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

January 31, 2008

NAME: Sample 48

AGE: 32

SEX: Female

EDUCATION: 13 years

MARITAL STATUS: Single

REFERRED BY: -------

DATE TESTED:

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 unelevated; her item responses were 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 consistently 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: Considering scales L, F, and K, she tended to be self-favorable and moderately minimizing of emotional problems in her approach to the inventory. The profile appears valid by the usual criteria for these scales.

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. Her scores on the scales measuring conscious defensiveness or

"faking good" were not elevated. Thus her elevation on scale K appears entirely attributable to sophisticated and genuinely self-favorable attitudes and to some emotional reserve; her score on K was not due to any intentional effort to bias her responses.

SYMPTOMS AND PERSONALITY CHARACTERISTICS

Underlying distrust and projections are indicated along with emotional distortions and estrangement. The pattern suggests significant deficits in her empathy and feeling for others. Her ways of making others annoyed at her or irritated with her would function to keep them at a distance and in part to control them. Her immaturity and uneven self-confidence would handicap her in sustaining close and warm relationships. Similar patients complained of transitory depressed moods in which they felt unappreciated and misunderstood if not unfairly treated. At times she is apt to be seen as self-defeating and self-punishing and as acting against her own longterm interests with lapses of her judgment and forethought. Nevertheless, her quite good level of ego strength which predicts organized functioning and immediate practical self-sufficiency in many areas.

She did not respond positively to any test items indicating frankly paranoid thinking. However, in a small subgroup of cases this pattern has been associated with persisting projections and jealousies. Other than their transient emotional outbursts, these patients showed little if any disorganization of behavior or breakdown of reality testing. Instead, they attempted to maintain careful controls and to play correct social roles.

The profile shows personality disorder tendencies. Problems of impulse control are indicated with occasionally impulsive, unpredictable, and possibly aggressive acts. A history of lying, petty stealing, and odd small ways of "cheating" would be typical. At times she would be seen as egocentric, immature, impulsive, childish, and demanding. Resentments are apt to be covered over by a controlled veneer of social correctness. In some similar cases a low tolerance for frustrations led to aggressiveness toward family members. Her rationalizations and efforts to maintain social control and correctness would only partially mask her uneven emotional depth and self-centeredness. In psychotherapy cases with related but more disturbed profiles the family histories involved some lack of closeness, but usually this was without open disruptions of these relationships. She is apt to use a variety of maneuvers to evade difficult life situations, such as drugs, alcohol, and various ways of acting out.

Difficulties around sexual behavior are fairly typical with this pattern. Verbalized guilt over past sexual activities would unevenly inhibit her future behavior. She could confuse sex with aggression, which would handicap her ability to love and to trust. Her balance of interests is rather feminine, including esthetic, cultural, or verbal interests and sensitivities. There is apt to be some rejection of aggressive masculine activities and a hypersensitivity to sexual roles.

The pattern suggests "black sheep" elements in her life style. Parental handling is apt to have been indifferent and lacking in affection if not hostile. Acting out could reflect negative underlying self-concepts as well as an opposition to family standards. Difficult sibling relationships and other family conflicts were common, and the childhood homes had frequently been disrupted by divorces and other upheavals. Personal goals are likely to shift from time to time with an uneven longterm persistence and a tendency to turn aside for immediate self-gratifications. Often with this pattern past school achievements were uneven if not less than expected for the patient's potentials.

DIAGNOSTIC IMPRESSION

Although the diagnoses associated with this profile are varied, they typically have reflected personality disorder trends; most often these were of borderline personality disorders. The pattern also suggests current anxiety and depressive trends.

TREATMENT CONSIDERATIONS

With this profile a history of past difficulties with authority or of brushes with the law would predict similar future involvements. Her responses suggest asking if she has been in trouble with the law. If currently involved, the stress of this could have precipitated or aggravated her symptoms or otherwise have led her to make professional contact. Her responses suggest a careful review of her sexual history as to repetitive and interpersonally destructive ways of getting into trouble around her sexual behavior.

Her high ego strength score would predict effectiveness and practical self-sufficiency in a wide variety of practical areas. However, the pattern predicts recurring impulse struggles and conflicts in her close relationships. She is likely to be evasive in interviews and unevenly involved in treatment. Her underlying distrust is likely to result in an initial slowness to self-exposure and in a defensiveness toward an exploration of her personal feelings and intimate reactions. A few similar cases have been seen as much as problems of developing controls as they were problems of increasing insight. Although critical of her childhood and current life, her negative underlying self-image would make it difficult to motivate her to actively put herself out to change her ways of adjusting.

