CALDWELL REPORT
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January 31, 2008

NAME: Sample 13

AGE: 39

SEX: Male

EDUCATION: 17 years

MARITAL STATUS: Married

REFERRED BY: ----------

DATE TESTED:

TEST ADMINISTERED: Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

TEST TAKING ATTITUDE

Attention and Comprehension: His score on the Variable Response Inconsistency scale (VRIN) was quite unelevated; his item responses were highly self-consistent throughout the inventory. This suggests that he was clearly able to read and comprehend the test items, that he was attentive in considering his responses, and that he carefully matched the item numbers in the booklet to the corresponding numbers on the answer sheet. He does not appear to have had any difficulties in understanding the content or responding to the format of the inventory.

Attitude and Approach: Considering scales L, F, and K, he tended to be self-favorable and moderately minimizing of emotional problems in his approach to the inventory. The profile appears valid by the usual criteria for these scales.

He made almost no atypical and rarely given responses to the items in the second half of the inventory (scale F-back). This was consistent with the relative absence of such rare answers to the earlier MMPI-2 items (scale F). The profile clearly does not appear to be of questionable validity because of atypical responding.

Socio-cultural Influences vs. Conscious Distortion: The supplemental validity scales showed an above average score on the scale (Ss) measuring his level of currently attained, recently experienced, or self-perceived socioeconomic status. He also showed a mild amount of conscious

defensiveness. It appears that most of his moderate elevation on scale K was due to an authentic sophistication in his self-presentation, and only a small amount of his self-favorableness on K was due to a deliberate slanting of his responses.

SYMPTOMS AND PERSONALITY CHARACTERISTICS

The profile indicates a vulnerability to become preoccupied with his physical pain and suffering. At least some aspects of localized pain, general malaise, weakness, and fatigue are apt to be seen as beyond medical expectations for his current physical status. Such symptoms as G.I. pain or other G.I. complaints, hypertension, vasomotor instability, and headache are often associated with this profile. Obesity or any of a variety of issues involving his eating habits would also be typical. At times he may deny his depression and show some indifference about his physical symptoms or about their consequences in his life. However, the secondary depression appears only partly expressed through the physical concerns and as only limitedly covered over. Depressive qualities would color the clinical picture with occasional breakthroughs of open distress. Nevertheless, the current level of organization of his immediate personal coping and practical self-sufficiency tests as basically adequate and at times as reasonably good.

Talkative about his current situation and concerns, he tests as repressive of internal feelings, as inhibited and avoiding of his conflicts and as poorly facing his personal problems. His symptoms may gain him reassuring attention and consideration, or effectively allow him to avoid or to say "no" to unwanted demands. He tests as naive and lacking in insight, and his acceptance of his angry feelings and sexual wishes appears poor. Others are apt to see him as much more self-centered, demanding, irritable, and emotional than he sees himself. He is also prone to frustration with his place in life, but he would have serious difficulties in facing this.

His efforts to be contented, cooperative, friendly, and cheerful would reflect his ideals but cover over his strong emotional reactions to rejections, to frustrations of his demands and wishes, and to losses of emotional support. He would be especially vulnerable to the death of a family member or other separation from an emotionally supporting person, tending to idealize the lost person and to reject criticism of them. His family ties appear reasonably firm so that family and marital problems are apt to be poorly faced or indirectly expressed through irritability. He would be seen as stereotyped and inflexible in his handling of emotional problems. He tests as mildly extroverted. His overall balance of interests appears quite masculine, such as mechanical and outdoor activities along with some disinterest in cultural and esthetic pursuits.

