CALDWELL REPORT
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January 31, 2008

NAME: Sample 49

AGE: 45

SEX: Male

EDUCATION: 17 years

MARITAL STATUS: Single

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 unelevated; his item responses were 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 consistently 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 did not show any significant amount of conscious

defensiveness, and there were no indications of any intentionally self-favorable slanting of his responses. He appears to be a person of above average socioeconomic status identification whose mild elevation on scale K was probably due to such factors as an emotional reserve or some general sophistication of his self-presentation.

SYMPTOMS AND PERSONALITY CHARACTERISTICS

The profile indicates active, energetic, and attention-seeking behaviors. The profile also suggests a positive personal tempo and optimistic moods. His humor may be seen as forced if not aggressive or sardonic. In a few of these cases there were manic-depressive elements in their histories. He tests as ambitious and as tending to overcompensate as if needing to prove himself. He appears talkative, outgoing, and extroverted if not socially assertive and dominant. Problems with anger and irritability appear recurrent; he could react with a quick temper to frustrations of his immediate wishes. When provoked, he could be directly or indirectly disruptive to others because of his temper or through his impulsiveness. Nevertheless, his overall level of personal effectiveness and practical self-sufficiency appears exceptionally well organized despite his occasional lapses of judgment and hasty acts.

Struggles to sustain his controls over his impulse pressures are indicated. The pattern suggests egocentric, self-indulgent, and self-dramatizing behaviors, although they appear only mildly above average. Difficulties around sexuality--or sexual overactivity--are common with this pattern. He tests as prone to recurrent family struggles and resentments with a lack of closeness, but he would seek to minimize these and at times would run away from confronting them. Some patients with his makeup have shown borderline or episodic alcoholic problems.

He tests as prone to externalize his problems, to see them as due to other people and difficult situations, and to have an uneven awareness of his own contributions to his difficulties. Rationalizing and covering over personal problems, he is apt to be seen as mildly self-centered and as somewhat lacking in emotional giving to others. The profile suggests a mild instability in his longterm pursuit of his goals, and he could change goals from time to time. His manipulations are apt to be highly effective toward short-term goals. His overall balance of masculine and feminine interests is within the normal range for his age and education.

In similar cases the relatively strong needs for egocentric gratifications appeared to extend back through adolescence and sometimes into childhood. A common childhood pattern was for the mother to have invested strongly in the development of the patient as a child, including strivings and hopes for his future that most women share more with their husbands. Some deprecated the role of the father which in turn instilled in these patients needs for autonomy and independence from authority. Although they often reported having had feelings of inferiority in their adolescent heterosexual relationships, this appeared to relate more to their

difficulties in forming stable loving relationships than to fundamental inhibitions and guilt. Many similar patients had achieved well in school for their abilities and some had periods when they had been outstanding students. For a few of these patients recurrent conflicts with superiors led to an eventual deterioration of their work histories.

DIAGNOSTIC IMPRESSION

Among psychotherapy patients, the most typical diagnoses reflect hypomanic or cyclothymic elements and personality disorder trends such as of the narcissistic or histrionic types. Some patients with histories of hypomanic and paranoid episodes have obtained similar profiles in intermediate and functioning phases. The profile is within the normal range, however, and it is diagnostically more mixed and less definitive than most profiles of this type.

TREATMENT CONSIDERATIONS

His responses suggest an evaluation of his use of alcohol. On the one hand, his pattern is fairly often associated with episodes of serious if not occasionally uncontrolled chemical abuse; on the other hand, his score on the MacAndrew Alcoholism Scale was well below the chronic alcohol abuse and daily chemical dependence range. His responses suggest asking if he has been in trouble with the law. If currently involved, the stress of this could have precipitated or aggravated his symptoms or otherwise have led him to make professional contact. His responses suggest a careful review of his sexual history as to repetitive patterns of getting impulsively involved in relationships that are ill-considered and self-defeating or that repeatedly go "emotionally unfinished". He may be "as if addicted" to sexual excitement.

A history of family struggles and other interpersonal conflicts would be prognostically adverse. In the clear absence of such a history, the prognosis would be good although recurring conflicts are likely. Contacts with informants have been important in many similar cases, including contacts with family members and any public agencies or professional people with whom they had been involved. If the current complaints bear on any legal action or compensation settlement, he shows a moderate potential for manipulating such a situation.

