Adaptation To What?
An Alternative Diagnostic Paradigm

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The following essay proposes a system of behavioral and diagnostic classification based on MMPI codetypes. These delineate adaptations that people make to a wide variety of often distressing, painful, and sometimes nightmarish adversities. The stress is on adaptation, how do people manage to survive the worst misfortunes of their lives. A commonality of adaptations implies a commonality of circumstances, and that in turn implies etiologic specificity. I think the most noteworthy absence in the DSM series is the absence of specific etiologies. This material is an effort to offer a series of potentially testable`and disprovable`etiologies.

I previously presented a Master Lecture to the Society for Personality Assessment which was published as, `What do the MMPI scales fundamentally measure? Some hypotheses` (Caldwell, 2001). That is the foundation for what I am developing here, and that paper should be read before this paper, as this writing assumes familiarity with the hypotheses as to the fundamental dimensions of fear. For convenience I will refer to that talk and the paper that followed from it as the `Fundamentally Measure` paper.

Fundamentally Measure interprets the eight basic scales of the MMPI as broad dimensions of fear learning that influence and shape the person`s pattern of survival. Here I am moving on to the intersections of those dimensions, that is, the code types. Some of these are simple two-scale patterns; some involve more complicated interactions. Meehl used to conceptualize points of intersection in k-dimensional space, and I remember thinking he was the only person I had ever known who probably could actually visualize in a k-dimensional space. I can barely make it through four, assuming that something like driving a car or playing squash--or just keeping my balance while walking across a room-- is truly operating in four dimensions.

There is an extensive literature on what is right and mostly wrong with the DSM's III, III-R, and IV. A recent book on this by psychologists is by Beutler and Malik (2002), Rethinking the DSM. It offers numerous ideas about what the deficiencies in the DSM are and some theoretical but mostly applied directions in which it might be refined. But nowhere do I find a meaningful alternative system, an alternative set of working constructs or labels. The following is my attempt to generate an actual alternative paradigm: a set of 23 labels to be considered. It is not presumed to be exhaustive; it is just a first approximation, but I obviously think it highlights a path worth pursuing.

The most immediate and crucial issue is, how do we decide whether this is any more meaningful than any other hypothetical system or wooly-headed set of categories? The chapter by Joiner and Schmidt (in Beutler and Malik, 2002) is a fairly brief and to the point discussion of Meehl et al.`s methods of taxometric analysis. The thinking is that, as in zoology and botany, a `taxon` should identify a non-arbitrary class. Joiner and Schmidt cited Plato: `The principle is that of division into species according to natural formation, where the joint is, not breaking any part as a bad carver might.` (p. 109) A taxon is a naturally homogeneous grouping. Aside from

differentiating animal species, perhaps the simplest human example is gender, a taxon with two non-arbitrary types, and separating the two genders is an obviously natural differentiation. Part of the argument is that the seemingly endless and unresolvable overlapping of multiple DSM categories for the same individual is surely the result of non-taxonic classification. The real challenge to ourselves as psychologists as well as to psychiatry is to demonstrate that all the DSM-V (or DSM-VI or DSM-VII?) categories that are retained are indeed truly taxonic. No small feat, but terribly needed.

Roger Greene and I have discussed the question of taxonicity and the MMPI. He posed the question, why does the MMPI depression scale turn out not to be taxonic? Considering the profound physiological effects of a severe depression, it surely seems it should be: it makes natural sense that there is a joint to be cleaved somewhere between normal functioning and marked psychomotor slowing. But three studies have not supported the expectation that the depression scale is taxonic.

In Meehl`s line of thought, quantifiable variables that are not taxonic are dimensional. A dimension in this usage is an accumulation of interrelated variables that, in the aggregate, determine an overall disposition. For example, as Roger and his friends demonstrated, the cluster of scales tapping conscious defensiveness, i.e., L, Wiggins` Sd, and Cofer, Chance, and Judson`s Mp, do form a taxon, an internally self-consistent and coherent shift in test taking attitude that is consistent across people. In contrast, scale K is dimensional with multiple and very largely independent influences on a person`s score including socioeconomic status, conscious defensiveness, and emotional constraint.

I have not been surprised that depression is dimensional and not taxonic. I expect, and I believe it is consistent with what I was saying in Fundamentally Measure, that the eight clinical scales of the MMPI are all dimensional. My present hypothesis is that the crucial taxonicity is in the code types. If you take a group of internalized condemnation or 278 clients (and I don`t mean `take` for a cheerful, humorous tour of the San Francisco Bay harbor), you get an almost dramatic homogeneity of great weights on their shoulders, of mind-warping logic that always leads to negative conclusions, of unending tension, of dreadful nightmares if you ask about them, etc. If we can ever find data to test the scales and the codes for taxonicity, I feel almost certain that the internalized condemnation of the 278 group will be taxonic.

I think each code type is pulling its own primary subset of items from each of the type-defining scales. The depression scale is, for example, a dimensional collection of many aspects of depression. In its original derivation there was no differentiation of subtypes of depression; they simply identified 50 patients that represented as much a `pure culture` sample of being seriously to severely depressed as they could find. But if depression has genuinely specific and distinguishable variants, their results should be dimensional and not taxonic. Note that I have six distinct subtypes of depression, and if I had put the `shallow bonded depression` or 274 code into the depression cluster rather than the cluster I called Adaptation to Impaired Bonding (which was a very close and ultimately arbitrary decision), I would have had seven distinct types of depression. So, to sum up so far, I expect taxonicity will prove to be in the codes and that all the eight basic scales will prove to be dimensional.

Next, I want to consider the etiologic implications of these adaptational hypotheses. The simple, obvious presumption is that shared qualities of experience condition or shape shared response dispositions. A vital part of what is going on can be understood--in learning terms--as sensitization: that a particular type of trauma produces a corresponding focus of lowered response thresholds and heightened responsivity to any threat of the renewal or reoccurrence of 7that

trauma. For example, in the codetype material below, the role-played nice presentation characteristic of the `rejection-sensitized syndrome` is shaped by having to inhibit `not nice` behavior in order to avoid having a parent shout at you or hit you. The unfairness sensitization syndrome is potently shaped by what are experienced as uncaring or cold (scale 4-Pd) and unduly harsh punishments (the `attack` aspect of scale 6-Pa). If you watch a `smiling grief syndrome` (smiling depression) person closely, note how intensely that person can become upset over the loss of something quite trivial. Ludwig van Beethoven was always short of money; he expressed the aggravation of this in a delightful number called `Rage over a lost penny,` even with an embarrassed, subdued ending when he finally found it. (Although Ludwig struggled about money, his MMPI would surely not have been a Pollyanna `23".)

It is interesting to note that physical abuse shows up most strongly in several related codes, yet the codes have specific differences in the quality and perception of the experience. In the `rejection-sensitized syndrome,` code 34/43, the focus is externalized as someone`s else`s feared outbursts; in unfairness sensitization, code 46/64, it is experienced as callous and harsh punishment; in persecutory bewilderment, code 86/68, it appears to be experienced as an incomprehensible assault, probably as having something to do with one`s intrinsic defectiveness; and the punitively disfavored child, code 89/98, may feel physically beaten on to conform and achieve beyond his/her capacities. In deeply alienating abuse, code 489, I think the experience of abuse is as utterly callous (4), openly hostile (8), and grossly devaluing (9) (Charles Manson`s mother sold his five-year-old body for occasions of whatever the buyer of the moment wanted to do with it, cold, cruel, and repudiating of his worth as a person). Note the histories of physical abuse in each of these syndromes but the contrasting qualities of the types of experience.

One might ask, does this formulation presume a single, specific etiology for each syndrome? I think these labels have to be considered as truly syndromal. That is, there can be more than one if not multiple avenues to any given configuration. For example, under `pervasive identity negation,` the 28/82 depression, I postulate two radically different etiological sequences. In the longstanding cases, i.e., having been unhappy well back into childhood (note a year`s delay of menarche among the women in the Marks & Seeman sample, 1963), a mother who fundamentally disliked the child (scale 8-Sc) and gave the child virtually no positive reinforcements (scale 2-D, the deprivation of rewards) has induced a negative identity early in the child`s life (e.g., perhaps maternal coldness in infancy if not from birth on), and it is an identity that seems extremely difficult to reverse. But when one looks at patients with serious neurologic disorders (e.g., Zev Goldberg, 19)--lo and behold- -there are many elevated to very elevated 28/82 profiles without past histories of chronic depression, badly damaged identities, or related psychopathology. The devastation of major aspects of brain functioning and the slowness and incompleteness of the recovery of such functioning can put the person into a state of utter hopelessness and helplessness. The post-trauma identity is crushed and profoundly negated (8), and a great many lifelong positive rewards are lost and never to be again (2). Given these very different avenues to an extensively overlapping outcome, it is a curious question whether a mixed sample of subjects with 28/82 codes but with diverse histories would nevertheless turn out to be a taxonic group. That is simply an empirical question if and when we can find the data.

This is not to presume that each person has had only one type of traumatic experience. For some people there are indeed crucial kinds of experiences that have had an overriding effect, but others have had a diversity of traumas, all of which have left major scars and sensitizations. This contrast is reflected in the MMPI profiles. The former typically have much more clear-cut code types of the sort described below. Those with multiple and diverse traumas typically obtain profiles

with multiply elevated scales, sometimes with three, four, or five scales at nearly equal levels of elevation. For the latter, I see no alternative but to describe, in one way or another, the fears and threats to which the person is strongly sensitized. In one respect this recapitulates the multiple diagnoses of the DSMs. But in another sense, if there are etiologic specificities that each pattern of sensitization entails (each sub-combination of MMPI scales), then this simply reflects the complexity of the person`s fear-shaping history.