Early interviews with similar patients have often benefitted from efforts to clarify all of the aggravating stresses. Hesitant to open up to authority figures, the patient may need to be directly confronted around her subtle ways of testing and provoking the therapist, of maintaining distance, and of confirming distrust. However, she could be slow to integrate broader interpretations such as of "infantile anger" if she were to see them as confirming covertly negative aspects of her self-image. The pattern recommends the talking out of current distresses and the clarification of her immediate problems. The profile suggests an alertness on the part of

the therapist to distortions in the patient's expressions of anger. The discovery of how her distrust keeps others at a distance and of how this protects her and yet defeats her needs for closeness can be meaningful and important in treatment. She could benefit from learning to see how she aggravates her interpersonal difficulties and what kinds of circumstances are personal "traps" into which she repeatedly falls. In general her persistence in treatment is likely to depend on the handling of the basic problem of trust.

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: EARLY SEXUAL ABUSE AND THE POISONING OF TRUST
ADAPTATION TO: experiences of fundamental emotional dishonesty
TRADITIONAL DIAGNOSIS: borderline personality disorder

PROTOTYPIC CHARACTERISTICS: a serious disruption of the ability to

engage and sustain trusting personal relationships, slow to develop trust, and quick to back away and turn off if trust is perceived to have been violated. Sexual relationships are marked by chronic problems and are often major source of professional Contact (whether voluntary treatment or legal restraint). Sexual relationships are emotionally perverse if not overtly sadomasochistic. Empathy for others is diminished or blunted if not marked by repeated "misreadings" or failures to anticipate the feelings of others. Self-empathy to gauge the person's own feelings is also impaired; internal feelings may be dimly felt and easily ignored or misread. "Adrenalin rush seeking behaviors" such as shoplifting, problematic sexual encounters or promiscuity, pathological lying, etc., counteract the numbed-out or "dead" feeling. The person may be vulnerable to suicide attempts at times when it is perceived that every friend they have has been alienated, possibly repeated suicide attempts under similar repetitive circumstances. The coercion of rescue reassures the person that there may be reason for hope (reducing a central tension of scale 2-D), that someone does care (4-Pd), and that someone believes I am worth the effort to save me (8-Sc).

CONTRIBUTORY SHAPING HISTORY: The consistency of the association of histories of sexual abuse with this code has long been almost amazing to me. This would include "sexualized" abuse such as inappropriate touching, undue fascination with the genitalia of the child, or other "overloads" of too early sexual input and stimulation in a manipulatively using or identity-abusive way. A woman was divorcing her husband, more than anything else because when his mother visited, they engaged in grossly inappropriate sexual touching in front of the children; the husband insisted that it was simply that he and his mother loved each other so much (in a simplistic sense, I would associate the unawareness of or indifference to the impact on the children and wife with the elevation on 4-Pd and the twisting of logic with the 8-SC). This is not to argue that sexual abuse is the necessary or the only origin of this pervasive distrust syndrome; devastating trust-violation experiences would strongly enhance the picture, so I am not proposing that the syndrome would never arise in the absence of sexual abuse. But the following hypotheses are described primarily in terms of sexual abuse both because of its prevalence in these histories and in the apparentness of the emotional dishonesty of the non-adult-rapist perpetrator in particular (the MMPI patterns of adult victims of rape by a stranger seem in my experience to be somewhat diverse, often including 6-Pa and not infrequently 2-D, although some 48/84 individuals, with impaired anticipation, do get themselves in "bad" settings and situations).

A central question is to inquire, what is the connection between sexual abuse and pervasive distrust? Although perpetrators surely vary widely in how they approach their victims, I believe many are likely to "come onto" the victim with a variety of flatteries and solicitations such as, "I am going to teach you a very secret, a very special game", "I cannot tell you how handsome you are", "I can only share how beautiful you are by touching you", "No one has ever been so special to me", perhaps leading to, "It really loves you when you kiss it". If compliments of this--or whatever--sort come from a close family member, a good family friend, a religious

person, or some other highly trusted and unchallengeable individual who then proceeds to exploit one's body totally to their own gratification (perhaps disregarding or even becoming increasingly aroused by urgent pleas to stop, "please, PLEASE don't do that"), then the flagrant contradiction between what the person says and what the person does is apt to be deeply recorded via the extreme emotional arousal of the victim.

