

## KAAREN BEKKEN, PH.D.

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### REPORT OF NEUROPSYCHOLOGICAL EVALUATION

Name:

Date of Birth:

Dates of Test: 6/16 and 7/14/2018

**REFERRAL and HISTORY:** Ms. M..... is a 48 year old woman who most recently has worked as a certified clinical research manager for ..... She was seen for an evaluation of neurocognitive function in the context of a 10 year history of worsening Fibromyalgia that is preventing her from being able to work.

Ms. M..... worked full-time at ..... until 10/2014, and went out on short-term disability (STD) until 2/2015. She returned to work part-time until 6/2015 but went out again on STD and then long term disability (LTD) for two years. In 12/2017, Liberty's LTD disability definition changed, and Liberty terminated her LTD benefits. They stated that she no longer met criteria, with "no diagnosis causing impairment" (i.e., a diagnosis "detectable using tests, procedures, or clinically examinations typically accepted in the practice of medicine"), and suggested that she was able to return to work on a full time basis with no restrictions or limitations.

However, a review of the records, statement from her treating fibromyalgia specialist, clinical interview, and history all clearly show Liberty's formulation to be incorrect. Records reviewed included those from Dr. Preston, Bidinger, Milford Regional Physicians Group, and Ithaca College, as well as her resume, narrative summary, and job description.

In terms of work and educational history, Ms. M.....

(work and educational history here)

Over time, however, she noticed that her health was suffering from all of the demands, and she began to make errors at work and home, missed meetings, and noticed cognitive issues. Colleagues commented on the change, and she shared her FM diagnosis with work. She continued to attempt to work until she went out on medical leave in October of 2014. After the 4 months and after medication changes, she attempted to return to work in February of 2015 but was unable to successfully complete her work responsibilities. She went out again on leave in June, and has been unable to return to work since that time. She has been unable to recover to a level that even approximates her baseline level, even after all of the time out of work and her numerous treatments.

Medical history includes Fibromyalgia (FM) diagnosed in 2008 (with continuing significant tender point exam and positive cytokine levels), as well as thyroid imbalance (Hashimoto's thyroiditis), sleep difficulty, and high blood pressure. Medications include allergy medications; psoriasis/eczema medications; Lunesta for insomnia; Zofran for nausea; Amlodipine for blood pressure; Zonisamide (an anti-epileptic that is also helpful in treating neuropathic pain); Sumatriptan as needed for migraine; Levothyroxine for thyroid; medical marijuana for pain since 2015; and Xanax (as needed for anxiety), Wellbutrin (depression), and Fluoxetine for mood.

She reports that pain symptoms began at age 16; prior to that, she had been very healthy. Doctors wondered whether she might have mono. She also developed a bout of allergies/respiratory problems, IBS, and frequent syncope with bowel movements. Because of syncope and seizure-type activity, she had to go to the emergency room on occasion. Her seizures have returned in the past year since she began taking Lyrica; they now take the form of uncontrolled jerking movements.

She reported that she had always had strengths in visuospatial processing and fact retrieval. She notes that she always a very organized person, to the point of excess when younger (OCD symptoms), and was always extremely good at multi-tasking. Now, she needs help with ADLs because of pain (dressing, cooking, bathing). On worse days, she must stay in bed all day; on better days, she can get out of bed, although she only leaves the house for appointments or when absolutely necessary.

Ms. M. rates pain as typically a 6 out of 10 in intensity on medication, with all kinds of pain (throbbing, stabbing, nerves, skin, bone). Headaches are constant, worsened by sound, light, smell, stress, and fatigue. She experiences auto-immune dysregulation. She has to force herself to eat, as the pain reduces her appetite. Sleep is impaired and variable. She either has difficulty

both falling asleep and staying asleep or she is completely “out” for 10 hours at a stretch. She never feels completely rested. She tracks sleep on a sleep log through an application and heart rate variability through another.

Pain has severely affected all aspects of her life, not just work, and is progressive in nature. She is unable to see friends on a regular basis. She cannot go out with them; they need to come to her, which has led to the loss of most of her social life. In the past, she was able to manage having dinner out of the house once per week with accommodations, but cannot do so now.

Cognitive deficits include memory, attention/concentration, and language deficits.

