appointment? (15-30 minutes, 60 minutes, 90 minutes)
- Timing of FB: day of testing (receptive consumer?), send report first, give it to them at the appointment, time of day?
- Use of visuals? A brain model? Tablet with 3D interactive maps? Powerpoint slides highlighting their profiles?
- What is the patient's learning style?
- Encourage the patient to summarize 3 main points.
- Offer recommendations and a care plan within the context of realistic resources and with an awareness of cultural considerations.

Putting Feedback to Work with Patients from Multiple Populations

Introduce and demystify the assessment

- Explain general cognitive constructs
  - Address the limitations of NP instruments, unnatural environment, may not pick up the problems, or may not evaluate what is pertinent to their culture (eg: EF).
  - Library metaphor for memory: storage vs. retrieval, encoding
  - Flood of information we are all faced with daily= ↓ memory
- Normalize the presenting symptoms
  - Cognitive landscapes have peaks and valleys
- Scaffolding language with hypothetical scenarios
  - Allow space to grieve
  - Create a healing process
  - Compliment their resiliency
  - Validate their concerns
- Map out a 5 year plan: helping the patient develop LT plan.



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Putting Feedback to Work with Patients from Multiple Populations

4 techniques to support memory (p 81-82).

- **Organization**-elaborate, reflect, question and reframe
- **Repetition**-is key, but HOW you repeat is important.
- **Elaboration**-tie new piece of information to something relevant
- **Attitude**-what do you say to yourself when you have a memory lapse?

ADHD

- Misconceptions and beliefs about ADHD can make intervention difficult to accept.
- Offer core deficit description of the disorder while engaging patients “directing your attention disorder.”
- Define the concept of developmentally appropriate attention skills.
- Explain difficulties with sustained attention: homework is like doing taxes.

ADHD

Metaphors:

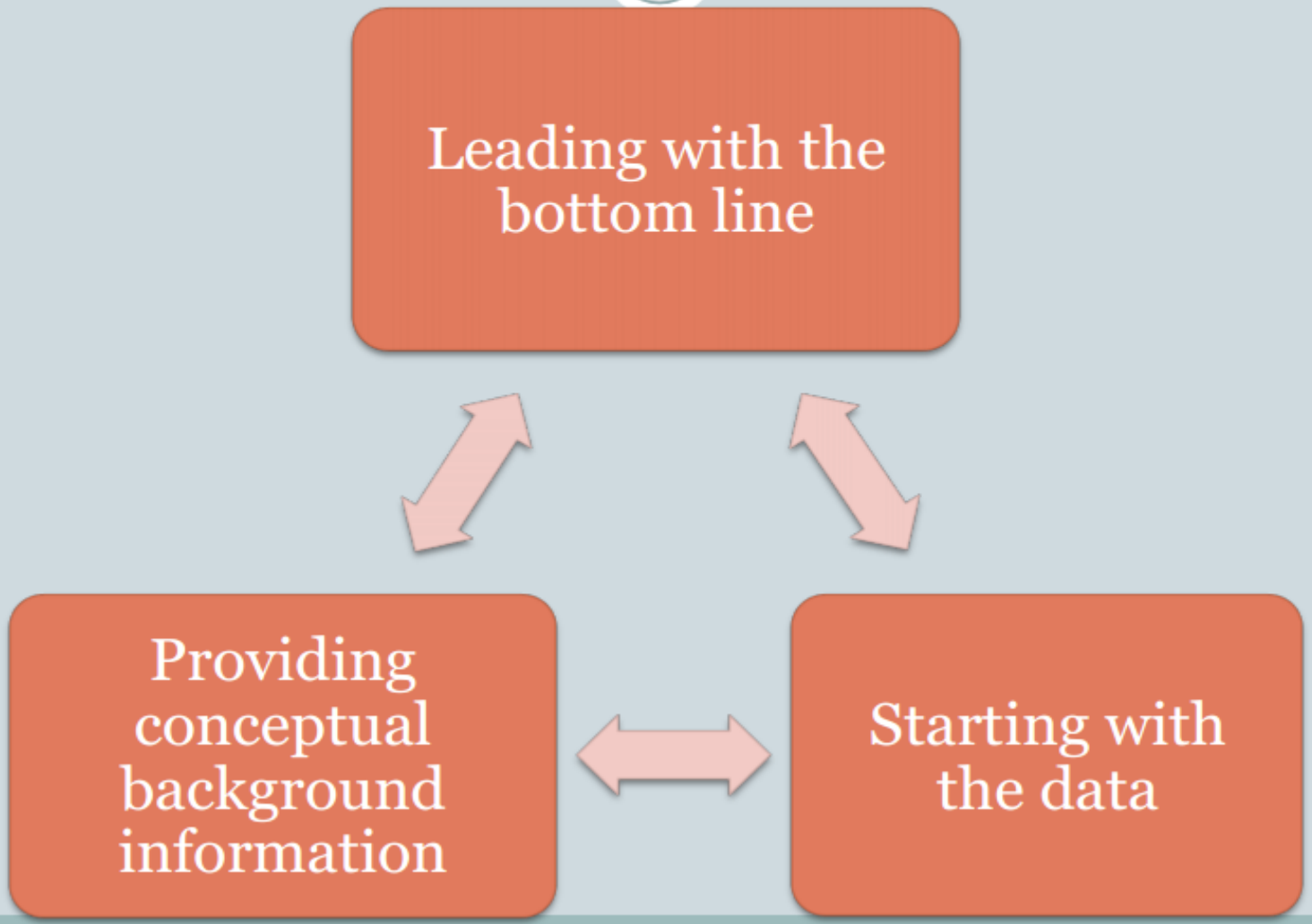
- ADHD has excellent ingredients but the chef isn't always available.
- **Mistake making machine**: performance deficit, and difficulties with impulsivity.
- **Driving uphill**: use more gas driving uphill, bc of the increased effort it takes.
- **Learned helplessness**-individuals with ADHD don't know how to try, and don't know the path.
- **Performance roller coaster**: run out of gas, become exhausted.
- **Brain vs. heart metaphor**: would you take medication for heart disease?
- **Computer w/o power**: computer is worthless without power, so is ADHD brain w/o medication.
- **Radio channel**: medications can help tune in the station
- **Bosses and workers**: EF metaphor, and the boss is "off duty."
  - Standing in line and acting out, tool: put hands in pocket
  - Executive secretary for CEOs-normalizing use of tools
  - Sluggish Cognitive Tempo described to patients.

- Most important thing: Patients with ADHD need to feel good about themselves.
- Important to change their academic self-esteem.
- Inoculate patients against inevitable failures.

Somatoform Disorder

- Deliver a message that will be heard constructively and acted upon.
- Respect the patient's genuine experience of their symptoms:
  - Disability framed as not having the ability to carry out ADL, and somatoform patients fit this definition, regardless of etiology.
  - Other factors contributing to their experience, such as role strain, chronic pain, sleep deprivation.
  - Praise overwhelmed patients
- Active therapeutic stance delivering the feedback: "You need help coping."
- Consider what is "honorable suffering"??
- Kettle metaphor for stress: built-up pressure, has to come out somehow.

Deciding what order to share information



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Psychiatric Illness

- Society's bias against mood and psychiatric illness complicates the process of FB.
- Offer written material, such as a brochure to explain cognitive illness in mental illness.
  - "Here's how it affects you in everyday life….."
- Keep in mind poor insight is common, and joining the patient's perspective allows them a sense of empowerment, allowing them to be more receptive to information you offer.
- Affective recovery and wellness revolution (p 155): reframing mental health care where patients are encouraged to take responsibility for their illness.
- Offer hope, with education that will empower them to manage their illness.

