

Chapter Eleven

ILLUSTRATIVE CASE REPORT

Like the results of any psychological test, those of the MMPI-2 may be interpreted “blind,” in isolation from information that specifies the setting and circumstances of testing, the examinee’s demographic position, legal status, presenting problems, reason for referral, history, and mental status. Without such information, interpretation must emphasize those actuarial features of the test that derive from research and clinical lore, the empirical correlates of scales, and the patterns they create as the basis for clinical prediction and personality description. In many situations a test-centered approach may be preferable, particularly when test results may figure in a current or future legal proceeding. In most routine clinical situations, however, the goals of assessment include an enhanced understanding of the patient within the context of his or her unique set of life circumstances, which requires blending test data with extra-test information that will enable the former to be construed in terms of the latter. The person-centered approach is especially apropos when test results are intended to serve as a source of feedback to the patient to enhance self-understanding, to select appropriate treatment measures and methods, or to enlarge the shared understandings between patient and clinician to strengthen the treatment contract and its focus.

BACKGROUND INFORMATION

Demographic information should include age, gender, marital status, educational attainment, usual occupation, and employment status. It is also helpful to have information regarding the patient’s sexual and religious preference, socioeconomic status/social class, and racial or ethnic group membership. Note if the patient’s native language is other than English, and list that language along with information about the patient’s instruction in and exposure to English, and whether the assessment was conducted in the native language with a translated version of the MMPI-2. Information regarding the setting or context of testing may specify private psychotherapy or assessment practice; psychiatric, neurological, or general medical setting; and whether the examinee is an inpatient or outpatient.

Assessments conducted in other settings should identify the type of setting or auspices and the purpose of the assessment: occupational (vocational or career counseling, vocational rehabilitation, employment screening, discipline, termination, promotion, sensitive occupations), domestic relations (conciliation, child custody), correctional (pretrial, presentence, prison classification), or disability (assessment of, eligibility for compensation, litigation/liability).

In some cases, information bearing on the patient's legal status may be important, whether the patient is voluntary and whether self-referred or other-referred and, if nonvoluntary, whether the assessment is court-mandated (e.g., for commitment, emergency care, police hold, including whether criminal charges are pending). The patient's legal status regarding competency, such as whether he or she is under conservatorship or guardianship, may also be relevant.

REASON FOR REFERRAL, PRESENTING PROBLEM, HISTORY, AND MENTAL STATUS

The presenting problem should be identified in both subjective (direct quote) and objective terms. If the reason for referral is different from the presenting problem (e.g., differential diagnosis, disposition or placement, recommendations for treatment), this should be noted. Personal history may include physical development including birth and complications, if any, normal milestones, and maturation. Social development may include information regarding family environment, the marital situation of the parents, the primary caretakers if they are not the parents, the patient's birth order, siblings and their ages, family atmosphere and relationships, methods of discipline, peer relationships and reference group(s), and delinquency. Information about educational and sexual development may cover school interest/motivation, favorite subjects, comportment, achievement, and any school problems; puberty, gender identification/preference, dating patterns, sexual information and initiation, and adjustment.

Information about adult development may include selection of an occupation, employment history (job changes, termination), occupational adjustment (responsibility, promotion, relations with coworkers, acceptance of supervision), marital history and adjustment, children, current living situation (apartment, house, renting vs. buying), current family and extrafamilial social supports, physical health status, and leisure activities and interests (hobbies, pastimes, etc.). Where indicated, history should include information about mental disorder: age and circumstances of onset, prior treatment and hospitalization, major life stresses, and response to treatment. When a personal history of mental disorder is present, family history should include information about mental illness and

hospitalization of first-, second-, and third-degree relatives, treatment and response to treatment, physical illness, addiction, criminality, and causes of death. Finally, as in all psychodiagnostic reports, detailed observations on mental status should be available.

The format of an MMPI-2 interpretive report may vary somewhat with the needs of the referrer and the preferences of the clinician preparing it, but a characteristic and flexible format includes, in order: a description of issues related to test validity, consistency, and test-taking attitude or accuracy; a general description of the profile, including its position in terms of the basic scale-level factor structure of the MMPI-2; a description of symptoms, complaints, attitudes, traits, dispositions, and other personality characteristics, including the patient's interpersonal/interactional style; a summary of the diagnostic implications of test findings; and a section elaborating on the implications of these findings for patient treatment or disposition. Within the main interpretive section of the report, some have found it convenient to present a brief introductory summary of the major implications of the profile and to subdivide test findings into categories of mood, cognition, interpersonal relations, and special problems (e.g., Nichols & Greene, 1995). Several report formats with samples for identical cases are available as examples in Friedman, Lewak, Nichols, and Webb (2001) and in Greene (2011).

