CALDWELL REPORT
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January 31, 2008

NAME: Sample 28

AGE: 61

SEX: Male

EDUCATION: 15 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 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. In contrast to his lack of substantial elevation on VRIN, he obtained a more elevated score on the True Response Inconsistency scale (TRIN). This indicates that he responded "true" to both items in an above average number of pairs of items that contradicted each other, suggesting a "when in doubt say true" attitude.

Attitude and Approach: He responded in a somewhat guarded, naive, and moralistic way toward some of the inventory items or toward the testing situation more generally. He also made a scattering of atypical and rarely given responses, suggesting some personal confusion or other difficulties in feeling sure how to respond to the items. Nevertheless, the profile is within acceptable limits on scales L, F, and K.

He made a few atypical and rarely given responses to the items occurring in the last half of the inventory (scale F-back). These were not notably disproportionate to his frequency of atypical responses to the earlier MMPI-2 items (scale F). The profile does not appear to be of

questionable validity because of atypical responding.

Socio-cultural Influences vs. Conscious Distortion: The supplemental validity scales indicate a mild, conscious tendency to try to "look good" on the MMPI-2. That is, he responded "too positively" to a variety of MMPI-2 items. Despite this he showed little elevation on scale K, suggesting either an uneven if not relatively limited level of sophistication and emotional restraint or possibly a current upheaval of his self-esteem. The fact that he obtained a below average score on the scale (Ss) measuring his level of currently attained, recently experienced, or self-perceived socioeconomic status--despite his defensive minimizing--also supports the impression of a generally lower level of sophistication in his self-presentation. His elevation on the L scale reflects a mixture of characterological elements and consciously defensive trends. There appear to be some naive properness, cautious self-control, and emotional restraint that would be longstanding. There also appears to be some conscious denial and guardedness toward the current testing, a hesitation around admitting faults or improprieties that might be held against him. These scores suggest an already proper person who had to take the MMPI-2 "against his will," so that he was protective as to how the test results might reflect badly on him or be used against him.

Despite his self-favorable responding, he made a few atypical and rarely given responses (scale F). Considering his relatively mild elevation on the "fake bad" scale (Ds), few if any of his clinical scores should be over-elevated, and those no more than slightly if at all. Rather, his elevation on the F scale appears primarily to reflect an occasional willingness to admit genuinely distressing and unusual experiences or attitudes on the MMPI-2. These scores suggest a person who is cautiously reserved in some areas but nevertheless relatively willing to admit to atypical reactions in other areas. In general, the extent of psychological distress that he reported does appear genuine.

SYMPTOMS AND PERSONALITY CHARACTERISTICS

The profile shows a severe depressive disorder. His profile would not rule out a psychotic depression or possibly a negative symptom schizophrenic decompensation. He tests as markedly fearful of emotional closeness with severe frustrations in his close relationships. He is apt to have many ways of keeping others at a distance. Pervasive insecurity, pessimism, and ambivalences are suggested along with complaints of confusion and loss of efficiency. Others would see him as disengaged and as very slow to involve himself in changing his current circumstances. Disturbances of sleep are very common with this pattern. He would be threatened by a loss of control, unable to "let go" even when appropriate. He is apt to appear very inhibited and lacking in spontaneity. Markedly vulnerable to insecurities in his social activities, he could become emotionally withdrawn and self-protective. He appears currently overwhelmed and severely decompensated.

The profile has often been associated with physical symptoms that are

secondary to the anxiety and expressive of the current conflicts. Conversion-like symbolizations of unreleased resentments, tensions, and aggressive impulses are particularly common. In similar cases such symptoms have also included dizziness, weakness, fainting, anorexia, atypical spells, and in rare cases paralyses. However, these atypical symptoms involved a displaced focus of anxiety rather than an effective solution or denial of it. In addition, the numerous physical preoccupations he expressed on the test suggest a wide variety of chronic somatic complaints to which he responds more intensely than would be medically expected. Gastrointestinal distress, headache, and fatigue would be typical, as would be unrelieved concerns about his health and overreactions to minor physical dysfunctions. He is apt to be seen as getting significant "secondary gain" from his symptoms and to attribute many of his current difficulties to his health problems. If there were a question of a chronic brain syndrome or other neurologic disorder, then the relative contributions of psychological versus neurologic elements are apt to be exceedingly hard to evaluate.

