CALDWELL REPORT
5839 Green Valley Circle
Suite 203
Culver City, CA 90230
310-670-2874
FAX 310-670-7907

January 31, 2008

NAME: Sample 46

AGE: 38

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: He was extremely self-favorable in his 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 his level of disturbance.

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, previously identified with, or self-perceived socioeconomic status. He also showed a mild amount of conscious defensiveness. It appears that most of his high elevation on scale K was due to emotional reserve and a genuinely sophisticated self-presentation, and only a small amount of his elevation on K was due to an intentionally self-favorable slanting of his responses.

SYMPTOMS AND PERSONALITY CHARACTERISTICS

He obtained a personality disorder profile on the MMPI-2. Resentments of family members are likely to be fixed and longstanding with many rationalizations and a slowness to forgive. He could become hostile, tense, and agitated when he feels trapped or threatened and then could react in self-centered ways. His judgment appears uneven with occasional lapses of forethought and breakdowns of his impulse controls. He would react with tension to the threat of punishment for acting out, but this is apt to be transitory and situational. Chronic alcoholism could readily aggravate these problems. He would also strive to maintain an outward manner of composure and imperturbability, as if he were "on top of everything". At times he may be seen as having an underlying coldness and indifference. Nevertheless, his ego strength tests as well above average for normal subjects which predicts practical effectiveness and self-sufficiency in a wide variety of areas.

He tests as tending to project his angry feelings and aggressive impulses onto others. Enviousness and feelings of unfair treatment may reflect underlying paranoid projections and subtle distortions of his reality testing. At times he could provoke others into reactions that he would take as confirming of his projections and in general he would tend to overreact to anger in others. His anger is apt to be expressed in indirect and possibly manipulative ways that are difficult for others to deal with. He could become critical and argumentative in order to defend against facing his own internal conflicts. He could rigidly overcontrol his hostility for long periods of time until it erupted in rare but dangerously explosive outbursts. It should be noted that some patients with this pattern were seen as more disturbed than their profile elevations had suggested; in part this was related to their abilities to agitate others in order to avoid subjective anguish.

Conflicts around his dependency needs, his demands on others for affection and sympathy, and his sensitivity to demands on him are common problem areas with this pattern. He would be seen as quick to resent what he would interpret as a personal rebuff. His moral values appear rigid and inflexible if not self-righteous and punitive toward those whom he sees as treating him unfairly. The pattern has particularly been associated with marital struggles and histories of divorce that involved rationalized and logically justified resentments, a subtle vindictiveness, and a slowness to "forgive and forget". Histories of difficulties around sexual impulsiveness are common with this pattern. His overall balance of masculine and feminine interests is within the normal range for his age and education. Despite his

interpersonal struggles, he tests as socially outgoing and extroverted, and he is likely to have many casual relationships rather than a few close and intimate ones.

Similar profiles have been related to a "chip on the shoulder" or "wounded pride" syndrome. In many of these cases temper tantrums had been a major way of getting what they wanted as children as well as a way of dealing with parental indifference and uneven affection. The threat of his anger could carry over into his adult life as a major way of coercing others and of gaining his wishes. Past rebelliousness toward maritally conflicted parents would be a typical history.

DIAGNOSTIC IMPRESSION

Among psychotherapy patients the diagnoses most commonly associated with this pattern are of passive-aggressive and paranoid personalities. A few of these cases were diagnosed as paranoia and still others as in reconstituted phases following overtly paranoid episodes. A secondary diagnosis reflecting chronic abuse of or dependence on alcohol, drugs, or other chemical agents may also be indicated. Although his responses appear to have been influenced by a 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

Phenothiazines and other somatic treatments have rarely been of benefit in similar cases. Some patients with this pattern reported good past effects from anti-anxiety agents and minor tranquillizing drugs, but they were especially prone to abuse them as well as sedative-hypnotics. His responses suggest an evaluation of his use of alcohol. The risk of loss of control through drinking could be serious. His makeup indicates a significant longterm risk of increasing dependence on alcohol. A past history of trouble with the law would suggest a risk of future difficulties. His responses suggests asking about current trouble with the law. If presently involved, the stress of this could have precipitated or exacerbated his symptoms or otherwise have led him to make professional contact. His responses suggest a careful review of his sexual history.

