Name:	Jane Jones	Referred By:	Dr. Zachary Example
Gender:	Female	Tested:	April 1, 2020
Age:	43	Processed:	April 3, 2020
Marital Status:	Divorced		
Education:	13		

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 mildly elevated but within the normal range. This indicates that she was able to read and comprehend most if not all of the test items, that she was rarely if at any time inattentive in considering her responses, and that she adequately matched the item numbers in the booklet to the corresponding numbers on the answer sheet. She does not appear to have had any serious difficulties in understanding the content or in responding to the format of the inventory.

Attitude and Approach: She made a few atypical responses to the inventory. Otherwise, her approach was straightforward and not unduly defensive. The profile appears valid by the usual criteria for scales L, F, and K.

She made very few atypical and rarely given responses to the items in the second half of the inventory (scale F-back). These were proportionately even less frequent than her scattered atypical answers to the earlier MMPI-2 items (scale F). In any case, there is no question as to the validity of the profile because of atypical responding.

Socio-cultural Influences vs. Conscious Distortion: The supplemental validity scales showed an average to below average score on the scale (Ss) measuring her level of currently attained, recently experienced, or self-perceived socioeconomic status. She did not show any significant amount of conscious defensiveness; her score on K was not distorted by any intentionally self-favorable slanting of her responses. Her K score was slightly higher than would have been expected for her Ss score; that is, this level of socioeconomic status identification is frequently associated with a lower level sophistication on K.

There were no indications on the Ds scale of any attempt to malinger or exaggerate her level of disturbance. The scattered atypical and rarely given responses shown in her elevation on scale F appear, in the absence of any Ds elevation, to reflect the valid reporting of some unusual experiences and attitudes on the MMPI-2. The elevation on F also suggests an internally driven person who may be described by such terms as dissatisfied, restless, changeable, or complex and

possibly as moody, talkative, opinionated, or curious (her F score was not at all due to exaggeration or overstatement). Despite the mildly elevated F score, her clinical scale scores are not likely to be over-elevated; the F score does not appear to reflect any consciously self-critical distortion or biasing of her responses. These scores suggest a person who is defensive in some areas but willing to report somewhat atypical reactions in other areas. The extent of distress that she did report indeed does appear genuine.

SYMPTOMS AND PERSONALITY CHARACTERISTICS

The profile indicates a moderately severe depression with sad moods, marked anxieties, and feelings of inadequacy along with tearfulness and crying. She is likely to suffer a loss of appetite and some decline in weight. The profile suggests a general decline in drive, energy, and alertness and a generally slow pace. However, she would try to cover over her depression, and "smiling depression" phases are strongly indicated. She appears mildly shy and socially inhibited and insecure. Her many insecurities would make her overly sensitive to criticism and to perceived rejections. The current level of her day-to-day coping and immediate practical self-sufficiency tests as quite uneven and as partially disorganized in a variety of areas.

Her profile suggests that her depression would be expressed through a variety of somatic symptoms that are at least partly on a psychological basis. Headaches, nausea, chronic tension symptoms, and back and chest pains are common complaints with this pattern along with undue tiredness and fatigue. She would overreact to tangible organic illnesses with apprehensions and fears of pain.

She tests as repressive, denying, and naive with little insight into her symptoms. She would be minimizing of socially unacceptable impulses; others would see her as socially correct and constricted and as lacking in spontaneity. Her strong underlying tendencies to externalize her problems and to rationalize her resentments would have actively contributed to past marital difficulties. She tests as inhibited and "bottled up", and sexual non-responsiveness are frequent complaints with this pattern. 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.

In many similar cases the interpersonal role was mainly defined by insecure needs for attention and affection and by a family role as the "unloved" member. Her strongly dependent needs for emotional support would make it upsetting and threatening for her to act in positive and assertive ways toward loved ones. She would have had repeated difficulties in dealing with any acting out behavior by family members such as drinking by her husband, misbehavior or delinquency by her children, or other impulsive or aggressive behaviors by loved ones. She is apt to see herself as self-sacrificing and family dedicated. Family alienation and estrangement appear moderately severe and persistent. Her severely limited tolerance for frustrations and her narcissistic demands on her family would make them feel repeatedly frustrated and resentful of her.