Repeatedly needing reassurances of being loved, he tests as immaturely emotional with many fears and inhibitions. His dependency needs would interfere with self-assertiveness and give him difficulties in handling acting out by family members.

He denied many minor faults and trivial moral deficits that most subjects readily admit. Others may see him as naive and unsophisticated perhaps with rural or "small town" values. These may derive from a strictly religious, foreign, or otherwise culturally atypical upbringing. He could "follow the rule book" in literal and unbending ways and be seen as "rubbing elbows poorly" with coworkers.

When emotional difficulties are of long duration, his profile has been described as the "burnt child" pattern type for which the phrase, "The burnt child fears the fire," has aptly characterized the chronic fears of emotional closeness and involvement. Relatively common was a pervasively negative relationship with the mother, who was disliking of the child and emotionally ungiving, so that life became a mostly barren and useless experience. In some similar cases their marriages had reactivated childhood dependency frustrations, especially if the male pressed his wife for the maternalistic care he had never received. His overall balance of masculine and feminine interests appears a bit more masculine than average for his age and education.

In those cases where the emotional difficulties and interpersonal distress were of relatively recent onset, given the absence of any such longterm history, the person has typically experienced a major downturn in his life, e.g., an identity-devastation such as non-recovering brain damage, abandonment in a vital relationship, or a career collapse in self-esteem-crushing circumstances. This downturn is perceived as debilitating of the person's capacity to function anywhere close to his previous level of competence, and past sources of pleasure and gratification are seen as having been terminated or made impossible for the rest of the person's life

(however accurate or inaccurate this perception may be seen to be). The person feels a mix of being alienated, worthless, and hopeless, and there is a resulting quickness to give up if not a general collapse of motivation. Life is now deeply frustrating, and frustrations are often expressed in a negativistic, peevish way that is ineffectual in gaining satisfaction or affection. Sexual interests are also likely to have disappeared.

DIAGNOSTIC IMPRESSION

The psychiatric diagnoses associated with this profile are mixed but most commonly reflect severe depressions. The depression may border on a psychotic breakdown. Although he showed a moderate level of morally proper and self-controlled responding, the preceding diagnostic impression does not appear questionable because of any excessive effort to deliberately distort the test results in a self-favorable direction.

TREATMENT CONSIDERATIONS

The profile suggests a moderate to severe suicide risk. This could be active such as through an overdose of sleeping pills or passive through a collapse of his will to live; what would be at first a minor and not life-threatening illness could have an unexpectedly rapid downhill course into a life-threatening breakdown. He tests as urgently needing external supports, either as hospital treatment or continuous and effective family care. If a significant suicidal risk was confirmed in the interview, then it could be crucial to arrange continuing human contact. This should include his knowing whom to contact and someone, family or professional, who will maintain contact with him.

Antipsychotic agents with sedating effects and anti-depressants have been used with most similar patients, often with best results from combinations of both. However, patients with similar patterns not infrequently have had difficulties in managing drugs including misuse, dependency, and rapid habituation. 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.

Difficulties in trusting and in relating emotionally are likely to make his response to treatment slow if not limited. Apathy and any longterm schizoid trends would be prognostically negative signs. His shyness and fears of losing emotional control could inhibit him from opening up in early interviews. He tests as prone to get others to tell him what to do, but ambivalent if not negativistic to decisions made for him by someone else. Although responsibility for decisions should be gently but firmly

encouraged, he is apt to need extensive support in order to take initiative and to mobilize his energies. He is particularly prone to provoke therapeutic rescue and then to back away abruptly from what he would fear as therapist demands on him and intolerable closeness in the treatment relationship.

The profile anticipates that he would be quite cautious in interviews about any possibly improper reactions he felt he was being asked to reveal if not at times a bit concrete or morally simplistic. 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. If he is currently going through an intense life crisis, then he may show fairly rapid and extensive emotional changes. Subsequent retesting is apt to be more than usually informative for reevaluating such shifts and for updating treatment directions and goals.

In many similar cases the precipitating circumstances involved personal "binds" that were partly due to the patients' ambivalences and to their avoidance of decisions and responsibility. Awareness of how his indirect expressions of hurt and angry feelings frustrate his needs to be loved and cared for by others appears limited. Discovery of his personal ways of keeping others at a distance--perhaps especially as he uses them on the therapist--is apt to be of direct benefit in treatment.