The sexual arousal of the perpetrator turns that person off to the feelings of distress of the victim, and this disregard is likely to be experienced as callous if not utterly cold. "That a person I care so much about could be so cold to me" would then be an occasion of the uncaring indifference I have hypothesized to be associated with elevations on scale Pd (Caldwell, 2001). Participation in such an unwanted and alien experience is likely to make the victim feel forever defiled (note the damaged identity aspect of scale 8-Sc in Caldwell, 2001). If, however, the experience also has some elements of attraction or more positive excitement as Well 33 revulsion, then the identity impact is likely to be especially difficult to integrate, "I absolutely hated it, but it's weird, it was kind of exciting". Along with great embarrassment, being terrified of potential retaliation as well as by the unknown consequences of telling any third party, especially adults in one's own family who are closely related to and perhaps dependent on the perpetrator, bottles up the complex of reactions entirely within the person with no direct source of relief. This promotes the generalization of distrust into permeating most or even all relationships whenever a contradiction between expressed loving care and the person's less caring actions is accurately detected or too easily misinterpreted. In those adult individuals who suffer fluctuating phases of depression, such downturns are apt to be increased by the sense of having been altered in such strongly undesirable but hopelessly irreversible ways as well as by despair over one's seemingly forever unstable and undependable relationships. In sum, my belief is that it is the crushing of trust that generates the depth of distrust; in the longer term, more importantly than any physical injury to the body of the victim, it is the capacity for loving trust that has been deflowered, ravished and toxified.

Given the common revulsion to the occasion of the abuse, what are the adaptive consequences of the victim subsequently becoming an adult participant in mutually desired sadomasochistic sexual encounters or even becoming a perpetrator? Is there a tension-reduction reinforcement? My hypothesis is that these are mastery experiences. Whereas in the initial experience(s) the person was typically a helpless victim, by later initiating similar behavior the person has taken control of the scene. This provides an immediately positive and hormonally reactive (and thus reinforcing) change of attentional focus whenever situational cues start to elicit upsetting memories and the negative arousal associated with the initial shaping experiences. Thus being in control of such activities--probably as well as recalling "delicious" memories of such in-control moments--is rewarded by the sustaining of the avoidance of what are likely to be acutely disturbing memories. Life situations that are experienced as being somehow abused in a situation that is out of one's control and under

the control of an unchallengeable offender are likely to recharge the needs to again be the sexual master in order to overcome and submerge the tension, hence the trigger to further sexual abuse or sexually energized abusive acts.

I have rarely (if ever) known of individuals where I felt that a relatively prototypic sexualized or similar emotional abuse syndrome was entirely of adult onset, although I would not rule that out. The strong heritability of 4-Pd and 8-Sc (DiLalla, Carey, Gottesman, & Bouchard, 1996) would be consistent with the likelihood of a more lifelong pattern of development, but that is not a necessary consequence. I would add that the disorientation of hippocampal neurons observed by Conrad and Scheibel (1987) would impair a broader contextual comprehension of the event(s), hence enhancing the spread of distrust. I have known of instances in which existing pre-abuse syndromal tendencies were limited or (observer-perceivedly) minimal, e.g., a possibly lower level of genetic vulnerability; then a severely abusive situation had potentiated those tendencies into centrally disruptive syndromal behaviors. But the determination of relative genetic vulnerabilities is beyond any technology of which I-am currently aware.

For codetype information see Archer, Griffin, Aiduk, 1995, Gilberstadt and Duker, 1965; Gynther, Altman, Sletten, 1973; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974; and Megargee, Carbonell, Bohn and Sliger, 2001. Conrad, A. J., & Scheibell, A. B. (1987). Schizophrenia and the hippocampus: The embryological hypothesis extended. Schizophrenia Bulletin, 13, 577587; DiLalla, D. L., Gottesman, I.I., Carey,G., & Bouchard, T. J., Jr. (1999). Heritability of MMPI personality indicators of psychopathology in twins reared apart. Journal of Abnormal Psychology, 105, 491499.