Learning Disorders and Developmental Disability

- Parent and patient fears about future functioning: allow for grieving the loss of an experience of parenting a typically developing child, or the pt living a normal life.
- Allow space in the room for an emotional reaction to mental retardation, or intellectual disability diagnosis.
- Use of the term “delayed” viewed as misleading (p 164): and the use of a *protracted trajectory* is offered.
- Assess parent/patient’s understanding of their limitations/abilities.
- Help families identify strengths that will serve them well in life.

Learning Disorders and Developmental Disability

- Sexuality: acknowledge the cultural discomfort with the topic, but the importance of the neuropsychologist bringing it up.
  - Motor deficit? How does one masturbate? The individual may not have the motor capabilities for sexual exploration.
  - How do you assure consented sexual activity?
  - How is the patient equipped to deal with this aspect of life?
  - What are the socially acceptable issues? Preparing them to not be ostracized by inappropriate behaviors.
- Foster functional independence.
- Explain the impact of focal impairments on global functioning: the patient may not be able to marshal their resources.
- Long-term planning: consider alternative life plans.
- Address working memory and processing speed input/output factors.

Learning Disorders and Developmental Disability

- Clutch metaphor: declarative vs. procedural components, and DD resulting in problems with the basal ganglia and cerebellum.

- Visuomotor deficits: difficulties copying notes in classes, making graphs, performing algebraic computations.

- Explaining dyslexia and language disorders:
  - Reading: need to take in, take apart, put together
  - Rapid naming, decoding words, comprehending the word, "span" for what you hear: **taxing working memory**.

  - There are 2 pathways to reading:
    - ↓Dorsal stream functioning (where pathway):
    - Ventral stream (what pathway)

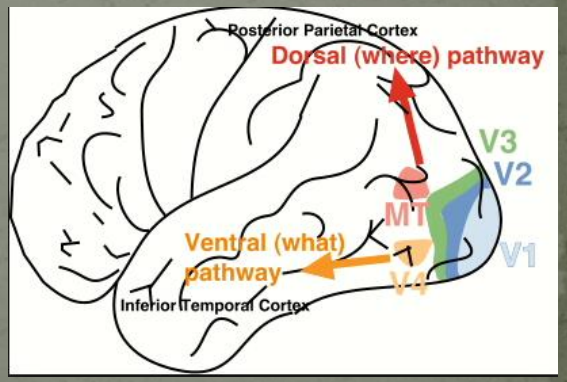

IMAGE SOURCE: http://lgn2v1.wordpress.com/2007/10/31/is-it-correct-to-say-what-and-where-for-ventral-and-dorsal-pathways-respectively/