Similar patients have been described as being at a "throw in the sponge" phase of their lives at the time of testing. Multiple childhood rejections and deprivations were reported, including poor or alcoholic fathers, emotionally ill parents, fathers or mothers who had died during the patient's childhood, and families that lacked affection either because of

strict and rigid attitudes or through an immoral and disorganized pattern. As children these patients handled stresses by repressiveness and by learning passive and dependent roles. However, their emotional reactions became attached to strong psychophysiologic reaction patterns as well as being expressed through symbolic conversions of their anxiety. It has been speculated that these life-long conditioned autonomic reactions directly contributed to their high incidence of organic breakdowns and psychophysiologic disorders. They tended to marry adaptable and well-liked wives on whom they depended in subtle if not open ways, but they rejected their children's demands rather as they had been rejected in their own childhoods. The onset of symptoms then appeared to follow an upheaval of their balance of negative input over positive gratifications, especially if such an upheaval coincided with physical symptoms that produced a large increase in the person's sense of vulnerability.

DIAGNOSTIC IMPRESSION

Diagnoses of conversion, pain, and hypochondriacal disorders and of psychophysiologic disorders are the most common with this pattern.

TREATMENT CONSIDERATIONS

The hysterical trends indicate a vulnerability to difficulties with dependency fostering drugs, particularly to barbiturates and analgesics. Medications and other medical interventions are apt to be short-lived in their effects; he appears suggestible and prone to develop side-effects. A serious polysurgical risk is indicated, and in many similar cases surgeries were followed by temporary benefits and persisting postoperative pain. Similar patients have often had prolonged and complicated surgical recoveries with needs for extended postoperative pushing in order to resume functioning; a great deal of caution would be indicated in hospitalizing him for medical treatment or in arranging extensive physical workups if the indications were unclear and equivocal.

Psychotherapeutic intervention is difficult where the patient is so strongly oriented toward physical illnesses and somatic explanations of his difficulties. Family consultation can be quite beneficial to evaluate the secondary gains and to arrange to minimize them. It can also be beneficial to inform them fully as to his current physical status, treatment needs, and capacity for work and activity. Stresses should be minimized if feasible, and work with the family may improve currently frustrating or rejecting relationships even if he does not identify them as such.

His mild tendencies to be self-protective in responding to the inventory may have involved both an element of conscious defensiveness and some more internalized or preconscious denial. This suggests considering how he expected the test results to be used. That is, he appears to have had some concerns lest the results reflect poorly on him or perhaps end up being hurtful to his self-interests. At the same time, the scores suggest a hesitation to admit genuine personal problems to himself. How to respond to

his needs to so moderate his responses and to present a socially desirable image of himself depends, of course, on the# context and circumstances of the testing. In general his emotional constrictions and his tendency to declare certain topics "off limits" could necessitate careful handling and patience in therapy.

Similar patients have frequently benefitted from the release of stored-up emotions. Often their personal conflicts were identified in part by what they specifically denied to be problems. Emotional catharsis is apt to relate to past rejections, hurt feelings, and unsatisfied needs for care and protection. Frequently this opened up around a loss of emotional support through separation from a loved one or unresolved grief over a loss such as the potentially permanent defeat of a crucial personal goal or the death of a parent or other family member. Similar patients had great difficulties in working through the anger phases of grief processes. An increased acceptance of his self-centered wishes, inhibited impulses, and intense emotions is apt to be the main benefit of treatment. Termination typically has involved some "face-saving" against the implication that his problems were all psychological; efforts to make such a face-saving adaptive rather than surgically self-destructive or otherwise self-defeating have been reported as beneficial.

Thank you for this referral.

Alex B. Caldwell, Ph.D.
Diplomate in Clinical Psychology

The preceding analysis is basically actuarial and probabilistic in nature in that the symptoms and personality characteristics presented in the report have been identified as disproportionately frequent among individuals obtaining similar scores and patterns of scores on the MMPI-2 (tm). The diagnosis of any individual, however, needs to be based on the integration of information from personal contacts, the person's history, other test results, and whatever independent data are relevant and available.

This report has an overall focus on psychotherapy intake, differential diagnosis, treatment planning, and related personality-dependent determinations. It provides assistance in the diagnostic process by providing an extended set of clinical hypotheses, the largest part of the basis for which is data from traditional psychiatric settings. The application of these hypotheses to an individual requires independent confirmation of them by the clinician and an allowance for the specific context of testing if it differs substantially from the primarily psychotherapeutic database.