Once the report format is selected, it is necessary to decide among various presentation styles. At one extreme is a style limited to the replicated empirical correlates of scale patterns (e.g., codetypes) and scores, and at the other extreme is a style that may limit the interpretation to the actual content of endorsed items (e.g., Greene & Nichols, 1995; Nichols & Greene, 1995). Both of these extremes have advantages and disadvantages, and either may be preferred for some circumstances and not for others. Moreover, for most codetypes, empirically derived profile correlates for the MMPI-2 are not yet available. Most commercial reports therefore reflect a combination of actuarial and empirical information with information from item content and blended with varying amounts of clinical lore. The Minnesota Report seeks to present findings that are maximally reliable by combining content and empirically supported relationships and is relatively conservative in exploiting scale patterning details. The Caldwell Report emphasizes empirically supported correlates and is much more exhaustive in exploiting inter-scale relationships, but it places less emphasis on item content. Regular users of the MMPI-2 should have experience with both reports.

The interpretive example that follows is formatted according to the outline given in Rapid Reference 11.1 and represents a hybrid of empirical and content-based approaches.

Rapid Reference 11.1

Outline for Sample MMPI-2 Report

- I. Protocol validity
 - A. Response omissions
 - B. Response consistency
 - C. Response accuracy
 - D. Test-taking attitude
- II. General description of profile
 - A. Profile code
 - B. Characteristics in terms of MMPI-2 factor structure
- III. Symptoms, problems, and complaints
 - A. Major interpretive implications (summary)
 - B. Mood
 - C. Cognition
 - D. Interpersonal relations
 - E. Other problems or issues
- IV. Diagnostic considerations
- V. Treatment considerations

THE CASE OF ANDREW M.

Reason for Referral

The patient is a 22-year-old, never-married Caucasian male high-school graduate with a Christian religious preference. He entered the hospital from another county on court commitment status as dangerous to self and others after refusing to eat, believing that his food was being poisoned, leading to a weight loss of more than 25% in 6 months and an assault on staff at another psychiatric facility. On admission to this hospital, he reported not knowing why he was hospitalized but suggested that staff in the previous facility thought he was not as “normal” as he should be. He was referred for assessment for differential diagnosis and treatment planning.

Background Information

The patient is the youngest of four siblings with three sisters 7, 8, and 10 years older, and he was born into an intact family of college-educated, middle-class

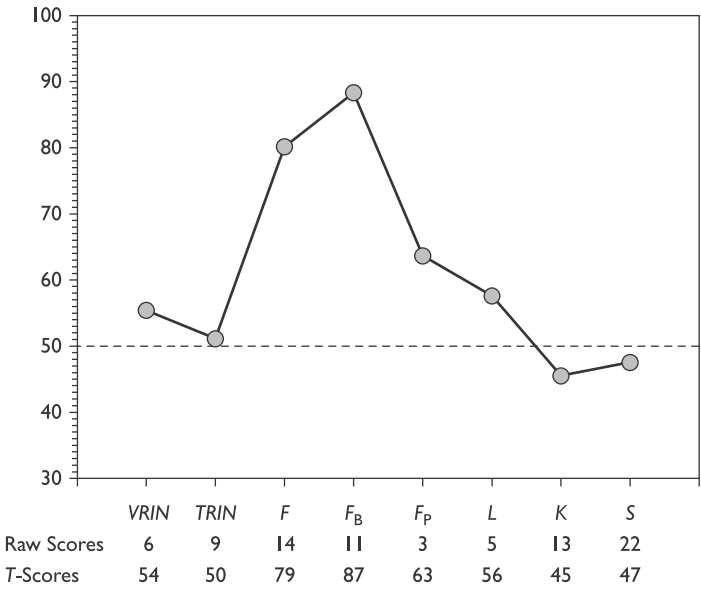
parents, the father an electrical engineer and the mother a staff writer for a newspaper. Delivery was normal and milestones were achieved on time, but the patient was hospitalized at 16 months for a severe bacterial infection. His parents divorced when the patient was age 2, and the mother remarried when the patient was 5. The mother retained primary custody, but visitations with his father were frequent until age 8, when the mother and her new husband relocated to another state. The patient got along well with both parents and siblings, had several peer friends, and enjoyed sports while growing up. Discipline in the home was relaxed. Comportment and achievement in school were average to above average, and the patient maintained a B average through the 10th grade, when he began to experiment with alcohol, marijuana, and later hallucinogenic mushrooms, ecstasy, and LSD. His grades deteriorated thereafter, but he was nevertheless able to graduate from high school on time. Sexual orientation is given as heterosexual but inactive. He had heterosexual friendships in high school and some thereafter, but he has never dated or been involved romantically. He has no occupation but has worked for brief periods at unskilled labor and in fast-food service. Family history is negative for mental disorder, but the patient describes his biological father as "alcoholic."