She takes a number of medications to support mood and works with a therapist (telehealth). The therapist is very helpful, and also works with her on chronic pain management. She also uses meditation and yoga (in bed or in wheelchair) and CBT techniques.

Family history includes early-onset front-temporal dementia in her mother, substance abuse, mood disorder, ASD, and ADHD.

**Previous Evaluations/Medical Records:** Ms. M\_\_\_\_\_ was evaluated in May of 2015 by Dr. Preston for an evaluation of memory and executive function. A full evaluation was not conducted, limiting comparability to scores to this current evaluation (results below). Vocabulary level was High Average and visual reasoning was Superior on the WAIS-IV, picture naming was intact, but scores on brief memory screening ranged from lower end of Average to Superior ranges. Digit span was High Average. Hypothesis testing was intact on the WCST (5 of 6 categories). Significant variability was present on the few D-KESF tasks administered, ranging from the bottom of the Average range to the top of the High Average ranges (25<sup>th</sup> to 84<sup>th</sup> percentiles). Surprisingly, based on this limited evaluation and without any measures of psychological functioning, he diagnosed depression and anxiety “by history”, attributing the significant variability to depression and anxiety. A re-evaluation of his findings suggests that the variability may more likely due to the increasing task demands and to temporal lobe functioning, although insufficient data is present in the report to address this.

She is followed by Dr. Bonnie Bidinger, rheumatologist, who indicated that she has followed Ms. M\_\_\_\_\_ since 2013 for a “severe case of fibromyalgia which has been resistant to multiple medications and numerous treatment modalities, with “diffuse pain of joints and muscles and severe fatigue which have made it impossible for her to maintain any type of work”. She points out that the LTD reviewer cites no evidence of abnormality in labs or imaging, which are not ways to measure severity. She also points out that Dr. Patel’s characterization of lack of diagnoses causing impairment is also incorrect. Finally, she also indicates that Dr. Yawingu’s claims of no objective clinical findings to support her inability to work is a clear misrepresentation of the nature of fibromyalgia, a chronic, noninflammatory pain condition. She opines, based on her experience and her >5 year relationship with Ms. M\_\_\_\_\_ as her treating specialist, that she meets the criteria for being disabled.

There is also a history of anxiety and depression, including mild post-partum depression and OCD symptoms, for which she underwent CBT, with benefit, and dysfunctional family dynamics

in childhood. Note that she was able to complete her college and work full-time with these conditions until the chronic pain from her fibromyalgia became disabling.

**EVALUATION PROCEDURES:** Evaluation consisted of an interview with Ms. M, administration of a testing battery, and review of available records. Tests administered:

Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV);  
Wide Range Assessment of Memory and Learning (WRAML-2);  
Rey-Osterrieth Complex Figure;  
Color Trails;  
Delis-Kaplan Executive Function System (D-KEFS), subtests;  
Paced Auditory Serial Addition Test (PASAT);  
TOMM;  
Rey 15-Word Test;  
Rey 15-Item Test;  
BRIEF-Adult Scale;  
Personality Assessment Inventory (PAI).

**Behavioral Observations:** Ms. M presented as a friendly woman who was casually dressed. She was fully cooperative with testing. She was in obvious pain, but persisted with breaks. Testing had to be split into two sessions, however, because the testing exacerbated pain. Speech was notable for word pauses and word-finding difficulty. Results are considered valid reflections of current capacity.

At our second evaluation, she communicated to me that she was not feeling well, and was at her typical baseline functioning. During this session, she was noted to have more word-finding difficulty and word-initial hesitations, as well as misinterpreting questions/directions.

**TEST RESULTS:** (See appendix for test results and percentiles)

**Intellectual Functioning:** The WAIS-IV was administered to assess information processing ability. The WAIS-IV consists of 10 core subtests used to derive a Full Scale IQ and four Indices. The Verbal Comprehension Scale measures the individual's ability to listen, comprehend, and verbally express him/herself. The Perceptual Reasoning Index measures nonverbal reasoning and visuospatial ability. The Working Memory Index assesses the ability to attend to and remember verbally presented information and, in some instances, re-organize that information before repeating it. The Processing Speed Index measures how quickly one can process and produce visual information using pencil and paper tasks.

