CALDWELL REPORT

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January 31, 2008

NAME: Sample 36

AGE: 38

SEX: Female

EDUCATION: 12 years

MARITAL STATUS: Married

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

DATE TESTED: August 1, 2007

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

TEST TAKING ATTITUDE

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

Attitude and Approach: She was extremely self-favorable in her approach to the inventory, covering over personal problems and minimizing weaknesses. Although the scores were extensively corrected for this understatement, the elevations may be distorted and incomplete. Considering just scales L, F, and K, the interpretive statements made are probably valid, but they may fail to fully reflect her level of disturbance.

She 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 a high score on the scale (Ss) measuring her level of

currently attained, recently experienced, or self-perceived socioeconomic status. She also showed a mild amount of conscious defensiveness. It appears that nearly all of her high elevation on scale K was due to a genuinely higher class sophistication in her self-presentation, and only a small to very small amount of her elevation on K was due an intentionally self-favorable slanting of her responses.

SYMPTOMS AND PERSONALITY CHARACTERISTICS

The profile suggests repressive and denying defenses with quite uneven insight and self-awareness. She would minimize shortcomings and limitations both in herself and others, righteously reacting as though everyone somehow were or ought to be much more virtuous than they are. Her outward composure and self-restraint would nevertheless be limited by a narrowly correct social etiquette. She would be quick to direct her attention and energy outwardly toward the problems of others rather than her own. It should be noted that some psychotherapy patients with related profiles were seen as more disturbed than their profile elevations suggested, apparently because of their abilities to agitate others around them in order to avoid subjective anguish and to defend against being seen as "mentally sick". Nevertheless, her personal coping and immediate practical self-sufficiency test as exceptionally well organized in a wide variety of areas.

What anxiety she experiences would come in brief and agitated episodes rather than as chronic worry. However, she would tend to deny and project, and at the time of testing she reported only a limited amount of anxiety and depression. She would strive to maintain an outward manner of composure and and imperturbability and of "being on top of things". Her relatively low level of depression predicts a general resiliency and ability to rebound quickly from stress. When threatened, her alertness and quick protectiveness toward anger directed at her could lead to preoccupations about the motives of and underlying intentions of others. At such times she would fixedly blame others and seek to externalize the focus of her conflicts away from herself.

The pattern suggests a potential for having reactions to somatic symptoms that others would see as more persistent and intense than medically expected if not at least partly psychological in origin. Typically her concerns would be neither severe nor incapacitating, and such briefly episodic complaints as gastrointestinal distress, headaches, and stiffness of the joints or joint pain would be characteristic. She would be seen as upset by and perhaps as overreacting to tangible but minor pains and physical distresses. If she became physically ill, she could find any prospect of a serious handicap of self-care or loss of self-control quite threatening.

Her moral rigidity and inflexibility would strongly inhibit natural expressions of anger. This could derive from strong religious or ethical beliefs. At times she could "preach" her values and apply them in fixed "good-bad" judgments. Hostility toward members of her family and marital

resentments would be denied and rationalized. The profile suggests strong needs to control her temper and possibly angry outbursts, but the rare expressions of anger that do occur are apt to be self-righteous and subtly punitive. In some cases the hostility was rigidly overcontrolled and temper was denied until it erupted in explosive outbursts, most often toward a member of the patient's family. Nevertheless, it should be emphasized that her conscience tests as well-integrated and strict and her interpersonal loyalties as generally stable and dependable.

Underlying conflicts and unreleased hurt feelings around sexuality are indicated. Some similar patients had periods in their histories of being quite active sexually, but this appeared to reflect the strength of their needs for positive emotional feelings around sexuality rather than any lack of conscience or deficit of internalized standards. In some cases sexual gratifications were strongly ego-emphasized despite the many inhibitions. Her interests and attitudes appear unusually masculine; esthetic sensitivities and abstract verbal pursuits would have little appeal to her. She could "dress well" with more than usual attention to her personal appearance and her attractiveness to the opposite sex.