Treatment efforts with similar patients have usually been oriented toward the handling of current difficulties. Heavy drinking, an interpersonal crisis, or other consequences of impulsive behavior are apt to have precipitated the current professional contact. In other cases, resentments of family demands for work and achievement had led to increasing internal pressures and emotional estrangement. If appropriate, information from family members and others could be particularly useful in helping the patient to recognize his rationalizations and externalizations. His longterm prognostic signs are quite mixed, but the relative normality of his profile and his good ego strength are favorable signs. Patients with

comparably good ego strength and self-sufficiency were quite able to meet their regular responsibilities and to sustain employment.

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: CONDITIONAL CARING

ADAPTATION TO: overcompensation for as-if-always contingent caring

TRADITIONAL DIAGNOSIS: narcissistic personality disorder (may be seen by history as partly or more primarily hypomanic, e.g., sometimes appears to be a "burned out

hypomanic")

PROTOTYPIC CHARACTERISTICS: charming, adventurous, risk-taking, and charismatic; also egocentric, rationalizing, impulsively acting out, and low frustration tolerance. The person may be athletic or mesomorphic (Gilberstadt & Duker, 1965). Consistently sexually attractive, this is the most sexually active of all MMPI code types (note how often public figures who get into sexual trouble are described as charismatic, charming, etc., the ambition being anchored in the 9-Ma and the losses of judgment in the 4-Pd). Overcoming the target's saying "no-no" resistance can in itself be strongly arousing. With moderate or greater profile elevations, they are often perceived as exploitative in their relationships (often drawn to other 49s, they may be mutually exploitative, thus confirming each other's world view) . Morals and self-restraints are less than solid and dependable, especially under stress and proportionately as the scale elevations increase.

CONTRIBUTORY SHAPING HISTORY: in early development, a parent, sometimes not warmly close to the other parent, may have strongly invested in the person as a child. As a child, the person may have been talented and energetic, and he became the expected deliverer of the invested parent's expectations of status, success, and/or excitement (e.g., vicarious) that were otherwise not being fulfilled. The higher level of energy (possibly a hypomanic element) and some contribution to the elevation on 4-Pd may both be genetically influenced. Providing a limited amount to little or no truly unconditional positive love, the more invested parent's approval and rewards are as if always contingent on the achievements or aggressive successes of the child (see Gilberstadt & Duker, 1965). The child gets rewarding attention when living up to that parent's expectations but a withdrawal of attention if not overt punishment when falling short. A sense of narcissistic entitlement would follow from expectations of special attention and reward when another person's demands are met. Successful entitlement manipulations maintain an ongoing reinforcement schedule for adult narcism. However, the person seems immediately sensitive to any criticism with an outpouring of rationalizations, self-justifications, and a readiness to deflect blame onto some third party or back onto the critic/accuser, as was probably adaptive in childhood for punishment avoidance.

Genetic factors are strongly implicated for both scales 4-Pd and 9-Ma in the Minnesota twin data (DiLalla, Carey, Gottesman, & Bouchard, 1996), over 50% of the heritability index, i.e., over half the variance, for both scales. Given that genetic loading, varying degrees of manipulativeness and self-centered exploitation by the parents would not be surprising. I would see this as a vulnerability to contingent caring, the 4-Pd being reactive to the limitation of caring (too little unconditional positive love) and the 9-Ma as activated by the heightened expectations and demands. Getting caught up in adult life circumstances and occupations in which half-truths, lying, and conniving are "par for the course" could also maximize those potentials.

For codetype information see Archer, Griffin, and Aiduk, 1995;

Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973; Kelley and King, 1977; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974; Megargee, Carbonell, Bohn, and Sliger, 2001. Also, 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 49

Distress & Depression
5T Suicidal
Thoughts

Ideas of Reference, Persecution, and Delusions

Peculiar Experiences and Hallucinations
298T
Sexual Difficulties
12F 121F 166T
Authority Problems
35T 266F
Alcohol and Drugs
264T 487T 511T
Family Discord
21T 125F 217F
Somatic Concerns

Aggressive Impulses
37T 213T

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Subscales

2-D and Subscales

		RAW	T
D	(full scale)	15	42
D1	Subjective depression	3	40
D2	Indecision-retardation	4	43
D3	Health pessimism	3	51
D4	Mental dullness	1	43
D5	Brooding, loss of hope	0	40