Another question is, how do genetic dispositions and traumatic experiences interact in this emotional learning formulation? I have long been bothered by simple assertions that x% of the variance of a given variable is genetic, and therefore the rest is environmental. What is so crucial but perhaps disguised by this simplistic quantification is how interactive experience is with genetic vulnerabilities. For example, the confusional irritability of a pre-schizophrenic child readily draws punishment from a perhaps irritable and ungratified parent. Increasingly severe punishments augment the confusion and incomprehensibility of experience, hence another cycle of more irritability and still more punishment, with adult paranoid schizophrenia as the eventual outcome.

The Minnesota twin studies (DiLalla, Carey, Gottesman, & Bouchard, 1996) put the genetic variance of scale 4-Pd at a disconcerting 61%, with scales 7-Pt and 8-Sc essentially equal and scale 9-Ma very close behind (note the transmission across generations of deeply alienated or 489 antisocial behavior). If a mother who bonds shallowly with others in general also predictably bonds poorly with her disposed-to-bond-poorly child, one has a direct paradigm for the perpetuation of shallow attachments over multiple generations. The child, even if difficult, needs consistent limits combined with large doses of unconditional love, the opposite of what is so likely to happen. My point is to attend less to the percentage values and instead to look carefully at the sequences of events where a genetic/biologic disposition elicits the very responses from others that can maximize the expression of that disposition: what is the interaction of this person`s vulnerabilities with his/her life experiences?

I obviously have become convinced that tracking the histories of adult constellations of distressing and less gratifying behavior back through what I think of as `emotional learning sequences` is our best route to locating the natural joints as recommended by Plato. Sigmund Freud`s goal was similar: what were the childhood events that made so much difference in the symptoms of his adult clients? To my taste, however, his explanations are too metaphorical and at times somewhat circular, whereas a basis in learning constructs will lead to testable predictability, to the replicable specification of antecedent probabilities. To be able to specify the patterns of punishments and rewards that create a particular psychopathological outcome would be a great gain in our field. Koch`s postulates (18 /19) asserted that a sufficiently precise specification of the symptoms would lead to the etiology, and that would lead to the treatment. That approach did wonders in infectious diseases. But in most systemic disorders, etiology is no guarantee of a cure. Psychiatric diagnoses are in that sense systemic: they are not due to the invasion of an identifiable organism. The ever-growing proliferation of DSM categories has clearly not led to the pinpointing of etiology (rather to a fixation on predominant symptoms), and the payoff has been very uneven to limited in identifying established and consistently effective treatments.

I would readily recognize that the accurate specification of the emotional learning history and biologic influences that have shaped a particular individual`s behavioral output does not guarantee a `cure.` But it does give us very interesting guidance where to start, what traumatic effects may need to be relieved, and what interventions are likely to be pertinent for that individual. It is also greatly facilitates empathy. To tell someone they have a histrionic personality disorder or a paranoid personality disorder is easily experienced as insulting and threatening. But to

understand that what the client is doing is what has enabled that person to survive the most difficult circumstances in their lives gets us `inside the head` of the person. It also can greatly facilitate self-acceptance in people who spend great amounts of psychic energy fighting their own proclivities. To sum up: I think there is a great amount of potential benefit in using a system of syndromes that are specific to the developmental histories, biologic dispositions, and emotionally shaping experiences of our clients.

In considering the following codetype material, it should be remembered that humans experience an infinite variety of personal experiences and life sequences. These are my attempt to delineate modal developmental patterns, and every individual`s life will vary in lesser or greater respects from what is typical. Nevertheless, I hope these outlines will help to make sense out of behaviors that at times seem unreasonable if not almost incomprehensible. As of this editing in May, 2006, this is a work in progress, and I will be adding more to it (e.g., such patterns as spike 9, 47/74, etc., as well as (of course) a list of references.

THE SYNDROMES: SUMMARY LISTING

LOSS-DEPRESSION SYNDROMES

Bravely smiling, unfinished grief (231)
Failed responsibility depression (273)
Internalized condemnation (278)
Martyred depression (26)
Capitulated depression (28)
Labile mood (29)

SOMATICALLY FOCUSED FEARS

Pervasive health sensitization (123)
Pain sensitization syndrome (13/31)
Pain-of-guilt inhibition syndrome (321)
Diffuse, somatically focused anxiety (137)

ADAPTATIONS INVOLVING IMPAIRED BONDING

Shallow bonded, ambivalent depression (274)
Rejection sensitization (34)
Unfairness sensitization (46)
Sexualized abusive-tension reduction (482/248)
As if always contingent caring (49)
The alienated predator (489)

REALITY CONFUSION

Nightmare dissociative escape (83/138)
Attack threat bewilderment (86)
Inferiority identity (87)
Overcompensation for a demeaningly and punitively disfavored childhood (98)

CONTROL ISSUES

Sensitization to the pain of humiliation (36)
Performance-control issues (93/139)
Exploitation sensitization (96)

LOSS-DEPRESSION SYNDROMES

Proposed diagnosis: BRAVELY SMILING, UNFINISHED GRIEF SYNDROME

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

MMPI/MMPI-2 code: 231/213

Prototypic characteristics: tearful eyes with smiling mouth; interpersonally inhibited, too-nice 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., West, Blumberg, & Ellis, 1952), and general risk of morbidity is increased (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., 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 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 the his/her own life. The person becomes acutely sensitized and strongly reactive to the defeat of personal expectations and to losses of hopes and goals.

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.

Proposed diagnosis: FAILED RESPONSIBILITY DEPRESSION

Adaptation to: high responsibilities with an insufficient amount of positive attention and approval

Traditional diagnosis: major depressive episode (may have strongly vegetative elements)

MMPI/MMPI-2 code: 273/723

Prototypic characteristics: acute worrying and depressed feelings over shortcomings of personal performance and preoccupied about unmet responsibilities, the person feels insecure and easily overwhelmed despite what may be relatively good achievements ('What is going to go wrong next?'). There are strong inhibitions of anger, denials of resentments, and an impaired ability to assert him/herself and to accept h/her own self-satisfying or self-gratifying impulses.

Contributory shaping history: high responsibilities at too early an age (e.g., as the oldest or the 'most responsible' sibling). Commonly the mother is seen as anxious and perfectionistic ('Yes, you did what I told you, but you know you can do better.'). The person becomes strongly sensitized to devaluations of his/her actions and shortcomings, to being seen as insufficient and unsatisfactory, and as providing less than the family or others deserve. The person learns to expect a withholding of attention and other rewards whenever judged negatively. The internalization of these traits subsequently comes out as perfectionistic expectations of the spouse, other family members, and/or subordinates. They fall apart as adults when overwhelmed by unexpected increments of responsibility. Self-putdowns elicit approving reassurances (with short-lived effects that do not relieve the ongoing depression and guilt, the same as it was in childhood). When imminent demands are reduced, they can go back to being responsible, but they need to develop an acceptance of pleasing themselves and having fun, even if responsibilities are not perfectly met.

For codetype information see Gilberstadt and Duker, 1965, Gynther, Altman, and Sletten, 1973; Kelley and King, 1977; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974.

Proposed diagnosis: INTERNALIZED CONDEMNATION SYNDROME

Adaptation to: unrelieved parental/familial condemnation

Traditional diagnosis: major depressive episode (descriptively a chronic, 'endogenous' depression, often strongly vegetative, especially if 4-Pd is not much elevated)

MMPI/MMPI-2 code: 2-7-8 (any order except 8 is less than or not much greater than 7 [28/82 becomes a capitulated depression], and 2 is not 10 points or lower than both 7 and 8 [78/87 becomes inferiority identity])

Prototypic characteristics: a longstanding depression usually of no volunteered onset. As if forever worrying, tense, and guilt-ridden, the person may feel plagued by obsessive feelings of inferiority and inadequacy and may have 'horrible' nightmares. Early morning ruminations can be very distressing and sleep-destroying. At more severe levels the person may show psychomotor slowing and/or a blunting of affect (if 4-Pd not much elevated as noted). There may also be distressing neurologic-like symptoms such as numbness, muscles twitching, heart symptoms, bothersome muscular movements, and a pain 'in the pit of my stomach.' This is the greatest suicide risk of all MMPI code types. Beware a deceptive absence of past suicide attempts in combination with years of suicidal rumination: there is a major risk that if an attempt is made, it will be successful.

Contributory shaping history: often the focus of open rejection in childhood, of stern, critical, and demeaning family attitudes. Personal peculiarities may have been the target of teasing and ridicule. Note the triangulation of: (1) a parent with strict or unattainably high values and expectations, (2) these values were rigidly enforced, and (3) the parent particularly disliked the patient as a child ('You never get it right, do you?'). More often a mother-child identity issue, it may be father-child, if the mother died relatively early in the patient's childhood, and especially if the child was made to feel responsible, or both parents may be against the child). The condemnations and rigidity of too-high expectations become strongly internalized so that successes are nevertheless seen as failures.

