Chapter 5

Results

5.1 Introduction

The results are presented in the following order: brief history and background, clinical impressions, test behaviour, medical investigations previously conducted, intelligence level, interactional analysis, Thematic Apperception Test, Millon Clinical Multiaxial Inventory, the Minnesota Multiphasic Personality Inventory and finally the 16 Personality Factor Questionnaire. The brief history and background, clinical impressions, test behaviour, medical investigations and intelligence level appear first to help place the individual in a context in which the ensuing test results can be better understood. The interactional analysis, TAT, MCMI-III, MMPI-2 and 16PF therefore follow after this information.

5.2 Individual number 1

5.2.1 Brief history and background

This individual is a white Afrikaans- speaking male in his mid- thirties. At the time of the murders he was in his early- twenties. He was previously engaged but has never been married. He is an only child and his biological parents are still married. He reports no history of physical or sexual abuse. He completed a primary and secondary education of ten years and was gainfully employed after the completion of his secondary- education.

The crimes for which he was charged, rape and murder, occurred over a three- year period. There were no reports of a history of watching violent pornography nor sexual fetishes. His victims were black and white females. He had no previous convictions.

5.2.2 Clinical impressions

The first impression of this person was one of aloofness. He came across as being emotionally 'cold'. This person was well dressed in his prison greens. He spoke well. He asked for a cigarette from the interviewer's pocket and offered one to each of the researchers. This can imply a high level of confidence on the part of the person. Both interviewers, the researcher and his colleague, a qualified clinical psychologist, felt that the individual was very confident during the interview. He seemed to take control of the situation and sat where he wanted to. He expressed his concern that the video- taped material was not to be used for media purposes.

5.2.3 Test behaviour

Individual number 1 was cooperative during the testing process. He seemed to cope well with the languages in which the testing was conducted. During the Thematic Apperception Test he seemed slightly uncomfortable about the test situation and sought the testers approval for his responses, upon not receiving any guiding feedback he seemed to become more anxious. During the more structured tests such as the 16PF, MMPI and MCMI and to a lesser degree the SAWAIS he seemed more comfortable.

5.2.4 Medical investigations previously conducted

Before being able to make any psychological conclusions it is necessary to determine if any medical problems, such as epilepsy, brain injury, thyroid problems, can be the cause of the manifested behaviours of the individual. With individual number 1 there were no medical problems detected during the forensic observation for the court proceedings. Furthermore the individual was determined fit to stand trial. These investigations involved routine blood work

(not specified on the available ward- round notes), CT scan and EEG were normal. There was also no medical history mentioned that was linked to the current context.

This individual's forensic observation file created during his evaluation of competency to stand trial, was destroyed during a fire at the institution where the observation took place. The only source of information from that time are case discussion notes from the forensic ward-round taken by one of the team members. The following are the details regarding the information available.

Developmental Problems: None reported

Medical of Psychiatric Illness: None reported

CT Scan: Normal

EEG: Normal

5.2.5 Intelligence level

This individual's intelligence level was measured by the South African Wechsler Adult Intelligence Scale. His full- scale IQ was in the normal range. His IQ, as measured by the same instrument at the time of his forensic evaluation of competency to stand trial was also in the normal range. This also corresponds with the researcher's clinical impression of his level of intelligence. For the full profile see appendix 2.

5.2.6 Interactional analysis

5.2.6.1 How does he speak?

Haltingly: the individual's language was quite broken and it seemed he didn't have an elaborate vocabulary.

Willingly/ Easily: he was not hesitant in describing the murders or other facts related to his life- circumstances.

Humoured: at certain points throughout the interviews he would have a slight smile on his face as if amused by something he was saying.

Abrupt: when discussing certain topics like his family.

Insincere

5.2.6.2 How does he speak about the problem?

Easily: he has no problem discussing any aspect of the murders.

Matter- of- Fact/ Casually: he seems to have the attitude that he committed the crimes and there is nothing he can do about it now so there is no need to be remorseful about something he cannot change. He often says things like "ek het dit gedoen" (I did it) in a matter- of- fact way.

Smilingly: often during his account of what happened, on various occasions, he would be speaking about a certain incident with a slight smile on his face. When questioned about this he replied that even though he knows the crimes were terrible there were certain things that occurred that he finds humorous in retrospect.

Accepting: he accepts that he committed the crimes and even before he was apprehended had decided that should anyone question him about the murders he would admit to them. Even with regards to his incarceration he accepts that he will be in prison for many years. He often stated that he is the kind of person that isn't bothered by much, even the circumstances in prison.

Feelingless: he didn't display any verbal or non- verbal signs of emotion during any of the interviews. He often used the phrase "dit was niks" (it was nothing) when discussing the crimes.

Incongruently: he would often verbally comment on how a crime was cruel but the non-verbal communication that came across was incongruent with what he was saying.

He would say "dit was wreed" (it was cruel) or, "ek wil my self verbeter" (I want to better myself) unconvincingly.

5.2.6.3 In what context does the problem appear?

Serial murders seemed to happen when he was bored and he sought a challenge to break the monotony. This involved risk- taking behaviour in the way of entering a flat and not knowing who or what awaited him. The murders always took place in a nearby urban area and the victims were always strangers.

5.2.6.4 What has been done to solve the problem?

Before he was apprehended no action was taken to resolve the problem. He stated that the only way he could have stopped was if someone caught him. Perhaps it can be said that his attempt to solve the problem was to allow himself to be caught. After his incarceration he had requested psychotherapeutic help.

5.2.6.5 Nature of person's relationships with people

Distant: His relationships with the researchers and with other people appear to be distant and therefore uninvolved.

Unemotional: There also seems to be little emotional involvement in any of his relationships. He seems to dislike the amount of effort necessary to maintain a relationship of give and take.

Non- Committal: This creates a non- committal and detached relationship.

Civil: In his interaction with the researchers he was civil and expressed his commitment to the research process, often saying "as ek iets begin dan maak ek hom klaar" (If I start something I

always finish it) but this can be attributed to the prison context where good behaviour can have a secondary gain for privileges and perhaps later for parole.

5.2.6.6 Context of the interview

Correctional Service Facility: Maximum Security

2 interviewers in the dual role of psychologist and researcher.

Voluntary participation.

Prison official's office.

Video camera.

5.2.6.7 Strong points of person

Artfully deceitful.

Makes researchers feel comfortable.

5.2.6.8 Negative points

Unemotional: this can make it difficult for him to make meaningful relationships in which he could do reality testing.

Broken way of speaking: this can make it difficult to follow and maintain a conversation also the possibility that he may be unable to bring across the message he wants to when speaking.

5.2.6.9 Effect of person on researchers

Interest: it was interesting to listen to this person.

At ease/ comfortable: his manner of interacting made one feel at ease when listening and conversing with this person.

Unemotional: it felt like a working relationship throughout the whole research process.

5.2.6.10 Summary of interactional analysis results

The following important aspects were taken from the interactional analysis. The individual spoke reasonably comfortably during the interviews, although he seemed to struggle for words at times as if he has a limited vocabulary to describe complex events, especially those emotional in nature. At times he appeared slightly amused, he was seen to have a slight smile or smirk during some of the discussions. At times he became fairly abrupt, especially when speaking about his family. This gave the impression that he, as with most interpersonal relations, had little insight into his family relations, and almost lacked the words to describe the relationship between two people.

In terms of how he spoke about the problem, the murders, he spoke quite easily about the events. This created almost a casualness about the discussion. His attitude was that he had committed the murders, therefore there was no sense in not being candid about them. This did not come across as bravado, or bragging however, the attitude could also be described as that of accepting in nature. The events were often described in an emotionless manner, although at times he would appear amused at what he was saying, when queried he would say that he was just thinking about something that, in retrospect, seemed amusing, for example when he asked an elderly lady if she had AIDS just before he raped her. He also spoke in an incongruent manner, verbally he would say that his crimes were cruel, but non- verbally there was no correspondence.

The nature of his relationships are distant and unemotional. At times he appears very non-committal about whether or not people maintain contact. He would often have pen- pal relationships yet when a pen- pal failed to continue to write to him in prison he seemed not to

be bothered by it. The impression was often created that he was trying to behave as he thought he should behave, as if following a 'manual', and lacked the backing insight to be able to explain for himself how a relationship should be maintained. He lacks the emotional connectedness that guides most 'normal' people in helping them determine how to behave in a relationship.

In terms of what contexts the problem appeared, it was usually when he was bored, and sought a challenge, there appeared to be a risk- taking element to his behaviour as he was often not sure if there were people in the homes he was breaking into. There seemed to be an escalation in the severity of the crimes, as a child he would steal money from his mother or mother's guests handbags, later, before the murders, he would break into homes to either steal small items, or just for the adventure, this was how the first murder took place, when the domestic helper found him in the house and he killed her (specific details of the event cannot be discussed due to confidentiality). Eventually the break- ins included rape and shortly thereafter rape and murder. The final escalation was rather rapid and the murders took place over a two year span.

5.2.7 Thematic Apperception Test (for full protocol see appendix 3)

5.2.7.1 Card 1

Approach to the test

As a rule (with every card, not only Card 1), the subject plays for time at the beginning, with comments like "OK" and "uhum". This may indicate a little anxiety or insecurity as regards the various stimuli of the cards.

The demands of his world

These are observed, but his inabilities are also clear - he tried to play the violin, but was not very successful, and now it is broken. It cannot be fixed and he is not going to try again either - he gives up.

Self- Concept

Appears to be insecure, poor self- concept.

The role of other people

They are also involved, but are not very supportive.

Observation

I observe that there is already a pattern which may be seen throughout: he knows what should be happening on the card, but his response style is full of insecurity as if he wants the tester to reassure him. (This is primarily seen in the use of words like "maybe" and "if".)

5.2.7.2 Card 2

The approach

As per Card 1.

Interpersonal relationships

He first says that it looks as if each is busy with his [sic] own things, thus they are isolated from one another. Then he does bring them into contact with one another after all: he first suggests a tenuous link between the pregnant woman and the man, then says that they have

come from home, and that the older people are the parents of the girl in the foreground. This is a good sign: in his world, people can be in supportive relationships with one another. However, there is a theme of sadness and hopelessness which appears in this card (I think that Card 1 also already indicates hopelessness.) The theme of relationships being destroyed (the young girl is going away) also comes to the fore.

5.2.7.3 Card 3BM

The theme of sadness (and loss as well) continues here. Here the relationship is also destroyed by someone and the central figure (with whom the subject identifies) suffers as a result. The suggestion of a car is interesting here. Although this card is concerned with frustrations and (self-directed) aggression, I would not interpret the car as a negative instrument whereby frustration will manifest as self-directed aggression. Rather, I would see it as a source of hope, that the subject thinks it possible to get up and go on with life, despite emotional pain. In the process, however, there is a moment where the subject becomes scared and struggles to restore calm - he sees the possibility of a firearm, with all its negative, hopeless, self-directed, destructive possibilities. The tester/ researcher's "As you wish" response was a good remark in this situation.

5.2.7.4 Card 4

On this card, which shows a heterosexual relationship, without focusing on the tender intimacy of Card 10 or the sexual intimacy of Card 13MF, it is not unusual to see conflict between the man and the woman. The subject initially observes conflict, but this upsets him to such a degree that he tries to avoid this by making the contact softer and more jovial. In this rather artificial way, he also tries to indicate that the friendly relationship will continue. Here I would like to put forward the hypothesis of an interpersonal conflict which is very

painful to him, and which came sharply to the fore here, and which he unsuccessfully tried to avoid.

5.2.7.5 Card 6BM

The theme which appears here harks back to Card 2. There the main figure with whom the subject identified had the experience of being unable to speak to the mother figure. On this card, the young man experiences a sad situation and he wants to speak to his mother, but she is totally inaccessible. With projective techniques, it is always important to note what is read into a card without the card having suggested it. With this card, for instance, the father was brought in. I suspect that the subject has a better relationship with his father than with his mother, but that he is scared that he will lose his father in some way, or has already actually lost him.

5.2.7.6 Card 7BM

Although there is more contact between the father and son than between the mother and the son, there are still communication problems between them. The theme of loss comes to the fore once again, this time with a faint suggestion that something went wrong between the person and a girlfriend. By the end, the response became unclear and uncontained. What stands out is that the subject has little hope that interpersonal problems will be solved.

5.2.7.7 Card 8BM

Traditionally, this is the card in which more overt aggression can be lived out. However, the theme of self-directed aggression (Card 3BM) came to the fore with the subject. It is almost as if the firearm which frightened the subject in Card 3BM has now actually become a suicide weapon. Only after the deed has been done, do people come forward to try and help. He distances himself from the situation through fantasy. He stands apathetically outside his body. "Are they going to save my life or not? It doesn't really matter" - he just waits to see what is going to happen.

5.2.7.8 Card 10

The idea of conflict, which is not suggested by this card, is read into the card. Tender intimacy follows. Different to the other cards, here the subject feels that it is possible for people to move closer together after conflict. I wonder if this is not wish-fulfillment for him, and if he did not really experience this. The fact that he then says that they have been married for 50 years already also suggests fantasy and wish-fulfillment.

5.2.7.9 Card 13MF

The sexual meaning of the card is denied. However, the fact that the woman is dead and the man finds her suggests that a sexual relationship with a woman has died for him. It is not very clear whether these were the subject's words or not, or if he is only playing with the idea that the man killed the woman, and then suppresses it (I am thinking of the words "the old hell" which he used).

5.2.7.10 Summary of the TAT

Profile Considerations: This person responded in slightly anxious manner. He sought direction from the tester but when he didn't receive it he became more anxious. He did however, cooperate with the test instructions.

Interpersonal Considerations: Relationships are noted but there is no emotional involvement between role- players. Others are not perceived as being supportive. This may be due to an insecure, poor self- concept on his part. While able to see interpersonal demands he is unable to effectively react to them, and may seek reassurance. People are seen as being isolated from each other, and what few relationships he does perceive are plagued by sadness and destruction. What few interpersonal relations he may perceive seem to filled with disappointment. Interpersonal conflict is experienced painfully for this person. Communication problems seem to be a common factor in interpersonal relations. It appears that interpersonal problems are perceived as unsolvable and therefore abandoned or avoided.

Diagnostic Considerations: A difficulty in dealing with life's demands creates anxiety for this individual. There are pervasive indications of sadness, possibly a depressed mood. A poor self- concept could be an integral part of this. Aggression can be seen as self- directed in certain instances, this can represent his bottling- up of emotions instead of expressing them through interpersonal means. There is a possibility that sexual concerns can be repressed by this individual.

5.2.8 Millon Clinical Multiaxial Inventory III Edition: Interpretive Report

5.2.8.1 Capsule summary

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken MCMI-III for non- clinical purposes may have distorted reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to inmates or their relatives.

Interpretive Considerations

The client is currently being seen as a correctional inmate, and he did not identify specific problems and difficulties of an Axis I nature in the demographic portion of this test.

Profile Severity

On the basis of the test data (assuming denial is not present), it may be reasonable to assume that the inmate is exhibiting psychological dysfunction of mild to moderate severity. The text of the following interpretive report may need to be modulated slightly downward given this probably level of severity.

Possible Diagnoses

He appears to fit the following Axis II classification best: Avoidant Personality Traits, Dependent Personality Traits, Schizoid Personality Features, and Borderline Personality Features. The major complaints expressed by the client's MCMI-III responses do not take the form of distinct Axis I symptoms.

Therapeutic Considerations

The shy and awkward demeanor of this inmate may cloak his resentment towards others, which is the result of feeling repeatedly rejected. Socially isolated and possessing a poor self-image, the inmate spends much of the time in quiet rumination. The prospect of psychotherapy may not be well- received. Fear of humiliation may lead to resistance. Although the advent of a therapeutic relationship may increase pre- existent anxiety and a desire for social isolation, compliance may be achieved with a treatment regimen that focuses on symptom relief and the acquisition of social skills.