Onset of illness dates to age 16 with increased isolation, fear, suspiciousness, irritability, and beliefs that some of his peers wished to harm him, leading to fistfights on a few occasions. Substance abuse that had started with alcohol and marijuana gave way to hallucinogens in late high school, accompanied by ideas of reference and the belief that Eric Clapton was having his guitar-playing skills transferred to the patient. He was first hospitalized at age 18 after feeling his face "melting" following LSD use, and he was diagnosed with depression with psychotic features at that time. The etiologic significance of his substance abuse for the onset and persistence of illness was uncertain.

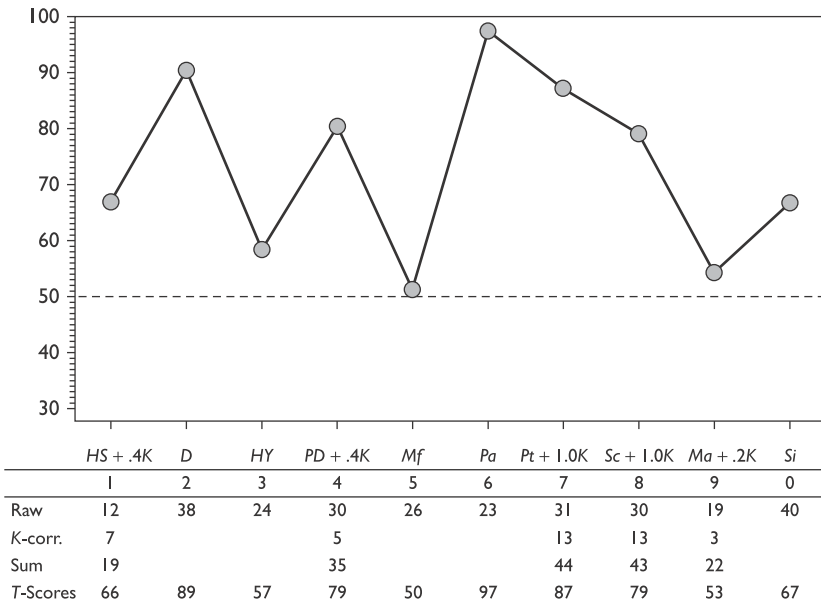
Admission mental status indicated the patient was oriented, alert, hyper-vigilant, and somewhat guarded. He exhibited mild psychomotor slowing with reduced movement and gesture and increased response latencies. Mood was moderately to severely depressed with suicidal ideation but no plan; mood was attributed to being in hospital. Affect was full range. Facies were typically serious, fearful, unhappy, or depressed. Thought was mildly to moderately disorganized with tangentiality and loss of track, especially when questions were not concrete. He reported being unsure whether he was hallucinating but thought he might be. Thought content was positive for somatic delusions, delusions of poisoning, and vague persecutory ideation about being mugged on the street and having a gun pointed at him. (The patient was badly beaten in a street fight two years earlier.) Memory and judgment were fair to good, but concentration was impaired. Insight was impaired to poor. He was considered to be at significant risk for suicide.