As an adult, the person typically becomes acutely sensitive to any attitudes in others or events that are perceived as confirming basic defects of the self or even relatively minor personal deficiencies. Some show a schizoid distancing from others; when married, the marriages seem empty of affection. Some become 'perpetual students'

with interests in obscure subjects such as philosophical and religious ideas. Many seem to be searching for the meaning of life in the absence of pleasure. Although usually presaged by negative family attitudes and often depressions in the family, a sufficiently catastrophic turn of life events with a perception of no real hope from any source can induce this internalized condemnation depression. I suspect this is commonly the final stage that many depressions gravitate into prior to the person's suicide (I accumulated have a few testings shortly before suicide, and they are consistently of this pattern). Gradually introducing the fact that a suicide is a killing, and then that killings (of all sorts) are profoundly damaging to the survivors, can disrupt the assertion that 'everyone has a right to put an end to their suffering, don't they, doctor?' The client's anger at you for overturning that applecart is a vital first step in helping the person to engage the flip side of anger only at the self (because that is the only direction of anger that was ever safe in childhood).

For codetype information see Gilberstadt and Duker, 1965, Kelley and King, 1977; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974.

Proposed diagnosis: MARTYRED DEPRESSION

Adaptation to: mean or cruel deprivation of love and positive attention

Traditional diagnosis: major depressive episode, often with paranoid elements

MMPI/MMPI-2 code: 26/62

Prototypic characteristics: a wounded, resentful, brooding depression. Criticisms and emotional hurts are felt as personally targeted (even if others have different perceptions of the 'attacking' person's motives). To forgive is to risk putting oneself into an intolerable level of vulnerability. The person becomes self-protective via an acute alertness to cruelty and withholding by others. With Si elevated and especially for women, the person may be painfully sensitive to any facial scarring or body dysmorphia.

Contributory shaping history: Threats of a parent's temper (or other family tempers) associated with mean-spirited punishments of the child are experienced as coercively controlling of the child's will. Frightening outbursts of temper by parents or others are shielded against by a victimized role fut a position in which the person is especially slow to forgive. The person as a child may have been the focus of 'cold silence' treatment, and if so (and

Si is at all elevated) becomes prone to retaliate with a 'clammed up' silence against others.

The wounded victim childhood persists into an adult role as martyred by the tempers and coercive aggressions of others as well as what is perceived as cruel withholding by others. Some clients have gotten caught in perceived traps in which any self-assertive action is guaranteed to make things worse. Over time such a circumstance can entrench this suffering martyrdom. How much the perception of being in such a trap is only of recent development or is in part predisposed by earlier experiences is sometimes a difficult clinical question.

For codetype information see Archer, Griffin, and Aiduk, 1995; Gilberstadt and Duker, 1965; Kelley and King, 1979c; Kelley and King, 1980.

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 'negative symptom' schizophrenic

MMPI/MMPI-2 code: 28/82

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; there are 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 was delayed over half a year on the average (Marks & Seeman, 1963).

In more recent onset cases, this adaptation may have 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 hopeless 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 stasis seems to the observer.

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.

Proposed diagnosis: LABILE MOOD SYNDROME

Adaptation to: low threshold for abrupt mood changes

Traditional diagnosis: rapidly cycling or shifting cyclothymic disorder is closest

MMPI/MMPI-2 code: 29/92

Prototypic characteristics: moods may change rapidly over days or hours, sometimes quite abruptly. There is often a strong achievement focus with acute but fluctuating upsets over self-perceived shortcomings; the person may be preoccupied with and driven by endless self-judgments. A quick temper (even in the absence of 4-Pd, 6-Pa, and 8-Sc) can cause sincere guilt for having lashed out. Intrapersonal emotional conflicts are often open and intense. Each interview may be a strongly emotional occasion around a new, recent crisis.

Contributory shaping history: The affectivity often has a strongly organic/biologic feeling to it. Positive neuropsychological findings would be important, but if subcortical (which would better fit the lability), they may be hard to demonstrate. The lability may also involve a family history of intensely emotional family members (e.g., degrees of bipolar genetics) so that the person as a child had to express emotions strongly to overcome the high background emotional 'noise' and fluctuating family thresholds for responding. There is a marked sensitivity to judgments by others that are seen as confirming prior negative self-judgments. (This is a relatively rare code in psychiatric populations but very distinctive when encountered.)

I do not have case data on adult onsets of this syndrome. I would expect a degree of the biologic disposition to have been present even if not previously expressed in obviously problematic ways; it would be an imminent threat of the frustration of strongly desired goals or a major defeat of positive expectations that would most likely precipitate this level of lability. The distraction of attention may serve in part to interrupt and moderate rising escalations of emotional arousal.

SOMATICALLY FOCUSED FEARS

Proposed diagnosis: PERVASIVE HEALTH SENSITIZATION SYNDROME

Adaptation to: overwhelming experiences of the imminence of dying

Traditional diagnosis: somatization disorder (lower K) or hypochondriacal disorder (higher K) with depressive elements

MMPI/MMPI-2 code: 123

Prototypic characteristics: much subjective attention to bodily integrity with marked persistence of somatic complaints that are seen as lacking a sufficient organic basis. (Use 1-Hs as an index of the amount of attention that is health directed including the potential for fear-magnified complaints, but current physical illness is a medical determination.) General motoric inhibition (conditioned freeze response) and avoidance of physical risk-taking are noteworthy. Repetitive doctor-going and food-intake preoccupations are typical. This pattern more often occurring in men than in women, they orient toward medical treatment and go to mental health settings reluctantly. However, the physician's response, 'Your symptom (today) is definitely not life-threatening (reassurance), but you should get more exercise (threatening)' is a mixed message to these patients.

Contributory shaping history: the psychologically most potent occasions are body experiences that are perceived to be (1) debilitating and (2) progressive and 'downhill.' The debilitation is not only the perceived greater vulnerability to any threats to one's physical integrity, it is also the loss (2-D) of at least some if not many of the active, enjoyment-seeking parts of the person's life, and any downhill progression restimulates the health fears (1-Hs) and magnifies the imminence of dying. The person thus becomes sensitized to small or even the slightest changes of internal bodily discomforts. A physiologic instability may be quite real: Gilberstadt and Duker (1965) speculate a genetic element considering the similarity of symptoms in family members (still a nature-nurture conundrum at present).

This syndrome can follow chronic sickliness in childhood or catastrophic health experiences as an adult, e.g., a near suffocation experience, a severe electrical shock, a toxic exposure with an acute bodily reaction, or a fall from a high place without a loss of consciousness. The pursuit of health-care attention and needs for immediate relief as well as endless talking about their bodies can function to block out the previous terror of imminently

dying. Fear arousal via the confrontation of terrifying (e.g., near death) past experiences(s) is persistently avoided lest acute fear arousal will physiologically aggravate and worsen the already vulnerable health status, 'I can't talk about that.'.

For codetype information see Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973.

Proposed diagnosis: PAIN SENSITIZATION SYNDROME

Adaptation: mitigation of painfully hope-breaking inputs

Traditional diagnosis: conversion hysteria (which is mainly pain, much less often other more esoteric, 'classical' symptoms)

MMPI/MMPI-2 code: 31/13 (most typically 312/132 or 1 and 3 as 'spiked' elevations)

Prototypic characteristics: physical pain focused together with a grasping at hopes as well as at physical/medical sources of pain relief. The physical basis of the pain complaints is seen as medically insufficient to explain the extent and intensity of the complaints (even though there may be well-defined and typically distressing organic medical disorders). The individual presents as very trusting: 'I am a very friendly, reasonable person to whom this painful malady has befallen. I've had to be so brave.' Pollyanna attitudes mark the avoidance of the pain of face-to-face anger. Failures to 'see' conflicts or other imminently negative and upsetting outcomes can become a sort of 'emotional blindness.' (At the extreme, e.g., 3-Hy over 90, this blindness seems unbelievable to the less experienced observer, who then thinks it must be faked, 'nobody could be that blind!' but the shifts of attention described below are quite total.)

Contributory shaping history: such factors as multiple rejections and deprivations, poor families, rigid family values, and disorganized families can set the stage for the inhibiting of any negative emotions, of always 'looking the other way' in order not to make a painful situation worse. Note the incidence of pre-pubertal parental deaths in Marks & Seeman (1963): 60% of their 13/31 patients reported a significant 'parent death,' more than any other code type (with the related 231 at 55%, other codes considerably less). I believe the shift of attention toward a focus of hope (however faint and tenuous) is reinforced not only by reduced disapproval at an interpersonal level but also at a neurophysiologic level by conditioned metenkephalin/opioid synthesis. The longer-term impact of such conditioning is the suppression of the healthily normal emotional

expressions of grief and anguish at the time of an emotional upset; for some an acute or potentially overwhelming emotional pain, especially the juxtaposition of somatic pain with an intense fright, can only be expressed as physical pain. Some who are thus strongly pain-sensitized seem to lose the basic ability to distinguish emotional pain from bodily pain.