Pa and Subscales

		RAW	T
Pa	(full scale)	11	53
Pa1	Persecutory ideas	2	52
Pa2	Poignant sensitivity	2	48
Pa3	Moral righteousness	6	56

3-Hy and Subscales

		RAW	T
Hy	(full scale)	22	52
Hy1	Denies social anxiety	6	61
Hy2	Need for affection	6	47
Hy3	Lassitude - malaise	3	52
Hy4	Somatic complaints	1	43
Hy5	Inhibits aggression	3	48

8-Sc and Subscales

		RAW	T
Sc	(full scale)	12	54
Sc1	Social alienation	3	51
Sc2	Emotional alienation	0	40
Sc3	Ego defect, cognitive	1	48
Sc4	Ego defect, conative	1	44
Sc5	Defective inhibition	0	40
Sc6	Sensorimotor dissociation	2	51

4-Pd and Subscales

		RAW	T
Pd	(full scale)	19	57
Pd1	Family discord	3	58
Pd2	Authority problems	4	53
Pd3	Social disinhibition	6	63
Pd4	Social alienation	5	56
Pd5	Self-alienation	3	48

9-Ma and Subscales

		RAW	T
Ma	(full scale)	21	59
Ma1	Opportunism	3	58
Ma2	Psychomotor acceleration	6	53
Ma3	Imperturbability	5	59
Ma4	Ego inflation	1	37

5-Mf and Subscales

		RAW	T
Mf	(full scale)	27	52
GM	Gender masculine	43	61
GF	Gender feminine	22	37

0-Si and Subscales

		RAW	T
Si	(full scale)	11	34
Si1	Shyness and self-consciousness	0	39
Si2	Social avoidance	1	41
Si3	Alienation - self and others	2	41

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Subscales

Major Clinical Variables

		RAW	T
ES	Ego strength	43	63
MAC-R	Potential alcoholism	20	48
SAP	Teen drugs/alcohol	12	57
AAS		5	60
Mt	College maladjustment	7	43
N-P	Neurotic-psychotic profile balance		66

Interpersonal Style Variables

		RAW	T
ER-S	Ego resiliency	23	60
EC-5	Ego control	6	35
ORIG	Need novelty	17	45
INT	Abstract interests	51	51
Do	Need for autonomy	16	48
Dy	Need reassurances	8	42
Pr	Intolerance	6	44
Re	Value rigidity	21	52
Et	Ethnocentrism	3	34
St	Status mobility	19	54
R-S	Repression-sensitization	15	39
Lbp	Low back pain	10	56
O-H	Overcontrolled hostility	16	62
Ho	Cynical hostility	16	47
Ba	Good teamworker	49	58

Distress-Control

		RAW	T
A	Level of distress	1	37
R	Emotional constriction	13	45
Ca	Caudality-distress	3	39
Cn	Control-facade	18	43
So-r	Life as desirable	35	61
Th-r	Tired housewife	7	42
Wb-r	Worried breadwinner	13	55
PK	PTSD	5	45

Validity & Stability

		RAW	T
VRIN	Response inconsistency	5	50
TRIN	T-F inconsistency	10	57T
F-back	Rare answers - back	1	46
F(p)	Psychiatric infrequency	0	41
S	Superlative self-presentation	32	58
Ds	Overemphasize-fake sick	14	57
Mp	Consciously fake good	8	45
Sd	Consciously fake good	11	45
Ss	SES identification	62	57
Ch	Correction for H	11	44
Re	Retest-consistency	29	61
Ic	Retest-item change	8	40
Tc	Retest-score change	8	43

Content Scales

		RAW	T
HEA	Health concerns	2	41
DEP	Depression	2	45
FAM	Family problems	5	50
ASP	Antisocial practices	10	53
ANG	Anger	4	46
CYN	Cynicism	7	46
ANX	Anxiety	4	47
OBS	Obsessiveness	1	37
FRS	Fears - phobias	4	51
BIZ	Bizarre mentation	1	46
LSE	Low self-esteem	0	35
TPA	Type A	6	44
SOD	Social discomfort	2	39
WRK	Work interference	1	36
TRT	Negative treatment indicators	2	43