Figure 1: MCMI-III Profile

ID NUMBER:
PERSONALITY CODE: - ** 2A 3 * 1 2B 8B 6A + 4 5 7 " 8A 6B ' ' // - ** - * //
SYNDROME CODE: - ** - * // - ** - * //
DEMOGRAPHIC: /CI/M/33/W/N/10/--/--/-----/--/-----/

Valid Profile

CATEGORY		SCORE RAW	SCORE BR	PROFILE OF BR SCORES 0 60 75 85 115	DIAGNOSTIC SCALES
MODIFYING INDICES	X	77	50		DISCLOSURE
	Y	11	51		DESIRABILITY
	Z	3	42		DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	9	74		SCHIZOID
	2A	7	75		AVOIDANT
	2B	5	68		DEPRESSIVE
	3	9	75		DEPENDENT
	4	12	42		HISTRIONIC
	5	9	42		NARCISSISTIC
	6A	8	60		ANTISOCIAL
	6B	3	26		SADISTIC
	7	10	39		COMPULSIVE
	8A	4	30		NEGATIVISTIC
	8B	4	68		MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	2	40		SCHIZOTYPAL
	C	9	68		BORDERLINE
	P	2	24		PARANOID
CLINICAL SYNDROMES	A	2	40		ANXIETY DISORDER
	H	1	30		SOMATOFORM DISORDER
	N	3	36		BIPOLAR: MANIC DISORDER
	D	5	68		DYSTHYMIC DISORDER
	B	4	60		ALCOHOL DEPENDENCE
	T	3	45		DRUG DEPENDENCE
	R	3	45		POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	4	60		THOUGHT DISORDER
	CC	2	40		MAJOR DEPRESSION
	PP	0	0		DELUSIONAL DISORDER

5.2.8.2 Response tendencies

No adjustments were made to the Base Rate (BR) scores of this individual to account for any undesirable response tendencies. The response style of this inmate showed no unusual test-taking attitude that would distort MCMI-III results.

5.2.8.3 Axis II: personality patterns

The following paragraphs refer to those enduring and pervasive personality traits that underlie this man's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up Axis I clinical syndromes, this section concentrates on his more habitual and maladaptive methods of relating, behaving, thinking, and feeling.

Most significant on the MCMI-III of this inmate are suggestions of a self- protective aloofness from others, a tendency to deprecate his self- worth, a general emotional sluggishness, a lack of positive affect, a social awkwardness, and an inclination to feel uncomfortable on most interpersonal relationships. Although he may want a measure of closeness and affection, he protectively denies this desire. He is likely to be a rather sad man who experiences a pervasive dysthymia with recurring periods of anxiety. His thinking may frequently be over controlled, although occasionally distracted by an upsurge of disruptive ideas. Fearing abandonment, he is overly concerned about social rebuff; this is often intensified by his tendency to anticipate- and thereby elicit- rejection.

Other significant traits may include a lack of initiative and competitiveness, persistent deprecation of his aptitudes, and a general avoidance of autonomous behaviour. He may evince a conciliatory submission to others and a dependent search for supportive persons or institutions. Yet he often denies this desire for independence, choosing instead to maintain a safe measure of interpersonal distance. Among the MCMI-III items he is likely to endorse is "In social groups, I am almost always very self- conscious and tense". He may typically assume a passive role in social relationships, willingly submitting to the demands of others to fulfill his dependency needs.

Given his apparent self- image of weakness and fragility and his frequent depressive mood, ordinary stresses and responsibilities may often seem excessively demanding. His passive and aloof lifestyle stems not only from a general depressive fatigability but also from a protective effort to dampen feelings of anxiety and to deaden excess sensitivity. Hence, his depressive blandness may be deceptive, overlying a deep dysphoric mix of inhibited anger, anxiety, and resentment. Careful probing of these denied feelings may be usefully pursued by his clinician.

This man may often be self- absorbed, lost in daydreams that may at times confuse fantasy with reality. Cognitively, he may report being distracted by inner thoughts that intrude on his normal social communications. To counteract these, he may seek to avoid emotional experiences and may attempt to suppress events that stir disturbing memories and feelings. These defensive efforts preclude a socially rewarding lifestyle, and together with his affective restraining and withdrawal behaviour, fail to elicit favourable attention and interest from others. As a consequence, he may drift further into his detached, socially anxious, depressive, and ineffectual life pattern.

5.2.8.4 Axis I: clinical syndromes

No distinctive Axis I clinical syndrome appears in this man's MCMI-III diagnostic picture (other than the general personality characteristics described previously). If denial tendencies are present, he may be covering up significant symptoms.

5.2.8.5 Noteworthy responses

The client answered the following statements in the direction noted in parentheses. These items suggest specific problem areas that the clinician may wish to investigate.

Health Preoccupation

No items endorsed.

Interpersonal Alienation

10. What few feelings I seem to have I rarely show to the outside world. (True)

27. When I have a choice, I prefer to do things alone. (True)

Emotional Dyscontrol

22. I'm a very erratic person, changing my mind and feelings all the time. (True)

Self- destructive Potential

24. I began to feel like a failure some years ago. (True)

142. I frequently feel there's nothing inside me, like I'm empty and hollow. (True)

Childhood Abuse

No items endorsed.

Eating Disorder

No items endorsed.

5.2.8.6 Possible DSM-IV multiaxial diagnoses

The following diagnostic assignments should be considered judgements of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-III differ somewhat from those in the DSM-IV, but there are sufficient parallels in the MCMI-III items to recommend consideration of the following assignments. It should be noted that several DSM-IV Axis I syndromes are not assessed in the MCMI-III. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self- report inventories such as the MCMI-III.

Axis I: Clinical Syndrome

The major complaints expressed by the inmate do not take the form of distinct or isolated symptoms but rather appear to reflect pervasive difficulties.

Axis II: Personality Disorders

The following personality prototypes correspond to the most probable DSM-IV diagnose (Disorders, Traits, Features) that characterise this inmate.

Personality configuration composed of the following:

Avoidant Personality Traits

Dependent Personality Traits

Schizoid Personality Features

Borderline Personality Features

Course: The major personality features described previously reflect long- term or chronic traits that are likely to have persisted for several years prior to the present assessment.

Axis IV: Psychosocial and Environmental Problems

In completing the MCMI-III, this individual identified the following problems that may be complicating or exacerbating his present emotional state. They are listed in order of importance as indicated by the client. This information should be viewed as a guide for further investigation by the clinician.

None Identified

5.2.8.7 Summary of the MCMI- III

Profile Considerations: The MCMI was valid and indicates a mild to moderate psychological problem in this individual. The problems appear to be more on Axis II of the DSM-IV Multiaxial Classification System, and not on Axis I. Therefore the main focus is on the personality of the individual.

Interpersonal Considerations: Axis II Personality Patterns are this individuals enduring and pervasive personality traits that underlie his emotional, cognitive and interpersonal difficulties. Most significant are the suggestions of a self- protective aloofness from others, tendency to deprecate his self- worth, general emotional sluggishness, lack of positive affect, social awkwardness, and inclination to feel uncomfortable in most interpersonal relationships. Although he may want a measure of closeness and affection, he protectively denies this desire. Fearing abandonment, he is overly concerned about social rebuff, this is often intensified by his tendency to

anticipate, and thereby elicit, rejection. He may interpersonally display a lack of initiative and competitiveness, and a general avoidance of autonomous behaviour, showing a conciliatory submission to others and a dependent search for supportive persons or institutions. He, however, will deny such a desire for dependence, choosing instead to maintain a safe interpersonal distance. He may typically therefore adopt a passive role in social relationships, willingly submitting to the demands of others to fulfill his dependency needs. Having a weak self- image and at times depressed mood leads him to struggle to deal with ordinary responsibilities, thus his passive and aloof lifestyle stems not only from a depressive position, but also functions as a protective measure to damped feelings of anxiety. At times he may be self- absorbed and appear 'lost' in daydreams. Avoiding stressful situations acts as a defensive measure which precludes a socially rewarding lifestyle. This, together with affective restraining and withdrawal, prevents him from eliciting favourable attention and interest from others. This leads to a vicious cycle where he drifts further into a detached, socially anxious, depressive and ineffectual life pattern.

Diagnostic Considerations: He is likely to be a sad man, experiencing pervasive dysthymia with recurring periods of anxiety. Linked with this, a low self- esteem leads to a deprecation of his aptitudes, and a general passivity. Certain ordinary situations will elicit anxiety and appear to be unsurmountable. His depressive 'blandness' may be deceiving, covering up a deep dysphoric mix of inhibited anger, anxiety and resentment. The following diagnostic labels can be used to try and describe this person:

Axis I: No clear syndrome, that which does appear seems linked to his pervasive difficulties.

Axis II: A personality configuration composed of the following: Avoidant Personality Traits, Dependent Personality Traits, Schizoid Personality Features, and Borderline Personality Features.

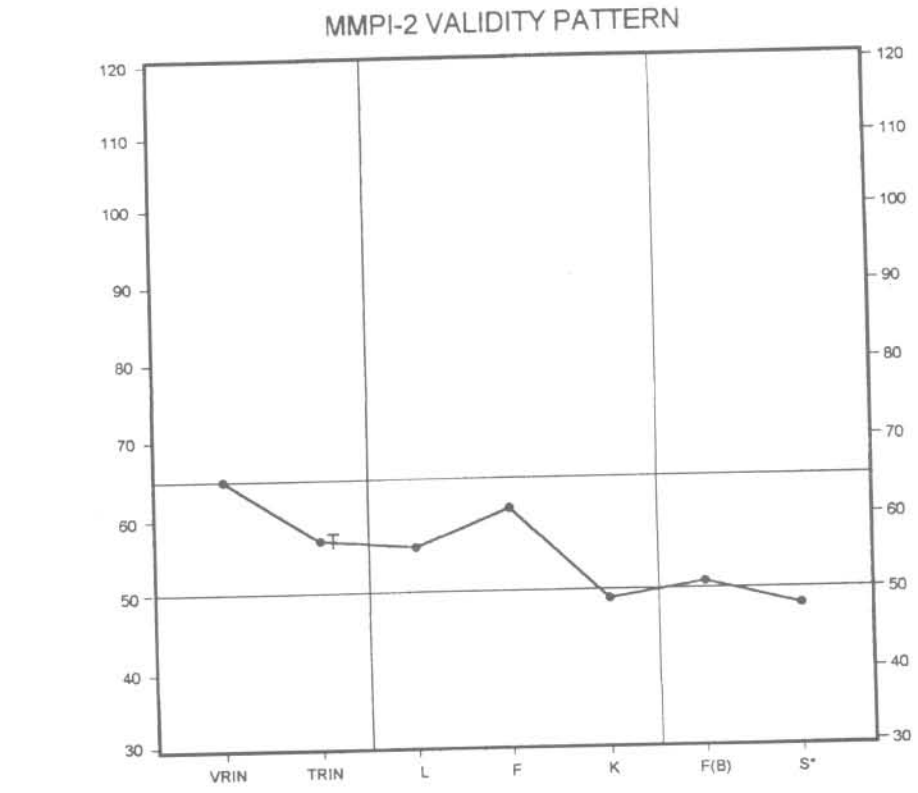
5.2.9 Minnesota Multiphasic Personality Inventory 2nd Edition (MMPI-2)

5.2.9.1 Profile validity

His MMPI-2 clinical profile is probably valid. The client's responses to the MMPI-2 validity items suggest that he cooperated with the evaluation enough to provide useful interpretive information. The resulting clinical profile is an adequate indication of his present personality functioning.

He has not indicated the highest level of education he has attained. The Minnesota Report has been processed as though he has completed a 12- year high school education. If the education level is actually different from high school, then the Minnesota Report, particularly interpretations related to educational background such as those based on the Mf scale, should be carefully evaluated and modified accordingly.

Figure 2



	VRIN	TRIN	L	F	K	F(B)	S*
Raw Score:	9	10	5	8	15	2	23
T Score:	65	57	56	61	49	51	48
Response %:	100	100	100	100	100	100	98

Cannot Say (Raw): 1

F(p) (Raw)*: 3

Percent True: 38

Percent False: 62

F(p) (T-score)*: 63

*Experimental

5.2.9.2 Symptomatic pattern

The MMPI-2 clinical profile type that includes Scales D, Pd, and Sc was employed as the prototype to develop this report. This profile type shows very high definition. The behavioural descriptions provided in the following narrative are likely to be an accurate portrayal of the client's personality and symptoms because his profile closely matches the profile characteristics on which the correlates are based. Acute distress,

depression, and tension are characteristic symptoms expressed in this MMPI-2 pattern. The client is likely to be moody, angry, distrustful, and quite resentful of others, possibly because he feels extremely insecure and inadequate and tends to blame others for his problems. Behavioural deterioration under stress is characteristic of individuals with this profile; however, persistent personality problems are also probably part of his clinical picture.

He probably has a very poor achievement or work history, and he may be having severe family problems. Acting- out behaviour and sexual maladjustment are characteristic problems for individuals with this profile.

In addition, the following description is suggested by the content of the client's item responses. He has difficulty managing routine affairs, and the items he endorsed suggest a poor memory, concentration problems, and an inability to make decisions. He appears to be immobilized and withdrawn and has no energy for life. He views his physical health as failing and reports numerous somatic concerns. He feels that life is no longer worthwhile and that he is losing control of his thought processes. He reports some antisocial beliefs and attitudes, admits to rule violations, and acknowledges antisocial behavior in the past.

5.2.9.3 Profile frequency

Profile interpretation can be greatly facilitated by examining the relative frequency of clinical scale patterns in various settings. The client's high- point clinical scale score (Pd) occurs in 9.1% of the MMPI-2 normative sample of men. However, only 3.3% of the normative men have Pd as the peak score equal to or greater than a T score of 65,

and only 1.9% have well- defined Pd spikes. This elevated MMPI-2 profile configuration (2-4/4-2) is very rare in samples of normals, occurring in less than 1% of the MMPI-2 normative sample of men.

The relative frequency of his profile in various correctional settings is informative. Megargee (1993) reported that this high- point clinical scale score (Pd) occurred in 36.8% of men in a state prison and 21.5% of men in a federal prison. Moreover, a large number of state prisoners (28.8%) and federal prisoners (11.7%) had a Pd spike equal to or greater than a T score of 65.

5.2.9.4 Profile stability

The relative elevation of the highest scales in his clinical profile shows very high profile definition. His peak scores on this testing are likely to be very prominent in his profile pattern if he is retested as a later date. His high- point score on Pd is likely to remain stable over time. Short- term test- retest studies have shown a correlation of 0.81 for this high- point score. Spiro, Butcher, Levenson, Aldwin, and Bosse (1993) reported a moderate test- retest stability index of 0.62 in a large study of normals over a five- year test- retest period.

5.2.9.5 Interpersonal relations

Poor social skills and disturbance in interpersonal relationships are hallmarks of such clients. He is overly sensitive and resistant to the demands of others, and he may be quite argumentative and obnoxious. He tries to stay aloof but may show dependency feelings and an exaggerated need for affection. He is very suspicious of others and rejects emotional ties. Many individuals with this profile never marry.

He is somewhat shy, with some social concerns and inhibitions. He is a bit hypersensitive about what others think of him and is occasionally concerned about his relationships with others. He appears to be somewhat inhibited in personal relationships and social situations, and he may have some difficulty expressing his feelings towards others.

5.2.9.6 Diagnostic considerations

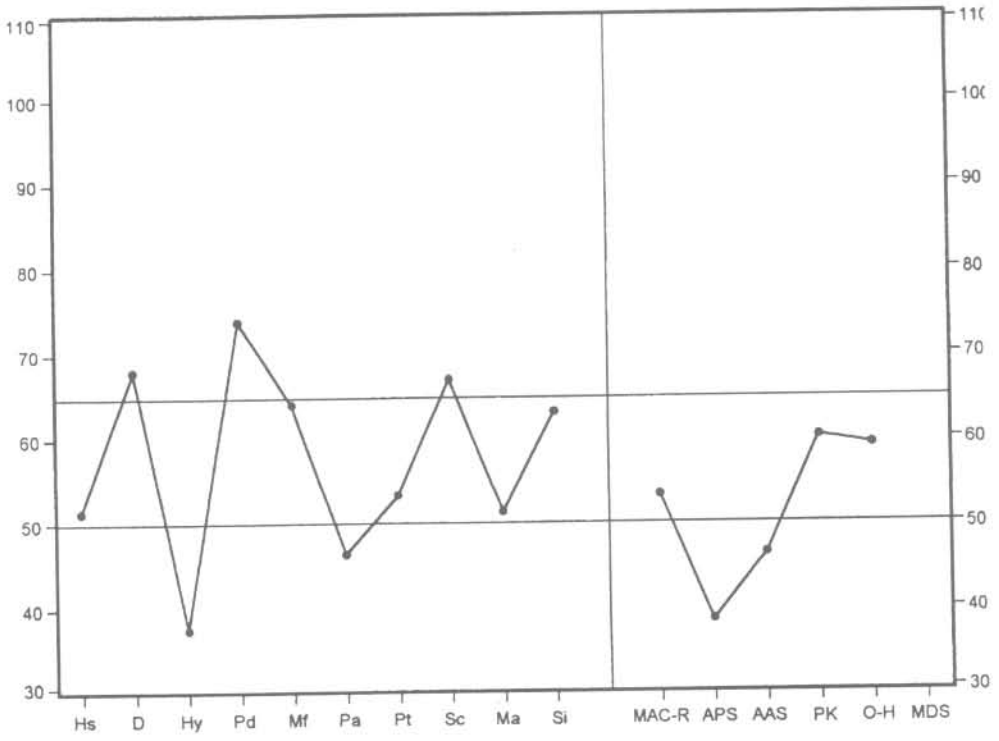
This individual's clinical profile indicates severe psychological disorder as well as antisocial features. His antisocial behavior may be a primary consideration. However, the possibility of a schizophrenic process should be evaluated. His response content is consistent with the antisocial features in his history. These factors should be taken into consideration in arriving at a clinical diagnosis.