I believe sensitivities to any perceived threats to the person's hopes or sense of well-being lead to automatic shifts of attention lest a surge of pain become overwhelming. Over time these shifts become so automatic and smooth as not to be noticed by the person (nor even by the professional observer who is not oriented to be alert for them). I consider repression to be the outcome of innumerable shifts of attention away from some painful memory (a woman, who at age 5 looking out a window saw her father run over and killed by a truck, had not recalled the event for many years). The repetitive opioid reinforcements of these shifts increasingly makes the memory inaccessible. Conversion is the automatic shift of attention away from an emotionally distressing idea or other input onto a familiar habituated physical pain. Belle indifference is the absence of concern due to the habituation. Denial is the shift of attention away from an immediately distressing input. A postoperative patient was asked about her husband who rarely visited her in the hospital. Without a pause she said, 'Oh, he was here two days ago. Look at those beautiful flowers over there. Mrs. Freund brought those from her garden. Aren't those colors gorgeous!' Or, after a noticeable pause, another 31 patient reacted to Rorschach card VIII, 'Such beautiful colors! What do other people see in that?' It can be instructive to be alert to such shifts in an interview, and possibly in therapy to immediately point out, 'You just changed (or shifted) what we are talking about.'

For codetype information see Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974; Prokop, 1988.

Proposed diagnosis: PAIN-OF-GUILT INHIBITION SYNDROME

Adaptation to: induction of painful guilt for violation of family values or for any family disloyalty as a major means of parent-child control

Traditional diagnosis: major depressive episode with hysterical conversion features (approximate fit)

MMPI/MMPI-2 code: 321

Prototypic characteristics: inhibited in a wide range of areas, feeling tense and nervous, inadequate, and self-

doubting. (It should be noted that, in contrast to the male-frequent 123 code, this pattern occurs much more often in women than in men). This is often a persisting depression with feelings of inferiority, fatigue, and intropunitive behaviors. There may be transitory occasions when painful resentments 'break through' the inhibitions, but guilt is likely to follow quickly. In some cases there is a dominant physical complaint with a more or less urgent want of attention; in other cases there are multiple health concerns with extensive medical histories (the sympathy of physicians is often elicited, and they may initially underestimate or even miss the extent of emotional involvement in the physical symptoms). Weakness, tremor, hypertension, blackouts, gastrointestinal complaints, and various psychophysiologic breakdowns have been noted in various cases.

Intense conflicts around sexuality (and especially about pregnancy and childbirth for women) are typical; complaints of genital pain are noteworthy. Women with this syndrome who are in their 30's and 40's are very prone to get hysterectomies: sixty percent of Marks and Seeman's (1963) women with 321 profiles had had hysterectomies (vs. 25% for code 13/31 and neither 231 nor any other of their sixteen codes over 15%). Patients with this codetype are less frequently seen in psychiatric settings (which they typically avoid), presenting much more often in gynecologic treatment contexts (consider the often marked contrast of moods between gynecologic and obstetric wards).
Contributory shaping history: I believe that a low constitutional/biologic threshold for anxiety together with a penetrating induction of guilt are the most likely anchors to this syndrome. Loyalty to he family is stressed, 'never to reflect badly on our family's values,' along with strong if not very restrictive parental limits, the strictness coming from one or often both parents. Their criticism of the child's behavior that is not family-acceptable is guilt-inducing, and the child's guilt often appears central in the maintenance of parental/family strictures. Being tidy, physically clean, and reasonably friendly are reinforced by the avoidance of moments of painful judgment. Inhibitions may also be anchored strongly in the mother's religious values which the child internalizes, and in some cases the mother-daughter symbiosis can be lifelong. For example:

> A woman's delivery was experienced by her mother as very painful and frightening; the clinician's perception was that the mother had never 'let go' of that traumatic event. At age 19 the client had an

affair and fell deeply in love; after the man abruptly terminated the relationship, her less attractive facial features and rather bony and angular physique attracted few men, and when attracted, her ambivalences were overwhelming. After her father had departed, she could never 'move out' on her suffering mother, with whom she went to church with great regularity (as if her purpose in life were to expiate her original sin). Years later, she and her mother would quibble each evening as to who was suffering the most, the other being responsible for preparing dinner (mutual control via the pain of guilt).

A restricted range of personal pleasures appears to contribute to the chronicity of the depression. As the body feels the painful losses of what might have been that follow from the self-inhibitory confinement, a variety of somatic symptoms increasingly come to press for sympathetic treatment. Sexual inhibitions commonly appear to be strongly impressed on the child, and sexual relationships (e.g., teens, twenties) that end in painful rejection, a forced abortion, rejection by the only individual with whom this person has fallen unrestrainedly in love, or other perceived-as-tragic outcomes are apt to be very hard to get over and may even be suffered as life-dominating tragic events (as in the above case, limited physical attractiveness would not be a helpful attribute). Subsequent sexual and marital relationships are often marked by ambivalences that do not get resolved. Thus they become sharply sensitive to a wide range of threats from negative judgments to losses of hope to unexpected bodily sensations, being persistently unable to escape the guilt over their shortcomings.

The frequency of this pattern in psychotherapeutic and psychiatric settings is low (I obviously expect the common setting to be gynecologic services), so I have little data on adult symptom onsets. I would expect a consistency of issues of guilt over violating parental inhibitions and interpersonal loyalties to be commonly predisposing, and then an identity-crushing abandonment or rejection by a loved one would be the turning point for the onset of complaints that led to professional contact. Beyond an expectation of pervasive inhibitions, I also do not have data on this pattern in males; the key sample in Marks and Seeman, 1963, was all female.

For codetype information see Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974.

Proposed diagnosis: DIFFUSE, SOMATICALLY EMPHASIZED ANXIETY

Adaptation to: devastating and unpredictable separation and loss-of-emotional-support experiences

Traditional diagnosis: generalized anxiety disorder (a good fit although actually diagnosed GAD cases are more heterogeneous)

MMPI/MMPI-2 code: 37, 73, or 137 in any order

Prototypic characteristics: episodes or 'attacks' of diffuse anxiety and worrying (overlapping with but differentiable from the extreme physiologic aspects of one or a few panic attacks with resulting fears of leaving home lest another attack occur, etc., which latter on limited data seem more code 23/32 associated). The worrying seems to others to be about less important or 'off-target' concerns rather than the person's realistic problems, and the anxieties are seen as substantially disproportionate to events, For example, a physician who mostly delivered babies almost dropped a (slippery) newborn; he ceased working due to his anxiety not long after that. His hands trembled doing the block design test; I said, 'you look nervous.' He exclaimed, 'Wouldn't you be nervous if your hands shook like that?' There may be much anxiety about anxiety or future unpredictable floodings of apprehensions. Strong needs for repetitive 'showings of support' from others may lead to what are seen as clinging and reassurance-dependent (or reassurance-desperate) behaviors. Poor financial management along with these reassurance needs leads to a repeated seeking of extra bits of money from others. They are attracted to hobbies that facilitate daydreaming (e.g., highly preoccupied with an elaborate adult train set). When married (they often are), the spouse is often seen in sharp contrast as a capable and 'together' person.

Contributory shaping history: childhood histories vary from one extreme of having been babied and catered to to a contrasting extreme of having been severely rejected, particularly by punitive, brutal, and/or alcoholic fathers. Held-in tension (e.g., scale 1 and the freeze response) together with an unstable physiology, especially of the vascular system, is associated with unpredictable (scale 7) bodily/health breakdowns, so that the person may become phobic about illnesses. The fears are seen as rational but diffuse (e.g., worrying about worrying, scales 3 plus 7). Sometimes the mothers was very frightened that her child might be injured, and she had become highly protective of the child. As adults, these 1-3-7s are acutely dependent on their spouses and/or other responsible figures at times of

change, e.g., moving residences and changing jobs can precipitate episodes of persisting or even disabling anxiety. Thus, any cues to possible withdrawals of protection and support can elicit marked lowerings of the threshold for anxiety about a wide range of displaced points of focus. Survival is how you manage your relationships with authority figures, how you ingratiate them, sustain their nurturance toward you, and never turn them against you.

This is a relatively infrequent pattern. The cases I have known about seemed consistently to have longstanding anxieties. I have no data base on adult onset in the absence of any earlier history of anxieties. I would expect a low biologic threshold for anxiety with a certain amount of prior vulnerability, so that a mixture of health and financial setbacks could precipitate symptoms that had not previously been seen.

For codetype information see Gilberstadt and Duker, 1965.

ADAPTATIONS INVOLVING IMPAIRED BONDING

Proposed diagnosis: SHALLOW BONDED, AMBIVALENT DEPRESSION

Adaptation to: unpredictable losses and withdrawals of caring due to parental (and others') ambivalences

Traditional diagnosis: dysthymia, or chronic depression in a passive dependent personality disorder

MMPI/MMPI-2 code: 2-7-4 (any order, 7 at least somewhat greater than 8)

Prototypic characteristics: fearful, worrying, feelings of depression, and anxious over minor or even trivial matters with verbalizations of guilt and self-depreciations (e.g., the adult narrative summary in Marks, Seeman, and Haller, 1974). Impulsive, ill-judged actions may be seen as repeatedly self-defeating of the person's own longer-term goals: short-term tension reduction repeatedly overrides more distant goals. Typically the person has trouble getting to sleep but otherwise there are few or only mild vegetative signs of depression along with some shallowness of affect (e.g., a monotonous voice). They are markedly prone to use alcohol to relieve distress (Gilberstadt & Duker, 1965). As adults the person may attach to an older individual of the opposite sex in a dependent if not symbiotic parent-child fashion. Some when sober manage adequately in sales and in mechanical work with 'power'-related objects such as cars and aircraft..