Contacts with wives and other family members have proven important in those similar cases in which they could be arranged. Such contacts have involved the clarification of the precipitating stresses, what was threatening or provoking the patients, and how dependable their controls had been. Such contacts could also help to evaluate paranoid trends such as increasing irritability, ideas of mistreatment or of persecution, jealousies, recent personality changes, and any other fixed projections of his anger. In a few similar cases, work with the family to help them to clarify their feelings toward the patient and to plan how to manage his behaviors was reported to be of as much longterm benefit as were the efforts

to treat the patient in psychotherapy,

He tests as having many subtle ways by which he would avoid facing his own internal conflicts. He would resist accepting what he would see as the vulnerable and exposed patient role. The motivation to change and the potential for insight and improvement appears quite limited. His makeup predicts a lack of psychological-mindedness and persisting difficulties in exploring his subjective feelings and emotions. The relatively low level of expressed depression and internalized anxiety would also predict against persistence in treatment. Although resentful of his childhood home and of how family members treated him, he is apt to be slow to reveal historical details because of his shame and his dislike of being seen as an angry and resentful person. Some similar patients have been able to put on a very good front of being cooperative, sociable, and well organized when wanting "out" of treatment.

The profile anticipates that he would be carefully understating of his private emotional feelings and quite cautious about any possibly improper reactions he might perceive he was being asked to reveal. Any public occasions in the past when he seriously lost self-control, openly violated his own moral self-expectations, or felt judged by others to be "crazy" could have contributed to his vulnerability to shame. His verbalizations of his feelings and his range of emotional intensity may be rather narrow and finely modulated. Thus, the therapist may have to "multiply" the intensity of such feelings in order to gain empathy for him. For example, the report that he is feeling "a little bit worse" may be a serious upset and "a little bit better" a major improvement. He may be specifically lacking in awareness as to how others perceive his behavior to be socially problematic. However fully self-justified he feels, he may be paying needless prices for the ways in which others feel "put off" by him.

The management of his anger in a current marital or family crisis is a likely focus of treatment, along with clarifying his ambivalences about divorce. However, a rapid uncovering of the full intensity of his anger could lead to continued acting out which he then would need to minimize or to withhold from the therapist. In similar cases it was reported to be important to stabilize their ego satisfactions by helping them to reality test their underlying self-concepts of being bright, individualistic, and talented. Typically, an effective appreciation of how he actively provokes anger and rejection by others would only follow an increased recognition of the intensity of his own hurt and angry feelings. In some similar cases it was seen as helpful to avoid an interruption of employment or, where already interrupted, to encourage that this be resumed. In other cases where a removal from stress and a period of "cooling off of anger" was indicated, it

was felt important to subsequently support the regaining of previous sources of self-esteem.

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 "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: UNFAIRNESS SENSITIZATION
ADAPTATION TO: cold judgments with unduly harsh punishments
TRADITIONAL DIAGNOSIS: paranoid personality disorder

PROTOTYPIC CHARACTERISTICS: acute sensitivity to perceived unfair

(especially punitive) actions against self and/or others. They can react with undercontrol and poor anticipation of the consequences of their actions, and they do not recognize their own internal conflicts and anxieties. Irritability is apt to lead to temper problems. The person's criticisms can be hyper-rational (the extreme being fixed paranoid beliefs). Although seen as egocentric and demanding of others, the person fends off demands on self. At more severe levels the person can become litigious or even dangerously retaliatory when he or she believes self (or society) to have been seriously and callously wronged--someone must be stopped from hurting others. A Neurotic-Psychotic Index over 70 or 80, associated with idiosyncratic understandings of one's world and misinterpretations of the intentions of others, would add to the potential dangerousness. Such high N-P Index values also add to the evasiveness, denial, and refusal to admit intrapsychic conflicts, i.e., letting no one in dangerously close to themselves. Relatively lower N-P Index values, e.g., under 60, are more associated with acting out, undercontrol of impulses, poor forethought, some narrow awareness of internal conflicts around intimacy and dependency, and self-dramatization.

CONTRIBUTORY SHAPING HISTORY: typically the parental expectations or rules were enforced quite literally, without consideration or flexibility regarding the needs and distresses of the child. Parental (or other family members') tempers are apt to have been intensely threatening and frightening to the person as a small child. The parents were experienced as punitive and coercive of the child's will and indifferent to the child's distress, and punishments were often severe (e.g., Marks, Seeman, & Haller, 1974, p. 213, about half of their 46/64 adolescent sample reported having been beaten with a strap; they were described as defiant, disobedient, restless, and negativistic) . Then as well as in adulthood the slightest cues of resentment or anger in another person become the alarm to immediate readiness and self-protection. Too many "uncalled for" hurts can eventually coerce retaliation ("I HAD TO STOP HiM FROM DOING THAT") . The 6-Pa minus 8-Sc slope assesses the degree of rationality in the self-justifications of such retaliatory actions: less 8 is more logical and fixed over time, the strapping being tied to a specific wrongdoing; with more 8 (smaller 6 minus 8 difference), the justifications are less plausible and more changeable, this latter probably reflecting the child's experience of the punishment as more irrational and personally hateful.

For codetype information see Archer, Griffin, and Aiduk, 1995, Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974.