Note that performance on this test is divided into several categories, with performance following a bell-shaped curve. The Average range includes those scores between which 50% of the population is expected to score if given the WAIS-IV (i.e., 90-109). An additional 16% of the population is expected to score in the next higher category, the High Average range, while another 9% do even better than that (Superior or Very Superior ranges). Conversely, 16% of the population will do somewhat below Average (i.e., in the Low Average range), while another 9% will do much worse than Average (i.e., in the Borderline or in the Extremely Low ranges). A score of 8 at the 25<sup>th</sup> percentile means that 75 of a random sample of 100 same-aged individuals did as well or better than s/he on a particular measure, while a score of 17 (99<sup>th</sup> percentile) means

that he did better than 99 of 100 same-aged peers. There was a significant verbal>nonverbal split. Scores follow (90-109=Average and 110-119=High Average):

Wechsler Adult Intelligence Scale -Fourth Edition (WAIS-IV)

WAIS-IV Index Scale	Composite Score	Descriptive Range
Verbal Comprehension	108	Average
Perceptual Reasoning	105	Average
Working Memory	97	Average
Processing Speed	100	Average
Full Scale IQ	104	Average

WAIS-IV subtest scores; scores of 8-11=Average; timed subtests are marked\*.

Verbal Comprehension		Perceptual Reasoning	
Similarities	14	Block Design*	12
Vocabulary	13	Matrix Reasoning	12
Information	8	Visual Puzzles*	9
Working Memory		Processing Speed	
Digit Span (5-6f,4-5r,4-5s)	9	Coding (0x)*	10
Arithmetic*	10	Symbol Search (0x)*	10

*(Digits forward: 37<sup>th</sup> percentile; Digits reversed: 50<sup>th</sup> percentile; Digits sequenced: 25<sup>th</sup> percentile)*

**Language Functioning:** Ms. M. WAIS-IV Verbal IQ was Average for age, but was a significant underestimate of potential. Verbal analogical reasoning for determining the similarity between two members of a semantic class was Superior. Ms. did well with expressive vocabulary for defining vocabulary words (top of the High Average range). Note that Vocabulary is a score that is resistant to many kinds of brain injury/disease. These scores set expectation at a very high level. In contrast, fund of acquired facts was notable for significant difficulty retrieving facts (low end of Average).

Her ability to call upon her rich vocabulary store when needed was significantly variable. Verbal fluency for naming to letter cues was High Average for age. However, she failed to show the expected enhancement for naming with the structure of semantic categories; her score was actually at the bottom of the Average range. Switching between categories was also Average.

**Nonverbal Functioning:** Nonverbal IQ on the WAIS-IV was Average. Visual analogical reasoning for completing matrices (untimed) was High Average for age, but performance was slow and she used verbalization to aid problem solving. In significant contrast, performance on an integrative puzzle task that required her to break shapes down into component parts (Visual Puzzles), a timed measure, was in the lower half of the Average range for age, with five “time failures” (i.e., inability to complete items in the allotted time). She had no difficulty copying block designs with colored cubes, with a score in the High Average range.

Visuomotor integration and organization for copying the Rey-Osterreith Figure was intact; as the

design is front of the examinee during the entire copy condition, a nearly-perfect copy is expected.

Slowed processing speed interfered with her ability to spot missing details from pictures; her score was in the lower half of the Average range overall, with five “time failures”. Timed symbol searching on the WAIS-IV (i.e., searching for exact symbol matches in a busy visual display) was Average, as was timed digit-symbol Coding.

**Executive Functioning:** Executive functions are those that regulate cognitive efficiency and efficacy. This includes ability to determine relevant from irrelevant detail; prioritize detail; generate a “game plan” and plan out the steps needed to achieve that goal; begin tasks; allocate, sustain, and regulate attentional resources to sustain effort to task; shift from detail to the big picture; evaluate problem solving approach “on line” to take into account feedback, and adjust the plan to fit any new information; multi-task; time management; optimize cognitive efficiency; shift cognitive sets when needed; and disengage from tasks when needed.

Speeded visuomotor tracking for a connect-the-numbers task on the Color Trails task was at the bottom of the Average range for age. Switching between numbers and letters was High Average due to verbalization.