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 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: CAPITULATED DEPRESSION
ADAPTATION TO: unending and unrelieved parental/familial/circumstantial identity negation
TRADITIONAL DIAGNOSIS: major depressive episode, may have schizoid or schizotypal elements and atypical motoric or other somatic reactions; some psychiatric patients are seen as marginally or overtly "negative symptom" schizophrenic

PROTOTYPIC CHARACTERISTICS: strongly prone to "give up", the most

limited average achievement level of all code types. They show some variation between a passive and apathetic anhedonia versus in some cases an emotional flailing about with little gain for the individual. Subjective feelings of hopelessness may be strong--this would be the MMPI expression of learned helplessness. Emotional flatness may disguise the depth of the depression. They are very prone to keep others at a distance and slow to become emotionally involved with others. Bodily systems are prone to malfunction with odd tremors or other peculiar neurologic-type complaints.

CONTRIBUTORY SHAPING HISTORY: in long-term (from childhood) cases, histories of deeply negative mother-child relationships are notably consistent, the mother being disliking and ungiving to the child with very few (if hardly any) rewards for successes or constructive behaviors; the child experiences few or virtually no reliable incentives for trying. The interpersonal disconnection is what I would expect from a childhood that was almost completely devoid of affectionate touching. For women, menarche had been delayed over half a year on the average (Marks & Seeman, 1963), suggesting ongoing physiologic consequences of such a childhood.

In more recent onset cases, this adaptation typically developed as a circumstantial response to life-devastating experiences such as accidents or other causes of serious brain trauma and chronically impaired cognitive capacities--again a feeling of utter defeat and uselessness with a helpless readiness to give up in the absence of perceived rewards for trying. The sensitivity to being identified as a worthless failure leads to a quickness to "run away" from the vulnerability of emotional closeness. Such withdrawal appears to be reinforced by the return to a familiar homeostasis, however empty and emotionally barren that emotional and physiologic stasis seems to the observer. A self-identity as a hopeless failure generates suicidal "might as well be dead" ideation. The commit risk is serious although not as severe as the internalized condemnation pattern (2-7-8) with its endless fears of what will go wrong next and "maddening" tension.

Intervention is very difficult. If the profile is much over T 70, psychotropic medications may well be needed, e.g., an antidepressant to alleviate the pervasively negative mood and an antipsychotic (despite no delusions or hallucinations) to help the mind to work better and thus to generate at least some increment in self-confidence. Abreaction of losses (saying "goodbyes") seems less relevant and helpful than for the other depressive syndromes; the person too easily gets further mired in hopelessness. Psychological intervention may need to start with small increments in self-confidence, e.g., praise for some action that is successful, even if limited to a level that others might find trivial (very much so if the T score on the Ego Strength scale is around or below 35) . Perceptions of being able to gain positive rewards for oneself and to have positive effects in someone else's or one's own life need encouragement until they can in effect become self-sustaining.

The most common context of litigation is for damages following head injuries. The incapacitation of previously effective and successful

cognitive capacities, with the commonly slow if not very gradual recoveries (many months to a year or two or even more) operates to establish the self-identity as useless and hopeless. Neuropsychological assessment becomes crucial to separate what may basically be a demoralized depressive collapse without brain injury or with no more than minor cognitive impairment versus an emotional capitulation following a substantial trauma. In the latter case, care may be quite extensive over time. In the former case, other significant factors are likely to have contributed to the depression, which then would likely be more readily amenable to treatment.

For codetype information see Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973; Kelley and King, 1979b Kelley and King, 1980; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974.

MMPI2 CRITICAL ITEMS
NAME: Sample 2 8

Distress & Depression
5T 73T 130T 165F 233T 301T
Suicidal Thoughts
215T
Ideas of Reference, Persecution, and Delusions
228T 314F
Peculiar Experiences and Hallucinations
32T 298T 311T
Sexual Difficulties
12F 166T 268T
Authority Problems
105T 266F
Alcohol and Drugs
229T
Family Discord

Somatic Concerns
2F 10F 101T 175T 224F
Aggressive Impulses
134T

Name: Sample 28
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Date Tested:

Subscales

2-D and Subscales

		RAW	T
D	(full scale)	38	89
D1	Subjective depression	22	90
D2	Indecision-retardation	8	65
D3	Health pessimism	7	83
D4	Mental dullness	11	91
D5	Brooding, loss of hope	7	79