MMPI2 CRITICAL ITEMS
NAME: Sample 46

Distress & Depression
5T Suicidal
Thoughts

Ideas of Reference, Persecution, and Delusions
466
T Peculiar Experiences and Hallucinations
96T
Sexual
Difficulties
12F 34F 121F
Authority Problems
35T 105T 266F
Alcohol and Drugs
264T 487T
Family Discord
125F
Somatic Concerns

Aggressive Impulses

Name: Sample 46
Referred by:
Date Tested:

Subscales

2-D and Subscales

		RAW	T
D	(full scale)	17	47
D1	Subjective depression	3	40
D2	Indecision-retardation	5	48
D3	Health pessimism	3	51
D4	Mental dullness	1	43
D5	Brooding, loss of hope	0	40

3-Hy and Subscales

		RAW	T
Hy	(full scale)	24	57
Hy1	Denies social anxiety	6	61
Hy2	Need for affection	11	67
Hy3	Lassitude - malaise	2	48
Hy4	Somatic complaints	0	38
Hy5	Inhibits aggression	3	48

4-Pd and Subscales

		RAW	T
Pd	(full scale)	21	69
Pd1	Family discord	1	45
Pd2	Authority problems	7	73
Pd3	Social disinhibition	6	63
Pd4	Social alienation	4	50
Pd5	Self-alienation	3	48

5-Mf and Subscales

		RAW	T
Mf	(full scale)	26	50
GM	Gender masculine	42	58
GF	Gender feminine	26	46

6-Pa and Subscales

		RAW	T
Pa	(full scale)	14	64
Pa1	Persecutory ideas	1	46
Pa2	Poignant sensitivity	3	55
Pa3	Moral righteousness	8	65

8-Sc and Subscales

		RAW	T
Sc	(full scale)	3	51
Sc1	Social alienation	0	39
Sc2	Emotional alienation	0	40
Sc3	Ego defect, cognitive	0	42
Sc4	Ego defect, conative	0	39
Sc5	Defective inhibition	0	40
Sc6	Sensorimotor dissociation		41

9-Ma and Subscales

		RAW	T
Ma	(full scale)	14	47
Ma1	Opportunism	1	42
Ma2	Psychomotor acceleration	3	39
Ma3	Imperturbability	6	65
Ma4	Ego inflation	1	37

0-Si and Subscales

		RAW	T
Si	(full scale)	11	34
Si1	Shyness and self-consciousness	0	39
Si2	Social avoidance	2	45
Si3	Alienation - self and others	0	38

Name: Sample 46
Referred by:
Date Tested:

Subscales

Major Clinical Variables

		RAW	T
ES	Ego strength	44	65
MAC-R	Potential alcoholism	24	57
SAP	Teen drugs/alcohol 13		60
AAS		5	60
Mt	College maladjustment	4	39
N-P	Neurotic-psychotic profile balance		68

Interpersonal Style Variables

		RAW	T
ER-S	Ego resiliency	26	67
EC-5	Ego control	8	41
ORIG	Need novelty	12	39
INT	Abstract interests	60	63
Do	Need for autonomy	21	65
Dy	Need reassurances	2	34
Pr	Intolerance	2	35
Re	Value rigidity	21	52
Et	Ethnocentrism	4	36
St	Status mobility	21	60
R-S	Repression-sensitization	7	34
Lbp	Low back pain	9	51
O-H	Overcontrolled hostility	18	69
Ho	Cynical hostility	5	34
Ba	Good teamworker	51	62

Distress-Control

		RAW	T
A	Level of distress	1	37
R	Emotional constriction	17	54
Ca	Caudality-distress	2	37
Cn	Control-facade	13	29
So-r	Life as desirable	37	65
Th-r	Tired housewife	6	40
Wb-r	Worried breadwinner	9	43
PK	PTSD	1	38

Validity & Stability

		RAW	T
VRIN	Response inconsistency	3	42
TRIN	T-F inconsistency	9	50
F-back	Rare answers - back	2	51
F(p)	Psychiatric infrequency	0	41
S	Superlative self-presentation	36	63
Ds	Overemphasize-fake sick	6	42
Mp	Consciously fake good	12	57
Sd	Consciously fake good	14	53
Ss	SES identification	62	57
Ch	Correction for H	8	39
Re	Retest-consistency	31	65
Ic	Retest-item change	5	37
Tc	Retest-score change	4	37

Content Scales

		RAW	T
HEA	Health concerns	0	33
DEP	Depression	0	36
FAM	Family problems	2	41
ASP	Antisocial practices	4	42
ANG	Anger	2	40
CYN	Cynicism	1	35
ANX	Anxiety	3	45
OBS	Obsessiveness	0	33
FRS	Fears - phobias	3	48
BIZ	Bizarre mentation	3	54
LSE	Low self-esteem	0	35
TPA	Type A	1	32
SOD	Social discomfort	2	39
WRK	Work interference	2	39
TRT	Negative treatment indicators		35