The Megargee system for classifying criminal offenders (Megargee, 1993) has often been found to be a useful typology for individuals facing incarceration. There is considerable research support for the view that the Megargee types are found in both men and women across a wide range of correctional facilities. The Megargee system allows for the classification of about two- thirds of the offender population. However, successful classification rates and the retest stability of an inmate's type have been found to vary across settings and for men and women.

This client fits equally well into more than one classification according to the Megargee classification rules. People with multiple classifications probably share characteristics associated with each of these groups.

Figure 3

MMPI-2 BASIC AND SUPPLEMENTARY SCALES PROFILE



	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	MAC-R	APS	AAS	PK	O-H	MDS
Raw Score:	5	27	14	27	33	9	13	21	18	36	22	19	2	14	15	*
K Correction:	8			6			15	15	3							
T Score:	51	68	37	74	64	46	53	67	51	63	53	38	46	60	59	*
Response %:	100	98	100	100	100	100	100	100	98	100	100	100	100	100	96	*

Welsh Code (new): 4'28+50-719/6:3# F-L/K:

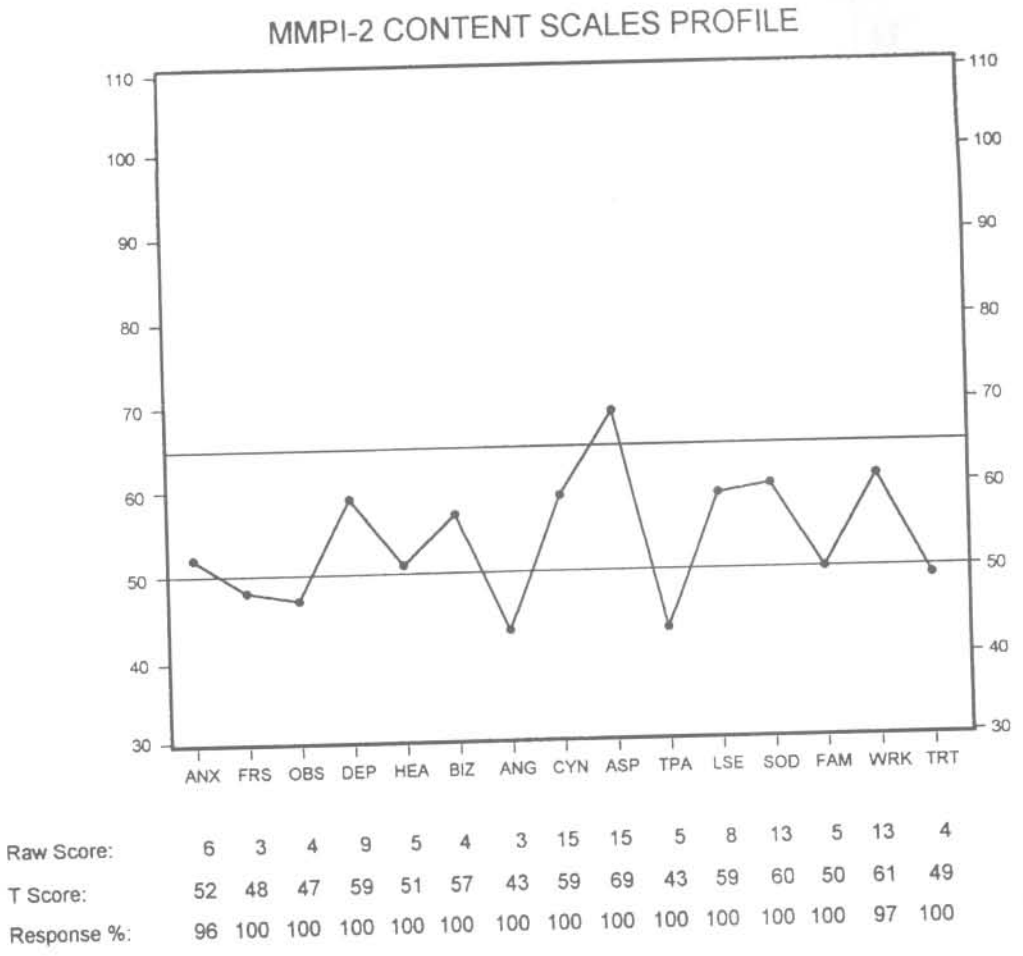
Welsh Code (old): 42"58'079-16/3: F-KL/?:

Profile Elevation: 55.90

Megargee Classification (Rev.): Multiply Classified*

*MDS scores are reported only for clients who indicate that they are married or separated.

Figure 4



5.2.9.7 Supplementary score report

Table 7

	Raw Score	T Score	Resp %
Anxiety (A)	12	53	100
Repression (R)	24	69	100

Ego Strength (Es)	33	40	100
Dominance (Do)	14	41	100
Social Responsibility (Re)	18	45	100
Post- Traumatic Stress Disorder- Schlenger (PS)	15	56	100
Depression Subscales (Harris- Lingoes)			
Subjective Depression (D1)	14	69	100
Psychomotor Retardation (D2)	9	70	100
Physical Malfunctioning (D3)	5	67	100
Mental Dullness (D4)	6	67	93
Brooding (D5)	2	51	100
Hysteria Subscales (Harris- Lingoes)			
Denial of Social Anxiety (Hy1)	3	45	100
Need for Affection (Hy2)	4	40	100
Lassitude- Malaise (Hy3)	3	52	100
Somatic Complaints (Hy4)	1	43	100
Inhibition of Aggression (Hy5)	1	33	100
Psychopathic Deviate Subscales (Harris- Lingoes)			
Familial Discord (Pd1)	2	51	100
Authority Problems (Pd2)	7	73	100
Social Imperturbability (Pd3)	4	51	100
Social Alienation (Pd4)	7	66	100
Self- Alienation (Pd5)	7	67	100
Paranoia Subscales (Harris- Lingoes)			
Persecutory Ideas (Pa1)	4	64	100

Poignancy (Pa2)	2	48	100
Naivete (Pa3)	0	30	100
Schizophrenia Subscales (Harris- Lingoes)			
Social Alienation (Sc1)	6	64	100
Emotional Alienation (Sc2)	3	69	100
Lack of Ego Mastery, Cognitive (Sc3)	4	66	100
Lack of Ego Mastery, Conative (Sc4)	6	71	100
Lack of Ego Mastery, Defective Inhibition (Sc5)	1	47	100
Bizarre Sensory Experiences (Sc6)	1	46	100
Hypomania Subscales (Harris- Lingoes)			
Amorality (Ma1)	2	50	100
Psychomotor Acceleration (Ma2)	5	49	91
Imperturbability (Ma3)	3	47	100
Ego Inflation (Ma4)	4	56	100
Social Introversion Subscales (Ben- Porath, Hostetler, Butcher, & Graham)			
Shyness/ Self- Consciousness (Si1)	7	56	100
Social Avoidance (Si2)	5	58	100
Alienation- Self and Others (Si3)	9	62	100

Uniform T scores are used for Hs, D, Hy, Pd, Pa, Pt, Sc, Ma and the Content Scales; all other MMPI-2 scales use linear T scores.

5.2.9.8 Experimental content component scales (Ben- Porath & Sherwood)

Table 8

	Raw Score	T Score	Resp %
Fears Subscale			
Generalised Fearfulness (FRS1)	0	44	100
Multiple Fears (FRS2)	3	47	100
Depression Subscales			
Lack of Drive (DEP1)	5	68	100
Dysphoria (DEP2)	0	42	100
Self- Deprecation (DEP3)	3	62	100
Suicidal Ideation (DEP4)	0	45	100
Health Concerns Subscales			
Gastrointestinal Symptoms (HEA1)	1	57	100
Neurological Symptoms (HEA2)	2	54	100
General Health Concerns (HEA3)	1	48	100
Bizarre Mentation Subscales			
Psychotic Symptomatology (BIZ1)	0	44	100
Schizotypal Characteristics (BIZ2)	2	54	100
Anger Subscales			
Explosive Behaviour (ANG1)	0	39	100
Irritability (ANG2)	1	41	100
Cynicism Subscales			
Misanthropic Beliefs (CYN1)	13	68	100
Interpersonal Suspiciousness (CYN2)	2	43	100

Antisocial Practices Subscales			
Antisocial Attitudes (ASP1)	12	66	100
Antisocial Behaviour (ASP2)	2	52	100
Type A Subscales			
Impatience (TPA1)	0	34	100
Competitive Drive (TPA2)	3	45	100
Low Self- Esteem Subscales			
Self- Doubt (LSE1)	4	59	100
Submissiveness (LSE2)	2	55	100
Social Discomfort Subscales			
Introversion (SOD1)	11	68	100
Shyness (SOD2)	2	47	100
Family Problems Subscales			
Family Discord (FAM1)	3	50	100
Familial Alienation (FAM2)	2	58	100
Negative Treatment Indicators Subscales			
Low Motivation (TRT1)	2	54	100
Inability to Disclose (TRT2)	1	45	100

5.2.9.9 Critical items

The following critical items have been found to have possible significance in analysing a client's problems situation. Although these items may serve as a source of hypotheses for further investigation, caution should be used in interpreting individual items because they may have been checked inadvertently.

The percentages of endorsement for each critical item are presented in brackets following the listing of the item. The percentage of the MMPI-2 normative sample of 1,238 men who endorsed the item in the scored direction is given.

5.2.9.9.1 Acute Anxiety Scale (Koss- Butcher Critical Items)

Of the 17 possible items in this section, 1 was endorsed in the scored direction:

208. I hardly ever notice my heart pounding and I am seldom short of breath. (False)

[N= 30.0]

5.2.9.9.2 Depressed Suicidal Ideation (Koss- Butcher Critical Items)

Of the 22 possible items in this section, 6 were endorsed in the scored direction:

9. My daily life is full of things that keep me interested. (False)

[N= 14.4]

71. These days I find it hard not to give up hope of amounting to something. (True)

[N= 30.7]

130. I certainly feel useless at times. (True)

[N= 34.3]

233. I have difficulty in starting to do things. (True)

[N= 35.2]

273. Life is a strain for me much of the time. (True)

[N= 16.0]

518. I have made lots of bad mistakes in my life. (True)

[N= 27.3]

5.2.9.9.3 Threatened Assault (Koss- Butcher Critical Items)

Of the 5 possible items in this section, 2 were endorsed in the scored direction:

85. At times I have a strong urge to do something harmful or shocking. (True)

[N= 18.5]

213. I get mad easily and then get over it soon. (True)

[N= 40.5]

5.2.9.9.4 Situational Stress Due to Alcoholism (Koss- Butcher Critical Items)

Of the 7 possible items in this section, 1 was endorsed in the scored direction:

518. I have made lots of bad mistakes in my life. (True)

[N= 27.3]

5.2.9.9.5 Mental Confusion

Of the 11 possible items in this section, 2 were endorsed in the scored direction:

31. I find it hard to keep my mind on a task or job. (True)

[N= 13.3]

316. I have strange and peculiar thoughts. (True)

[N= 14.9]

5.2.9.9.6 Persecutory Ideas (Koss- Butcher Critical Items)

Of the 16 possible items in this section, 3 were endorsed in the scored direction:

216. Someone has been trying to rob me. (True)

[N= 2.6]

259. I am sure I am being talked about. (True)

[N= 18.4]

314. I have no enemies who really wish to harm me. (False)

[N= 11.6]

5.2.9.9.7 Antisocial Attitude (Lachar- Wrobel Critical Items)

Of the 9 possible items in this section, 5 were endorsed in the scored direction:

35. Sometimes when I was young I stole things. (True)

[N= 58.0]

227. I don't blame people for trying to grab everything they can get in this world. (True)

[N= 39.9]

240. At times it has been impossible for me to keep from stealing or shoplifting something. (True)

[N= 6.6]

254. Most people make friends because friends are likely to be useful to them. (True)

[N= 23.8]

266. I have never been in trouble with the law. (False)

[N= 40.9]

5.2.9.9.8 Family Conflict (Lachar- Wrobel Critical Items)

Of the 4 possible items in this section, 1 was endorsed in the scored direction:

21. At times I have very much wanted to leave home. (True)

[N= 31.9]

5.2.9.9.9 Somatic Symptoms (Lachar- Wrobel Critical Items)

Of the 23 possible items in this section, 2 were endorsed in the scored direction:

53. Parts of my body often have feelings like burning, tingling, crawling, or like "going to sleep." (True)

[N= 18.8]

255. I do not often notice my ears ringing or buzzing. (False)

[N= 21.7]

5.2.9.9.10 Sexual Concern and Deviation (Lachar- Wrobel Critical Items)

Of the 6 possible items in this section, 3 were endorsed in the scored direction:

12. My sex life is satisfactory. (False)

[N= 26.7]

34. I have never been in trouble because of my sex behaviour. (False)

[N= 19.3]

166. I am worried about sex. (True)

[N= 15.1]

5.2.9.10 Omitted items

The following items were omitted by the client. It may be helpful to discuss these item omissions with this individual to determine the reason for noncompliance with the test instructions.

15. I work under a great deal of tension.

5.2.9.11 Summary of the MMPI-2

Profile Considerations: Individual number 1's MMPI profile is indicated as being probably valid. The scales used in compiling the test conclusions were scales D, Pd, and Sc. In terms of profile frequency, 3.3% of normative men have a Pd spike equal to and slightly above 65, and 1.9% have a Pd spike significantly elevated above 65. This particular profile occurs in less than 1% of the MMPI normative sample population. This high Pd scale is probably stable over time.

Interpersonal Considerations: This profile is characterised by poor social skills and marked disturbance in interpersonal relations. Such individuals tend to be overly sensitive and resistant to the demands of others. He tries to stay aloof but may show dependency feelings. He is often suspicious of others and rejects emotional ties. Many individuals with this type of profile never marry. Because this individual feels extremely insecure and inadequate and tends to blame others for his problems he is often moody, angry, distrustful and resentful of others. His behaviour may deteriorate under distress. He may display acting- out behaviour. Being somewhat shy, he has social concerns and inhibitions. He tends to be hypersensitive about what others think of him and is occasionally concerned about his relationship with others. Being inhibited in interpersonal relationships and social situations, he may have difficulty expressing feelings towards others.

Diagnostic Considerations: These could indicate primarily a severe psychological disorder with anti- social features. Furthermore, a schizophrenic process may be considered. In terms of the supplementary scales, significant scores were for Repression (69). For the Harris- Lingoes Depression Sub Scales a score of 69 for

Subjective Depression, 70 for Psychomotor Retardation, 67 for Physical Malfunctioning, and 67 for Mental Dullness. For the Psychopathic Deviate Subscale of the Harris- Lingoes, a score of 73 for Authority Problems, 66 for Social Alienation, 67 for Self Alienation was obtained. The Schizophrenia scale of the Harris- Lingoes, had the following elevated scales; 69 for Emotional Alienation, and 71 for Lack of Ego Mastery, Conative.

Acute distress, depression and tension characterise this person. He will tend to be moody, angry and resentful of others. People with sexual maladjustment are characteristic for this type of profile. He has difficulty managing routine affairs and displays poor memory and concentration. This can affect his ability to make decisions. At times he may withdraw and become immobilized. His distress may manifest itself in somatic complaints, perhaps due to his inability to respond on an emotional level and deal with difficulties on an interpersonal level. These difficulties lead to a decrease in self- worth. This type of profile indicates some anti- social beliefs and attitudes.

Therefore, the profile indicates a severe psychological disorder as well as antisocial features, with the antisocial features being the primary consideration. The possibility of a schizophrenic process should be evaluated.

Axis I: No clear syndrome, depressive mood and anxiety might better be explained by more pervasive difficulties.

Axis II: Antisocial Personality Features.