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THE ADAPTATION AND ATTACHMENT HYPOTHESES SUPPLEMENT:

The following paragraphs present my current hypotheses as to etiologic and developmental factors that likely contribute to the behaviors associated with the codetype to which this profile best conforms. The following description characterizes a relatively serious if not severe level of disturbance. Typically an individual with a moderate although not severely elevated profile will show an intermediate level of sensitization so that the adaptive responses to the aversive shaping experiences described below are demanding of but not overwhelming of the person's attentional energy and somewhat less disruptive of day-to-day functioning. THIS DESCRIPTION IS NOT MODIFIED OR ADJUSTED TO THE LEVEL OF DISTURBANCE OR SECONDARY VARIATIONS OF THIS PERSON'S PROFILE: IT IS AN ETIOLOGIC PROTOTYPE FOR ANYONE WITH THIS GENERAL PATTERN TYPE. It is intended to generate hypotheses as to how the individual "got this way". This prototype material will always be the same for any profile corresponding to his code type. At least three fourths of the reports currently processed will have these paragraphs--the other quarter are of more or less rarely occurring codes, and for want of code-specific data they will not have these paragraphs at this time.

My belief is that all behaviors are adaptive given the person's biologic/constitutional makeup and life experiences. An awareness of adaptational benefits is potentially helpful: (1) in understanding the origins and adaptive self-protections of the person's present behaviors, (2) in providing test-result feedback to the client as well as in explaining the person's conduct to judges and any other parties appropriately involved, and (3) in guiding psychotherapeutic intervention. These inductive hypotheses are based on an extensive searching for developmental information on pattern-matched cases. Some interpretations are supported by published data (e.g., Gilberstadt & Duker, 1965, Hathaway & Meehl, 1951, Marks & Seeman, 1963), etc., and others are based on clinically examining any cases I have been able to access on whom pertinent information has been available. Your feedback to me will be much appreciated regarding: (1) whatever in the material that follows is clearly a misfit to this individual, (2) more precisely targeted word choices, phrasing, and especially the person's own words for crucial experiences, and (3) behavioral characteristics that are likely to generalize to the code type but are missing here. For everyone's sakes, don't hesitate to send me a note.

PROPOSED DIAGNOSIS: INTENSIFIED PAIN-FEAR CONDITIONING
ADAPTATION TO: experiences of simultaneous intense fear and acute bodily pain and suffering
TRADITIONAL DIAGNOSIS: pain and conversion disorders (which latter clinically have been mainly complaints of pain, much less often other more esoteric, "classical" symptoms)
PROTOTYPIC CHARACTERISTICS: persisting physical distress concerns with a related focus on personal hopes as well as on potential medical and emotional sources of pain and distress relief. Especially when emotionally

upset, the range of physical discomforts and/or the intensity of reported distress are greater than medically expected, even though there may be well-defined and understandably distressing organic medical disorders from which the person is suffering.

The individual frequently presents as very trusting: "I am a very friendly, reasonable person to whom this painful malady has befallen. I've had to be so brave". Pollyanna attitudes mark the avoidance of the pain of face-to-face anger. Always being "nice" increases the hope for solace when suffering. Failures to anticipate or "see" interpersonal conflicts or other imminently negative and upsetting outcomes can become a sort of "emotional blindness". At the extreme, e.g., 3-Hy over 85 or 90, this blindness seems unbelievable to many observers, who then think it must be faked, "nobody could be that unaware I" But the shifts of attention described below can be quite total. At age 12 my own mother lost her mother; she could never understand my sister's enjoyment of mystery programs on TV: "Somebody always dies".

CONTRIBUTORY SHAPING HISTORY: In those cases with health issues dating back to early age levels (perhaps minimized or denied by the person but confirmed by family members), such factors as multiple rejections and deprivations, poor families, rigid family values, and emotionally disorganized families can set the stage for the inhibiting of any negative emotional expressions, of always "looking the other way" in order not to make a painful situation worse. Note the incidence of pre-pubertal parental deaths in Marks & Seeman (1963): 60% of their 13/31 patients reported a "parent death" which was more than any other code type (the related 231 was at 55%; all of their other codes were at least somewhat less). My hypothesis is that familial inhibition of open expressions of emotional anguish (e.g., your father just died and you are told, "Be quiet--You must be brave") would tend to orient attention onto how badly your body feels, perhaps establishing or considerably enhancing a fear/distress to body pain association.