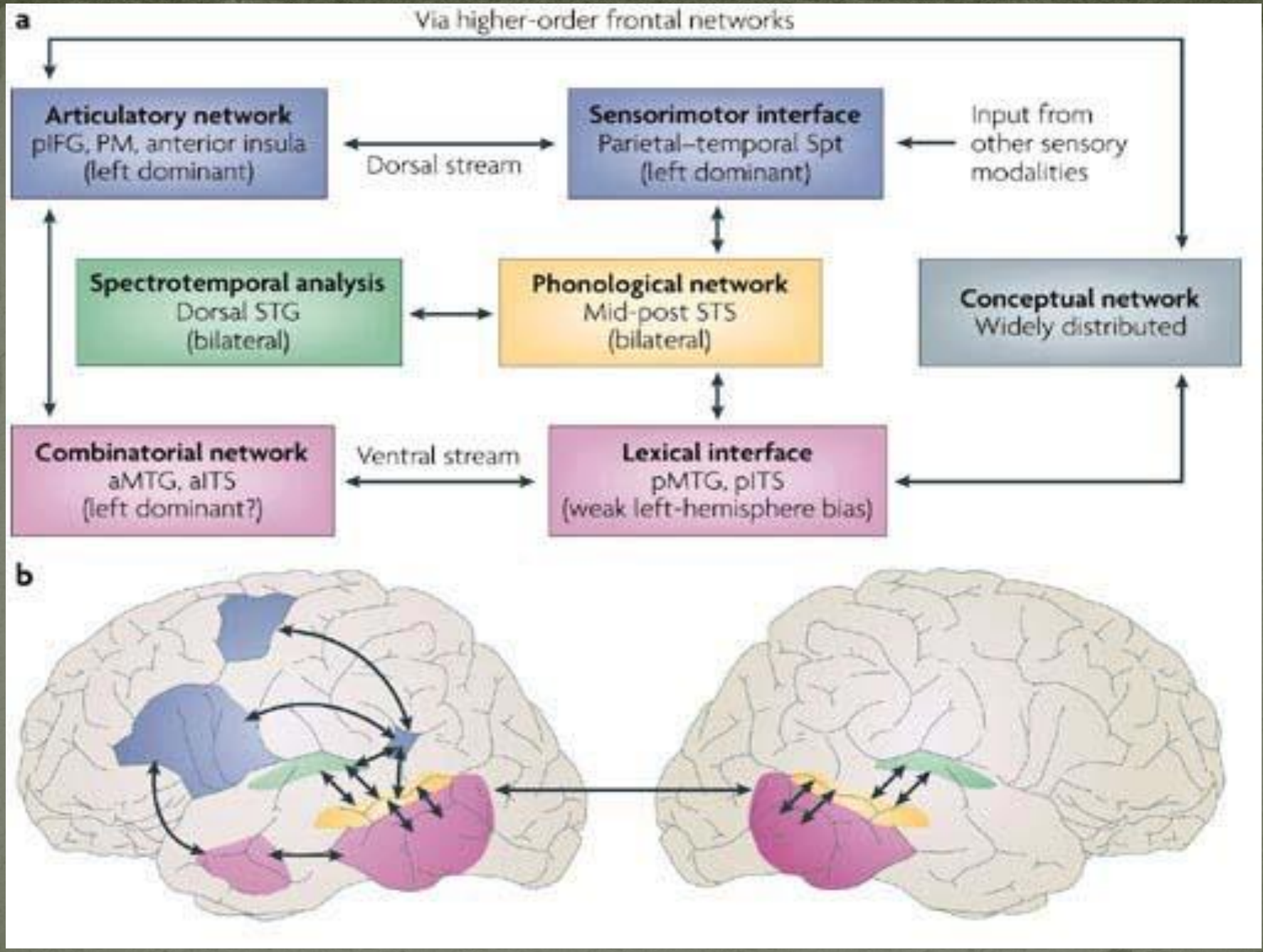

IMAGE SOURCE:

Learning Disorders and Developmental Disability

- Use specific test performance to explain cognitive profile, for example use of the ROCF: Copy as a way to highlight reading difficulties, piecemeal approach, at expense of the gestalt.

- Will I be able to go to college? Medical school?
  - Difficulties balancing hope, with realistic expectations.
  - Explore what they want to do after college, as a way to transition into planning, workshops, and field experience.

- Functional independence questions for patients/families:
  - Visualize realistic vision
  - Identify the barriers
  - Safety concerns

- Accommodations: help develop realistic expectations, tips regarding how to manage the terrain of IEPs/Goals and uses.

- Important to connect the dots regarding: cognitive, social and emotional processes.

Autistic Spectrum Disorders

- Another kind of learning disability: Social learning.
- Explain:
  - Stereotyped behaviors
  - Formal communication style
  - Sensory sensitivities: overwhelmed by all the input
  - Needs and services for all family members
- Discuss the diagnosis and how it can be limiting or liberating and how it might lead to the next step for them.