Contributory shaping history: interpersonal bonding is shallow and undependable. A 'key' parent at times came to the child's rescue (often an ambivalent, demand-resenting rescue) but at other crucial times was emotionally 'not there' for the child. The 'key parent' is consistently of the opposite gender, i.e., focal mother-son and father-daughter relationships. The failures of parental/familial caring are unpredictable for the child, as the parent easily becomes self-interest absorbed, and the parent (with their own elevation on 4-Pd) may then react negatively to the needs of the child, with the parents 'turning on' and 'turning off' with little consideration for the child's feelings (note the sum of the consequences of 2 = loss, 4 = impaired bonding, and 7 = unpredictability). The lack of self-discipline appears to follow in part from the absence of consistent parental discipline. Note that alcohol is as if 'perfectly designed' to mitigate the depression (2), to relieve the boredom and anguish of life emptiness (4), and to dull the impact of unexpected negativities (7), the perfect answer to their tension and anxiety. The child effectively learns that sufficiently extreme self-blame

elicits short-term caring, but this results in more parental (and key other) turning off in repetitive cycles. The person is quickly sensitive to ambivalences and perceived indications of indifference in important others with an underlying fear that when you get badly hurt is when you care about someone who does not really care about you. The crucial other's occasions of self-preoccupation are readily misperceived as a turning off toward oneself; shallow and protectively ambivalent caring becomes the adaptive way to maintain a manageable level of emotional equilibrium and homeostatic stability.

For codetype information see Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973; Kelley and King, 1977c; Kelley and King, 1980; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974; Megargee, Carbonell, Bohn, and Sliger, 2001.

Proposed diagnosis: REJECTION-SENSITIZATION SYNDROME
Adaptation to: ever-present threat of rejection
Traditional diagnoses: elements of histrionic and narcissistic personality disorders, each a quite uneven fit
MMPI/MMPI-2 code: 34/43
Prototypic characteristics: seen as prone to role-playing: seeking to be seen as popular and 'nice,' the person may be perceived as sometimes playing desirable roles in artificial or phony ways with white lies and little deceits. The person is seen as pervasively denying of having personal problems, however obvious they may seem to others. Being a high school cheerleader is a natural outlet for 34/43s (enthusiastic responding as polarly opposite to rejection). A relatively strong to rigid overcontrol of anger with occasional accumulated outbursts or explosions of resentments would be typical. Some 43 males have choked their wives, seemingly to stop the criticisms they had not constructively confronted but could no longer endure. Talkativeness (often in a 'chatty' way) and a good initial impression can facilitate employment in sales work, and it may often be a protective 'teflon covering' if one goes into politics (the sale of one's image?). I believe the O-H scale adds to the 34/43 tendency to hold in resentments until too much comes out all at once, although 34/43 profiles elevated over T-70 or T-75 can be very explosive. These are the 'pit bulls' in Jacobsen's and Gottman's pit bull vs. 'cobra' distinction. Note Davis and Sines (1971) and Persons and Marks (1971) as a demonstration of the consistency of codetype behavior in two very different settings, i.e., clinical versus criminal.

Contributory shaping history: typically one or both parents were demanding of particular patterns of 'correct' behavior that do not challenge or upset that parent. The person is apt to have grown up under the threat of an explosive parental temper, and the child may have been struck one or a few (or numerous) times, even if denyingly minimizing of the importance of this in interviews as an adult. The parents are often more 'into themselves' than into the child. 'Good' behavior and 'white lies' that avoided rejection and punishment in childhood remain prominent in adult life. Strongly protective of their likeable and positive social role, much (often indirect) effort can go into avoiding social insult, physical punishment, or simply confrontational rejections; their outwardly sociable and enthusiastic behaviors protect against and conceal their fears of the pain of rejection.

For codetype information see Davis & Sines, 1971, Gilberstadt and Duker, 1965; Kelley and King, 1979a; King and Kelley, 1977; Persons & Marks, 1971.

Proposed diagnosis: UNFAIRNESS SENSITIZATION SYNDROME

Adaptation to: cold judgments with unduly harsh punishments
Traditional diagnosis: paranoid personality disorder
Typical MMPI/MMPI-2 code: 46/64
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, and they do not recognize their own anxieties and internal conflicts. 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 retaliative 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, adds 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. Lower N-P Index values are more associated with acting out, undercontrol of impulses, poor forethought, awareness of internal conflicts around intimacy and dependency, and self-dramatization.

Contributory shaping history: typically the parental expectations or rules are 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. 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.

Proposed diagnosis: SEXUALIZED ABUSIVE-TENSION REDUCTION SYNDROME

Adaptation to: mastery over sexualized abuse

Traditional diagnosis: borderline personality disorder

MMPI/MMPI-2 code: 48/84, may be a combination of 2-4-8 (in any order, but not 9 greater than each of 1, 2, 3, 6, and 7'see alienated predator for 4-8-9)

Prototypic characteristics: emotionally abusive adult relationships; sexual issues often a main focus with perverse if not overtly sadomasochistic sexuality. An impaired ability to trust others (if severe and valid MMPI-2 elevations, then extremely slow to trust) is associated with poor empathy if not an inability to 'read'others. Self-empathy to gauge the person's own feelings is also poor. 'Adrenalin rush seeking' behaviors such as shoplifting, problematic sexual encounters, 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 attempts under similar repetitive

circumstances. The coercion of rescue reassures the person that there may be reason for hope (2), that someone does care (4), and that one is seen as worth the effort to save them (8).

Contributory shaping history: when the development is from early life on, it is likely to have been shaped to an important degree by crucial occasions of overtly sexual abuse or of '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. Intimate physical contact in childhood may have been'or seem in memory to have been'always abusive, often with a lifelong impairment of trust. 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 (in a perhaps simplistic sense, I would associate the unawareness of or indifference to the impact on the children--and wife--with the 4-Pd and the twisted logic with the 8-Sc). In numerous cases, occasions of overt sexual abuse by trusted or unchallengeable adults, with some confounding elements of fascination, flattery, and pleasure by the child, were crucial turning points. The abuse was typically experienced as callous or cold to the person's own distress and protestations to stop (scale 4-Pd) and as deeply defiling of one's identity (scale 8-Sc): 'I can never ever be the same person I was.' Sexually 'turning on' a threatening person gains an important degree of control in both child and adult interactions, but when misinterpreted this can lead to re-victimization as an adult. Taking initiative in the recapitulation of sadomasochism in adult life (abusive personal relationships, aggressive social interactions, or overt sexuality) appears to represent a 'mastery' in the reversal from having been a helpless victim as a child to now being in control of the abusive adult interaction. Life situations that are experienced as being somehow abused in a situation that is out of one's control are likely to recharge the needs to again be the sexual master in order to overcome and dissipate the tension.

I have rarely (if ever) known of individuals where I felt that a relatively prototypic sexualized abuse syndrome was entirely of adult onset, although I could not unequivocally rule that out. Strong heritability of 4-Pd and 8-Sc in (DiLalla, Carey, Gottesman, & Bouchard, 1996) would also be consistent with a more lifelong pattern of

development. I have known of instances in which pre-existing tendencies were of limited or minimal disruption, e.g., a subdued vulnerability; then a severely abusive situation had potentiated those tendencies into centrally disruptive behaviors. As noted, the latter characteristically included suicidality and possibly suicide attempts.

For codetype information see Archer, Griffin, and Aiduk, 1995, Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974; Megargee, Carbonell, Bohn, and Sliger, 2001.

Proposed diagnosis: AS IF ALWAYS CONTINGENT CARING SYNDROME

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')

MMPI/MMPI-2 code: 49/94

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. They are often perceived as exploitative in their relationships (often drawn to other 49s, they may be mutually exploitative). 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/she 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 to some degree hypomanic) and some contribution to the elevation on 4-Pd may both be genetically influenced. Giving 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 himself/herself, 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.

Proposed diagnosis: THE ALIENATED PREDATOR SYNDROME

Adaptation to: pervasive, deeply alienating abuse

Traditional diagnosis: antisocial personality disorder

MMPI/MMPI-2 code: 4-8-9 (any order except not both 8 and 9 > 4, for which see Overcompensation for a Demeaningly and Punitively Disfavored Childhood, 98/89)

Prototypic characteristics: marked to severe underlying distrust; prone to lie (even while staring intently at you) or to actively conceal their own behavior to escape punishment. The person may be very skilled (well practiced) at telling the interviewer what the latter wants to hear (may be an 'artist' at escaping discipline). They are

capable of potentially dangerous 'adrenalin rush seeking' behavior, including both sexual and non-sexual aggression if not assaults as well as all kinds of high-risk activities, unrestrained drug and alcohol abuse, etc. Scale 6 as fourth in the code turns this all much more malicious and cruelly destructive. Without 6 up, it is seen more as endless manipulation; as noted in the report that 'manipulation and counter manipulation are the central realities of life.' Contributory shaping history: In some cases the abuse was of multiple forms and often consciencelessly exploitative or extreme, both physical and sexual abuse. The emotional disconnection is what would be expected if childhood touching and imitate contact had been consistently if not grossly abusive. Biologic factors may be strongly disposing, e.g., a congenitally unruly and trouble making child. Note the strong genetic component of all three scales in the Minnesota twin data (DiLalla, Carey, Gottesman, & Bouchard, 1996; the three scales 4-Pd, 8-Sc, and 9-Ma have heritability factors of 61%, 61%, and 55% respectively). Note also the data on low salivary cortisol in conduct disordered childhood (McBurnett, Lahey, Rathouz, & Loeber, 2000) associated with persistently disruptive aggression. These historical and biologic factors appear readily additive; conduct disordered childhoods continue into a physically and sexually aggressive--and with this pattern potentially predatory--adulthood.