The intense fear can also be contiguous with bodily sensations. Repeated or extreme associations of fear with a specific sensory input can lead to an alteration of the perception of that input. For example, repeated exposure to terrifying sounds can lead to a reduction of hearing and "hysterical deafness". Caldwell Report will soon have available CD copies of a radio dramatization of Starke Hathaway's treatment of hysterical deafness in an adolescent girl (on a isolated Minnesota farm, the other three family members were all deaf but could lipread, and a suggestible 15 year old girl was the only source of warning and alarm for dangerous sounds during the night). A conditioned activation, night after night, of the olivocochlear bundle that inhibits transmission from the cochlea to the central nervous system would offer a potential explanatory mechanism for a valid perceptual reduction of what is heard. A selective deafness (what activated her fears and hence the neural bundle) eventually spread, and she "discovered" that she was deaf but could "lipread". Thus the conversion metaphor, her fears "converted" her desperate need not to hear into

hysterical deafness. Note that hypothesizing the same distress-fear conditioning etiology for pain disorders as for conversion disorders makes the DSM separation seems a superficial if not arbitrarily symptomatic distinction.

In adult onset cases this profile pattern is often seen after a terrifying injury or other bodily trauma. This is usually physically dramatic to the individual, e.g,, a large object falls, crashing down on one's head (with little more than a momentary loss of consciousness), or in a health-dangerous environment a soldier falls ill or is in acute physical pain in the anticipation or midst of horrifying combat, e.g., Gulf War Syndrome. THE SIMULTANEOUS EXPERIENCING OF ACUTE BODILY PAIN WITH AN EXTREME FRIGHT CONDITIONS THE ASSOCIATION OF THE TWO, i.e., UNEXPECTED PAIN AROUSES A STRONG SENSE OF FEAR, AND OCCASIONS OF FEAR ACTIVATE DISTRESSING BODILY SENSATIONS. For example, the threat of a tragic loss or of an angry confrontation, when one has become acutely pain-fear sensitized, can quickly arouse fear-associated physical symptoms and thus an immediate sense of danger to the person's sense of physical well-being. Conversely, an increment of pain or other somatic distress can arouse a heightened if not intense level of fear; so much fear can generate a misattribution of the perceived seriousness and the cause of the pain or an increased sensitivity and awareness of any concurrent and previously mild or unnoticed discomforts. For example, fear due to the experience of an unexpected increase in a particular pain can set the stage for an at least transitory "conversion" symptom (e.g., an accelerated heartbeat when threatened with a major loss or someone's sharp attack, "Oh, my heart doesn't feel right. Did I have some kind of a heart attack? I don't know if the tests the doctor made were good enough"). Toward the extreme, some who are strongly pain-sensitized seem to lose the basic ability to distinguish emotional pain from bodily pain, so that an acute or potentially overwhelming emotional pain is only experienced and expressed as physical anguish.

The longer-term impact of such conditioning is the suppression of the healthily normal range of emotional expressions of anguish and grief at the time of an emotional upset as well as the confounding of subsequently self-owned anger (consider, "That hurt me, and I am p..... off. I don't want you to say that to me again". In contrast to, "What you said wasn't real nice; it wasn't as sensitive as I know you can be"). Focusing on points of hope operates to mitigate or inhibit upsets. I believe the shift of attention toward a focus of hope (however faint and tenuous) is reinforced not only by reduced annoyance and social avoidance by others at an interpersonal level but also at a neurophysiologic level by conditioned met enkephalin/opioid synthesis. Especially strong or autonomically dominant peripheral vasoconstriction responses may have a significant connecting effect between fear and the somatic focus, that is, peripheral vasoconstriction in response to a fear threatening stimulus would focus the attention on "what is happening in my body". To my awareness, whether injuries enhance subsequent peripheral vasoconstriction is not known.