Initially he spent most of his time in his room and actively avoided interaction with staff. He was often seen in his bathroom staring at his face in the mirror. Sleep was undisturbed; energy appeared to be within normal limits. While out on the ward the patient appeared profusely hallucinated, apparently seeing things that were unseen by others, including faces in his room, was often seen staring or glaring at nothing in particular, and spoke of reading others' lips and speaking in a foreign language. Responses to questions were vague and mildly perplexed, with frequent losses of place in his stream of thought. He described his mood as depressed and fatigued and voiced concerns that others were confusing him with his father or stealing from his father. Worries that he had cancer of the genitals and a stricture in his throat were incorrigible to medical reassurance.

Figure 11.1 Validity Scales Profile for Andrew M.



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Figure 11.2 Clinical Scales Profile for Andrew M.

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Test Findings

Andrew initially refused to participate in psychodiagnostic assessment, but after a period of modest improvement on risperidone he agreed to cooperate with testing and was administered the MMPI-2 at 6 months after admission.

In the interpretive sections that follow, the scales and patterns deemed to warrant most of the inferences are given at the end of sentences in parentheses. The scales and patterns referenced are illustrative and selective rather than definitive and exhaustive. Rapid Reference 11.2 presents the patient’s scores for validity scales and indices; Rapid Reference 11.3 presents the patient’s scores for all other scales and subscales.

Rapid Reference 11.2

Validity Scale Scores and Indices for Andrew M.

(All scores are in T-scores unless otherwise noted.)

Omissions: Consistency:

Cannot Say (?) = 3 (raw) VRIN = 54

TRIN = 50

Accuracy:

F = 79

F_B = 87

F_P = 63

D_S = 65

F-K = 1 (raw)

L = 56

K = 45

S_S = 30

S = 47

SI = 60

S2 = 50

S3 = 35

S4 = 35

S5 = 43

Mp = 58

Sd = 59

Percent True (T%) = 47

Mean Elevation (M8; Scales 1, 2, 3, 4, 6, 7, 8, and 9) = 76

Rapid Reference 11.3

Clinical, Subscale, Content, PSY-5, RC, and Supplementary Scales and Indices for Andrew M.

Clinical Scales and Subscales

Scale 1 = 66

Scale 2 = 89

D-O = 88

D-S = 63

D1 = 82

D2 = 59

D3 = 91

D4 = 82

D5 = 74

Revised D Subscales

Dr1 = 77

Dr2 = 49

Dr3 = 79

Dr4 = 84

Dr5 = 72

Scale 3 = 57

Hy-O = 73

Hy-S = 38

Hy1 = 30

Hy2 = 47

Hy3 = 75

Hy4 = 62

Hy5 = 55

Scale 4 = 79

Pd-O = 82

Pd-S = 56

Pd1 = 58

Pd2 = 60

Pd3 = 33

Pd4 = 66

Pd5 = 67

Scale 5 = 50

Mf1 = 23

Mf2 = 50

Mf3 = 42

Mf4 = 39

(continued)

Mf5 = 60

Mf6 = 2

Mf7 = 63

Mf10 = 17

Scale 6 = 97

Pa-O = 84

Pa-S = 73

Pa1 = 82

Pa2 = 62

Pa3 = 65

Scale 7 = 87

Scale 8 = 79

Sc1 = 59

Sc2 = 69

Sc3 = 84

Sc4 = 60

Sc5 = 75

Sc6 = 95

Scale 9 = 53

Ma-O = 54

Ma-S = 54

Ma1 = 58

Ma2 = 49

Ma3 = 35

Ma4 = 43

Scale 0 = 67

Si1 = 71

Si2 = 49

Si3 = 53

Hopelessness

Hp = 72

Paranoia Factors

Pf1 = 59

Pf2 = 74

$Pf3 = 103$

$Pf4 = 98$

Cognition Scales

$CogProb = 72$

$DisOrg = 76$

Content and Content Component Scales

$ANX = 70$

$FRS = 80$

$FRS1 = 98$

$FRS2 = 61$

$OBS = 63$

$DEP = 71$

$DEP1 = 57$

$DEP2 = 76$

$DEP3 = 83$

$DEP4 = 62$

$HEA = 70$

$HEA1 = 44$

$HEA2 = 80$

$HEA3 = 81$

$BIZ = 77$

$BIZ1 = 67$

$BIZ2 = 73$

$ANG = 56$

$ANG1 = 52$

$ANG2 = 61$

$CYN = 44$

$CYN1 = 44$

$CYN2 = 43$

$ASP = 53$

$ASP1 = 46$

$ASP2 = 74$

$TPA = 48$

$TPA1 = 63$

(continued)