6-Pa and Subscales

		RAW	T
Pa	(full scale)	10	49
Pa1	Persecutory ideas	2	52
Pa2	Poignant sensitivity	5	68
Pa3	Moral righteousness	1	32

3-Hy and Subscales

		RAW	T
Hy	(full scale)	35	84
Hy1	Denies social anxiety	3	45
Hy2	Need for affection	3	36
Hy3	Lassitude - malaise	12	93
Hy4	Somatic complaints	11	91
Hy5	Inhibits aggression	4	55

8-Sc and Subscales

		RAW	T
Sc	(full scale)	35	86
Sc1	Social alienation	6	64
Sc2	Emotional alienation	3	69
Sc3	Ego defect, cognitive	7	84
Sc4	Ego defect, conative	9	87
Sc5	Defective inhibition	2	54
Sc6	Sensorimotor dissociation	13	104

4-Pd and Subscales

		RAW	T
Pd	(full scale)	19	52
Pd1	Family discord	0	38
Pd2	Authority problems	5	60
Pd3	Social disinhibition	3	45
Pd4	Social alienation	4	50
Pd5	Self-alienation	7	67

9-Ma and Subscales

		RAW	T
Ma	(full scale)	19	51
Ma1	Opportunism	2	50
Ma2	Psychomotor acceleration	6	53
Ma3	Imperturbability	2	41
Ma4	Ego inflation	5	63

5-Mf and Subscales

		RAW	T
Mf	(full scale)	23	44
GM	Gender masculine	33	40
GF	Gender feminine	20	33

0-Si and Subscales

		RAW	T
Si	(full scale)	39	
Si1	Shyness and self-consciousness	6	53
Si2	Social avoidance	7	67
Si3	Alienation - self and others	10	65

Name: Sample 28 Page 2 (MMPI-2)
Referred by: ---------- Subscales
Date Tested:

Major Clinical Variables

		RAW	T
ES	Ego strength	20	14
MAC-R	Potential Alcoholism	20	48
SAP	Teen drugs/alcohol	10	52
AAS		3	51
Mt	College maladjustment	28	76
N-P	Neurotic-psychotic profile balance		49

Interpersonal Style Variables

		RAW	T
ER-S	Ego resiliency	12	33
EC-5	Ego control	9	45
ORIG	Need novelty	38	69
INT	Abstract interests	45	42
Do	Need for autonomy	14	41
Dy	Need reassurances	20	57
Pr	Intolerance	19	72
Re	Value rigidity	21	52
Et	Ethnocentrism	14	56
St	Status mobility	12	43
R-S	Repression-sensitization	76	75
Lbp	Low back pain	10	56
o-h	Overcontrolled hostility	11	45
Ho	Cynical hostility	28	62
Ba	Good teamworker	35	25

Distress-Control

		RAW	T
A	Level of distress	21	65
R	Emotional constriction	17	54
Ca	Caudality-distress	20	76
Cn	Control-façade	22	53
So-r	Life as desirable	18	23
Th-r	Tired housewife	26	82
Wb-r	Worried breadwinner	17	67
PK	PTSD	21	72

Validity & Stability

		RAW	T
VRIN	Response inconsistency	5	50
TRIN	T-F inconsistency	12	72T
F-back	Rare answer - back	5	63
F(p)	Psychiatric infrequency	3	63
S	Superlative self-presentation	20	44
Ds	Overemphasize-fake sick	18	65
Mp	Consciously fake good	13	59
Sd	Consciously fake good	15	56
Ss	SES identification	36	17
Ch	Correction for H	23	66
Rc	Retest-consistency	15	33
Ic	Retest-item change	38	71
Tc	Retest-score change	24	64

Content Scales

		RAW	T
HEA	Health concerns	17	76
DEP	Depression	14	68
FAM	Family problems	6	52
ASP	Antisocial practices	10	53
ANG	Anger	11	67
CYN	Cynicism	20	74
ANX	Anxiety	14	70
OBS	Obsessiveness	7	56
FRS	Fears - phobias	5	54
BIZ	Bizarre mentation	8	70
LSE	Low self-esteem	4	51
TPA	Type A	14	68
SOD	Social discomfort	16	68
WRK	Work interference	15	65
TRT	Negative treatment Indicators	15	76