I believe these heightened sensitivities to any perceived threats to

the person's hopes or sense of well-being lead to AUTOMATIC SHIFTS OF ATTENTION lest a surge of pain become overwhelming. Over time these shifts become so automatic and smooth as not to be noticed by the person (nor even by many professional observers if not attuned to watch for them). Specifically, I consider REPRESSION be the outcome of innumerably repeated shifts of attention away from some painful memory whenever a cue of that memory is even remotely approached. The repetitive opioid reinforcements of these shifts of attention away from the threat of the painful memory can progressively make that memory inaccessible and hence "repressed". For example, a woman in her early 70's presented with complaints of declining memory and impaired attention, which did not test as neuropsychological^ nor neurologically explainable. A year or so earlier, a bit before the time of the onset of her symptoms, her husband had choked to death at the dinner table. She had not recalled that, at age 5 she was looking out a window of her home and saw her father run over and killed by a truck, for many decades until the too-similar tragedy precipitated obtaining treatment for her symptoms; treatment eventually led to the memory. Thus, her distress appeared to have been sharply intensified by the prior unresolved but inaccessible grief, and successful treatment focused on resolving that accumulated grief.

A persisting CONVERSION symptom is the outcome of a repetitive shifting of attention away from a distressing threat onto a familiar and habituated physical pain, e.g., pressure to do something stressful is seen as somehow a danger to physical systems such as an undue strain on one's vulnerable heart. Belle indifference is the absence of emotional/fear arousal due to the habituation together with the effectiveness of the automatic shifting of attention in blocking the distress response to an imminent interpersonal threat.

DENIAL is the shift of attention away from an immediately distressing input. A postoperative patient was asked about her husband who rarely visited her in the hospital. Without a pause she said, "Oh, he was here two days ago. Look at those beautiful flowers over there. Mrs. Freund brought those from her garden. Aren't they gorgeous!" Or, after a noticeable pause, another 31/13 patient reacted to Rorschach card VIII, "Such beautiful colors! What do other people see in them"? It can be instructive to be alert to such shifts in an interview, and possibly in therapy to immediately ask, "You just made a shift in what we are talking about. Did something just cross your mind?" Thus, the person adapts to the threat of a surge of pain by reflexive and classically conditioned shifts of attention that mitigate or avoid hope-breaking inputs.

The Hy scale readily partitions into two limitedly correlated halves. The degree of emphasis can vary widely from one person to another. Some can have high elevations on the somatic part (Hy Obvious or Hy3 + Hy4) without much elevation on the interpersonal part: the person is body suffering-focused and consolation--and care--needy. Others can have high elevations on the interpersonal trust part (Hy Subtle or Hy1 + Hy2 + Hy5) and be problem-denying, Pollyanna, and approval-needy; a singular conversion

symptom can emerge in a period of intense stress and perceived threat. In the preceding, I have attempted to illuminate the underlying connections between these halves. The subscales give us this balance.

For codetype information see Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974; Prokop, 1988.

MMPI2 CRITICAL ITEMS
NAME: Sample 13

Distress & Depression
165F 180T
Suicidal Thoughts

Ideas of Reference, Persecution, and Delusions

Peculiar Experiences and Hallucinations

Sexual Difficulties

Authority Problems

Alcohol and Drugs

Family Discord
217F
Somatic Concerns
10F 141F 164F
Aggressive Impulses

Name: Sample 13
Referred by:
Date Tested:

Subscales

2-D and Subscales

		RAW	T
D	(full scale)	25	64
D1	Subjective depression	8	53
D2	Indecision-retardation	6	54
D3	Health pessimism	5	67
D4	Mental dullness	7	72
D5	Brooding, loss of hope	1	45

6-Pa and Subscales

		RAW	T
Pa	(full scale)	10	49
Pa1	Persecutory ideas	0	40
Pa2	Poignant sensitivity	1	41
Pa3	Moral righteousness	8	65