TPA2 = 40

LSE = 77

LSE1 = 80

LSE2 = 55

SOD = 60

SOD1 = 56

SOD2 = 63

FAM = 60

FAM1 = 60

FAM2 = 49

WRK = 67

TRT = 66

TRT1 = 66

TRT2 = 60

PSY-5 Scales

AGGR = 46

PSYC = 81

DISC = 53

NEGE = 73

INTR = 66

RC Scales

RCd = 73

RC1 = 65

RC2 = 75

RC3 = 45

RC4 = 71

RC6 = 76

RC7 = 77

RC8 = 80

RC9 = 47

Supplementary Scales

A = 71

R = 50

Es = 30

$H_o = 50$
 $O-H = 52$
 $Do = 38$
 $Re = 37$
 $Mt = 71$
 $PK = 68$
 $PS = 76$
 $GM = 30$
 $GF = 44$
 $MAC-R = 60$
 $APS = 65$
 $AAS = 60$

Protocol Validity

The patient's profile of approved validity scales is presented in Figure 11.1. The obtained profile was valid. The patient responded to the items at an average level of consistency ($VRIN$, $TRIN$) for normals, suggesting that he read the items carefully and was attentive to and understood their semantic characteristics. Responses to three items were omitted (96, 281, and 473). He presents himself as being in considerable distress (F , FB), but with no evident effort to exaggerate (Fp , Ds). The Mean elevation on the eight clinical scales ($M8$; Graham et al., 2002) is 76, and $F + Fb + |F - Fb|$ is 174 (Cramer, 1995). The quality of distress he reports appears to be predominantly affective and akin to panic, with distress caused by psychotic mentation being secondary ($FB > F$). He made a conscious effort to deny minor failings (L , Mp) and to project a mildly inflated social image (Sd). However, others are likely to view his level of disturbance as more severe than he does ($K > Es$). His efforts to minimize abnormal adjustment appear to be focused on denying cynical, suspicious, and resentful attitudes toward others ($S1$); however, he readily admits dissatisfaction with his basic life circumstances and current situation, and to anger, irritability, or impatience with others, especially when he feels provoked ($S3$, $S4$). Despite his efforts to deny problems in several areas, his coping capacity and emotional stability appear to be significantly reduced (K), and self-concept and self-esteem are generally inferior and impaired (Ss). The overall pattern of scores in this area suggests a severely compromised emotional equilibrium against which his usual defensive operations are inadequate to contain or reduce distress, or to preserve his ability to cope (e.g., $F - K$, $K > Es$).

Clinical Profile

The MMPI-2 profile shown in Figure 11.2 is markedly elevated, with 7 of the 10 clinical scales exceeding $T=65$. The profile code is 6*27*48 01+-395/ $F'-L/K$. In terms of the basic factor structure of the MMPI-2, the pattern of scores emphasizes distress, discomfort, and negative emotionality (First Factor: $A = 71$, $RCd = 73$). He scores in the middle range on the control dimension (Second Factor: $R = 50$, $DISC = 53$).

Symptoms, Problems, and Complaints

The profile suggests a severe personality disturbance with mixed features of mood and thought disorder (2, 6, 8), and high levels of anxiety and tension (7, ANX , $NEGE$, $RC7$) that appear to center on extreme fearfulness (FRS , $FRS1$), paranoid ideation (6, $Pa1$, $RC6$), and fears of loss of control ($Sc5$). A psychotic disorder is probable ($L + Pa + Sc - Hy - Pt = 88$, $PSYC > NEGE$).