Scales 8-Sc and 9-Ma and the 89/98 code type have associations with brain injuries and neuropsychological disorders. But I have never seen much connection between organic brain insults and the development of or substantial increases in elevations on 4-Pd. The only connection I have seen is the opposite direction, i.e., the 4 preceding the injury, 'f... them for trying to make me wear a helmet on my motorcycle.' What I have not seen is the development of a major degree of predatory psychopathy in the absence of any precursory experiences or tendencies.

The DSM-IV specifies a more or less lifelong pattern for Antisocial Personality Disorder or, as I prefer, The Alienated Predator Syndrome, and this is in agreement with the MMPI data. Nevertheless, as with other codes, the heritability values would attribute close to half of the elevations as due to experiential or 'environmental' contributions. In these latter I see the exploitative abuse discussed above as likely to be the most central factor in maximizing the predatory outcome: abuse that begets abuse.

For codetype information see Megargee, Carbonell, Bohn, and Sliger, 2001.

REALITY CONFUSION

Proposed diagnosis: NIGHTMARE DISSOCIATIVE ESCAPE SYNDROME

Adaptation to: incomprehensible and inescapable nightmarish experiences

Traditional diagnosis: no fit

MMPI/MMPI-2 code: 83, 38, or 138 in any order

Prototypic characteristics: a variety of somatic complaints, some that are somehow odd or peculiar; particularly code-distinct are disturbances of the focus of the person's attention including dizziness or fainting spells and often including atypical neurologic-like or questionably neurologic symptoms. The ruling out of an actual neurologic disorder is often a central issue since this can be either a neurologic profile or a pseudoneurologic profile (or both?). The most code-prototypic symptoms are dissociative 'spells' in which the person is in varying degrees disoriented as to what is going on around them. These spells can be brief, seconds or minutes, or they may last for and hour or two. Lesser spells are episodes of intense nervousness without specific disorientation. In one case a woman talked about very upsetting childhood scenes (in hindsight, too much arousal), and after the session she was seen walking out into a busy street at first oblivious of the blasting of car horns at her; in the next session she reported that, after the previous session, when driving home she had found herself in a distant part of town with no memory of how she got there. Sometimes these spells involve episodes of acute agitation, e.g., 'restless, overbearing, excitable, loud, short-tempered, and pacing' (Gilberstadt & Duker, 1965, p. 43) or of disconnected talking, but these transitory psychotic episodes of occasionally berserk excitement tend to be brief and to subside.

More than for any other code, there are visual problems such as blurry vision or odd visual sensations, e.g., 'blackness in front of me.' At the extreme, this is the only code with any frequency of visual hallucinations, e.g., 'I have a picture of Jesus Christ at the foot of my bed. I looked at him the other morning, and he was speaking to me. I could see his lips moving.' What seemingly should be very distressing complaints may be expressed with an odd absence of normally associated affect, e.g., a strangely flat reporting of unrelieved depression with suicidal ideation. There are distinct peculiarities in the stream of thought with unpredictable shifts of the focus of attention, often with no apparent connection or transition. A confusing

melange of religious, sexual, and possibly political preoccupations may be seen as naive and unrealistic.

These individuals lack internal self-structuring and are in need of structure and goal guidance. The person may have a history of doing well in highly structured situations, e.g., succeeding well in school where assignments were explicit and straightforward, but falling apart on graduation or after dropping out when choices were uncertain and without unequivocal direction. Thus the person needs assistance in staying focused on what is important to them and where they want their lives to go. Contributory shaping history: typically there were bewildering and terrifying childhood scenes, examples are such as frightening craziness by a family member, weird threats toward the (perhaps small) child (for example, a near-naked, schizophrenic uncle wandering around the house menacingly wielding a large screwdriver in the presence of his niece), observing intra-familial violence or similar horrors, or being present at other bizarre forms of morbidity or sexuality. Any infliction of pain in the midst of terror could greatly intensify the pain-fear underlay that drives scale 3-Hy and thus the person's sensitivity to possibly threatening bodily discomforts. As a little child there were no perceived-to-be-available, active escapes from these scenes, and the adaptation was dissociation as an 'internal' escape, a blocking or shutting off of perception. External expressions of affect also became shut down lest the person be overwhelmed and out of fear that an intense expression of emotion would increase the danger (e.g., by drawing it on oneself), or probably both. The spells then were the only way to escape unprocessable input, and the visual symptoms would have developed from the past needs to block out images of unbearable visual scenes. Over time, the sensitization is to any input or even hint of some thought or image that is threatening but not readily manageable, so the system automatically 'spaces out' in order to escape the pain and bewilderment. Even the odd switches of attention in the flow of the stream of thought seem to reflect a very momentary spacing out.

Often the mother (occasionally also the father) was dominant and rigid with a strong focus on religion. Dealing with her may have been the main source of organization of the child's emotional life. Later without her to react to, there was too little established self-organization.

This adaptation seems to date back to early years rather than to have a traumatic adult onset; the closest adult analogy would be torture, but for adults the images of

escape, retaliation, and so forth are in many ways different from those of early to middle childhood. It is definitely possible that the effects of early traumas of this sort may be masked for many years by circumstances in which the person's choices are consistently obvious and in effect pre-structured, and then this syndrome could be triggered by emotionally corresponding adult experiences. I am not personally aware of cases where that has appeared to be the case; I expect they would be seen by those who work with torture victims. Family histories of mental illnesses seem relatively common in my impression of clinical cases, but I have no data on this point (e.g., beyond the often extreme maternal dominance, it is rarely mentioned one way or the other in the Atlas cases, Hathaway & Meehl, 1951).

Although I believe this is fundamentally a dissociative disorder, the symptoms do not match any of the DSM categories. The 38 spells are often brief, e.g., minutes or rarely an hour or two with a full return to the person's identity. There is not a persisting loss of information as in Dissociative Amnesia; there is no extended travel with identity confusion as in Dissociative Fugue, there are no second or multiple personalities as in Dissociative Identity disorder; and they are not characterized by the sense of detachment from one's body or mental processes that is described under Depersonalization Disorder. Nevertheless, I think it is a more or less momentary dissociative escape from the prompting of unmanageable memories of nightmarish experiences.

See Gilberstadt and Duker, 1965; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974.

Proposed diagnosis: ATTACK THREAT BEWILDERMENT

Adaptation to: incomprehensible experiences of threat to your identity or your body

Traditional diagnosis: paranoid schizophrenia

MMPI/MMPI-2 code: 86/68

Prototypic characteristics: changeable persecutory ideation, possibly fluctuating or more fixed and persisting delusions, peculiar experiences and perhaps auditory hallucinations, marked to extreme distancing from others, and a potentially dangerous temper. There is typically an awareness of the person's own disturbed memory and mental struggles but otherwise poor insight. Seriously disturbed individuals, often with highly elevated profiles, keep a great deal of distance from everyone; they encourage liking by others considerably less than any other code type (Marks

& Seeman, 1963). Less disturbed individuals are cautiously selective as to who they let get close to them. This corresponds to what I believe to be the 'psychological distancing' quality assessed by Goldberg's Neurotic-Psychotic Index (1965; scales 6, 8, and L minus scales 3 and 7'consider the barricaded wall that would be anticipated from primary elevations on L, 6, and 8).
Contributory shaping history: disturbed and broken homes are typical with consistently poor socialization. Severe disturbances in one or more family members are not unusual but not invariant: a genetic vulnerability is undisputed, but its mechanism is still obscure. (I remain intrigued by the altered CNS functioning reported by Conrad & Scheibel, 1987, an apparently constitutional disorganization of the physical orienting of hippocampal neurons in deceased schizophrenics never treated with neuroleptics, a fundamental disruption of contextual meaning.) Irritability as a child often provoked punishment, sometimes very harsh (e.g., 'repeated thrashings' in about 50% of the Marks, Seeman, & Haller 86/68 adolescent sample, 1974). A disorganization of brain functioning would be an understandable basis for the bewilderment'the impaired ability to make sense of a dangerously threatening world (the brain is always trying to make sense of experience, but under severe duress a dysfunctional brain can make important interpretations that do not correspond to others' perceptions). Thus, thrashings, other physical punishments, being shouted and cursed at, and any other harsh punishments by one's own (to be beloved?) father and mother would be an overload to a derailed brain, a bewildering moment when reality easily gets misinterpreted. The punishments, as assaults on one's person, are then reflected in the elevations on 6-Pa, attack fear; an identity as defective, someone who gets incomprehensibly more abuse than anyone else, is reflected in the elevation on 8-Sc, identity hatred fear. And if the parent appears to enjoy thrashing the 'bad seed' out of you, the only thing that is certain may be that there is something profoundly bad in you. As adults they are acutely sensitized to any perceived threat of 'attack' on themselves, I believe to be a recapitulation of incomprehensible and assaultive childhood punishments.

For codetype information see Archer, Griffin, and Aiduk, 1995, Gynther, Altman, and Sletten, 1973; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974; Megargee, Carbonell, Bohn, and Sliger, 200.