Acquired Brain Injury: TBI & Cerebrovascular Accidents

- Primary theme: Goal of preserving hope

- Explain:
  - **TBI recovery curve**
  - **Recovery of awareness**: beginning with serious safety concerns, poorly thought-out decisions, premature RTW, ways of jeopardizing future reintegration into the community. *Have patients relay their understanding of the findings, as a way to highlight cognitive functioning.
  - **Developmental trajectory** for young patients
  - **Family support** as a predictor of outcome in TBI
  - **Expectation for improvement**
  - **Prognosis** is difficult to predict
  - **Step by step approach to recovery**
  - **Share successful examples** to foster hope
  - **Explain emotional changes**, such as depression and apathy as underappreciated aspects of TBI

Acquired Brain Injury: TBI & Cerebrovascular Accidents

- Returning to work (RTW):
  - Help patients recognize when it's too early

  Remind them that NP testing does not produce valid information about fatigue, pain, or other MS symptoms that impact work capacity

  - Try to understand what work meant to them
  - What resources do they have: do they have access to ST disability support?
  - Are they financially able *not* to RTW?
  - What type of support exists at work?
  - Can you delegate at work?
  - RTW in a stepwise process

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Metaphors:

- **Broken leg**: you wouldn't run a marathon with a broken leg, give yourself time to heal.
- **Spare tire**: Develop Plan B.
- **Pole vaulting**: you're currently walking with a walker, lets get you up to speed for pole vaulting.
- **Juggling**: as a compensatory strategy for frontal lobe functioning
- **Renegotiate your environment**: setting up the environment to function as the frontal lobes with reminders, alarms, decrease sound/sensory stimuli.
- **Tipped bookshelf**: rehab as a way to straighten up the bookshelf.
- **Organ of thinking**: as a way of explaining the TBI.
- **Christmas time in the mall**: explaining how disorganizing the effects of overstimulation on the TBI individual's behavior: they're feeling, tasting, smelling, hearing everything all at once.

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- Enlist the patient in a self-assessment regarding the ability to RTW.

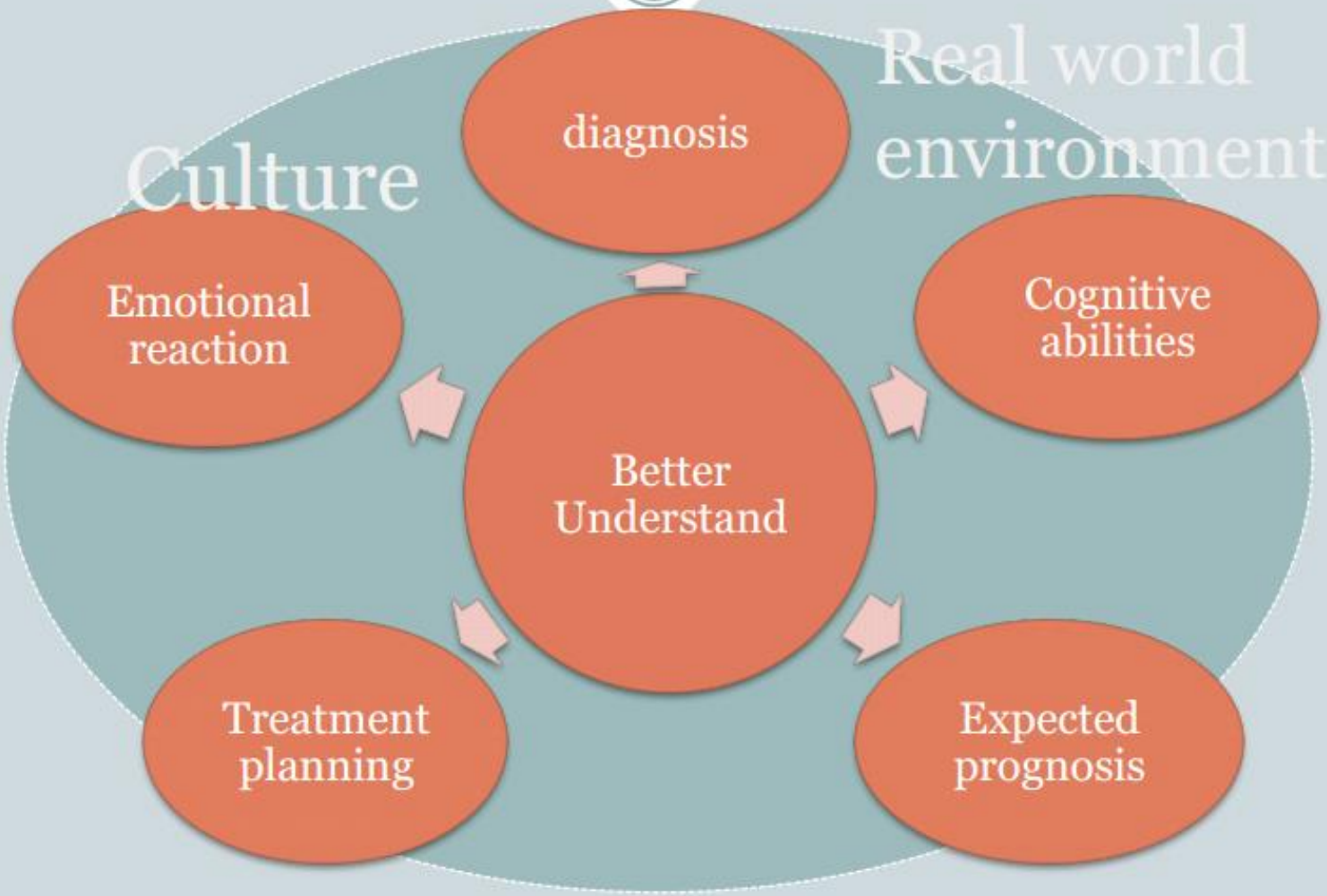
- Encourage them to define, and rate themselves on the following constructs needed to function at work
  - Motor functioning
  - Fine-gross motor functioning
  - Information processing
  - Language abilities
  - Social interaction skills: interpersonal insensitivity?
  - Getting along with peers, authority figures
  - Self-control (and impulse control concerns)
  - Self-awareness