Mood and affect are marked by depression, brooding, emotional withdrawal, and anhedonia; feelings of helplessness and hopelessness; mental insufficiency; and guilt (2, $D-O$, $D1$, $D5$, $Dr1$, $RC2$, $Sc2$, DEP , $DEP2$; Hp ; $D4$, $Dr4$; $Pd5$). The level of depression is relatively severe, with probable psychomotor slowing (2, 9 [relatively low], $2-9 = 36T$, $D4$, $Dr4$), limited affective expression ($Sc4$), stereotypically depressed ideation (DEP), loss of interest ($Sc2$), inhibition and withdrawal from his usual activities ($D2$, $D4$, $D5$), and preoccupation with ill and declining health ($D3$, $Dr3$, $Hy3$, $HEA3$, $RC1$). Some patients with similar profiles seemed at times to blame their depression on others or particular circumstances, giving the impression of being “depressed at” someone or something (2-6). His level of anxiety is such as to suggest that he feels overwhelmed (2-7, A , ANX , $NEGE$, $RC7$). He experiences doubt and uncertainty when faced with decisions or in determining a course of action, with a tendency to obsess and ruminate about dire consequences for the choices he may make (7, ANX , OBS). At times, the stress of worry and doubt become so great that he may overreact to minor stresses with agitation and irritability ($ANG2$, $TPA1$) or lose control and react impulsively or aggressively as a means of resolving tension (4, $NEGE$). To the extent that anger is present, he tends to feel anger at both himself and others, which may leave him feeling tense and “trapped” (6-7, $ANG2$, $TPA1$, $NEGE$). Others would tend to see him as more angry and resentful than he sees himself (6, $ANG2$, $TPA1$, $NEGE$ vs. $Pa3$, $ANG1$, $CYN1$, $CYN2$, $TPA2$). He may develop obsessions or compulsive rituals and symptoms as a means of controlling his anxiety (7, OBS). He complains of light and easily disturbed sleep, nightmares, and being frightened at night (items 5, 30, 471).

Cognition is positive for disordered and inefficient thought processes, with significant problems in memory, attention, concentration, and judgment (*CogProb*, *D4*, *Dr4*, 8, *Sc3*); complaints of intrusive and disruptive thoughts, feelings, and impulses (*Sc3*, *Sc5*, *RC8*); and doubt and indecision (7, *OBS*). At times, his level of detachment interferes with his ability to distinguish between internal and external reality (*DisOrg*, *RC8*, 6-8, *PSYC*), leading to the development of delusional beliefs (*RC6*, *Pa1*, 6, *BIZ1*, *PSYC*). His thought content appears disturbed (*BIZ*, *BIZ1*, *BIZ2*, *PSYC*), with an emphasis on delusions of control and persecutory ideation (*Pf3*, *Pf4* [see Appendix], *RC6*, *Pa-O*, *Pa1*, 6, *BIZ1*, *PSYC*). Such ideation may also include chronic feelings of mistreatment and of being unfairly blamed and punished (6-4, *Pa-O*, *Pd4*, 8, *PSYC*), but resentment is deemphasized (*Pf1*).

To at least some extent his detachment and withdrawal from the interpersonal (*Sc1*, *Pa-O*, *DEP*) and material (*Sc2*, *Sc4*, *DEP1*) worlds coincides with increased health concern (*HEA3*, *Dr3*, *RC1*), feelings of an altered body image, and unusual motor and sensory experiences (*D3*, *Hy3*, *Sc6*, *HEA2*, *BIZ2*); these may well also involve delusional elements. Self-esteem is very low (7-8, *LSE*, *LSE1*, *Hy2*), with themes of self-devaluation and a tendency toward self-criticism (2-7, 2-8, 7-8, *Pd5*, *Sc1*, *DEP*, *DEP3*); at times these dominate his ideational production. He tends to internalize stresses ($[2 + 5 + 0] - [3 + 4 + 9] = 16$; $[2 + 7 + 0] - [4 + 6 + 9] = 13$) and to feel an exaggerated sense of responsibility for his problems and failings (*Pd5*). Characteristic defenses include projection (*Pf4*, *Pa1*, *Pa-O*, *RC6*, 6, *Pd4*), somatization (*D3*, *Hy-O*, *Sc6*, *HEA*, *HEA2*, *HEA3*, *RC1*), and rationalization/ intellectualization (4, 5, 6, 7).