Continuing self-control and careful avoidance of criticism are self-protective behaviors that would influence many aspects of her life style. Underneath this would be overlearned but unverbalized fears lest she be attacked and be caused pain and humiliation by loved ones. The pattern suggests a public role of being cooperative and sociable with a strictly correct etiquette. In their past school histories, these patients were described as having been cooperative, reliable, and conscientious. Some had mothers who were described as "neurotic", but the patients' needs to avoid shame and embarrassment had led to a strict covering over or minimizing of their resentments. Often one or both of their parents had been seen by the community as moral and "upright"; in those cases where one parent was not very responsible or proper, the other typically presented a sharp contrast of rigid and puritanical attitudes. The relationships with their fathers were often described much more positively than their mother-daughter relationships, and some had been very boy-oriented in adolescence without close girl-to-girl relationships. Many had married "right out of high school". As adults these patients became strongly "home oriented" and placed high values on having good and stable homes. Their marriages and home lives were marked by subtle power struggles around "proper family values". It should be re-emphasized that her profile is mostly within the normal range. If she currently is seriously stressed (e.g., marital strife, child custody litigation, threatening accusations, etc.), this would likely have increased the elevation of her profile. In this case, the kinds of childhood experiences just described may have been only occasional without a severe or chronic impact, and she would have shown a relatively normal long-term adjustment in the absence of such stresses. Nevertheless, some elements of these childhood experiences are likely to have "set up" the behavioral tendencies being elicited by her current circumstances. That is, the current profile would represent a fluctuating, stress-exacerbated rise in the level of her defenses.

DIAGNOSTIC IMPRESSION

The profile suggests hysterical trends with a mixture of conversion, dissociative, and anxiety symptoms. Sotne similar patients showed paranoid trends clinically that they had rigidly covered over in responding to the test. Her profile is mostly within the normal range, however, and it is not diagnostically definitive. It may reflect no more than an adjustment disorder of adult life. Although her responses appear to have been influenced by a very high level of personal reserve and sophistication, the preceding diagnostic impression does not appear to be questionable because of any excessive effort to deliberately distort the test results in a self-favorable direction.

TREATMENT CONSIDERATIONS

Contacts with family members or other informants could help to clarify what the current stresses are, what are the secondary gains from her symptoms, and how such gains can be minimized. Such contacts could also help to evaluate any covert paranoid trends such as unreasonable jealousies, temper outbursts, recent personality changes and increasingly fixed projections and blaming of others.

Psychotherapeutic intervention is difficult where the patient is so repressive, limited in insight, and rejecting of the idea that she may have a "mental illness". Her denial and her sensitive pride suggest many resistances to intensive interviewing about intimate feelings and private reactions. She would emphasize external stresses and situations and would not want to be seen as emotionally disturbed. Motivation for treatment could be very situational, hesitant, and quick to subside. She could quickly reject treatment if she felt that her interpersonal role was being demeaned or that the therapist thought of her in any way at all as "crazy" or insane. The therapist should anticipate early requests for answers and advice which could come with an intention not to continue if unsatisfied. Seductiveness toward a male therapist would be likely at some point in therapy. This could develop at a time when she felt threatened and wanted to avoid an emotional pain such as her response to negative feedback from the therapist.

The profile anticipates that, in response to interview questions, she would be markedly understating if not highly sophisticatedly disguising of any personally upsetting or disruptive experiences. Any public occasions in the past when she seriously lost self-control, openly violated her own moral self-expectations, or felt judged by others to be "crazy" could have contributed to her vulnerability to shame. Her verbalizations of her emotions may be so finely modulated and her range of emotional intensity so narrow that it would be unusually hard for the interviewer to feel with her. The interviewer may have to "multiply" her statements in order to gain empathy for her. For example, the report that she is feeling "just a little bit" worse may be a serious upset and "a little bit better" a major improvement. In general her emotional constrictions and her tendency to

declare certain topics "off limits" could necessitate careful handling and patience in therapy. She may be specifically lacking in awareness as to how others perceive her behavior to be socially problematic. However fully self-justified she feels, she may be paying needless prices for the ways in which others feel "put off" by her,

Marital misunderstandings and unreleased resentments are a likely focus of interviews with this profile. The profile suggests reflections of her emotional overcontrol inviting catharsis, a gradual acceptance of angry feelings, and the development of new ways to express them. Even a mild ventilation of her repressed feelings would be an important initial step in treatment. Treatment experiences that would help to relieve her underlying fears of being caused pain by loved ones and of any possibilities of hostile and humiliating attacks could be particularly helpful. Dealing with anger toward the therapist or toward members of a therapy group could be a very constructive process for her to work through. A longterm goal would be an increased acceptance of the intensity and directions of her own emotional reactions. It should be re-emphasized that the relative normality of her profile is a favorable prognostic sign.

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.

This report was prepared for our professional clientele. In most cases this is confidential information and legally privileged. The ongoing protection of this privilege becomes the responsibility of the professional person receiving the attached material from Caldwell Report.