5.2.10 The 16 Personality Factor Questionnaire

Table 9

Low	1 2 3 4 5 6 7 8 9 10	High	Scale	Raw	STEN	Adjusted
Aloof	1 2 3 4 5 **6** 7 8 9 10	Warmhearted	A	10	6	6
Concrete	1 2 3 4 5 6 7 8 **9** 10	Abstract	B	11	9	9
Unstable	1 2 3 4 5 6 7 8 **9** 10	Stable	C	23	9	9
Humble	**1** 2 3 4 5 6 7 8 9 10	Assertive	E	6	1	1
Serious	1 **2** 3 4 5 6 7 8 9 10	Enthusiastic	F	7	2	2
Undependable	1 2 3 4 **5** 6 7 8 9 10	Conscientious	G	12	5	5
Shy	1 2 **3** 4 5 6 7 8 9 10	Adventurous	H	5	3	3
Tough Minded	1 2 3 4 5 **6** 7 8 9 10	Sensitive	I	9	6	6
Trusting	1 2 3 **4** 5 6 7 8 9 10	Suspicious	L	9	4	4
Practical	1 2 3 4 5 **6** 7 8 9 10	Imaginative	M	14	6	6
Unpretentious	1 2 **3** 4 5 6 7 8 9 10	Shrewd	N	8	3	3
Confident	1 2 3 **4** 5 6 7 8 9 10	Apprehensive	O	8	4	4
Conservative	1 2 3 4 5 **6** 7 8 9 10	Liberal	Q1	10	6	6
Group Dep.	1 2 3 4 5 6 7 **8** 9 10	Self-Sufficient	Q2	17	8	8
Uncontrolled	1 2 3 4 5 6 **7** 8 9 10	Self-Control.	Q3	14	7	7
Relaxed	1 2 3 4 5 6 **7** 8 9 10	Tense	Q4	12	6	7

5.2.10.1 Warnings

The first warning indicates that the respondent may have distorted some of his responses positively. The second warning indicates that he may have distorted some of his responses negatively.

5.2.10.2 Broad clinical dimensions

This report is based on the interplay between two factors, degree of adjustment and the degree of inner control.

Adjustment Factors: This individual appears to be adequately adjusted emotionally and will cope with life in a similarly adequate manner. This is not to say that occasional problems will not occur. In explaining this, his slightly elevated threat-sensitivity, expressed as slight shyness, suggests that he is likely to react somewhat fearfully to a wide range of situations. Secondly, he is rather self- confident and resilient, with little concern for the approval of other people. This suggests an adequate emotional armour. Thirdly, he is rather prone to stress and anxiety and is usually somewhat tense and over wrought. This indicates either poor coping abilities or the presence of an environmental stressor.

Control Factors: In this case, the general effectiveness of emotional control is seen to be somewhat above average which suggests some ability to exercise emotional restraint. More specifically, he has a very realistic outlook on life and is able to exercise an uncommon degree of restraint in emotionally- charged situations. This suggests a person who presents an almost emotionless front to the world. Secondly, showing an average regard for what is conventionally considered to be right or wrong

may provide him with a level of social restraint and compliance. Lastly, he is at least somewhat socially precise and careful about living up to normal expectations. This suggests that he will tend to have set standards for his behaviour and to restrain his emotional expression in accordance with such standards.

Patterns of Social Interaction: His somewhat introverted pattern on the high- order scale suggests some movement away from social interaction moderated by some degree of warmth toward other people, reduced interesting belonging to social groups, an introspective, very cautious and inhibited lack of communication, and shyness and a tendency toward emotional restraint and constricted affect.

By itself, average warmth toward other people merely suggests the ability to get on with others while retaining some degree of restraint in his emotional expression. This may allow him to be critical and aloof at times. Having mentioned his tendency to want to be independent of social groups, note that this also implies a "rugged individualism" and a tendency to reject social norms. He may value his independence substantially. His disregard for group affiliation may constitute a temperamental tendency to withdraw rather than a need for self- sufficiency. This is quite possibly the result of a range of pathological processes. As he is rather insightful and bright, he will listen to advice and apply it if it makes sense rather than consistently to do his "own thing". With a tendency to trust others, his low group affiliation is probably the result of a preference for a reliance on his own resources rather than generated by a paranoid fear of others. In any event, his relatively positive self- esteem suggests introversion as a preference rather than a compulsion.

It is likely that he will take life far too seriously and hardly ever "loosen up" or laugh. In such cases of "fearful inhibition", it is important to look for a history of punishment and failure. As he is somewhat socialised, this may enable him to lower his defences without fear of loss of self- control. With an elevated level of insight, inhibition is quite probably not a part of a strategy to prevent social blunders from occurring. Of interest, he will appear to be rather self- confident which, in the face of social inhibition, suggests a specific fear which he tries to deal with by immobilising himself.

As he has a strong need for security and certainty in his life, he will tend to establish obsessive routines for doing things and to have an extremely high concern that others approve of what he does. He will usually rehearse actions beforehand. It is possible that he has sufficient warmth towards others to lead him not to withdraw socially despite his intense security needs. This may be associated with alcoholism. Extreme submissiveness, in this context, further suggests that he will be totally independent on others for providing him with a secure routine. Suicide is not uncommon in cases like this. He is, however, not really suspicious and will tend, rather, to be somewhat tolerant of others as long as they do not directly threaten his safety. Lastly, he is very deeply conflicted as far as inhibition is concerned. More specifically, a very introspective aspect which clashes with a low degree of inhibition suggests some form of heroic fantasy existence verging on psychosis.

Identifiable Psychological Processes: Despite a high degree of emotional stability, there are pathological signs in this profile which require additional discussion. In the light of a fair degree of personal adequacy, this is not likely to be related to guilt as he

will be somewhat insensitive to the approval or disapproval of others. Furthermore this individual may lack a sense of self, as indicated by extremely low dominance, and move from encounter to encounter while never really expressing any opinions, thoughts or ideas. As he may not be inclined to express difficulties, a deeply internalised difficulty may be fuelling that aspect of pathology which is not visible on the surface. There is reason to believe that this individual will become depressed and even physically ill very easily and will approach interactions or events with extreme caution.

The following composite scales may clarify this profile:

Table 10: Composite scales

Depressive:	6
Obsessive:	6
Manic:	3
Anxious:	6
Socially Phobic:	7
Paranoid:	5
Antisocial:	5
Passive- Aggressive:	8
Socially Dependent:	5
Socially Avoidant:	6
Narcissistic:	3
General Pathology:	3

This socially phobic pattern is characterised by low emotional stability linked to extreme shyness. This may be found separately or linked to the socially avoidant pattern which is often used as a means of controlling the anxiety which is resultant and which is socially crippling. A number of primary factors can be used to determine the exact nature of this pattern.

The passive- aggressive pattern is identified by very low assertiveness and high suspicion. Anger builds up inside as it cannot be adequately expressed and suspicion and blaming of others then leads this to being expressed in ways which satisfy the need to punish the "wrong doers"while not directly involving him.

5.2.10.3 Summary of the 16-PF

Profile Considerations: There are indications that he may have distorted some responses in a negative way and some in positive way.

Interpersonal Considerations: He has a somewhat introverted pattern on the higher-order scales which suggest movement away from social interaction. This is moderated by a slight degree of warmth towards people, which could merely suggest an ability to get on with others, reduced interest in belonging to social groups, an introspective, cautious and inhibited lack of communication. This is coupled with a shyness and tendency toward emotional restraint and constricted affect. This may allow him to be critical and aloof at times. He rejects social norms and values his independence, with his independence suggesting a temperamental tendency to withdraw rather than a need for self- sufficiency. This withdrawal is also not out of a paranoid fear of others, but rather a preference instead of a compulsion.

Diagnostic Considerations: At times this person will become depressed and even physically ill. His socially avoidant pattern may be a means of controlling anxiety, which can at times become overwhelming. A passive- aggressive pattern can develop due to low assertiveness and possible suspicion. Anger may build up inside but cannot be adequately expressed, it is released in a manner that does not directly involve the targets of such anger. He may establish obsessive routines to deal with anxiety arising from a lack of certainty and security in his life.

5.3 Individual number 2

5.3.1 Brief history and background

This individual is a white Afrikaans- speaking male in his late- thirties. At the time of the murders he was in his late- twenties. He was previously married. He is the middle child of three children and his biological parents are still married. He reports having been sexually abused by his elder brother from the age of 10 until the age of 15. There is no history of family violence. There is no reported history of violent pornography nor sexual fetishes. He completed a primary and secondary education of ten years, is a tradesman and was gainfully employed for various periods after the completion of his education.

The murders for which he was charged occurred over a three- year period. The victims were white and black males. He had a previous conviction for theft.

5.3.2 Clinical impressions

This individual was meticulously dressed. He wore slip- on leather shoes, had seams sown into his prison green pants, cuffs on the bottom of his pants. His clothes were

well ironed, both his head and face were neatly shaved and he was wearing aftershave. He was cautious about trusting us and wanted to first consult with his lawyer, at one point he seemed to be testing us by asking who the other participants were. He was friendly when he entered and shook hands with us. He too asked for a cigarette out of my top pocket. He presented himself well in his appearance and in posture. He appeared emotionally distant and rather intellectual.

5.3.3 Test behaviour

This individual was cooperative throughout the testing process. He expressed no problems understanding any of the test instructions. He was very willing to partake in any process that he felt would help improve himself.

5.3.4 Medical investigations previously conducted

As with individual number 1 there were no medical problems detected during his forensic investigation. Some of the tests conducted were; thyroid function test, HIV Elisa, Urine- Cannabis, P- Glucose, Liver functions, Urea and electrolytes, Full blood count and platelets, chest examinations, and CT scan. There was no significant psychiatric history prior to the offences. There were two parasuicide attempts in 1981 and 1990. After the 1990 parasuicide he was comatose for two weeks, his age at this time was approximately 27. During the time of the offences a general practitioner had treated him for insomnia and "stress". He described two episodes of having lost consciousness following motor vehicle accidents in 1977 and 1984 at the ages of 14 and 21 respectively. There is no history of epilepsy. He had been treated for gastric ulcers since 1979 when he was approximately 16 years of age. He currently experiences stomach related problems. There was previously a long history of alcohol

abuse. There is also a intermittent history of cannabis and mandrax (methaqualone) abuse. This individual was deemed fit to stand trial.

Thyroid Function Test: results normal

HIV Elisa: Negative

Cannabis- Urine: Negative

Serum Chemistry

P- Glucose (Random): Within normal range

Liver Function Tests (Blood):

S- Bilirubin total: 26 umol/l

S- Bilirubin conjugated: 8 umol/l

S- Albumin: 69 g/l

Urea and Electrolytes

S- Carbon Dioxide: 29 mmol/l

Full Blood Count & Platelets

MCH: 33.7 pg

Differential Count

No flags

Erythrocyte Sedimentation Rate

No flags

Chest Examination

The heart is normal size, shape and position and there is no evidence of cardiac chamber enlargement. The aortic arch is left- sided and normal and the pulmonary outflow tract is within normal limits. Both lung fields are clear. The hila are normal

and there is no evidence of pleural reactions. No other lung pathology noted. No evidence of Koch's is noted.

CT Scan Brain

A normal pre and post contrast CT brain scan was obtained with a normal density of the brain tissue in the cerebral hemispheres and in the cerebellum with a normal size, shape and position of the ventricles. There is no evidence of intra- cranial haemorrhage, neither were there any mass of cystic lesions demonstrated. There are also no abnormal calcifications in the brain. No vascular abnormalities were noted.

5.3.5 Intelligence level

This individual's intelligence level was measured by the South African Wechsler Adult Intelligence Scale. His full- scale IQ was in the normal range. His IQ, as measured by the same instrument at the time of his forensic evaluation of competency to stand trial was also in the normal range. This also corresponds with the researcher's clinical impression of his level of intelligence. For the full- scale see appendix 2.

5.3.6 Interactional analysis

5.3.6.1 How does he speak?

Blaming: he seems to imply that others influenced him to do things he was against doing. One gets the feeling from the language he uses that this person has an external locus of control. This gives the impression that he tries to put himself in a good light.

Melodramatic: his tone of voice and mannerisms give the impression he an actor on a stage, this does not necessarily mean he is not telling the truth. Sometimes certain traumatic events he describes are casually discussed while others are given great detail, this can give the impression of inconsistency in his story.

Story- telling: when he speaks it seems like he is narrating a story. What he says seems to be logically told, he speaks in a manner that makes the listener feel like he is going through a process. This creates the impression that the interviewee wants the listener to fully understand his position and the circumstances surrounding the events.

Friendly: the speaker communicates in a friendly manner and makes the listener feel at ease, he has a very gentle way about him. He is polite and well mannered.

5.3.6.2 How does he speak about the problem?

Blaming: Blaming others in a subtle manner he often describes how people dominated him, from his father, brother to people with whom he had relationships.

Narrative: Again his manner of describing the crimes was one of a narrative, a story. He places all the crimes in a context before discussing them, this creates the impression that he wants people to be able to understand how and why the events occurred. This also gives the impression it is very important for him that people understand his involvement in what happened and how he became involved and to what degree. He gives the impression of an innocent victim, forced to participate involuntarily with threats if he didn't cooperate.

Ambiguity: the type of language he uses sometimes indicates that he is uninvolved and clueless about what happened and why, but other times he seems to know more about particular events than in comparison to his previous dialogue.

Helpless: he gives the impression of being a helpless, coerced victim in the events that took place.

5.3.6.3 In what context does the problem occur?

The problem occurred in the presence of a second individual with whom the subject was involved with romantically at the time. There was a strong emotional tie between the two individuals.

5.3.6.4 What has been done to solve the problem?

During the murders this individual pleaded with his partner to stop, he offered to support his partner financially and take care of his partner.

After the murders this individual became religious and has tried to improve himself through scholarly activities and teaching other inmates inside the correctional facility.

5.3.6.5 Nature of relationships with people

Symbiotic: he needs other people, especially romantically yet it would appear that in return for his emotional needs being satisfied the other people abuse him.

Authoritarian: his partner and other important people near him seem to dominate him.

Assimilation: he adjusts to fit in with the people he is with, whether it be in the workplace or casual relationships, or romantic relationships. This allows him to be manipulated easily.

Dependant: he appears to be dependant on others approval and sanction.

5.3.6.6 Context of interview

Correctional Service Facility: Maximum Security

Two interviewers in dual role of psychologists and researchers.

Voluntary participation.

Video camera.

5.3.6.7 Strong points

Motivated

Post school training

Humour

5.3.6.8 Negative

Very dependant on others therefore easily manipulated.

5.3.6.9 Effect of client on researcher

Likeable and elicits feeling of sorrow for the individual.

5.3.6.10 Summary of the interactional analysis

The following points are highlighted from the interactional analysis. His manner of speaking can be characterised as 'blaming'. He would imply that others had influenced his behaviours. His manner of describing events were in a slightly melodramatic fashion, as if he was narrating a story. He often created the impression that he was a helpless victim of others' manipulations. The murders occurred with another individual with whom this person was involved. In this relationship individual number 2 was described as being the more submissive one.

In terms of the nature of his relationships with others, they tend to be symbiotic in nature, him needing others to satisfy his emotional needs, but in return he was often emotionally abused. Relationships were perceived as authoritarian with him being the submissive partner. This ties up with a dependent stance, he would assimilate to others' behaviours, for example at a new workplace he would start to behave as his co- worker would. He admittedly needed the sanction and approval of others.

The problem would usually appear in the presence of a second individual, with whom the individual was romantically involved. There was a strong subjective bond between this individual and his partner.

5.3.7 Thematic Apperception Test (for full protocol see appendix 3)

5.3.7.1 Card 1

Approach to the Test and to Demands

The person's approach to the test is rather fast, 5 seconds. He plays for time as indicated by the "uh" but then launches into the test. He sees the young boy as a central figure, sees the violin, refers to it indirectly and what it is used for. But when the impact of it hits him he withdraws faster than he began and then starts to increasingly distance himself from the stimulus of the card to the point where he carefully places it in a display case (but doesn't play it) and the photos are placed somewhere and protected.

Outside World and its Demands

The fact that he initially acknowledges all the elements of the demands (the boy, the violin and the fact that it is supposed to be played) but later tries hard to distance himself from them, amongst others he tries to move to the past by saying it belongs to a person from the past. A hypothesis can be drawn that he is capable of determining demands, but realises he cannot fulfill them. He then makes use of inadequate defence mechanisms. When he describes the demands it seems as though he first intellectualises about them, using the word "think" and then wonders what the world expects of him "what must he play?". It is not about what he himself wants to do.

When the demands on himself become too much (before he has even attempted to deal with them) he uses the above mentioned techniques to place them outside of his reach. He continually puts it out of his reach: it is first a taboo (it belonged to his father or another important figure), then it is placed in a display case, eventually the whole situation becomes a photograph.