He feels that others do not understand him, and he may have great difficulty in communicating his thoughts and feelings to others in a coherent and organized fashion (6-8, *Sc3*, *BIZ2*). For the time being at least, he may prefer fantasy and daydreaming to interpersonal interaction (6-8, 2-8, 7-8, *BIZ2*). Although his relations with others are severely strained by his problems in thinking and communication, these are not entirely rejected (*Pd4* > *Sc1*, *Ho*). In fact, he may wish for closer relationships but not know how to achieve them and is fearful that others may not be able or inclined to accept him (8, *LSE*). He is severely lacking in self-confidence (*LSE1*, *Hy2*) and feels awkward, inept, and easily embarrassed in social situations (0, *Si1*, *SOD2*, *INTR*). Current interactions would be marked by rigidity, suspiciousness, and mistrust, and an inability to comply, or to comply only grudgingly or resentfully, with reasonable requests because of these (6-4, *Pa1*, *Pa1* > *Pd4*) and the sense of fear that they engender (*FRS*, *FRS1*, *Sc1*, *Si3*). He is highly sensitive to any form of criticism or rejection and quick to interpret malevolent intent to situations that others would see as innocent and benign (6-2, 6-4, 6-8). He is inclined to overreact to demands made on him at this time because of his feelings of vulnerability to others' hostility toward him (6-4, 6-8, *Pa1*) and his fears of losing control of negative impulses (6-7, *FRS*).

In general, however, his conflicts with others are primarily an outgrowth of his current symptomatic status rather than characterological or passive-aggressive trends (*Sc4*, *Ma4*, *TPA*, *TPA2*, *AGGR*, *Pf1*, and *Ho* [note the relatively low score]), despite some degree of chronicity in his alienation (*8*, *Pd4*, *Pa1*). When less severely symptomatic, he is better able to take others at face value and indeed may be seen as generous in his appraisals of others, even to the point of naivete (*CYN1*, *CYN*, *RC3*, *Pa3*, *Ho*). It is possible that his somatic concerns and preoccupations reflect, at least in part, an effort to obtain dependency gratifications and maintain a sense of ongoing relatedness with others that he feels unable to pursue through conventional means of communication because of his current impairments in mood and cognition. Mild to moderate family discord is reported (*Pd1*, *Sc1*, *FAM*, *FAM1*), but he continues to feel generally connected to and supported by his immediate family (*FAM2*).

His pattern of social behavior is currently regarded as predominantly introversive (*Hy-S*, *Hy1*, *Pd3*, *0*, *Si1*, *SOD*, *SOD2*) caused by his fears and feelings of incompetence in social interaction rather than out of avoidance of social gatherings as such (*Si2*, *SOD1*). When interaction cannot be avoided, he tends to appear passive and unassertive (*Pd3*, *5*, *Mf7*, *Ma4*, *Si1*, *Do*, *GM*, *TPA2*, *LSE1*, *AGGR*), except when the demands of others impinge upon his areas of delusional conviction.

He admits to a history of delinquency (*Pd2*, *ASP2*) but generally denies antisocial attitudes (*ASP1*). His basic orientation to others appears to be fundamentally trusting (*CYN*, *CYN1*, *CYN2*, *RC3*, *Ho*), even in his relations with authority figures (*Ma4*, *CYN2*, *ASP1*). In particular, hostile and aggressive attitudes toward others are denied (*D-S*, *ANG*, *ANG1*, *TPA*, *TPA2*, *AGGR*), although he does admit to moderate impatience and irritability (*ANG2*, *TPA1*). He also admits to substance use and to problems secondary to such abuse (*AAS*), and he appears to remain at some risk for substance abuse in the future (*MAC-R*, *APS*).

His pattern of masculine and feminine interests is consistent with masculine gender identity (*Mf6*, *Mf10*). He tends to enjoy vigorous, outdoor, stereotypically masculine activities and pastimes (*Mf1*), and he admits aesthetic or intellectual interests (*Mf5*) but denies stereotypically feminine interests (*Mf3*).

Diagnostic Considerations

The profile reflects a severe thought disorder that may at times be masked by depression, fear, and anxiety. Given the unfavorable base rates for Delusional Disorder, a diagnosis of Schizophrenia, Paranoid Type, should be considered, but with Delusional Disorder to be ruled out. Also to be ruled out are Major Depression with Psychotic Features and Bipolar Disorder, Depressed Type. On balance, the

profile is somewhat more consistent with thought disorder than mood disorder, although both thought disorder and depression appear to require treatment. It is suggested that his current depressed mood and its concomitants are secondary to schizophrenic disorganization and its consequences as perceived by the patient for current and anticipated failures and frustrations, reduced satisfactions in interpersonal relationships, and impairment in aspirations for achievement in work and in life more generally. A secondary diagnosis of Substance Use Disorder also appears warranted, by history. Diagnosis on Axis II is deferred pending the resolution of Axis I disorder, as his current level of symptomatology is such as would obscure any stable pattern of traits and attitudes related to personality disorder. At such time as the Axis I disorder becomes resolved, however, Dependent, Paranoid, and Schizotypal Personality Disorders might be considered on Axis II.