On a visual initiation task, D-KEFS Design Fluency, Ms. M. was able to connect dots to make unique patterns at only a Low Average level, with no errors. In the Empty Dot condition, which features distractors, her score was also Low Average. Performance was also Low Average in the Switching condition, as she was able to use a verbalization strategy to switch between the empty and filled dots.

Ms. M. showed relative difficulty planning ahead on a problem solving task with executive components (Tower, D-KEFS). Her score was Average for achievement, with only 7 of the 9 designs completed within the allotted time. Mean time to make her first move was very slowed.

Resistance to interference, another measure of intact frontal lobe functioning, was assessed with the D-KEFS Color-Word task. Performance in the simpler condition, Color Naming, was deficient, slowed by the set-shifting demands of the task (e.g., need to alternate between the different colors); on this task, she was asked to name a color display of red, green, and blue squares. On the (color) word reading task, score was still deficient for age, however. She had significant difficulty in the Interference condition, in which she had to multi-task, namely say the color of the ink in which the (color) words were printed (i.e., the word red, written in green ink: red). Finally, performance was Low Average for the Inhibition/Switching condition (same as above, except when the word was written inside a box).

**Memory Functioning:** Working Memory (WAIS-IV) was Average for age overall, below cognitive expectations. Immediate span for digit repetition was in the lower half of the Average range overall, intact for 5-6 digits in a forward direction and 4-5 in a reverse direction. Mental computation was Average for age. WRAML-2 Verbal Working Memory was Borderline, however, consistent with the added sequencing demands.

Her ability to sustain attention on a mental arithmetic task was assessed on the PASAT, which

requires serial mental addition. Her score in the simpler condition was Average, as was her score in the slightly faster condition.

The WRAML-2 was also administered to assess memory functioning both relative to age peers and relative to her own potential. The following table shows results. Overall, there was significant variability in skill levels (<1<sup>st</sup> ->99<sup>th</sup> percentiles for age; Deficient to Very Superior ranges, a significant amount of scatter). As on the WAIS-IV, Standard Scores of 90-109 are Average and subtest scores of 25<sup>th</sup>-74<sup>th</sup> percentiles are Average. **It is also important to note that scores significantly above the Average range are expected given her premorbid intellectual prowess. These scores were not obtained on most subtests, however, consistent with her report of memory deficits.** There was a significant discrepancy between verbal and nonverbal memory.

Scale/subtest	Score	Description	Scale/subtest	Score	Description
Verbal Memory	108	Average	Visual Memory	88	Low Average
Story Memory, Immediate	11	63%-Average	Design Memory, Immediate	9	37%-Average
Story Memory, Delayed	8	25%-Average	Design Memory, Recognition	12	75%-High Avg
Story Recognition	13	84%-High Avg	Picture Memory, Immediate	7	16%-Low Avg
Verbal Learning, Immediate	12	75%-High Avg	Picture Memory, Recognition	8	25%-Average
Verbal Learning, Delayed	12	75%-High Avg			
Verbal Learning Recognition	12	75%-High Avg	Screening Memory	98	Average
			Verbal Recognition	115	High Average
Working Memory			Visual Recognition	100	Average
Verbal Working Memory	4	2% -Borderline	General Recognition	109	Average

Auditory Memory was Average overall, below IQ expectation. Immediate recall of two stories was Average for age, a significant weakness when compared with potential. She showed additional loss over a delay (bottom of the Average range). Recognition memory was High Average, however, consistent with a retrieval and encoding deficit.

Repetition of word pairs over 4 learning trials was High Average. After a delay, recall was good, as was recognition.

Visual memory was significantly weaker than Verbal memory overall, falling only in the Low Average range. Immediate design reproduction was Average for age, with good recognition recall after a 30 minute delay. Delayed recall of the complex Rey-Osterreith figure showed excessive loss (almost 2/3) falling in the Low Average range. Immediate recall of detail from pictured scenes on the WRAML-2 was Low Average immediately, with minimal loss after a 30 minute delay.