Proposed diagnosis: INFERIORITY IDENTITY SYNDROME

Adaptation to: familial treatment as inferior, deficient, defective

Traditional diagnoses: (1) obsessive-compulsive (predominantly obsessive), or (2) marginally schizophrenic, in a few severe cases overtly schizophrenic with markedly obsessive ideation

MMPI/MMPI-2 code: 78/87

Prototypic characteristics: repetitive, obsessive preoccupations and a troubling if not pervasive sense of inferiority with feelings of inadequacy and debilitating anxieties. Easily intimidated socially even if not also shy, they are nevertheless quick to resent being 'babied.' They develop persisting difficulties'which can be significantly disabling--in sustaining concentrated attention. This persisting struggle impairs school and, later, work performances. Petulant and ineffective temper outbursts may precipitate ridicule, both in childhood and as adults. As adults they gravitate into subordinate or other-dominated roles and relationships. Adult occupations commonly are in work that does not require sustained intellectual concentration. They struggle in family and work situations over an immature and perfectionistic idealism that others do not match up to.

Contributory shaping history: familial (usually) treatment was as the 'inferior sibling' from an early age, along with an often babying kind of protection by parents and possibly older siblings. Males are often dominated by strict fathers and stronger older brothers. Constitutional factors may be ambiguous but are often suspected; Gilberstadt and Duker postulated an 'inherent anxiety.' Thus the adaptation may be due in part to constitutional limitations that provoke the negative family attitudes. Ridicule of personal habits such as food finickiness, stammering, and especially enuresis may deeply damage their self-esteem. One mother hung her son's wet bed sheets across the front porch for the other schoolchildren to see on their way to school, hoping to motivate him to stop bed-wetting. Simplistically, the 8-Sc is the internalization of the dislike and hatred of one's identity by family members and peers, and the 7-Pt is the painful unpredictability of teasing, of when and for what you will next be ridiculed, and all the other endless and unexpected negative inputs. They seem unable to respond directly or strongly to criticism or teasing by others. Instead, they may 'buy it off' (undoing) via open self-criticisms that overtake or exceed those coming from others, a self-negating way to take control over hostile input.

This is typically done with a touchy irritability, although the habituation of the self-negations helps to minimize the sting.

For codetype information see Archer, Griffin, and Aiduk, 1995; Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973; Kelley and King, 1980.

Proposed diagnosis: OVERCOMPENSATION FOR A DEMEANINGLY AND PUNITIVELY DISFAVORED CHILDHOOD

Adaptation as: overcompensation for demeaning and punitive disfavorment

Traditional diagnosis: least disturbed as mild hypomanic (at times 'tangential' or 'inappropriate'); more severe descriptively as 'schizo-manic' excitability; extreme is catatonic

MMPI/MMPI-2 code: 98/89

Prototypic characteristics: talkative but easily tangential if not overtalkative and openly digressive; under stress speech may vary from rapid to retarded. The energy and activity levels are notably high, as high or higher than any other code type. The threshold for intense emotional reactions is apt to be low to very low--they are readily upset as well as provocative and agitating of others. This includes a low threshold for aggression, which is rarely an alien concept for these individuals; at more severe levels, these outbursts can become dangerous. Socially the person may be seen as immature and regressive. Laughter can be a loud and often short staccato burst with a sudden termination; others may find it startling and disconcerting.

At relatively severe levels, when the person is threatened and becomes excited, thinking can become overideational or ruminative with some flight of ideas. Personal gestures are distinct if not in some way peculiar, stiff, or awkward; at severely disturbed levels there may be bizarre posturing. During an acute or severe phase, the person can be seriously uncontrolled, e.g., possible hyperactive psychotic episodes that are driven by delusions and hallucinations with a potential for dangerously assaultive acts. The extreme is a catatonic excitement or a collapse or 'flip' into rigid immobility. They also are at risk for self-mutilation in order to escape from a hated or intolerable circumstance (exceptional levels of adrenalin may enable this by masking physical pain). Religious convictions are commonly intertwined in the person's stream of thought (perhaps following twists and turns of the mother's religious strictures), and these beliefs may be

highly unorthodox or, as noted, delusional. One inpatient firmly asserted that 'for the purity of society, all prostitutes must be eliminated.' Another complained loudly about smelling the stench of sin.

Problems are apt to be handled in personally stereotyped ways. Achievements consistently fall short of unrealistic or far-too-high asserted self-expectations. Job satisfaction and adjustment are poor, often with intense frustration. They are strongly prone to feel they should be in different (and usually more esteemed) jobs; as in childhood, this latter assertion may serve in part to blunt criticism of the current work performance. Sexual identity issues are quite frequent. Adult love relationships are conflicted and often break down; marriages are relatively infrequent and rarely successful.

Contributory shaping history: typically put down and disfavored in demeaning and negative comparisons to better organized and more accomplished siblings or other family members. Unruliness driven by hyper energy as a child often drew harsh and abusive punishment from both the father and the mother; the father may be especially intimidating toward the child and the mother especially will and value dominant. The relationship between the parents typically was openly conflicted and unstable often ending in divorce, and some of their anger is likely to have been displaced as dominance and cruelty toward the child. This parental dominance and intimidation is then recapitulated by the child in the dominance and intimidation of smaller, younger, or otherwise more vulnerable children: this is the bully pattern on the MMPI. The bullying is a discharge of the child's punishment tension as well as a mastery experience to override what may have been experienced as staggering abuse. The emergence of unrealistic if not somehow grandiose self-expectations and expressed life goals appears to compensate for the failures of achievement and identity insults as well as the family and other contextual denigrations; the assertion of such improbable self-expectations may have a blocking effect on the demeaning parental put-downs.

The disfavoring comparisons by family members and others make them acutely sensitive as teens and adults to any real or perceived rejections by a lover in favor of a 'superior' rival. Some then 'run away' from such a disfavorment by suddenly deciding they must be homosexual. Thus, overcompensations for these issues of punitive criticism and disfavorment come to dominate much of the person's life.

There often appear to be substantial genetic/ physiologic contributions to both the hyper aspects (9-Ma) and the ideational distortions (8-Sc), which would presumably heighten the likelihood of provocative hyper qualities as well as increasing the vulnerability to the kinds of childhood abuse described. Such contributions would be supported by the Minnesota twin data (the heritability factors of 55% for 9 and 61% for 8, DiLalla, Carey, Gottesman, & Bouchard, 1996, 1996) as well perhaps as relatively positive medication responses if they stay on their meds. In some cases the abuse is so marked as to make the biologic contribution obscure; in other cases the abuse seems in major degree to have been a desperate attempt to try to control a child who was wild and unmanageable almost from birth on.

Aside from the potential temporal fluctuations of scales 8 and 9 over time, as well as 2-D, 6-Pa, and 7-Pt, etc., this appears to be a longterm and persisting pattern of behavior. I do not recall having seen it in circumstances of origination in adult life with one exception. This is the occurrence of 89/98 profiles in a subset of individuals with serious brain traumas. These people oddly may not show the hyperactive pressures usually associated with the codetype, sometimes relatively active but in other cases hardly so at all. I think of this as a variant of the 'spurious 9" effect: a high 9 without apparently intense internal pressures. The Harris and Lingoes' subscales do not seem to help differentiate this effect. My hypothesis is that somehow the item responses partly reflect a major difficulty in keeping their mind in focus. I do not know whether they are responding more to the subjective feelings of aggression expressed in the items (out of intense frustration, e.g., an impulse to do something harmful or shocking) or the inability to stay mentally in focus without a working sample of such profiles.

For codetype information see Gilberstadt and Duker, 1965; Gynther, Altman, and Sletten, 1973; Marks and Seeman, 1963; Marks, Seeman, and Haller, 1974; Megargee, Carbonell, Bohn, and Sliger, 2001.

CONTROL ISSUES

Proposed diagnosis: SENSITIZATION TO THE PAIN OF HUMILIATION

Adaptation to: being controlled by threat of personal and social humiliation

Traditional diagnosis: no fit

MMPI/MMPI-2 code: 36, 63, or 136 in any order

Prototypic characteristics: strongly sensitive to criticism; follows strict ethical values that avoid being put down. Although trying to be forgiving, they momentarily can become sharply critical of someone they perceive to have demeaned or insulted them. They usually are well-dressed and well-bathed, often very aware of physical presentation and attractiveness in self and others. This was the modal code in the early Hathaway and Monachesi adolescent research identifying high school girls who subsequently entered beauty queen contests, and the code is relatively often associated with physical beauty in women. In adult women for whom physical beauty or the consciousness of or pride in physical appearance become a too vital part of their identity, aging can be a very difficult transition (e.g., observe the response of women clients with this syndrome to card 13F of the TAT). On limited data, it is my impression that 36/63 males like 'nice' or more formal dress or possibly uniforms. As scales 1-Hs and 3-Hy become elevated over T-65, they are likely to have a variety of physical complaints, e.g., headaches, fainting spells, or (almost specific to this pattern) joint pain'the latter probably from holding the body and limbs 'too correctly.'

Often they are achievement and self-advancement oriented; having a knowledge base that avoids being criticized as not well informed or embarrassed as ignorant can become quite important. The person is likely to be seen as strongly value-controlling in adult relationships, both as self-control and as a moral value-based control of others. For some this derives from strict religious values. Others may find the 36/63 person self-righteous: note whether the raw score on the 'self-righteousness subscale' Pa3 is 7, 8, or all 9 items. If, for example, one's spouse is perceived as humiliating or disgracing one in public, the divorce proceedings are apt to become very painful and unforgiving.