MMPI2 CRITICAL ITEMS
NAME: Sample 48

Distress & Depression
130T 140F 165F 223T
Suicidal Thoughts
506T
Ideas of Reference, Persecution, and Delusions

Peculiar Experiences and Hallucinations

Sexual Difficulties
121F
Authority Problems
35T 84T 105T 266F
Alcohol and Drugs
264T
Family Discord
21T 83F
Somatic Concerns

Aggressive Impulses
389T

2-D and Subscales

		RAW	T
D	(full scale)	23	55
D1	Subjective depression	9	53
D2	Indecision-retardation	6	52
D3	Health pessimism	3	48
D4	Mental dullness	3	52
D5	Brooding, loss of hope	2	47

6-Pa and Subscales

		RAW	T
Pa	(full scale)	13	59
Pal	Persecutory ideas	0	39
Pa2	Poignant sensitivity	4	59
Pa3	Moral righteousness	8	65

3-Hy and Subscales

	RAW	T	RAW	T
Hy	(full scale)	26	58	
Hyl	Denies social anxiety	6	61	
Hy2	Need for affection	10	63	
Hy3	Lassitude - malaise	1	43	
Hy4	Somatic complaints	2	45	
Hy5	Inhibits aggression	5	62	

8-Sc and Subscales

		RAW	T
Sc	(full scale)	16	65
Scl	Social alienation	5	57
Sc2	Emotional alienation	O	40
Sc3	Ego defect, cognitive	1	49
SC4	Ego defect, conative	1	44
Sc5	Defective inhibition	2	53
Sc6	Sensorimotor Dissociation	2	50

4-Pd and Subscales

		RAW	T
Pd	(full scale)	20	63
Pdl	Family discord	3	56
Pd2	Authority problems	5	69
Pd3	Social disinhibition	6	64
Pd4	Social alienation	3	44
Pd5	Self-alienation	2	43

9-Ma and Subscales

		RAW	T
Ma	(full scale)	17	53
Mal	Opportunism	1	45
Ma2	Psychomotor acceleration	6	55
Ma3	Imperturbability	4	56
Ma4	Ego inflation	2	43

5-Mf and Subscales

		RAW	T
Mf	(full scale)	41	38
GM	Gender masculine	32	55
GF	Gender feminine	27	30

0-Si and Subscales

		RAW	T
Si	(full scale)	15	37
Sil	Shyness and self-ccnscicusness	0	38
Si2	Social avoidance	1	42
Si3	Alienation - self and others	1	38

Major Clinical Variables

		RAW	T
ES	Ego strength	38	57
MAC-R	Potential Alcoholism	20	53
SAP	Teen drugs/alcohol	8	49
AAS		4	61
Mr	College maladjustment	13	51
N-P	Neurotic-psychotic profile balance		54

Interpersonal Style Variables

		RAW	T
ER-S	Ego resiliency	20	53
EC-5	Ego control	7	28
ORIG	Need novelty	19	47
INT	Abstract interests	50	52
Do	Need for autonomy	22	70
Dy	Need reassurances	13	45
Pr	Intolerance	3	37
Re	Value rigidity	22	53
Et	Ethnocentrism	9	45
St	Status mobility	19	54
R-S	Repression-Sensitization	28	45
Lbp	Low back pain	8	46
O-H	Overcontrolled hostility	16	59
Ho	Cynical hostility	8	39
Ba	Good teamworker	48	56

Distress-Control

		RAW	T
A	Level of distress	10	48
R	Emotional constriction	18	54
Ca	Caudality-distress	5	42
Cn	Control-facade	22	53
So-r	Life as desirable	31	54
Th-r	Tired housewife	16	57
Wb-r	Worried breadwinner	14	56
PK	PTSD	6	46

Validity & Stability

		RAW	T
VRIN	Response inconsistency	4	46
TRIN	T-F inconsistency	9	50
F-back	Rare answers - back	3	54
F(p)	Psychiatric infrequency	2	57
S	Superlative self-presentation	31	57
Ds	Overemphasize-fake sick	13	54
Mp	Consciously fake good	6	43
Sd	Consciously fake good	12	50
Ss	SES identification	66	64
Ch	Correction for H	18	55
Rc	Retest-consistency	27	57
Ic	Retest-item change	17	46
Tc	Retest-score change	11	45

Content Scales

		RAW	T
HEA	Health concerns	7	53
DEP	Depression	7	54
FAM	Family problems	12	65
ASP	Antisocial practices	7	52
ANG	Anger	8	56
CYN	Cynicism	2	38
ANX	Anxiety	7	51
OBS	Obsessiveness	4	46
FRS	Fears - Phobias	7	51
BIZ	Bizarre mentation	0	39
LSE	Low self-esteem	4	49
TPA	Type A	2	36
SOD	Social discomfort	2	29
WRK	Work interference	4	43
TRT	Negative treatment Indicators	5	51