She would want to be seen as responsible and as trying hard, but decisions and family demands would leave her worried and insecure. Mild to moderate stresses are apt to make her feel inefficient and tense. Family relationships in her childhood are apt to have been conflictual, although she would have ambivalent wishes to cover over and to avoid confronting her upsetting memories. Where the fathers were not absent from the home, similar patients have usually described their fathers as passive and indifferent and felt hurt by their lack of affection. In her childhood, physical and emotional complaints along with direct demands were likely to have been a major way of obtaining maternal attention.

DIAGNOSTIC IMPRESSION

The profile has usually been associated with depressive and anxiety disorders. Secondary diagnoses reflecting emotionally explosive, passive-dependent, and hysterical dissociative personalities are also common among these cases.

TREATMENT CONSIDERATIONS

The profile suggests a mild suicide risk; this could become serious if her situation became worse and she saw her life as increasingly hopeless. The risk of physical invalidism due to her emotionally based complaints is moderately severe. Disability payments could easily enhance her invalidism and have many adverse effects with this psychological makeup. 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 symptoms could prove mildly chronic with a slowness in mobilizing her efforts to change and to improve her situation. The pattern suggests a variety of narcissistic manipulations, and understanding them may be vital in managing her treatment. 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.

A phase of rapid improvement or even a "flight into health" with a denial of need for treatment would not be at all unusual with this pattern. This could be a positive response to reassurance as well as an avoidance of exploring psychological problems. However, the depression can return just as abruptly. She is apt to have unduly high hopes for treatment - probably of a wishful quality - but she would be quick to feel disappointed that treatment was not helping her. She would be reluctant to criticize the therapist to his face and would express these feelings indirectly through criticisms of previous doctors or by complaints to her family and friends. Feelings that the therapist was being critical of her or pushing her to be critical of loved ones would be quite difficult for her to confront and verbalize. Criticisms of other doctors could immediately precede an abrupt and unexpected termination of psychotherapy. Contacts with family members and other informants could help to

clarify what the current stresses are, what the secondary gains from her symptoms are, and how such gains can be minimized.

The long-term prognosis is fair, and she should show a mild to moderate improvement in response to treatment. She is apt to focus on her current distresses and then on hurt feelings in her family relationships. Readjustment to separation from or to the loss of a loved person, to a recent rejection by a supporting family member, or to a related loss of emotional support is likely to be of central importance in treatment. An increasing recognition and acceptance of her family resentments and aggressive as well as sexual impulses could lead to much more adaptive expressions of them. If a past role of hard work and self-sacrifice has broken down, she would benefit from a role that is increasingly independent but without undue demands and pressures on her.

Thank you for preferring Caldwell Reports.

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 Reports.

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 her 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: UNRESOLVED GRIEF ADAPTATION TO: grieving blocked by needs to avoid acute pain as well as critical judgments of self and by others

TRADITIONAL DIAGNOSIS: major depressive episode (descriptively a "smiling depression" or a "somatically expressed" depression), typically with fluctuating but at times substantial vegetative depressive involvement

PROTOTYPIC CHARACTERISTICS: tearful eyes with smiling mouth; interpersonally inhibited, toonice persona; issues of guilt, both personally expressed and induced in others. The person is avoiding of the pain and regrets of confrontation with difficulties around self-assertion ("I have tried so hard to be good to my family"). Resentments are covered over so that hurt feelings and other interpersonal suffering is experienced as bodily pain and feeling ill. Cancers can progress rapidly (e.g., note also K up and 9-Ma below T 60 in West, Blumberg, & Ellis, 1952), and the general risk of morbidity is increased (e.g., Shekelle, Raynor, Ostfeld, Garron, Bieliauskas, Liu, Maliza, & Paul, 1981).