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 elevated and more severely disturbed profiles of the codetype to which this profile best conforms. Thus, the following description characterizes a relatively severe level of disturbance. Individuals with relatively unelevated profiles as in this case, typically show lower levels of sensitization and only selective aspects of this description. The adaptive responses to the aversive shaping experiences described below place demands on the attentional energies of the person, especially under threatening circumstances, but generally they are not overwhelmingly strong; at times of stress they are apt to interfere with day-to-day functioning but not to disrupt it grossly (which latter often does happen for individuals with markedly elevated profiles) . THIS DESCRIPTION IN NOT MODIFIED OR ADJUSTED TO THE MILD 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 for clinical consideration as too how the individual 1f"got this way". This prototypic material will always be the same for any profile matching this code type. About three fourths of the reports currently processed will have these paragraphs--the other fourth are 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 inferences 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), 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 sake, don't hesitate to send me a note.

PROPOSED DIAGNOSIS: SENSITIZATION TO THE PAIN OF HUMILIATION
ADAPTATION TO: being controlled by threat of personal and social humiliation
TRADITIONAL DIAGNOSIS: no fit

PROTOTYPIC CHARACTERISTICS: strongly sensitive to criticism; follows strict ethical values that avoid being put down. Although acting so as to be seen as forgiving, they momentarily can become sharply critical of someone they perceive to have demeaned or insulted them. They usually are well-dressed and well-bathed, often very aware of physical presentation and attractiveness in self and others. This was the modal code in the early Hathaway and Monachesi adolescent research identifying high school girls who subsequently entered beauty queen contests, and the code is relatively often associated with physical beauty in women. In adult women for whom physical beauty or the consciousness of or pride in physical appearance become a too vital part of their identity, aging can be a very difficult transition (e,g., observe the avoidant response of women clients with this syndrome to card 13F of the TAT) . On limited data, it is my impression that 36/63 males like "nice" or more formal dress or possibly uniforms. As scales 1-Hs and 3-Hy become elevated over T-65, they are likely to have a variety of physical complaints, e.g., headaches, fainting spells, or (almost specific to this pattern) joint pain--the latter probably from holding the body and limbs "too correctly".

Often they are achievement and self-advancement oriented; having a knowledge base that avoids being criticized as not well informed or embarrassed as ignorant can become quite important. The person is likely to be seen as strongly value-controlling in adult relationships, both as self-control and as a moral value-based control of others. For some this derives from strict religious values. Others may find the 36/63 person self-righteous: note whether the raw score on the "self-righteousness subscale" Pa3 is 7, 8, or all 9 items. In divorce and custody cases, for example, if one's spouse is perceived as humiliating or disgracing one in public, the proceedings are apt to become very painful and unforgiving.

CONTRIBUTORY SHAPING HISTORY: acute humiliations as a child, perhaps especially in front of family members, with will-coercive pressures to behave according to parental values and expectations in a "more mature" or "adult" way even at an early age. There can be an identity conflict of markedly contrasting parents, e.g., the father is impulsively self-gratifying and the mother is highly moralistic: "What does that make me--I come from both of them"? Past family tensions and resentments are covered over and evaded or denied in a vigilant avoidance of social embarrassments; this may be the sibling that most carefully opts to avoid public humiliation. The sensitivity to perceiving psychotherapy as a threatening engagement needs to be handled carefully.

For women, one of the attention-drawing consequences of beauty often seems to be experiences of male attention as the threat of an impersonal assault on her body, again a will-coercive threat (which is the major connection between 36/63 and beauty). Sexual histories often are active; private and mutually pursued and shared sexual affection is in many ways a polar opposite to public harassment, humiliation by frustrated males, and their sexually motivated deceptions, hence sought-after intimacy is a desirable relief. The person (male or female) is likely to be sharply and

self-protectively sensitive to honesty vs. dishonesty both in themselves and others; dichotomously, the other person may become either an always-trusted ally or has told a hurtful untruth and is therefore to be shut out or at least never completely trusted. Thus, life adaptation becomes the maintenance of a role that is "above criticism" while controlling others "for their own good".