**Checklists:** On the PAI, a self-report questionnaire, several of the subscale scores were clinically elevated (i.e., at or above a Tscore of 70) or moderately elevated (i.e., Tscore=65 or above). This is consistent with her deficits being due to pain and not psychological factors. All of the subscales were elevated on a scale that assesses whether the respondent reports a greater than normal amount of physical complaints when compared with others her age. As she is suffering from a chronic, debilitating pain syndrome, scores might be expected to far exceed typical scores. Elevation was also seen on the physiological subscales for depression and anxiety, but not the affective scales, again consistent with her pain profile instead of a mood-based disability.

**“Effort” Measures:** Observationally, Ms. M was very cooperative with all measures presented and persevered on tests she found more difficult. The pattern of responses reveals no evidence of malingering or “faking bad”, a feat that would require a great deal of sophistication about neuropsychological testing to carry off successfully. For example, there was no evidence of failing simpler items and passing harder items, which is often seen when one is putting in insufficient effort in the service of trying to amplify deficits (i.e., malingering). In addition to qualitative and quantitative analyses of the data for effort and consistency, measures of “effort”, typically used to detect malingering or exaggeration of deficits, were administered. Ms. M passed those, as well.

On a 15-word forced recognition measure that is often used to detect problems with effort, Ms. M’s recognition of list items was adequate, consistent with good effort (9 words). Similarly, on a 15-item recognition measure, she retrieved 12 of the 15 simple designs, as expected.

In addition, on a normed test of effort, the TOMM, Ms. M’s performance matched expectations, and was well above both chance levels and those of a control group of patients who were judged to be “At-Risk” for malingering.

TOMM Subtest	Obtained Score	Chance	TBI mean	At-Risk mean
Trial One	50	25	45.9	25.3
Trial Two	50	25	49.4	32.6
Retention	50	25	49.5	35.1

Finally, pattern of performance and cognitive deficits displayed are consistent with profile in a bright individual, with no bizarre responses or responses patterns evident or unusual symptoms provided. Thus, based on all these factors and measures, results are felt to be a valid reflection of current abilities.

### **SUMMARY AND IMPRESSIONS:**

Cognitive deficits relative to High Average-Superior premorbid IQ, including in the areas of:

- Lexical access, auditory processing
- Visuomotor integration and organization
- Executive functioning
- Processing speed (many “time failures”)
- Memory (working memory, verbal memory, visual memory, fact retrieval)

Significant variability is present in Ms. M’s cognitive profile as a whole, with scores ranging from the 91<sup>st</sup> to below the 1<sup>st</sup> percentiles for age, i.e., at times as well or better than 91 of 100 people her age and at times worse than 99 of 100 people her age. This is an extreme amount of variability. Given a premorbid potential calculated as falling in the High Average to Superior ranges for age (based on educational achievement, profession, and using Lezak’s “best performance” model), this is evidence of significant impairment. In fact, only 22% of subtest scores fell within expected levels, and a full 24% of subtest scores fell in the Low Average to deficient ranges (i.e., worse than 76-99 people her age), significantly below expectation in someone of her educational status and ability. Even scores in the Average range (45% of scores)

should be considered below expectation.

Ms. M continues to be totally disabled from work for multiple reasons. Physically, she would be unable to perform the job duties, given her severe pain syndrome, constant headache, lack of endurance, and significant fatigue. Cognitively, her language processing deficit, executive function deficits, slowed mental agility, and other areas of compromise indicate that she would be unable to carry out the organizational, memory, speed, and executive aspects of her occupation. The effect of her physical and cognitive symptoms is emotionally distressing, but she is coping for that distress through medication and therapy, and there is no evidence that emotional factors are a significant contributing factor to her disability.

In addition, the effects of her cognitive deficits, exacerbated by chronic pain and its effects on physiological state, will be more apparent in the work settings than in the quiet, distraction-reduced 1:1 setting, as was the case. Although she is bright and hard-working, and may be able to compensate to some extent for these deficits for a short period of time (i.e., for a test session), the mental effort required to perform near potential is exhausting and cannot be sustained.

There is no logical reason for denial of her LTD claim, especially based on Liberty's "no diagnosis causing impairment" argument. As pointed out by Dr. Bidinger, and as Liberty's rheumatologist must know, Fibromyalgia (FM) is diagnosed by:

- (1) pain and symptoms based on the total number of painful areas in 19 parts of the body, severity of this pain, fatigue, waking unrested, cognitive deficits, other physical symptoms,
  - (2) symptom duration for a least three months at a similar level, and
  - (3) that are not due to another health problem
- (as per American College of Rheumatology definition).