Self- Concept

The boy feels inferior to the person who owns the violin. If this appears on another card one can make a hypothesis of feelings of inferiority in relationships.

Attitude Towards Other People (and Authority) in His World

Although he says he must play the violin, implying that other people expect it of him, he doesn't involve anyone in a supportive role in the process. Although the authority figure is not physically present he still plays an important inhibiting role so the person almost doesn't dare play the violin.

Aspirations, Ambitions, Possibilities of Achieving Success

An hypothesis can be made that he is paralysed in the shadow of the authority figure from the past, he is therefore incapable of having ambitions or achieving success. A hypothesis of depression can also be considered, because the father/ authority figure is no longer present, but is a memory or reminder that must be preserved. But the opposite possibility also exists, perhaps he is there and the testee protects himself from him by trying to pack him away.

5.3.7.2 Card 2

Entrance to the Card

His entrance is much longer than on the other cards, 18 seconds. This can indicate feelings of insecurity in interpersonal relations.

Interpersonal Relations

Initially the two women, "twee vroumense", and the man are not seen in relation to each other. The link is only made later in the response. The hypothesis made here is that the person is not very content in his family situation, and feels isolated within it.

The word "vroumense", 'women' is a somewhat crude word, and it can be queried whether his attitude towards the prominent women in his life is not perhaps contemptuous. If he says that the woman "vertoon wragtig swanger" then his choice of words are again crude and again possibly in a despising manner. It can also indicate that he is fascinated by this. Just as in card 1 the authority figure is from the past. The main figure is more distanced from them than the card suggests. Two themes that appear in card 1 appear here also: the girl's emotions when she wants to look back and reminisce, while she is actually looking forward is one of heartache that also inhibits her since she wants to move on.

5.3.7.3 Card 3BM

The themes of heartache and depression appear again on this card. When this person is confronted with frustration he gives up all hope. To a degree the aggression is directed inwards by means inflicting pain on the self with an injection. He wants to make it a firearm but tones it down to a injection needle. A firearm would be a more

aggressive way to react towards the self. The term "verslaaf" (addict) indicates dependency. Dependency in the way that he cannot defend himself against prominent (inhibiting) authority figures, this had already appeared on cards 1 & 2. The fact that he calls the figure "dit" (it) and doesn't ascribe a sex to the figure can possibly indicate a uncertainty with regards to his own sexual identity.

5.3.7.4 Card 4

Although incidences appear here where the person seems to identify with the card, and from the use of the word "kinderjare" (childhood) can assume that the person is an adult, he projects the card onto his parents, and sees them here in a relationship. Hypotheses that can be made from this are: he himself is afraid of intimate relationships, or that his relationship with his parents inhibits him.

In the relationship he sees on the card the father is cold and inaccessible and aloof. He displays no heartache or sorrow. The mother pleads, speaks nicely, tries hard to make contact, but the father has completely severed contact.

5.3.7.5 Card 6BM

The test person easily sees the mother- child relationship. The theme in this card is the same as in card 4, with the difference that here it is the child that is pleading and the mother is inaccessible. The theme is that of rejection.

In one incident he does try to escape from the theme of rejection by talking about "slegte nuus" (bad news). He isn't completely successful and relapses with renewed zeal into the theme of rejection. His choice of words parallel those used on card 4:

Boy (mother in card 4) asks, pleads, begs, (hat in hand, 'please' in his eyes). The mother (father in card 4) is cold, aloof, bitter and not heart- sore. This heart- sore/ ache becomes a domineering theme in the cards. The 'good' people in the cards have it but the other people do not.

5.3.7.6 Card 7BM

Here he also easily sees the card's stimulus value of father- son relationship. When one looks at the testee's response one can hypothesize that this card is very important to him. The relationship is sketched as a good one. The father speaks while the son listens attentively, in the previous cards one person was always speaking, pleading, while the other was always cold, aloof and inaccessible. In this card where the testee identifies with the son, the communication problem is remedied by the son. In the previous two cards he was powerless- either the parents were speaking with each other and he cannot solve the problem, or the mother remains aloof when he wants to try and communicate with her.

Here the father speaks and the son can take the initiative to listen, to be with him. Then he comes loose, he becomes free to carry on, to continue with his life. Now his father is no longer in the past, in a cupboard or book (card 1)- he is next to him, and this empowers him to carry on.

There are two reservations with regards to the above mentioned interpretations:

i) The response seems very idealistic and this could possibly due to wish-fulfillment: perhaps his father is really unapproachable and his life really as it appears on the previous cards- his father's attitude still inhibiting him.

ii) Logically following the preceding, will the individual ever be able to shake himself loose from this inhibiting impact on his life?

5.3.7.7 Card 8BM

Traditionally this card was the overt- aggression card because there were many aggressive and violent responses offered by respondents. There are also opportunities for sublimation. In the response the person falls back upon themes of powerlessness and the inability to do something about bad circumstances, when he responds that he is being operated upon. He escapes by using fantasy and perhaps even death when he mentions the spirit or soul ('gees') which leaves the body. The thought that he wants to move on appears again here, but here it is in the form of a fantasy and even possibly a death- wish. Different to some of the previous cards he doesn't fall back upon the past which entraps him but rather makes use of an unrealistic method to escape it.

5.3.7.8 Card 10

The person's shortest responses appear on this card. A hypothesis around this can be that intense closeness or intimacy is an area of uncertainty for him, possibly even anxiety. His response contains uncertainty and this can support the above mentioned hypothesis; "...mekaar omhels, jy weet, blydskap, ... kan ook wees... dat die man die vrou probeer vertroos." But if one puts aside this hypothesis there is the possibility of signs of tenderness. If one compares it with other appropriate cards the following comes to light: the message is different in comparison to card 4 where the person is cold and inaccessible towards his wife. If one compares card 10 to card 7BM where the person the testee identifies with is capable of listening and caring (as opposed to

his father in card 4) it might be possible that the side of him that can care cautiously comes to light.

5.3.7.9 Card 13MF

The testee lingers first in the beginning, "Hier... wat ek sien is, ek sien uh..." this can indicate that he is uncomfortable with the impact of the card. He toys with two types of emotions in the context of sexuality:

* Remorse: because he did something wrong. This feeling overwhelms the first part of his response. Even if he has normal sexual relations it is wrong and he has remorse. He could have also progressively done worse, he could have raped or killed her.

* The second emotion is softer, it is grief, sorrow, a theme that has presented itself repeatedly throughout the test. Sorrow because she is dead and he discovered her. Strictly speaking in this card he is grieving over something he has done. He then tries to further excuse himself by saying it was a suicide.

5.3.7.10 Central themes in individual number 2's Thematic Apperception Test

1. Noticeably in many of the cards there are indications that this person's past interpersonal relations were emotionally traumatic and that he is continually drawn back to these when he actually wants to be free from them to carry on with his life. It is almost as if his past was so traumatic that it has a hold on him preventing his from creating a future. Twice it is indicated that the testee tries to escape the grip of the past, in card 7BM and card 10, except if 7BM is wish fulfilling, an option which cannot be discarded.

2. Hand in hand with the above- mentioned theme is the theme of sorrow and depression which he struggles to escape.

5.3.7.11 Summary of TAT

Profile Considerations: This individual was fairly comfortable with the cards, he did not seem to seek reassurance from the tester.

Interpersonal Considerations: This individual is able to notice the demands society places on him by tries to distance himself from them, via ineffective means, such as avoidance. There are also indications of feelings of inferiority. In terms of the demands placed on him he feels relatively alone, without any support in achieving those goals. Women are perhaps seen with slight contempt by this individual. Familial relations appear almost non- existent and very inhibited. Indications of dependency appear in the test responses. Themes of rejection in interpersonal relations are also common. The idea of the sanctioning of his behaviour by a more 'senior' person as being important, featured again in this test. His powerlessness in most interpersonal relations is noticed. Traumatic interpersonal relations seem to characterise this individual's history, these still play a strong role in the determining of his current relations.

Diagnostic Considerations: This individual tends to withdraw from responsibilities, especially of an interpersonal nature. These cause great anxiety for him which he has trouble controlling, this can leads to various somatic complaints. It is the very awareness coupled with the inability to effectively resolve the situation that creates the anxiety. Feelings of inferiority and depression are prevalent on the test responses. The

feelings of inferiority and the inability to deal with anxiety provoking situations can lead to him preferring a dependent position in relation to stronger figures, as a means of coping.

5.3.8 Millon Clinical Multiaxial Inventory IIIrd Edition

5.3.8.1 Capsule summary

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for non- clinical purposes may have distorted reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to inmates or their relatives.

Interpretive Considerations

The client is a 36- year- old divorced white male with 10 years of education. He is currently being seen as a correctional inmate, and he did not identify specific problems and difficulties of an Axis I nature in the demographic portion of his test.

Profile Severity

On the basis of the test data, it may be assumed that the inmate is experiencing a severe mental disorder, further professional observation and inpatient care may be appropriate. The text of the following interpretive report may need to be modulated upward given this probable level of severity.

Possible Diagnoses

He appears to fit the following Axis II classifications best: Paranoid Personality Disorder, with Avoidant Personality Traits, Depressive Personality Traits, and Schizotypal Personality Features. Axis I clinical syndromes are suggested by the client's MCMI-III profile in the areas of Delusional (Paranoid) Disorder, Generalized Anxiety Disorder, and Psychoactive Substance Abuse NOS.

Therapeutic Considerations

This inmate often feels misunderstood, tense, and depressed. Overly sensitive to how others react to him, he frequently overreacts, withdrawing or displaying self-derogating attitudes. He may be erratic in relating to therapists and may have been disappointed in or ambivalent about plans for his treatment. Calm expressions of genuine interest and attention may help moderate his discomfort and depressive feelings.

Figure 5: MCMI-III Profile

ID NUMBER: Valid Profile
PERSONALITY CODE: 2A 2B ** 1 * 3 8A 8B 6B + 7 6A 5 " 4 ' ' // P S ** - * //
SYNDROME CODE: - ** A T R * // - ** PP * //
DEMOGRAPHIC: ,/CI/M/36/W/D/10/--/--/----/--/----/

CATEGORY		SCORE RAW	SCORE BR	PROFILE OF BR SCORES (0 / 60 / 75 / 85 / 115)	DIAGNOSTIC SCALES
MODIFYING INDICES	X	153	88		DISCLOSURE
	Y	11	51		DESIRABILITY
	Z	12	65		DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	17	84		SCHIZOID
	2A	21	97		AVOIDANT
	2B	17	94		DEPRESSIVE
	3	15	73		DEPENDENT
	4	0	0		HISTRIONIC
	5	12	39		NARCISSISTIC
	6A	8	48		ANTISOCIAL
	6B	16	64		SADISTIC
	7	22	51		COMPULSIVE
	8A	16	72		NEGATIVISTIC
	8B	13	70		MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	21	90		SCHIZOTYPAL
	C	12	67		BORDERLINE
	P	26	108		PARANOID
CLINICAL SYNDROMES	A	10	83		ANXIETY DISORDER
	H	2	53		SOMATOFORM DISORDER
	N	9	61		BIPOLAR: MANIC DISORDER
	D	8	69		DYSTHYMIC DISORDER
	B	6	63		ALCOHOL DEPENDENCE
	T	16	78		DRUG DEPENDENCE
	R	17	76		POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	9	60		THOUGHT DISORDER
	CC	2	33		MAJOR DEPRESSION
	PP	11	76		DELUSIONAL DISORDER

5.3.8.2 Response tendencies

The BR scores reported for this individual have been modified to account for the high self- revealing inclinations indicated by the high raw score on Scale X (Disclosure) and the psychic tension indicated by the elevation on Scale A (Anxiety).

5.3.8.3 Axis II: personality patterns

The following paragraphs refer to those enduring and pervasive personality traits that underlie this man's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up Axis I clinical syndromes, this section concentrates on his more habitual and maladaptive methods of relating, behaving, thinking and feeling.

There is reason to believe that at least a moderate level of pathology characterises the overall personality organisation of this man. Defective psychic structures suggest a failure to develop adequate internal cohesion and a less than satisfactory hierarchy of coping strategies. This man's foundation for effective intrapsychic regulation and socially acceptable interpersonal conduct appears deficient or incompetent. He is subjected to the flux of his own enigmatic attitudes and contradictory behaviour, and his sense of psychic coherence in often precarious. He has probably had a checkered history of disappointments in his personal and family relationships. Deficits in his social attainments may also be notable as well as a tendency to precipitate self-defeating vicious circles. Earlier aspirations may have resulted in frustrating setbacks and efforts to achieve a consistent niche in life may have failed. Although he is usually able to function on a satisfactory basis, he may experience periods of marked emotional, cognitive, or behavioural dysfunction.

The MCMI-III profile of this man appears to reflect an intense conflict between his desire to withdraw from personal relationships, his fear of independence, and a growing sense of unworthiness and despondency. He would very much like to depend on friends and family, but he has learned to anticipate disillusionment and

discouragement in these relationships. His deflated sense of self- worth and his expectation of personal failure and social humiliation limit any efforts he might make to become autonomous or to overcome his dispirited feelings. Moreover, he believes that others have either deprecated or disapproved of his occasional attempts at confidence building or self- assertion. He sees no alternative but to give up hopelessly or to give in to his gloomy and sorrowful state. This restriction of choice stirs deep resentments within him. As a consequence, he may experience anxiety and dejection, interspersed occasionally with petulant, erratic, and passive- aggressive acts, and periodic criticism of others for their lack of support. The dependency security that he seeks, however, may be seriously jeopardized when he voices his discontent too strongly. To bind his resentments and thereby protect against further loss, he will characteristically withdraw, becoming even more anxiously depressed. The referring clinician may want to determine whether this man's moods change almost from day to day and whether he feels empty and hollow at times.

The erratic moodiness of this man may only add to the humiliating reactions he gets from others, which may serve to further reinforce his self- protective and depressive withdrawal. Every avenue of potential gratification seems full of conflict. He fears standing on his own because of his shaky sense of self- esteem. On the other hand, he cannot depend on others because of his fearful mistrust of them. Anticipating disillusionment, he may behave petulantly and irritably, thereby incurring the very rejection and disappointment he expects but seeks to avoid.

Unable to overcome the feeling that life is meaningless and empty, and unable to muster the skills to overcome the deficits he sees within himself, he is likely at times

to become cranky, if not explosive, but then to turn against himself, expressing self-pity and a deep sense of personal unworthiness and uselessness. Often feeling misunderstood, unappreciated, and demeaned by others, he may add to his dismay by turning ridicule and contempt on himself. He sees few of the attributes he admires in others within himself, and this awareness intrudes upon his thoughts and interferes with his behaviour, ultimately upsetting his sense of identity and his capacity to cope effectively with ordinary life tasks. Extended periods of exhaustion and chronic depression may be typical. Simple tasks may demand more energy than he can muster, What few efforts he can make may give way to emotional outbursts under the slightest of family or social pressures.

5.3.8.4 Axis I: clinical syndromes

The features and dynamics of the following Axis I clinical syndromes appear worthy of description and analysis. They may arise in response to external precipitants but are likely to reflect and accentuate several of the more enduring and pervasive aspects of this man's basic personality makeup.

A number of delusional facets to this man's thinking (eg. Transient ideas of reference, mixed jealousy, and persecutory beliefs) interweave with other features to constitute a mini- paranoid episode. He believes that he has been betrayed or forsaken by persons whose support he had hoped to gain. His previously repressed resentments have slipped through once- adequate controls, breaking through as irrational, but brief, expressions of anger and suspicion. Tensions are likely to accumulate, compelling him to be quite touchy and irritable.

That this aggrieved and unhappy man reports the symptomology of an anxiety disorder is not unexpected. Much of his run- of- the- mill existence may be fraught with discontent and suffering; hence, that he notes the diffuse fears, mental distractibility, and fatigue that typify the anxiety syndrome should not be surprising. Plagued by doubts, expecting the worst, and repeatedly undoing opportunities to better his circumstances, this man seems to create life stressors that promote the worries and anguish that characterise his general anxiety state.

This man's MCMI-III responses suggest that he has abused or is currently abusing drugs. Whether these agents are legal or illicit is not possible to determine from these test results, but whatever their origin, they have probably been maintained as instruments to help relieve the persistent tension and social inadequacies that this man experiences interpersonally. The drugs may embolden him, although more probably is their function in generating feelings and fantasies that supplant the alienation of his daily reality.