3-Hy and Subscales

		RAW	T
Hy	(full scale)	33	79
Hy1	Denies social anxiety	6	61
Hy2	Need for affection	11	67
Hy3	Lassitude - malaise	8	75
Hy4	Somatic complaints	4	57
Hy5	Inhibits aggression	2	40

8-Sc and Subscales

		RAW	T
Sc	(full scale)	11	58
Sc1	Social alienation	1	43
Sc2	Emotional alienation	0	40
Sc3	Ego defect, cognitive	5	72
Sc4	Ego defect, conative	4	60
Sc5	Defective inhibition	1	47
Sc6	Sensorimotor dissociation	2	51

4-Pd and Subscales

		RAW	T
Pd	(full scale)	15	50
Pd1	Family discord	1	45
Pd2	Authority problems	2	40
Pd3	Social disinhibition	5	57
Pd4	Social alienation	3	45
Pd5	Self-alienation	1	38

9-Ma and Subscales

		RAW	T
Ma	(full scale)	13	43
Ma1	Opportunism	0	35
Ma2	Psychomotor acceleration	6	53
Ma3	Imperturbability	3	47
Ma4	Ego inflation	2	43

5-Mf and Subscales

		RAW	T
Mf	(full scale)	19	36
GM	Gender masculine	43	61
GF	Gender feminine	26	46

0-Si and Subscales

		RAW	T
Si	(full scale)	17	41
Si1	Shyness and self-consciousness	2	42
Si2	Social avoidance	1	41
Si3	Alienation - self and others	3	44

Name: Sample 13 Page 2 (MMPI-2)
Referred by: ---------- Subscales
Date Tested:

Major Clinical Variables

		RAW	T
ES	Ego strength	35	45
MAC-R	Potential Alcoholism	13	32
SAP	Teen drugs/alcohol	8	46
AAS		0	36
Mt	College maladjustment	15	56
N-P	Neurotic-psychotic profile balance		25

Interpersonal Style Variables

		RAW	T
ER-S	Ego resiliency	26	67
EC-5	Ego control	14	60
ORIG	Need novelty	11	38
INT	Abstract interests	54	55
Do	Need for autonomy	17	51
Dy	Need reassurances	10	44
Pr	Intolerance	3	37
Re	Value rigidity	26	65
Et	Ethnocentrism	5	38
St	Status mobility	20	57
R-S	Repression-sensitization	29	47
Lbp	Low back pain	13	69
o-h	Overcontrolled hostility	14	55
Ho	Cynical hostility	4	33
Ba	Good teamworker	50	60

Distress-Control

		RAW	T
A	Level of distress	7	46
R	Emotional constriction	20	61
Ca	Caudality-distress	6	45
Cn	Control-façade	17	40
So-r	Life as desirable	32	54
Th-r	Tired housewife	12	52
Wb-r	Worried breadwinner	10	46
PK	PTSD	4	43

Validity & Stability

		RAW	T
VRIN	Response inconsistency	1	34
TRIN	T-F inconsistency	10	57T
F-back	Rare answer - back	0	42
F(p)	Psychiatric infrequency	0	41
S	Superlative self-presentation	41	68
Ds	Overemphasize-fake sick	5	40
Mp	Consciously fake good	13	59
Sd	Consciously fake good	12	48
Ss	SES identification	59	53
Ch	Correction for H	10	42
Rc	Retest-consistency	28	59
Ic	Retest-item change	15	47
Tc	Retest-score change	12	48

Content Scales

		RAW	T
HEA	Health concerns	10	62
DEP	Depression	2	45
FAM	Family problems	1	37
ASP	Antisocial practices	0	30
ANG	Anger	4	46
CYN	Cynicism	0	32
ANX	Anxiety	7	53
OBS	Obsessiveness	2	41
FRS	Fears - phobias	5	54
BIZ	Bizarre mentation	0	39
LSE	Low self-esteem	0	35
TPA	Type A	8	48
SOD	Social discomfort	2	39
WRK	Work interference	8	52
TRT	Negative treatment Indicators	1	39