Based on the criteria above, Ms. M does carry a clear, recognized diagnosis. The Fibromyalgia diagnosis has been formally recognized in medicine for over 15 years and carries an extensive literature, but there is no clear biological marker for the disease. Lab tests are usually helpful in determining comorbid diagnoses, but there does not exist a definitive laboratory test for FM. Those who work with FM patients, e.g., rheumatologists, all are clearly aware of this, and also clearly aware that this is a real diagnosis. Most agencies, such as Social Security Disability rely on the ACR criteria for diagnosis.

She has continued significant tender point elevations (16/18 in April of 2018) and a positive score of **73** on the FM test through EpicGenetics (7/18/2017, measuring production of cytokines). **Thus, there is clear gold-standard diagnostic criteria that Ms. M clearly meets.** This then counters Liberty's basis for denial or long-term disability benefits. Further, there is no treatment for FM, just symptom management which is of variable success depending on level of FM.

Her treating Fibromyalgia specialist, Dr. Bidinger, has ruled her disabled from work.

Similarly, her assessment at Ithaca College found her to be "unable to perform her own occupation or any other sedentary occupation" based on their 3/29/2018 CardioPulmonary Exercise Test Protocol due to her chronic fatigue, myalgia, exercise intolerance, heartburn, chest

pain, and debility.

Fibromyalgia has also been associated in the literature with cognitive dysfunction (Landro et al., Sletvold, Grace et al., Cote and Moldofsky, etc.), especially in the areas of memory and executive functions, that is separate from weaknesses also seen in depression, fatigue, sleep disorder, and other conditions (e.g., Parl et al., 2001). Dysfunction is present in the neuropsychological evaluation today.

Further, her profile, even in the 1:1 setting, is incompatible with the demands of a high-level research coordinator. Given that she experienced extreme and prolonged discomfort following only a few hours of testing at each session, her pain syndrome and cognitive deficits mean that she cannot perform the material duties of her job nor any gainful occupation for which she may reasonably become qualified for based on education, training and experience.

Given today's results, Ms. M is considered permanently disabled from that profession or any profession that shares those or similar demands.

I am available for questions that might arise about my findings or conclusions.

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Kaaren Bekken, Ph.D., Neuropsychologist  
Licensed Psychologist, Certified Health Care Provider

**TEST SCORES:**

(Standard Score of 90-109=Average; 25<sup>th</sup>-74<sup>th</sup> percentiles=Average)

**Intellectual Functions:****Wechsler Adult Intelligence Scale -Fourth Edition (WAIS-IV)**

WAIS-IV Index Scale	Composite Score	Descriptive Range
Verbal Comprehension	108	Average
Perceptual Reasoning	105	Average
Working Memory	97	Average
Processing Speed	100	Average
Full Scale IQ	104	Average

WAIS-IV subtest scores; scores of 8-11=Average; timed subtests are marked\*.

Verbal Comprehension		Perceptual Reasoning	
Similarities	14	Block Design*	12
Vocabulary	13	Matrix Reasoning	12
Information	8	Visual Puzzles*	9
Working Memory		Processing Speed	
Digit Span (5-6f,4-5r,4-5s)	9	Coding (0x)*	10
Arithmetic*	10	Symbol Search (0x)*	10

(Digits forward: 37<sup>th</sup> percentile; Digits reversed: 50<sup>th</sup> percentile; Digits sequenced: 25<sup>th</sup> percentile)

**Language Functions:****D-KEFS. Letter Fluency:**

Letter	75 <sup>th</sup> percentile (High Average)
Categories	25 <sup>th</sup> percentile (Average)
Switching	50 <sup>th</sup> percentile (Average)