CONTRIBUTORY SHAPING HISTORY: Such circumstances as family illnesses, family is poor, parental depressions, and rigid values set the stage for a strict upbringing with little by way of positive rewards or pleasures for the child. This syndrome may then develop from past occasions or sequences of loss, e.g., a relatively early parental death (especially age 4 or 5 up to puberty; Marks

& Seeman, 1963), at which time grief was actively inhibited by family members and/or others who were critical and negatively judging of the person's emotional output ("Stop being so emotional!").

The syndrome may also develop in adult life when vital expectations (can no longer work, never having a child,losses of social support, declining health, etc. are permanently defeated), especially if the person's longer term style has been to be brave and to inhibit expressions of anger in fear of judgment as a somehow "bad" person. E.g., a laborer of limited education (no desk work skills) who has always dutifully supported his large family has a permanently incapacitating accident with major persisting pain. Such sequences of experiences strongly inhibit grieving promptly and fully, and the person is subsequently unable to "let go" and get on with self-pleasing initiatives and active self-gratifications in her own life. The person becomes acutely sensitized and strongly reactive to the defeat of even relatively minor personal expectations as well as losses of hopes and goals.

Suggestions for treatment follow closely the loss/depression paradigm in the "What do the MMPI scales fundamentallymeasure"? article (Caldwell, 2001). The "Hegelian thesis" is saying repeated goodbyes to what was and what might have been. Tears need to be actively shed. The antithesis is the rediscovery--or perhaps in these cases the discovery--of self-assertion and constructive anger, which is the return of energy. The synthesis is the development of new or modified and adapted sources of positive rewards and pleasures in life. This synthesis is the resolution of the grief.

If the 2-D T score is over much over 95 male or about 105 or more female, then somatic intervention may well be necessary before psychological interventions are likely to be of significant benefit. But elevated secondary scores on 4-Pd (e.g., over T 70 on the MMPI-2) anticipate an "emotionally turned off" quality that is apt to undermine or defeat the benefits of medications.

Presuming a valid Unresolved Grief profile in a forensic context, e.g., Workers Compensation, the perception of personal tragedy is typically a central issue. "What is lost is irretrievable. My life is in permanent ruin". Elevation on 1-Hs and 3-Hy (especially the Hy-3 and Hy-4 subscales) may reflect direct distress over physical damage or debilitation, but they may also be magnified and exacerbated by the associated anguish and pessimism (note also the D-3 subscale as reflecting health pessimism). Prolonged litigation may operate to reinforce the pessimism via repeated and more-or-less public assertions of "the hopelessness of my situation." With T scores over 70 some allowance for treatment will likely be indicated; see the preceding paragraph and the Treatment section of the narrative report.

For codetype information see Archer, Griffin, and Aiduk, 1995, Gynther, Altman, and Sletten, 1973:Gynther, Altman, and Sletten, 1973:Gynther, Altman, and Sletten,1973; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974.