Related to but beyond his characteristic level of emotional responsivity, this man appears to have been confronted with an event or events in which he was exposed to a severe threat to his life, a traumatic experience that precipitated intense fear or horror on his part. Currently the residuals of this event appear to be persistently re-experienced with recurrent and distressing recollections, such as in cues that resemble or symbolise an aspect of the traumatic event. Where possible he seeks to avoid such cues and recollections. Where they cannot be anticipated and actively avoided, as in dreams or nightmares, he may become terrified, exhibiting a number of symptoms or intense anxiety. Other signs of distress might include difficulty falling asleep,

outbursts of anger, panic attacks, hypervigilence, exaggerated startle response, or a subjective sense of numbing and detachment.

5.3.8.5 Noteworthy response

The client answered the following statements in the direction noted in parentheses. These items suggest specific areas that the clinician may wish to investigate.

Health Preoccupation

No items endorsed

Interpersonal Alienation

10. What few feelings I seem to have I rarely show to the outside world. (True)

18. I'm afraid to get really close to another person because it may end up with my being ridiculed or shamed. (True)

27. When I have a choice, I prefer to do things alone. (True)

48. A long time ago, I decided it's best to have little to do with people. (True)

63. Many people have been spying into my private life for years. (True)

69. I avoid most social situations because I expect people to criticise or reject me. (True)

92. I'm alone most of the time and I prefer it that way. (True)

99. In social groups I am almost always very self- conscious and tense. (True)

105. I have little desire for close relationships. (True)

161. I seem to create situations with others in which I get hurt or feel rejected. (True)

165. Other than my family, I have no close friends. (True)

167. I take great care to keep my life a private matter so no one can take advantage of me. (True)

174. Although I'm afraid to make friendships, I wish I had more than I do. (True)

Emotional Dyscontrol

9. I often criticise people strongly if they annoy me. (True)

83. My moods seem to change a great deal from one day to the next. (True)

96. People have said in the past that I became too interested and too excited about too many things. (True)

116. I have had to be really rough with some people to keep them in line. (True)

134. I sometimes feel crazy- like or unreal when things start to go badly in my life. (True)

Self- Destructive Potential

24. I began to feel like a failure some years ago. (True)

154. I have tried to commit suicide. (True)

Childhood Abuse

81. I'm ashamed of some of the abuses I suffered when I was young. (True)

132. I hate to think about some of the ways I was abused as a child. (True)

Eating Disorder

121. I go on eating binges a couple times a week. (True)

163. People say I'm a thin person, but I feel that my thighs and backside are much too big. (True)

5.3.8.6 Possible DSM-IV multiaxial diagnoses

The following diagnostic assignments should be considered judgements of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-III differ somewhat from those in the DSM-IV, but there are sufficient parallels in the MCMI-III items to recommend consideration of the following assignments. It should be noted that several DSM-IV Axis I syndromes are not assessed in the MCMI-III. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self- report inventories such as the MCMI-III.

Axis I: Clinical Syndrome

The major complaints and behaviours of the inmate parallel the following Axis I diagnoses, listed in order of their clinical significance and salience.

297.10 Delusional (Paranoid) Disorder

300.02 Generalised Anxiety Disorder

305.90 Psychoactive Substance Abuse NOS

Axis II: Personality Disorders

Deeply ingrained and pervasive patterns of maladaptive functioning underlie Axis I clinical syndromal pictures. The following personality prototypes correspond to the

most probable DSM-IV diagnoses (Disorders, Traits, Features) that characterise this inmate.

Personality configuration composed of the following:

301.00 Paranoid Personality Disorder with Avoidant Personality Traits

Depressive Personality Traits and Schizotypal Personality Features

Course: The major personality features described previously reflect long- term or chronic traits that are likely to have persisted for several years prior to the present assessment. The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

Axis IV: Psychosocial and Environmental Problems

In completing the MCMI-III, this individual identified the following problems that may be complicating or exacerbating his present emotional state. They are listed in order of importance as indicated by the client. This information should be viewed as a guide for further investigation by the clinician.

None Identified.

5.3.8.7 Summary of the MCMI-III

Profile Considerations: The Base Rate scores for this profile were modified to account for the high self- revealing inclinations indicated by a high raw score on scale X (Disclosure) and the psychic tension indicated by the elevation on scale A (Anxiety). The profile was determined as being valid.

Interpersonal Considerations: There is a moderate level of pathology that characterises this individual's personality structure and therefore interpersonal behaviour. There are indications that he has failed to develop a satisfactory hierarchy of coping strategies, with his foundation for socially acceptable interpersonal conduct seems to be deficient or incompetent. His behaviour is influenced by the flux of his own enigmatic attitudes and is often contradictory. There is a history of disappointments in interpersonal relations, including familial relationships. His shortcomings in social attainments are noticeable as well as a tendency to precipitate self- fulfilling prophecies in terms if interpersonal failures. Earlier attempts at achieving social attainments may have resulted in frustrating setbacks, leading to him being unable to achieve a niche in life.

This individual experiences a conflict between his need to withdraw from interpersonal relationships, his fear of independence, and a growing sense of unworthiness and despondency. While he would like to be able to depend on friends and family, history has taught him to anticipate disillusionment and discouragement from these relationships. This low sense of self- worth and expectation of interpersonal failure and humiliation limit any attempts he might make to become autonomous or overcome dispirited feelings. In addition, he feels that others have thwarted or disapproved of his rare attempts at confidence building or self- assertion. This restriction in his available interpersonal choices stirs resentment in him, consequently he may experience anxiety and dejection, interspersed with occasional passive- aggressive attacks, and periodic criticism of others for lack of support. The dependency security he seeks, can be jeopardized when he voices strong criticism, to

bind his resentments and thereby protect himself from further loss he will tend to rather withdraw, leading to him becoming even more anxiously depressed.

His erratic moodiness adds to the humiliating reactions he gets from others, thus reinforcing his self- protective and depressive withdrawal. Every avenue of potential gratification seems full of conflict. While he fears standing alone because of his shaky sense of self- esteem, he cannot depend on others because of his fearful mistrust of them. Anticipating disillusionment, he may behave in a manner that incurs the very rejection and disappointment he expects yet paradoxically seeks to avoid. This pattern of interpersonal behaviour leads to him feeling that life is meaningless and empty, this coupled with his inability to effectively change the situation, leads him to become cranky, at times explosive, but then to turn the aggression onto himself, expressing self- pity and a deep sense of personal unworthiness and uselessness. This ridicule and contempt is turned onto himself. Simple tasks may demand more energy than he can muster, and what few efforts he can make give way to emotional outbursts under the slightest family or social pressure.

Diagnostic Considerations: As previously indicated the profile suggests that there is a mild level of pathology characterising the overall personality organisation of this man. His sense of self is often precarious and he often precipitates a self- defeating vicious circle in terms of interpersonal disappointments. Although he is usually able to function on a satisfactory basis, he may experience periods of emotional, cognitive, or behavioural dysfunction. As mentioned, this individual expresses an intense conflict between his desire to withdraw from others, a fear of independence, and an increasing sense of unworthiness and despondency as a result of this behaviour. This pattern stirs

deep resentments within him, resulting in him experiencing anxiety and dejection, with passive- aggressive behaviours as a result. His moodiness only adds to the negative reactions received by others, further enforcing a depressive withdrawal. He is often overcome by feelings of hopelessness and meaninglessness, leading him to become cranky and explosive, which is often turned against himself. Extended periods of exhaustion and chronic depression may be typical.

His thinking may have delusional facets to it in the form of transient ideas of reference, mixed jealousy, and persecutory beliefs, thus creating mini- paranoid episodes. He exhibits signs of heightened anxiety which are characterised by diffuse fears, mental distractibility, and fatigue. He is plagued by doubts, expecting the worst, and repeatedly sabotaging opportunities to better his circumstances. There are indications that he is or was previously abusing drugs. These can be used as means to help relieve persistent tension and social inadequacies. They may also serve to help relieve the anxiety surrounding traumatic events he has experienced. Residuals of this include persistent re- experiencing of the event, recurrent and distressing recollections such as cues that resemble or symbolise an aspect of the traumatic event. Avoidance behaviour is present to deal with such cues. When such cues come in the form of dreams or nightmares he may become terrified, experiencing intense anxiety. Other signs might include difficulty falling asleep, anger outbursts, panic attacks, hyper vigilance, exaggerated startle response, or a subjective sense of numbing and detachment.

The following possible DSM-IV diagnostic features were indicated by the test:

Axis I: Delusional (Paranoid) Disorder

Generalised Anxiety Disorder

Psychoactive Substance Abuse NOS

Axis II: Paranoid Personality Disorder

with Avoidant Personality Traits

Depressive Personality Traits

and Schizotypal Personality Features

5.3.9 The Minnesota Multiphasic Personality Inventory 2nd Edition

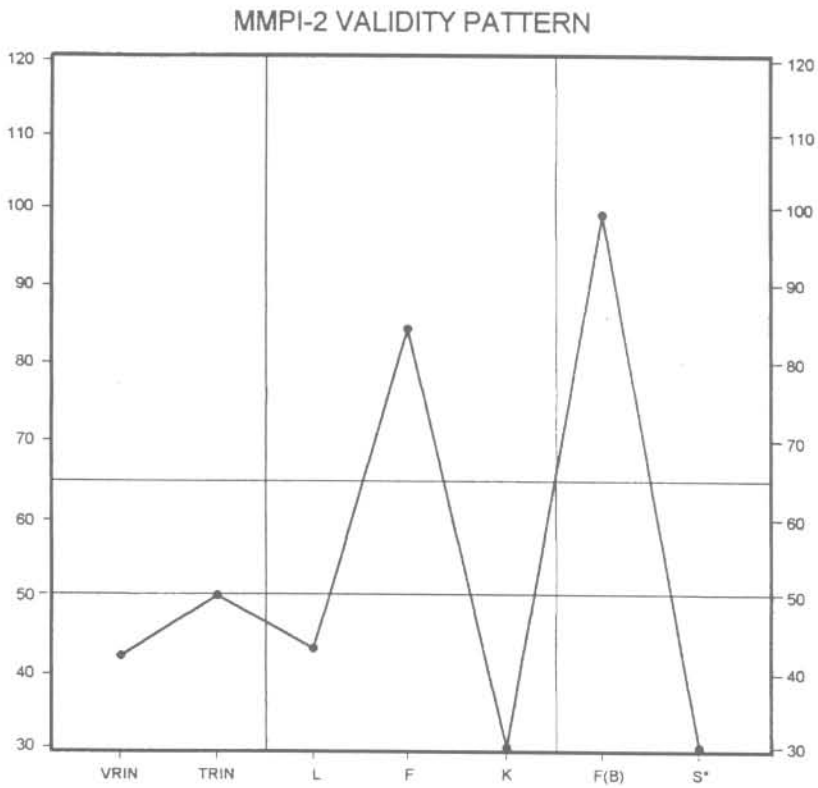
5.3.9.1 Profile validity

This MMPI-2 profile should be interpreted with caution. There is some possibility that the clinical report is an exaggerated picture of the client's present situation and problems. He is presenting an unusual number of psychological symptoms. This response set could result from poor reading ability, confusion, disorientation, stress, or a need to seek a great deal of attention for his problems.

His test- taking attitudes should be evaluated for the possibility that he has produced an invalid profile. He may be showing a lack of cooperation with the testing or he may be malingering by attempting to present a false claim of mental illness. Determining the sources of his confusion, whether conscious distortion of personality deterioration, is important because immediate attention may be required. Clinical patterns with this validity profile are often confused and distractible and have memory problems. Evidence of delusions and thought disorder may be present. He may be exhibiting a high degree of distress and personality deterioration.

The client's response to items in the latter portion of the MMPI-2 were somewhat exaggerated in comparison to his responses to earlier items. There is some possibility that he became more careless in responding to these latter items, thereby raising questions about that portion of the test. Although the standard validity and clinical scales are scored from items in the first two- thirds of the test, caution should be taken in interpreting the MMPI-2 Content Scales and supplementary scales, which include items found throughout the entire profile.

Figure 6



	VRIN	TRIN	L	F	K	F(B)	S*
Raw Score:	3	9	2	16	4	14	5
T Score:	42	50	43	85	30	100	30
Response %:	100	100	100	98	100	100	100

Cannot Say (Raw):	2	Percent True:	63
F-K (Raw):	12	Percent False:	37
F(p) (Raw)*:	6	F(p) (T-score)*:	84

5.3.9.2 Symptomatic patterns

This report was developed using the Pa and Sc scales as the prototype. The client appears to be quite confused and disorganised and is experiencing severe personality deterioration. His MMPI-2 clinical profile reflects and active, florid psychotic process, which includes a loss of contact with reality, inappropriate affect, and erratic, possibly assaultive, behaviour. He is preoccupied with bizarre ideas and abstract thoughts, and probably has delusions and hallucinations. He tends to project blame onto others and appears to withdraw into fantasy in an attempt to deal with his distress. In an interview, he is likely to be circumstantial, tangential, and disorganised. He may not be able to contribute to his own defence in a legal hearing because his behaviour is inappropriate and his thoughts are illogical.

5.3.9.3 Profile frequency

Profile interpretation can be greatly facilitated by examining the relative frequency of clinical scale patterns in various settings. The client's high- point clinical scale score (Pa) occurs in 9.6% of the MMPI-2 normative sample of men. However, only 3% of the sample have Pa as the peak score at or above a T score of 65, and only 2.2% have well- defined Pa spikes. This elevated profile configuration (6-8/8-6) is very rare in samples of normals, occurring in less than 1% of the MMPI-2 normative sample of men.

The relative frequency of his profile in various correctional settings is informative. Megargee (1993) reported that this high- point clinical scale score (Pa) occurred in 13.4% of men in a state prison and 16% of men in a federal prison. Moreover, 7.9% of the state prisoners and 11.7% of the federal prisoners had the Pa scale spike at or

above a T score of 65. Megargee (1993) reported that this elevated profile configuration (6-8/8-6) occurs with some frequency in prison samples (2.9% in a state prison and 6.8% in a federal prison).

5.3.9.4 Profile stability

The relative elevation of the highest scales in his clinical profile shows a very high profile definition. His peak scores on this testing are likely to be very prominent in his profile pattern if he is retested at a later date. His high- point score on Pa is likely to show moderate test- retest stability. Short- term test- retest studies have shown a correlation of 0.67 for this high- point score. Spiro, Butcher, Levenson, Aldwin, and Bosse (1993) reported a moderate test- retest stability of 0.55 in a large study of normals over a five- year test- retest period.

5.3.9.5 Interpersonal relations

Disturbed interpersonal relations are characteristic of individuals with this profile type. The client feels socially inadequate, has very poor social skills, avoids close relationships, and views others as unfriendly or threatening. He is fearful and suspicious of other people. He tends to feel insecure in personal relationships, is hypersensitive to rejection, and may become jealous at times. He tends to need a great deal of reassurance. Individuals with this profile are quite self- absorbed and find marital relationships problematic. Marital breakup is not uncommon.

He is a very introverted person who has difficulty meeting and interacting with other people. He is shy and emotionally distant. He tends to be very uneasy, rigid, and over controlled in social situations. His shyness is probably symptomatic of a broader

pattern of social withdrawal. Personality characteristics related to social introversion tend to be stable over time. His generally reclusive behaviour, introverted lifestyle, and tendency toward interpersonal avoidance may be prominent in any future test results.