**WIAT-III, Oral Discourse Comprehension:** Standard Score=90 (Average)

**Visuospatial and Executive Functions:****D-KEFS:**

Design Fluency	
Simple Dots	9 <sup>th</sup> percentile ( <b>Low Average</b> )
Circle (distraction)	9 <sup>th</sup> percentile ( <b>Low Average</b> )
Switching	16 <sup>th</sup> percentile ( <b>Low Average</b> ); 50% errors
Tower, Total Achievement	50 <sup>th</sup> percentile (Average)
Mean 1 <sup>st</sup> move time	<1 <sup>st</sup> percentile ( <b>deficient</b> )
Color-Word	
Color Naming	<1 <sup>st</sup> percentile ( <b>deficient</b> )
Word Reading	16 <sup>th</sup> percentile ( <b>Low Average</b> )
Interference	1 <sup>st</sup> percentile ( <b>deficient</b> )
Interference/Switching	16 <sup>th</sup> percentile ( <b>Low Average</b> )

**Color Trails:**

Number Sequencing	Standard Score=91 (Average)
Color-Number Switching	Standard Score=110 (High Average)

Rey-Osterrieth Complex Figure:

Copy Condition

35/36 pts; Standard Score=115 (High Average)

Delayed Recall

12/36; Standard Score=84 (**Low Average**)

Recognition

18/24; 5<sup>th</sup> percentile (**Borderline**)**Memory Functions:**WRAML-2:

Scale/subtest	Score	Description	Scale/subtest	Score	Description
Verbal Memory	108	Average	Visual Memory	88	Low Average
Story Memory, Immediate	11	63%-Average	Design Memory, Immediate	9	37%-Average
Story Memory, Delayed	8	25%-Average	Design Memory, Recognition	12	75%-High Avg
Story Recognition	13	84%-High Avg	Picture Memory, Immediate	7	16%-Low Avg
Verbal Learning, Immediate	12	75%-High Avg	Picture Memory, Recognition	8	25%-Average
Verbal Learning, Delayed	12	75%-High Avg			
Verbal Learning Recognition	12	75%-High Avg	Screening Memory	98	Average
			Verbal Recognition	115	High Average
Working Memory			Visual Recognition	100	Average
Verbal Working Memory	4	2% -Borderline	General Recognition	109	Average

Paced Auditory Serial Addition Test:

3 second

Standard Score=99 (Average)

2 second

Standard Score=98 (Average)

**Checklists and Effort Testing:**

Personality Assessment Inventory (shaded scores are significant)

PAI Scale/Subscale	T	PAI Scale/Subscale	T	PAI Scale/Subscale	T
<b>Validity</b>		Mania	45	<b>Other Scales</b>	
Inconsistency	61	Activity Level	42	Alcohol Problems	41
42Infrequency	40	Grandiosity	51	Drug Problems	42
Negative Impression	51	Irritability	43	Suicidal Ideation	56
Positive Impression	52	Paranoia	43	Stress	64
		Hypervigilance	42		
		Persecution	42	<b>Interpersonal</b>	
<b>Clinical</b>		Resentment	47	Dominance	60
Somatic Complaints	<b>96</b>	Schizophrenia	51	Warmth	56
Conversion	<b>87</b>	Psychotic Experience	40		
Somatization	<b>89</b>	Social Detachment	49	<b>Treatment</b>	
Health Concerns	<b>94</b>	Thought Disorder	64	Aggression	38
Anxiety	53	Borderline Features	44	Aggressive Attitude	34
Cognitive	38	Affective Instability	45	Verbal Aggression	42
Affective	49	Identity Problems	47	Physical Aggression	46
Physiological	<b>75</b>	Negative Relations	50	Nonsupport	56
Anxiety-Related Dis.	45	Self-Harm	37	Treatment Rejection	57
Obsess-Compulsive	52	Antisocial Features	44		
Phobias	43	Antisocial Behaviors	43		
Traumatic Stress	45	Egocentricity	45		
Depression	<b>74</b>	Stimulus-Seeking	48		
Cognitive	<b>67</b>				
Affective	58				
Physiological	<b>84</b>				

TOMM:

TOMM Subtest	Obtained Score	Chance	TBI mean	TBI At-Risk mean
Test One	50	25	45.9	25.3
Test Two	50	25	49.4	32.6
Retention	50	25	49.5	35.1

15-Item Test:

12/15 correct (adequate effort)

15-Word Test:

9/15 correct (adequate effort)

Reliable Digit Span (RDS-2):

passed