Caldwell
REPORTS

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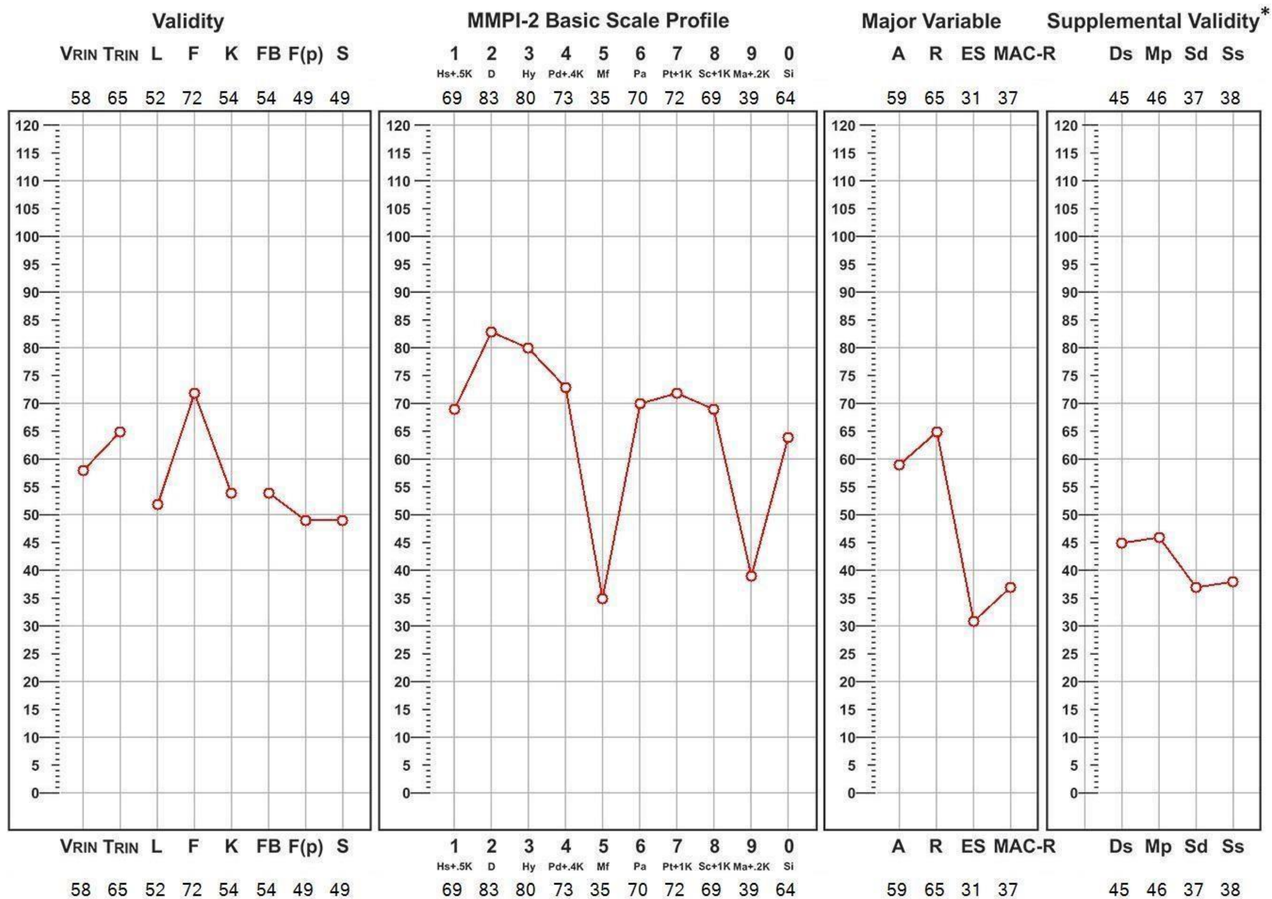
MMPI-2 Code 2 3 " 4 7 6 ' 1 8 0 - / : 9 5



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* Special scales that are not included in the MMPI-2 approved and published by the University of Minnesota Press.

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MMPI-2 Code 2 3 " 4 7 6 ' 1 8 0 - / : 9 5

	RAW	K	RAW+K	T
?	0			
L	4			52
F	10			72
K	17			54
1-(Hs)	13	9	22	69
2-(D)	36			83
3-(Hy)	35			80
4-(Pd)	25	7	32	73
5-(Mf)	42			35
6-(Pa)	16			70
7-(Pt)	22	17	39	72
8-(Sc)	21	17	38	69
9-(Ma)	11	3	14	39
0-(Si)	40			64

2-D and Subscales

		RAW	T
D	(full scale)	36	83
D1	Subjective depression	21	82
D2	Indecision-retardation	10	73
D3	Health pessimism	6	70
D4	Mental dullness	8	75

6-Pa and Subscales

		RAW	T
Pa	(full scale)	16	70
Pa1	Persecutory ideas	3	57
Pa2	Poignant sensitivity	4	59
Pa3	Moral righteousness	7	60
D5	Brooding, loss of hope	7	73

3-Hy and Subscales

		RAW	T
Hy	(full scale)	35	80
Hy1	Denies social anxiety	5	56
Hy2	Need for affection	8	55
Hy3	Lassitude - malaise	11	83
Hy4	Somatic complaints	6	61
Hy5	Inhibits aggression	4	54