MMPI2 CRITICAL ITEMS
NAME: Sample 36

Distress & Depression

146T

Suicidal Thoughts

Ideas of Reference, Persecution, and Delusions

Peculiar Experiences and Hallucinations

Sexual Difficulties

Authority Problems

Alcohol and Drugs

Family Discord

217F

Somatic Concerns

Aggressive Impulses

Name: Sample 36
Referred by: ---------
Date Tested: 08/01/07

Subscales

2-D and Subscales

		RAW	T
D	(full scale)	18	46
D1	Subjective depression	3	39
D2	Indecision-retardation	5	46
D3	Health pessimism	6	70
D4	Mental dullness	1	43
D5	Brooding, loss of hope	1	42

6-Pa and Subscales

		RAW	T
Pa	(full scale)	12	56
Pa1	Persecutory ideas	0	39
Pa2	Poignant sensitivity	2	46
Pa3	Moral righteousness	8	65

3-Hy and Subscales

		RAW	T
Hy	(full scale)	27	61
Hy1	Denies social anxiety	6	61
Hy2	Need for affection	12	71
Hy3	Lassitude - malaise	2	47
Hy4	Somatic complaints	1	41
Hy5	Inhibits aggression	5	62

8-Sc and Subscales

		RAW	T
Sc	(full scale)	3	55
Sc1	Social alienation	0	38
Sc2	Emotional alienation	1	49
Sc3	Ego defect, cognitive	0	43
Sc4	Ego defect, conative	1	44
Sc5	Defective inhibition	1	46
Sc6	Sensorimotor dissociation	1	45

4-Pd and Subscales

		RAW	T
Pd	(full scale)	10	45
Pd1	Family discord	1	44
Pd2	Authority problems	3	53
Pd3	Social disinhibition	6	64
Pd4	Social alienation	1	33
Pd5	Self-alienation	0	34

9-Ma and Subscales

		RAW	T
Ma	(full scale)	16	53
Ma1	Opportunism	2	54
Ma2	Psychomotor acceleration	4	45
Ma3	Imperturbability	6	69
Ma4	Ego inflation	2	43

5-Mf and Subscales

		RAW	T
Mf	(full scale)	30	65
GM	Gender masculine	40	68
GF	Gender feminine	37	48

0-Si and Subscales

		RAW	T
Si	(full scale)	12	34
Si1	Shyness and self-consciousness	2	41
Si2	Social avoidance	1	42
Si3	Alienation - self and others	0	38

Major Clinical Variables

		RAW	T
ES	Ego strength	41	64
MAC-R	Potential Alcoholism	15	40
SAP	Teen drugs/alcohol	7	46
AAS		0	39
Mt	College maladjustment	5	40
N-P	Neurotic-psychotic profile balance		59

Interpersonal Style Variables

		RAW	T
ER-S	Ego resiliency	31	78
EC-5	Ego control	14	50
ORIG	Need novelty	9	36
INT	Abstract interests	59	65
Do	Need for autonomy	18	56
Dy	Need reassurances	4	34
Pr	Intolerance	4	39
Re	Value rigidity	24	59
Et	Ethnocentrism	3	33
St	Status mobility	17	48
R-S	Repression-sensitization	10	36
Lbp	Low back pain	9	50
o-h	Overcontrolled hostility	19	70
Ho	Cynical hostility	5	35
Ba	Good teamworker	49	58

Distress-Control

		RAW	T
A	Level of distress	1	37
R	Emotional constriction	25	73
Ca	Caudality-distress	1	34
Cn	Control-façade	13	29
So-r	Life as desirable	36	64
Th-r	Tired housewife	5	35
Wb-r	Worried breadwinner	10	44
PK	PTSD	1	39

Validity & Stability

		RAW	T
VRIN	Response inconsistency	1	34
TRIN	T-F inconsistency	10	58T
F-back	Rare answer - back	0	42
F(p)	Psychiatric infrequency	2	57
S	Superlative self-presentation	42	70
Ds	Overemphasize-fake sick	2	35
Mp	Consciously fake good	12	61
Sd	Consciously fake good	11	47
Ss	SES identification	65	63
Ch	Correction for H	5	34
Rc	Retest-consistency	32	67
Ic	Retest-item change	6	63
Tc	Retest-score change	4	35

Content Scales

		RAW	T
HEA	Health concerns	2	40
DEP	Depression	1	39
FAM	Family problems	2	39
ASP	Antisocial practices	1	36
ANG	Anger	0	31
CYN	Cynicism	0	32
ANX	Anxiety	3	43
OBS	Obsessiveness	1	37
FRS	Fears - phobias	2	38
BIZ	Bizarre mentation	0	39
LSE	Low self-esteem	0	35
TPA	Type A	2	36
SOD	Social discomfort	2	39
WRK	Work interference	4	43
TRT	Negative treatment Indicators	0	35