Contributory shaping history: acute humiliations as a child, perhaps especially in front of family members, with will-coercive pressures to behave according to parental

values and expectations in a 'more mature' or 'adult' way even at an early age. There can be an identity conflict of markedly contrasting parents, e.g., the father is impulsively self-gratifying and the mother is highly moralistic: 'What does that make me--I come from both of them?' Past family tensions and resentments are covered over and evaded or denied in a vigilant avoidance of social embarrassments; this may be the sibling that most carefully opts to avoid public humiliation. The readiness to perceive psychotherapy as a threatening engagement needs to be handled carefully.

For women, one of the attention-drawing consequences of beauty often seems to be experiences of male attention as the threat of an impersonal assault on her body, again a will-coercive threat (which is the major connection between 36/63 and beauty). Sexual histories often are active; private and mutually pursued and shared sexual affection is in many ways a polar opposite to public harassment, humiliation by frustrated males, and motivated deception, hence sought-after intimacy is a desirable relief. The person (male or female) is likely to be sharply and self-protectively sensitive to honesty vs. dishonesty both in themselves and others; dichotomously, the other person may become either an always-trusted ally or has told a hurtful untruth and is therefore to be shut out or at least never completely trusted. Thus, life adaptation becomes the maintenance of a role that is 'above criticism' while controlling others 'for their own good.'

Proposed diagnosis: PERFORMANCE-CONTROL ISSUES SYNDROME
Adaptation to: perfectionistic parental expectations (milder), impossibly high expectations (more severe)
Traditional diagnosis: no fit; elements of hypomanic performance pressure and hysteroid denial
MMPI/MMPI-2 code: 93, 39, or 139 in any order
Prototypic characteristics: perfectionistic demands of self and others; relatively high achievement expectations and ambitions; and experienced by others as unwantedly controlling. Cutting remarks and occasional 'spell-like' explosive outbursts can be a focal problem: if the person is less disturbed, then the possibility of another outburst is experienced as interpersonally controlling; with higher profile elevations, the outbursts are increasingly disruptive and threatening. These outbursts are often a source of marital conflict if married as well as distress in their other close relationships; antagonistic in-law conflicts and divorces are common. Somatic concerns tend to

be acute and dramatic but transitory, e.g., abdominal and back pain, eye complaints, hearing loss, headaches, numbness, tremor, or odd neurologic symptoms. There may be an abrupt hysterical conversion episode if scales 1 and 3 are elevated in a 'V' configuration with scale 3 five to ten T-score points or more above 2; the symptoms can disappear just as suddenly as they came on.

There may be gaps of memory, most likely of painful events or uncomfortable and unwanted information. There is often some degree of hypomanic coloring such as inflated self-esteem and unduly optimistic expectations. Occasional paranoid ideas seem more to focus attention externally and away from internal conflicts rather than as a protective adaptation against any recurrence of past severe physical punishments.

Contributory shaping history: relatively ambitious if not high achievement expectations and pressures on an energetic child, and the child may have been pushed to ever higher and possibly never-quite-reachable performance levels--a judgment or critique is always just around the corner. The parents may show the child off as unusually talented or perfect. An unsatisfactory performance can provoke urgent verbal disapproval or a dismaying withholding of rewards; in more severe cases there may be inflexible and strict if not castigating parental judgments and anguishing punishments (elevated 139's are notoriously explosive as acutely upsetting past punishments set the stage for the present releases of over-accumulated tensions when under intense stress). There may be a subtle but strong encouragement of an imperturbable self-presentation: one should not lose one's composure. Needs for positive attention and praise are strong and persistent, probably the recapitulation of what were the 'best moments' in their childhoods. These sensitizations make the person sharply reactive to criticism and yet critical of less than perfect performances of their spouses and other family members. Living one's life is, after all, a performance.

The energy level (anticipated by the 9-Ma) is likely to have some genetic contribution, e.g., other family members are also described as active and energetic. When stresses are moderate and not threatening, the person (with milder MMPI-2 elevations) can maneuver for long periods of time in smooth and effective ways, but increasing demands and especially the imminent threat of a defeat of a major personal goals or of a failure of ambitions can escalate the amount of tension that has to be held in. The intensity of

an unexpected outburst can then be startling to those who are close to the individual.

For codetype information see Gilberstadt and Duker, 1965; Kelley and King, 1979a

Proposed diagnosis: EXPLOITATION SENSITIZATION SYNDROME

Adaptation to: coercive exploitation

Traditional diagnosis: usually this is a distinct personality type with no diagnostic fit, especially if the profile is close to or within the normal range; if the disturbance is more severe, then often paranoid: paranoid personality, paranoia, or at the extreme an atypical paranoid schizophrenia, or else a bipolar manic episode with paranoid elements.

MMPI/MMPI-2 code: 69/96

Prototypic characteristics: readily elicited security vigilance around any threats that are perceived as coercive or exploitative. Tense, high-strung, and jumpy when threatened, the person can be too quick to make emergency responses to perceived dangers and very sensitive to any judgments of personal failure or of public insult or rejection. The person may also have a self-righteous temper and be quite slow to forgive. When agitated or upset, thinking may go off in directions others see as irrelevant. Multiple pursuits and activities may distract attention away from points of distressing frustration, but hypomanic elements most often stop short of overtly manic episodes. In a few cases, there are florid manic episodes with marked hyperactivity, and ideas of reference can shade into persecutory delusions.

Contributory shaping history: may have felt taken advantage of or exploited as a child, such as having to help take care of a disabled or impaired family member with quite limited attention to self and feelings of having been denied desired self-gratifications. This leads to an adult overprotection against being victimized by anyone. Typically one or both parents are strict but not necessarily without affection. One of the parent-child relationships may well have been notably tense even though the expected resentments may (or may not) later be covered over or very slow to be admitted. But rigid punishment can lead to resentments of perceived 'wrongs' or undeserved deprivations by others. Parental pressures may induce an internalization of too high or expansive self-expectations. The adaptive focus is on external threats and frustrations and consistently away from personal shortcomings.

There are often strong pressures to succeed as an adult. But the development of a critical, demanding, or hostile relationship that recapitulates (perhaps desperately) aversive childhood experiences is apt to be very difficult for the person to manage, e.g., spouse, in-laws, at work, etc. This then can eventually precipitate the emergence of symptoms that had not been evident or present for many years. There may also be important biologic contributions to the strong affective pressures (this presumption would appear to be supported by the heritability loading in the (DiLalla, Carey, Gottesman, & Bouchard, 1996) as well as by consistently positive responses to anti-manic medications).

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

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[[**A main #1, elevated**]]

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 level of disturbance; a person with a less elevated profile may show only limited or selected aspects of this description and those to a milder degree. 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 matching this code type. About two thirds of the reports currently processed will have these paragraphs'the other third 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 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 sakes, don't hesitate to send me a note.

[[**B main #2 unelevated**]]

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; less elevated profiles, as in this case, will likely show only a few selected aspects of this description and those to a milder degree. 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 as to how the individual 'got this way.' This prototype material will always be the same for any profile matching this code type. About two thirds of the reports currently processed will have these paragraphs'the other third 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 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 sakes, don't hesitate to send me a note.

[[**C no etiology pp,**]]

At present I have not formulated a set of etiologic/developmental hypotheses paragraphs for about one-third of the reports we are preparing, including one for the codetype to which this profile corresponds. I regret any disappointment this may cause. I felt it better to make the material available for all the patterns that are covered than to hold it off indefinitely until all possible profiles have been covered.

If you have information on this individual as to any particular 'turning point' experiences in this person's life or early shaping experiences that subsequently had major behavioral consequences, I would greatly appreciate a note describing them. A consistency across cases of such inputs within a codetype will be most helpful in formulating hypotheses. The Atlas and other such sources can then help me validate the generality of the attitudes and events to be considered.

[[**D no etiology pp, nondefensive C-dash,**
all of:
RL < 9
T Mp < 65
T Sd < 65]]

At present I have not formulated a set of etiologic/developmental hypotheses paragraphs for about one-third of the reports we are preparing, including one for the codetype to which this profile corresponds. I regret any disappointment this may cause. I felt it better to make the material available for all the patterns that are covered than to hold it off indefinitely until all possible profiles have been covered.

This is the one pattern for which I may never be able to generate a specific developmental pattern. The predictions would essentially be about relatively healthy and wholesome childhood experiences and either a subsequent absence of major traumatic adult experiences of possibly a confidence and self-esteem-enhancing history of having overcome any such traumas. A note regarding any evidence supporting or rebutting such expectations for this individual would be much appreciated.

[[**E no etiology pp, defensive C-dash, not the preceding rule**]]

At present I have not formulated a set of etiologic/developmental hypotheses paragraphs for about one-third of the reports we are preparing, including one for the codetype to which this profile corresponds. I regret any disappointment this may cause. I felt it better to make the material available for all the patterns that are covered than to hold it off indefinitely until all possible profiles have been covered.

The defensiveness makes the relative normality of this profile questionable, i.e., as discussed in the narrative report, there may be more disturbance than has been admitted. If this person is showing problematic or disturbed behaviors, then any information you could provide me on this individual as to particular 'turning point' experiences in this person's life or early shaping experiences that subsequently had major behavioral consequences would be greatly appreciated.