8-Sc and Subscales

		RAW	T
Sc	(full scale)	21	69
Sc1	Social alienation	7	65
Sc2	Emotional alienation	1	49
Sc3	Ego defect, cognitive	5	74
Sc4	Ego defect, conative	7	75
Sc5	Defective inhibition	2	53
Sc6	Sensorimotor dissociation	2	50

4-Pd and Subscales

		RAW	T
Pd	(full scale)	25	73
Pd1	Family discord	3	56
Pd2	Authority problems	3	53
Pd3	Social disinhibition	4	52
Pd4	Social alienation	7	65
Pd5	Self-alienation	5	58

9-Ma and Subscales

		RAW	T
Ma	(full scale)	11	39
Ma1	Opportunism	1	45
Ma2	Psychomotor acceleration	0	25
Ma3	Imperturbability	3	50
Ma4	Ego inflation	4	56

5-Mf and Subscales

		RAW	T
Mf	(full scale)	38	0
GM	Gender masculine	22	39
GF	Gender feminine	40	56

0-Si and Subscales

		RAW	T
Si	(full scale)	40	64
Si1	Shyness and self-consciousness	7	55
Si2	Social avoidance	3	51
Si3	Alienation - self and others	11	66

Major Clinical Variables

		RAW	T
ES	Ego strength	25	31
MAC-R	Potential alcoholism	14	37
AAS		2	50
Mt	College maladjustment	22	64
N-P	Neurotic-psychotic profile balance		39

Validity & Stability

		RAW	T
VRIN	Response inconsistency	7	58
TRIN	T-F inconsistency		765F
F-back	Rare answers - back	3	54
F(p)	Psychiatric infrequency	1	49
S	Superlative self-presentation	25	49

Interpersonal Style Variables

		RAW	T
O-H	Overcontrolled hostility	17	63
Ho	Cynical hostility	20	54

Distress-Control

		RAW	T
PK	PTSD	22	71

Content Scales

		RAW	T
HEA	Health concerns	7	53
DEP	Depression	14	65
FAM	Family problems	3	42
ASP	Antisocial practices	6	49
ANG	Anger	5	47
CYN	Cynicism	12	54
ANX	Anxiety	16	71
OBS	Obsessiveness	7	53
FRS	Fears - phobias	9	56
BIZ	Bizarre mentation	2	52
LSE	Low self-esteem	7	54
TPA	Type A	4	41
SOD	Social discomfort	11	56
WRK	Work interference	19	69
TRT	Negative treatment indicators	8	57

Supplemental Scales*

		RAW	T
SAP	Teen drugs/alcohol	12	61
Ds	Overemphasize-fake sick	8	45
Mp	Consciously fake good	7	46
Sd	Consciously fake good	8	37
Ss	SES identification	49	38
Ch	Correction for H	25	67
Rc	Retest-consistency	18	40
Ic	Retest-item change	31	60
Tc	Retest-score change	24	62
ER-S	Ego resiliency	17	46
EC-5	Ego control	15	54
ORIG	Need novelty	24	53
INT	Abstract interests	42	41
Do	Need for autonomy	13	39
Dy	Need reassurances	25	59
Pr	Intolerance	12	56
Re	Value rigidity	21	50
Et	Ethnocentrism	14	55
St	Status mobility	15	42
R-S	Repression-sensitization	56	61
Lbp	Low back pain	12	63
Ba	Good teamworker	39	36
Ca	Caudality-distress	14	60
Cn	Control-facade	15	34
So-r	Life as desirable	20	33
Th-r	Tired housewife	12	49
Wb-r	Worried breadwinner	9	41

* Special scales that are not included in the MMPI-2 approved and published by the University of Minnesota Press

MMPI-2 CRITICAL ITEMS

The Caldwell report also provides the clinician with lists of critical items endorsed by the test-taker. They are not posted in this sample report i n order to protect the integrity of the test.