Neurological Disorders

Various conditions addressed:

- Cancer: goals of FB dependent upon stage of tx, and nature of cancer
  - LT effects of radiation addressed, explaining impact on white matter.
  - Effects of neurosurgery, however, consider the consequences of allowing a tumor to grow
  - “Bad brain vs. no brain” metaphor
  - Pediatric cancer and females greater likelihood of cognitive decline.
- Genetic disorders explored
- Seizure disorders and 5-7x more likely to have ADHD , and seizure medications cause sedation and inattention.
- Hepatitis: Interferon tx can increase impulsivity

An effective feedback sessions allows:



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Communicating Assessment Results to Other Professionals

- Written reports, interdisciplinary meetings, telephone calls-listed as forms of communicating the results.
- Big picture input, or the real world implications
- Only hit the highlights
- Brain in a bag technique-function as a way to connect to academic or employment needs.
- Military community: “preserving the asset” and “investment in the soldier” language.

Some suggested reading

- Larrabee GJ (Ed); *Forensic Neuropsychology: A Scientific Approach*; OUP, 2005
- Lees-Haley P & Cohen LJ. "The Neuropsychologist As Expert Witness: Towards Credible Science in the Courtroom". Chap 15 in JJ Sweet (Ed) "*Forensic Neuropsychology: Fundamentals and Practice",* 443-473; Swets & Zeitlinger, 1999
- Sawaya M. "Pertinent Legal Aspects". Chapter 18 in GW Jay (Ed) "*Minor Traumatic Brain Injury Handbook",* 329-343; CRC Press, 2000
- Ziskin J; *Coping with Psychiatric and Psychological Testimony, Volumes 1, II, & III; 5th Edition;* Law and Psychology Press, 1995
- McCaffree et al; *Practitioner's Guide to Symptom Base Rates in the General Population*; Springer, 2006
- Martelli, M. F., Zasler, N. D., & Garyon, R. (1999). Ethical considerations in medicolegal evaluation of neurologic injury and impairment following acquired brain injury. *Neurorehabilitation*, *13*, 45-66