5.3.9.6 Diagnostic considerations

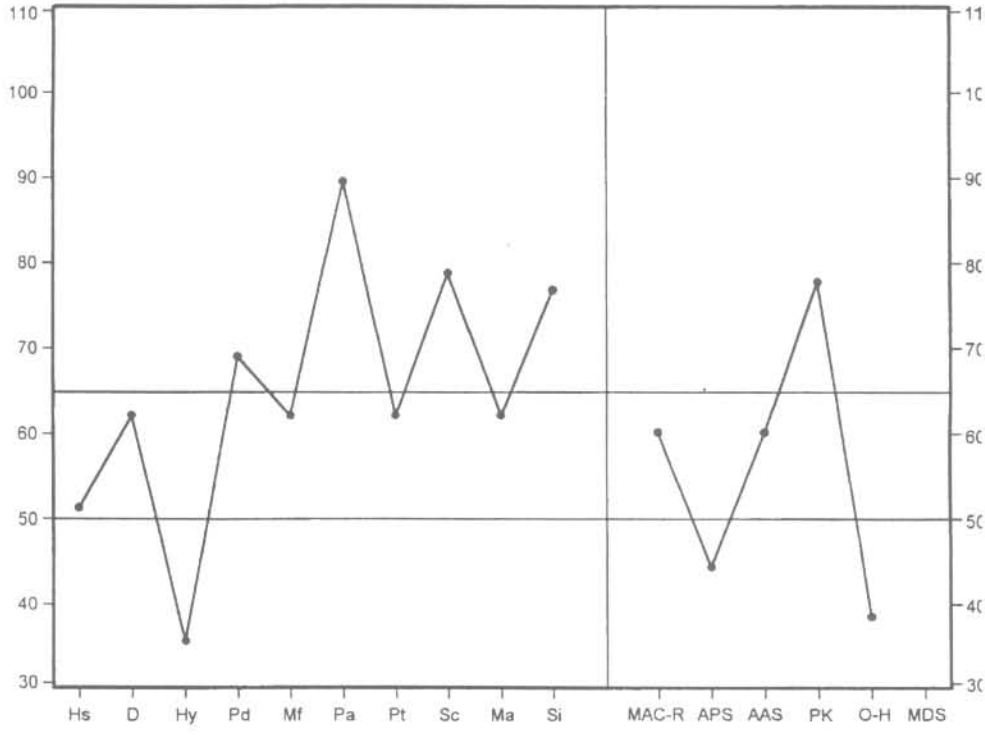
The most likely diagnosis is Schizophrenia, possibly Paranoid type, or a Paranoid Disorder. The Megargee system for classifying criminal offenders (Megargee, 1993) has often been found to be a useful typology for individuals facing incarceration. There is considerable research support for the view that the Megargee types are found in both men and women across a wide range of correctional facilities. The Megargee system allows for the classification of about two- thirds of the offender population. However, successful classification rates and the retest stability of an inmate's type have been found to vary across settings and for men and women.

The client fits the criteria for more than one classification according to the primary Megargee classification rules. However, the classification described in this report represents the best fit using the secondary rules. This client's profile matches those of Type C offenders in the Megargee typology. Individuals matching this profile type are among the most difficult criminal offenders. They are often viewed as distrustful, cold, irresponsible, and unstable. They tend to have antisocial, aggressive, and hostile attitudes towards others. They engage in violent crimes against other people and usually have an extensive criminal record. They tend to come from deviant and stressful home environment and typically have a great deal of difficulty adjusting to society. They are viewed by others as alienated, bitter, rigid, and dogmatic. Their

interpersonal relationships are quite disruptive; their suspicious attitudes and deep-seated hostility toward others make them a difficult case for rehabilitation. Research supports the view that Type C inmates typically have problems adjusting to prison life. It may be necessary to segregate them from weaker or more vulnerable inmates during incarceration.

Figure 7

MMPI-2 BASIC AND SUPPLEMENTARY SCALES PROFILE



	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	MAC-R	APS	AAS	PK	O-H	MDS
Raw Score:	11	24	13	29	32	21	28	39	24	49	25	21	5	25	9	*
K Correction:	2			2			4	4	1							
T Score:	51	62	35	69	62	90	62	79	62	77	60	44	60	78	38	*
Response %:	97	100	98	100	100	100	100	100	100	100	100	100	100	100	100	*

Welsh Code (new): 6*"80'4+2579-1/:3# F'"+-/L:K#

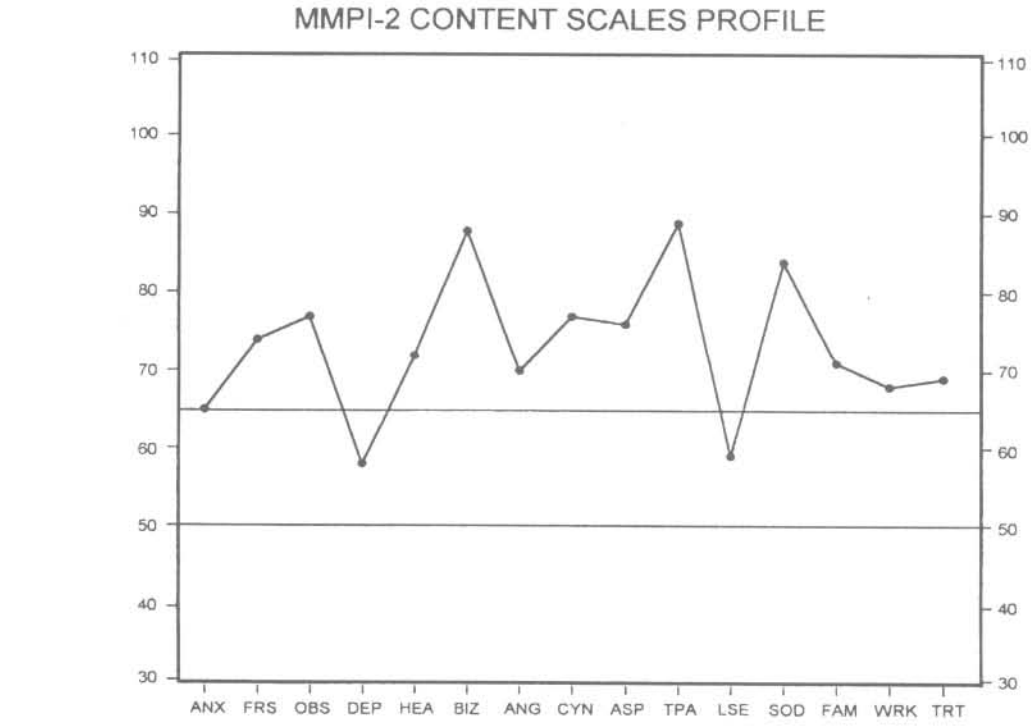
Welsh Code (old): 8*6"45029'7-1/3: F'"-/L?:K#

Profile Elevation: 63.80

Megargee Classification (Rev.): Charlie, High

*MDS scores are reported only for clients who indicate that they are married or separated.

Figure 8



	ANX	FRS	OBS	DEP	HEA	BIZ	ANG	CYN	ASP	TPA	LSE	SOD	FAM	WRK	TRT
Raw Score:	12	11	13	8	15	13	12	21	17	19	8	22	13	17	12
T Score:	65	74	77	58	72	88	70	77	76	89	59	84	71	68	69
Response %:	100	100	100	100	97	100	100	100	100	100	100	100	100	100	100

5.3.9.7 Supplementary score report

Table 11

	Raw Score	T Score	Resp %
Anxiety (A)	24	70	100
Repression (R)	15	50	100
Ego Strength (Es)	22	30	100

Dominance (Do)	11	31	100
Social Responsibility (Re)	13	32	100
Post- Traumatic Stress Disorder- Schlenger (PS)	27	71	100
Depression Subscales (Harris- Lingoes)			
Subjective Depression (D1)	12	64	100
Psychomotor Retardation (D2)	6	54	100
Physical Malfunctioning (D3)	5	67	100
Mental Dullness (D4)	2	48	100
Brooding (D5)	5	68	100
Hysteria Subscales (Harris- Lingoes)			
Denial of Social Anxiety (Hy1)	1	34	100
Need for Affection (Hy2)	0	30	100
Lassitude- Malaise (Hy3)	1	43	10
Somatic Complaints (Hy4)	5	62	94
Inhibition of Aggression (Hy5)	4	55	100
Psychopathic Deviate Subscales (Harris- Lingoes)			
Familial Discord (Pd1)	4	65	100
Authority Problems (Pd2)	5	60	100
Social Imperturbability (Pd3)	0	30	100
Social Alienation (Pd4)	10	82	100
Self- Alienation (Pd5)	9	77	100
Paranoia Subscales (Harris- Lingoes)			
Persecutory Ideas (Pa1)	11	106	100
Poignancy (Pa2)	6	76	100

Naivete (Pa3)	2	36	100
Schizophrenia Subscales (Harris- Lingoes)			
Social Alienation (Sc1)	12	88	100
Emotional Alienation (Sc2)	1	50	100
Lack of Ego Mastery, Cognitive (Sc3)	4	66	100
Lack of Ego Mastery, Conative (Sc4)	1	44	100
Lack of Ego Mastery, Defective Inhibition (Sc5)	8	96	100
Bizarre Sensory Experiences (Sc6)	11	95	100
Hypomania Subscales (Harris- Lingoes)			
Amorality (Ma1)	3	58	100
Psychomotor Acceleration (Ma2)	7	58	100
Imperturbability (Ma3)	0	30	100
Ego Inflation (Ma4)	9	89	100
Social Introversion Subscales (Ben- Porath, Hostetler, Butcher, & Graham)			
Shyness/ Self- Consciousness (Si1)	12	71	100
Social Avoidance (Si2)	7	67	100
Alienation- Self and Others (Si3)	12	71	100

Uniform T scores are used for Hs, D, Hy, Pd, Pa, Pt, Sc, Ma, and the Content Scales; all other MMPI-2 scales use linear T scores.

5.3.9.8 Experimental content component scales (Ben- Porath & Sherwood)

Table 12

	Raw Score	T Score	Resp %
Fears Subscales			
Generalised Fearfulness (FRS1)	6	98	100
Multiple Fears (FRS2)	5	56	100
Depression Subscales			
Lack of Drive (DEP1)	2	51	100
Dysphoria (DEP2)	3	68	100
Self- Depreciation (DEP3)	2	55	100
Suicidal Ideation (DEP4)	0	45	100
Health Concerns Subscales			
Gastrointestinal Symptoms (HEA1)	3	83	80
Neurological Symptoms (HEA2)	7	87	100
General Health Concerns (HEA3)	2	56	100
Bizarre Mentation Subscales			
Psychotic Symptomatology (BIZ1)	4	91	100
Schizotypal Characteristics (BIZ2)	7	86	100
Anger Subscales			
Explosive Behaviour (ANG1)	4	64	100
Irritability (ANG2)	7	72	100
Cynicism Subscales			
Misanthropic Beliefs (CYN1)	13	68	100

Interpersonal Suspiciousness (CYN2)	8	71	100
Antisocial Practices Subscales			
Antisocial Attitudes (ASP1)	13	69	100
Antisocial Behaviour (ASP2)	3	59	100
Type A Subscales			
Impatience (TPA1)	6	68	100
Competitive Drive (TPA2)	9	76	100
Low Self- Esteem Subscales			
Self- Doubt (LSE1)	2	49	100
Submissiveness (LSE2)	6	83	100
Social Discomfort Subscales			
Introversion (SOD1)	15	79	100
Shyness (SOD2)	6	68	100
Family Problems Subscales			
Family Discord (FAM1)	6	65	100
Familial Alienation (FAM2)	1	49	100
Negative Treatment Indicators Subscales			
Low Motivation (TRT1)	5	71	100
Inability to Disclose (TRT2)	5	75	100

5.3.9.9 Critical items

The following critical items have been found to have possible significance in analysing a client's problem situation. Although these items may serve as a source of

hypotheses for further investigation, caution should be used in interpreting individual items because they may have been checked inadvertently.

The percentages of endorsement for each critical item are presented in brackets following the listing of the item. The percentage of the MMPI-2 normative sample of 1,138 men who endorsed the item in the scored direction given.

5.3.9.9.1 Acute Anxiety State (Koss- Butcher Critical Items)

Of the 17 possible items in this section, 8 were endorsed in the scored direction:

5. I am easily awakened by noise. (True)

[N=41.4]

59. I am troubled by discomfort in the pit of my stomach every few days or oftener. (True)

[N= 6.7]

140. Most nights I go to sleep without thoughts or ideas bothering me. (False)

[N= 22.6]

218. I have periods of such great restlessness that I cannot sit long in a chair. (True)

[N= 30.1]

223. I believe I am no more nervous than most others. (False)

[N= 15.6]

301. I feel anxiety about something or someone almost all the time. (True)

[N= 14.8]

444. I am a high- strung person. (True)

[N= 21.9]

463. Several times a week I feel as if something dreadful is about to happen. (True)

[N= 4.4]

5.3.9.9.2 Depressed Suicidal Ideation. (Koss- Butcher Critical Items)

Of the possible items in this section, 6 were endorsed in the scored direction:

71. These days I find it hard not to give up hope of amounting to something. (True)

[N= 30.7]

146. I cry easily. (True)

[N= 12.9]

215. I brood a great deal. (True)

[N= 14.6]

233. I have difficulty in starting to do things. (True)

[N= 35.2]

518. I have made lots of bad mistakes in my life. (True)

[N= 27.3]

524. No one knows it but I have tried to kill myself. (True)

[N= 1.5]

5.3.9.9.3 Threatened Assault (Koss- Butcher Critical Items)

Of the 5 possible items in this section, 3 were endorsed in the scored direction:

37. At times I feel like smashing things. (True)

[N= 39.4]

213. I get mad easily and then get over it soon. (True)

[N= 0.45]

389. I am often said to be hotheaded. (True)

[N= 16.9]

5.3.9.9.4 Situational Stress Due to Alcoholism (Koss- Butcher Critical Items)

Of the 7 possible items in this section, 4 were endorsed in the scored direction:

264. I have used alcohol excessively. (True)

[N= 44.5]

487. I have enjoyed using marijuana. (True)

[N= 34.2]

502. I have some habits that are really harmful. (True)

[N= 27.8]

518. I have made lots of bad mistakes in my life. (True)

[N= 27.3]

5.3.9.9.5 Mental Confusion (Koss- Butcher Critical Items)

Of the 11 possible items in this section, 3 were endorsed in the scored direction:

32. I have had very peculiar and strange experiences. (True).

[N= 23.8]

311. I often feel as if things are not real. (True)

[N= 8.3]

316. I have strange and peculiar thoughts. (True)

[N= 14.9]

5.3.9.9.6 Persecutory Ideas (Koss- Butcher Critical Items)

Of the 16 possible items in this section, 13 were endorsed in the scored direction:

42. If people had not had it in for me, I would have been much more successful. (True)

[N= 4.1]

99. Someone has it in for me. (True)

[N= 5.0]

124. I often wonder what hidden reason another person may have for doing something nice for me. (True)

[N= 29.2]

138. I believe I am being plotted against. (True)

[N= 2.4]

145. I feel that I have often been punished without cause. (True)

[N= 9.1]

216. Someone has been trying to rob me. (True)

[N= 2.6]

228. There are persons who are trying to steal my thoughts and ideas. (True)

[N= 3.8]

241. It is safer to trust nobody. (True)

[N= 19.7]

251. I have often felt that strangers were looking at me critically. (True)

[N= 23.8]

259. I am sure I am being talked about. (True)

[N= 18.4]

314. I have no enemies who really wish to harm me. (False)

[N= 11.6]

333. People say insulting and vulgar things about me. (True)

[N= 6.2]

361. Someone has been trying to influence my mind. (True)

[N= 4.3]

5.3.9.9.7 Antisocial Attitude (Lachar- Wrobel Critical Items)

Of the 9 possible items in this section, 7 were endorsed in the scored direction:

27. When people do me wrong, I feel I should pay them back if I can, just for the principle of the thing. (True)

[N= 26.7]

35. Sometimes when I was young I stole things. (True)

[N= 58.0]

105. In school I was sometimes sent to the principle for bad behaviour. (True)

[N= 30.9]

227. I don't blame people for trying to grab everything they can get in this world. (True)

[N= 39.9]

240. At times it has been impossible for me to keep from stealing or shoplifting something. (True)

[N= 6.6]

254. Most people make friends because friends are likely to be useful to them. (True)

[N= 23.8]

266. I have never been in trouble with the law. (False)

[N= 40.9]

5.3.9.9.8 Family Conflict (Lachar- Wrobel Critical Items)

Of the 4 possible items in this section, 1 was endorsed in the scored direction:

21. At times I have very much wanted to leave home. (True)

[N= 31.9]

5.3.9.9.9 Somatic Complaints (Lachar- Wrobel Critical Items)

Of the 23 possible items in this section, 10 were endorsed in the scored direction:

33. I seldom worry about my health. (False)

[N= 37.1]

53. Parts of my body often have feelings like burning, tingling, crawling, or like "going to sleep". (True)

[N= 18.8]

59. I am troubled by discomfort in the pit of my stomach every few days or oftener. (True)

[N= 6.7]

111. I have a great deal of stomach trouble. (True)

[N= 6.1]

142. I have never had a fit or convulsion. (False)

[N= 7.2]

159. I have never had a fainting spell. (False)

[N= 27.0]

164. I seldom or ever have dizzy spells. (False)

[N= 9.2]

229. I have had blank spells in which my activities were interrupted and I did not know what was going on around me. (True)

[N= 7.5]

255. I do not often notice my ears ringing or buzzing. (False)

[N= 21.7]

295. I have never been paralysed or had any unusual weakness of any of my muscles. (False)

[N= 14.5]

5.3.9.9.10 Sexual Concern and Deviation (Lachar- Wrobel Critical Items)

Of the 6 possible items in this section, 5 were endorsed in the scored direction:

12. My sex life is satisfactory. (False)

[N= 26.7]

34. I have never been in trouble because of my sex behaviour. (False)

[N= 19.3]

121. I have never indulged in any unusual sex practices. (False)

[N= 36.9]

166. I am worried about sex. (True)

[N= 15.1]

268. I wish I were not bothered by thoughts about sex. (True)

[N= 21.0]

5.3.9.10 Omitted items

The following items were omitted by the client. It may be helpful to discuss these item omissions with this individual to determine the reason for noncompliance with the test instructions.