Treatment Considerations

Both the current profile and the patient's symptomatology appear less than usually stable, and retesting should be considered upon any significant change in mental status. Although the pattern of his symptoms and problems is unstable, the chronicity of severe disturbance would suggest a guarded prognosis, even considering his recent modest improvement. Positive prognostic factors would include the patient's age, the absence of a strong family history of mental disorder, his willingness to complete the MMPI-2 after initial refusals, his current emotional discomfort, his bias toward the internalization of stresses, and his basic desire for relatedness, however fearful and apprehensive.

Current suicide risk appears only somewhat reduced from that on admission, and continued vigilance and precautions to manage this risk are recommended. Staff should be especially alert for any sudden change in mood or comportment, including positive change, and rapidly assess the implications of such change for suicide risk. Given his prior assault and current unstable mental status, the possibility of future assault on peers or staff should not be overlooked. A buildup of frustrations or an increase in his conflicts with others could increase risk of violent acting out toward either self or others.

Standard chemotherapeutic approaches to the treatment of thought and mood disorder appear appropriate, but with the caveat that excessive sedation may interfere with the patient's self-protective hypervigilance, thereby increasing his feelings of vulnerability to perceived threats and risking panic or overreaction.

Psychotherapeutic measures are unlikely to be effective until symptoms come under better control and the patient has experienced sufficient relief that he no longer feels under near-constant external and internal threat. Similar patients have

responded well to a therapeutic style that is conducive to the patient feeling in control of interaction. At this time the patient should probably not be pressed to interact with caregivers, but nondemanding inquiries into his comforts and satisfactions and how these might be enhanced may be well tolerated when the patient initiates interaction. In particular, efforts to socialize him into accepting the patient role or to have him acknowledge having a “mental illness” should be avoided, as such efforts are likely to be construed as criticism if not rejection. Both clinician and staff should guard against reacting to the patient’s rigidity and stubbornness, while providing a level of support that he can perceive as concerned but not controlling.

Upon further improvement in mental status and an observed increase in the patient’s tolerance for interaction, efforts to engage the patient in psychotherapy may be tentatively recommended. Short-term behavioral interventions directed toward problems and concerns the patient raises may provide the best initial focus of treatment, pending the establishment of a therapeutic alliance. The alliance with similar patients tends to be highly fragile and easily undermined by the patient’s suspiciousness and hypersensitivity, and a tendency to see the therapist as unsympathetic, critical, blaming, or even treacherous. Such patients tend to feel vulnerable to the therapist and commonly resort to intellectualization, rationalization, hyperrationality, and even belligerence as a means of self-protection and to prevent premature incursions into more tender emotional areas in which the patient feels least able to cope and confide. These include feelings of hurt and shame, loneliness and isolation, rejection, and emotional vulnerability to the therapist, among others. The clinician should be alert to the possibility of elements of delusional ascriptions or attributions involving him or her, and to avoid overreactions should these occur.

Issues of constancy, dependency, and trust tend to be persistent and require adroit handling by the therapist to avoid premature termination. The patient may experience a cognitive-behavioral approach to depressive cognition as helpful and as neutral and safe, providing him both a degree of symptomatic relief and insulation from deeper emotional issues and fears, especially as these may become incited in the therapeutic relationship. Concurrent supplemental training in assertiveness and social skills have been helpful to similar patients in increasing their ability to confront emotional issues less fearfully, especially when framed to address “common, practical problems in living.”

With increasing patient confidence and comfort, a focus on patterns of interaction that leave the patient feeling coerced, helpless, uncared for, or rejected is usually appropriate, including the feelings of anger and resentment that such feelings may engender, in turn. A concurrent focus on achieving a greater balance

between self- and other-interest in his day-to-day choices, on the resolution of feelings about past wrongs and rejections, and increasing insight into how he may provoke others would lead to a greater ability to place his interactions with others in a more benign perspective, even when these are stressful. A decreased reliance on the need to deny, rationalize, or justify feelings of anger and resentment will signal significant improvement, especially when accompanied by an increased ability to take a more generous and forgiving stance toward the failings of both self and others.