47. I am almost never bothered by pains over my heart or in my chest.

258. I can sleep during the day but not at night.

5.3.9.11 Summary of the MMPI-2

Profile Considerations: This profile should be interpreted with caution. There were some indications that the picture presented was an exaggeration of the individual's present situation and problems. His response style can indicate the following: poor reading ability, confusion, disorientation, stress, or a need to seek a great deal of attention for his problems. Clinical patients with this type of validity profile are often confused and distractible and have memory problems. Evidence of delusions and thought disorder may be present. He may be experiencing a high degree of distress and personality deterioration. This individual's high- point clinical scale score (Pa) occurs in 9.6% of the MMPI-2 normative sample of men, with only 2.2% having such well defined Pa spikes. This elevated profile configuration is very rare in samples of normals, occurring in less than 1% of the MMPI-2 normative sample of men. This profile is more common in prison samples, with 7.9% of state prisoners and 11.7% of federal prisoners having Pa scale spikes at or above a T score of 65. The elevated scales are likely to be prominent even if retested at a later date.

Interpersonal Considerations: People with a similar profile are most likely to have disturbed interpersonal relationships. He may feel socially inadequate, has poor social

skills, avoids close relationships and may view others as unfriendly or threatening. He tends to be very suspicious of others. In his interpersonal relationships he tends to feel insecure and is hypersensitive to rejection, becoming easily jealous at times. He would need a great deal of reassurance in his relationships. Due to such problems he may become self- absorbed and if married may find marital relationships problematic, with marital break ups common.

These difficulties make him a fairly introverted person who has difficulty meeting and interacting with others. He would tend to be shy and emotionally distant when in the presence of others. In social situations he will be uneasy, rigid, and over controlled.

Diagnostic Considerations: On this tests a possible diagnosis of schizophrenia should be investigated, possibly of a paranoid type, or a paranoid disorder. According to the Megargee typology, he falls into the Type C offender who is often seen as distrustful, cold, irresponsible, and unstable. They also tend to have antisocial, aggressive and hostile attitudes towards others. They tend to engage in violent crimes against other people and usually have an extensive criminal record. They also tend to come from deviant and stressful home environments and typically have a great deal of difficulty adjusting to society.

The following was indicated as a possible DSM-IV diagnosis for this individual:

Axis I: Schizophrenia, possible Paranoid type, or a Paranoid Disorder

5.3.10 The 16 Personality Factor Questionnaire

Table 13

Low	1 2 3 4 5 6 7 8 9 10	High	Scale	Raw	STEN	Adjusted
Aloof	1 2 **3** 4 5 6 7 8 9 10	Warmhearted	A	4	2	3
Concrete	1 2 3 4 5 **6** 7 8 9 10	Abstract	B	8	6	6
Unstable	1 2 3 4 5 **6** 7 8 9 10	Stable	C	13	4	6
Humble	1 2 **3** 4 5 6 7 8 9 10	Assertive	E	9	3	3
Serious	1 **2** 3 4 5 6 7 8 9 10	Enthusiastic	F	6	2	2
Undependable	1 2 3 4 5 6 **7** 8 9 10	Conscientious	G	16	7	7
Shy	1 2 **3** 4 5 6 7 8 9 10	Adventurous	H	4	2	3
Tough Minded	1 2 3 4 5 6 **7** 8 9 10	Sensitive	I	8	6	7
Trusting	1 2 3 4 **5** 6 7 8 9 10	Suspicious	L	12	6	5
Practical	1 2 3 4 5 6 7 **8** 9 10	Imaginative	M	18	8	8
Unpretentious	1 2 3 4 5 6 **7** 8 9 10	Shrewd	N	14	7	7
Confident	1 2 3 4 5 6 7 8 **9** 10	Apprehensive	O	20	10	9
Conservative	1 2 3 4 **5** 6 7 8 9 10	Liberal	Q1	8	5	5
Group Dep.	1 2 3 4 5 6 7 8 9 **10**	Self- Suff.	Q2	19	10	10
Uncontrolled	1 2 3 4 **5** 6 7 8 9 10	Self- Control.	Q3	8	4	5
Relaxed	1 2 3 4 5 6 7 8 **9** 10	Tense	Q4	22	10	9

5.3.10.1 Warnings

There is an indication that this respondent may have distorted some responses negatively. These results may be contaminated due to this subject having responded

randomly to the items. Deal with these results carefully, there is an indication of overall pathology which requires examination.

5.3.10.2 Broad clinical dimensions

This report is based on the interplay between two factors, degree of adjustment and the degree of inner control.

Adjustment Factors: Individual number 2 shows a very low level of emotional adjustment and is likely to have grave difficulties coping with life as he apparently lacks access to the appropriate emotional resources. In explaining this, his slightly elevated threat- sensitivity, expressed as slight shyness, suggests that he is likely to react somewhat fearfully to a wide range of situations. Secondly, he is apprehensive and prone to emotional disturbances as a result of poorly developed defence systems. This is evidenced by a limited ability to remain unaffected by pressure or criticism. Thirdly, he reports a high number of tension- related symptoms. This indicates either his poor ability to deal with environmental stress or that he is currently experiencing extreme pressure. In either case, he is pressure- sensitive.

Control Factors: In this case, an average level of overall emotional restraint is predicted. More specifically, he is somewhat realistic about life. This reflects an average ability to exercise emotional restraint and to draw on inner resources when confronted by emotionally charged situations. Secondly, he is rather well socialised and has a rather good ability to determine what is conventionally right and wrong in various situations. This suggests some level of social restraint over the expression of his emotions. Lastly, he has some set standards of conduct to which he conforms thus

showing an average level of internalised social norms. This may suggest an ability to reference his behaviour against these and so to exercise some degree of restraint.

Patterns of Social Interaction: His pronounced introversion on the high- order scale suggests a strong drive away from social interaction moderated by a somewhat cold or indifferent attitude toward other people, a strong preference for independence from social groups, an introspective, very cautious and inhibited lack of communication, and shyness and a tendency toward emotional restraint and constricted affect.

By itself, rather low warmth may be suggestive of some cynical distortion of reality and a rather pessimistic view of life. This is often found in people who have a history of dissatisfying or hurtful relationships. In the face of reduced emotional adjustment, the likelihood of social withdrawal is increased, as is a feeling of bitterness toward others. The possibility exists that he may project his own problems onto others. Furthermore, the possibility exists that he has been dominated in the past and has withdrawn to some degree as a result. This hints at feelings of helplessness and self-pity. His consistently very cautious approach to life further increases the tendency toward social withdrawal as a means of controlling his fear. This suggests that he is very afraid of making a fool of himself which, in turn, suggests low social competence. What is more, his need for safety and predictability has probably led him to become rather cautious as other people may introduce insecurity and danger to which he may prefer the relative safety of isolation. Lastly, a pronounced need to be socially independent strongly suggests withdrawal from any form of group interaction whenever possible.

Having mentioned his disregard of social groups and his need to be self- sufficient, note that this also implies a rejection of group norms and a tendency to be non-conforming in many areas of his life. His disregard for group affiliation constitutes a temperamental withdrawal response rather than a need for self- sufficiency. This is quite probably the result of a range of pathological processes. With moderate degree of insight, he will tend to listen to the advice of others (even of he doesn't always accept it) which may be of more value than resolutely doing his "own thing". With only an average level of interpersonal trust, the possibility that he will experience group involvement as threatening from time- to- time cannot be excluded. In any event, he has a very poor self- perception and avoids group membership out of a fear of rejection. This may be explained by his belief that he is unworthy of being part of a group and he may simply avoid being rejected.

It is likely that he will take life far too seriously and hardly ever "loosen up' or laugh. In such cases of "fearful inhibition", it is important to look for a history of punishment and failure. As he has an average control factor, this inhibition is possibly the result of his personal history. It is possible that such inhibition plays some part in the maintenance of self- control. With an average level of insight, however, he should be able to perceive social relationships without too much difficulty thus rarely making social blunders. As he is an extremely apprehensive person, the inhibition he displays may result from a very negative self- perception and the presence of guilt or shame. Inhibition could then result from a fear of exposure and retribution.

As he has a strong need for security and certainty in his life, he will tend to establish obsessive routines for doing things and to have an extremely high concern that others

approve of what he does. He will usually rehearse actions beforehand. It is likely that he is rather withdrawn and possibly shows paranoid tendencies. He will tend to avoid attention out of fear that others will disrupt his hard won security and safety. Clearly, this points to some feeling of insecurity. Rather high submissiveness in this context may indicate the presence of suicidal tendencies as he will feel unable to do anything about his insecurity. He is, however, neither particularly suspicious nor trusting of others but may be wary, watching for signs that they will violate his sense of security and safety. Such violations will prompt him to avoid dealing with people. Lastly, he is very deeply conflicted as far as inhibition is concerned. More specifically, a very introspective aspect which clashes with a low degree of inhibition suggests some form of heroic fantasy existence verging on psychosis. Again, poor adjustment moderates this entire analysis and suggests that his coping skills are severely compromised.

Identifiable Psychological Processes: With a slight degree of emotional instability, there are distinctly pathological signs in this profile which require additional discussion. In the light of extreme feelings of personal inadequacy, this is almost certainly related to self- reproach which will be associated with guilt. Phobic symptoms can be expected to emerge under these conditions. Furthermore, this individual may lack a sense of self because of low dominance and simply move from encounter to encounter while never really expressing any opinions or ideas. As he is rather insecure and intuitive, imagined problems are often created in the absence of any present difficulties. Often resultant from a highly protected childhood, this points to poorly developed defences and a tendency toward anxiety disorders. There is reason to believe that this individual will become depressed and even physically ill very easily and will approach interactions or events with extreme caution.

The following composite scales may clarify this profile:

Table 14: Composite scales

Depressive:	9
Obsessive:	6
Manic:	4
Anxious:	9
Socially Phobic:	8
Paranoid:	7
Antisocial:	3
Passive- Aggressive:	7
Socially Dependent:	3
Socially Avoidant:	8
Narcissistic:	4
General Pathology:	5

The depressive personality pattern is characterised by a low level of self- esteem and a consequent apprehensive view of the future, a tendency to be introspective and fearful of failure, and a strong cynical distortion of reality characterised by some degree of coldness towards other people. Classically, one would expect him to report a fatigued state accompanied by hypersomnia, poor concentration and feelings of hopelessness and despair. There are a number of factors which are of importance in this class of affective disorder and which provide guidelines in assessing a therapeutic process. Feelings of extreme failure and helplessness are likely to accompany depression and are quite possibly due to unexpressed anger or anger "turned inwards". An excessively

harsh socialisation process underlies feelings of worthlessness and extreme fear of failure. There is likely to be some evidence of bitterness towards the past which will require you to take a fairly extensive history. There is little doubt that this client is in a state of deep "psychological" pain and is likely to worry about problems to the point of exhaustion. Born of crippling self- doubt, feelings of shame, guilt and self-deprecation are quite likely. Here, a major focus will have to be the reframing this self- directed negativity if any therapeutic process is to be successful.

The Anxious personality pattern, characterised by a high level of apprehension and symptoms of tension, is complex in its associations as it can result from a wide range of factors and their interplay. Accompanied by significant indication of depression, agitated depression is suggested. In this case, the remarks pertaining to depression presented above will also apply. It would be advisable to examine this client for evidence of fearful paranoid fantasies as there is an indication that he is not always in touch with conventional reality. Also, examine the use of alcohol or narcotics in alleviating anxiety as an addictive personality is suggested here. Showing an extreme disaddiliation from society, he may be anxious as a result of an inability to form meaningful relationships with groups of people. Such personally enforced isolation is very uncommon and probably requires examination.

The socially phobic pattern is characterised by low emotional stability linked to extreme shyness. This may be found separately or linked to the socially avoidant pattern which is often used as a means of controlling anxiety which is resultant and which is socially crippling. A number of primary factors can be used to determine the exact nature of this pattern.

The paranoid personality profile is indicated by a cold, cynical attitude towards people and a very pronounced suspicion about their real intentions towards him. Characterised as jealous and often aggressive, he will avoid intimacy, resent criticism and rather blame others. This is often found to be associated with chronic CNS impairment, obsessive conditions and abuse of stimulants (amphetamines). Such people rarely seek treatment although they may be quite disturbed. As this client is somewhat detached from reality, it is likely that any revenge fantasies are quite elaborate and that this disorder assumes psychotic elements. Delusions of grandeur and a false sense of self- importance may be quite pronounced. As this is accompanied by a strong avoidance of group interaction, it is quite likely that groups are blamed and suspected of plotting against him.

The passive- aggressive pattern is identified by very low assertiveness and high suspicion. Anger builds up inside as it cannot be adequately expressed and suspicion and blaming of others then leads this to being expressed in ways which satisfy the need to punish the "wrong doers" while not directly involving him. This is significantly amplified by a tendency to loose touch with reality as this , once again, introduces some psychotic aspects into his behaviour as imagined events trigger the assault on the 'guilty' others.

Characterised by a profound shyness, hypersensitivity and low self- esteem, the socially avoidant pattern suggests a person who prefers to avoid social interaction rather than face social disapproval even though they have a great need for interpersonal involvement. This is often accompanied by high anxiety scores as a

result of the tension between the need to approach others on the one hand, and the need to avoid social rejection on the other.

5.3.10.3 Summary of the 16-PF

Profile Considerations: There were indications that this individual distorted some responses in a negative manner and some items were possibly answered randomly. There was a warning indicating a strong possibility of overall pathology.

Interpersonal Considerations: This individual shows a very low level of emotional adjustment and likely to have difficulty copping with life as he apparently lacks access to the appropriate emotional resources. What seems as slight shyness, suggests that he is likely to react fearfully to a wide range of situations. Due to poorly developed defence systems he will likely be prone to emotional disturbances. This is evidenced by a limited ability to remain unaffected by pressure or criticism from others. He also reports a wide range of tension- related symptoms possibly due to his inability to deal with such situations, or environmental stress.

He appears to have an average level of emotional restraint, he appears to be fairly well socialised and possesses an ability to determine what is conventionally right and wrong in various situations. He appears to have some set of internalised norms which guide his behaviour, this can suggest an ability to reference his behaviour against these and so to exercise some degree of restraint.

He is a pronounced introvert and moves away from social interaction, moderated by a somewhat cold and indifferent attitude towards other people. He has a strong

preference for independence from social groups, and an introspective, cautious and inhibited lack of communication. He tends to wards emotional restraint and constricted affect.

His low warmth and pessimistic view of life is often found in people who have a history of dissatisfying or hurtful relationships. He may project his own problems onto others. The possibility exists that he has been dominated in the past and has withdrawn to some degree as a result. This helps create a very cautious pattern of interpersonal interaction, him possibly fearing making a fool of himself, thus suggestive of low social competence.

His disregard for social groups and need to be self- sufficient also implies a rejection of group norms and tendency to be non- conforming in may areas of his life. This disregard for group affiliation constitutes a temperamental withdrawal response rather than a need for self- sufficiency. He avoids group membership out of fear for rejection. He has a strong need for security and certainty in his life and may tend to establish obsessive routines. He will avoid conflict that could threaten his safety and security, his submissiveness may indicate the presence of suicidal tendencies.

Diagnostic Considerations: Due to a low level of emotional adjustment he experiences a number of tension related symptoms. The may be a result of or causal factor in his pronounced introversion. Linked to this is a cynical distortion of reality and rather pessimistic view of life. This pessimism is linked to a bitterness towards others. Previous interpersonal disappointments lead him to experience feelings of helplessness and self- pity This causes him to avoid group membership out of fear of

rejection. These are closely linked to his negative self- perception. By projecting this onto his environment he adopts a paranoid outlook on the outside world. Due to his feelings of insecurity and submissiveness he is a prime candidate for suicidal tendencies. To transcend his position he may make use of some form of heroic fantasy existence which verges on psychosis.

Anxiety seems to play a strong role in this person's life, this can be possibly generated by the conflict between his history of disappointment with others and a need for reinforcement from others. Submissiveness can be a tool whereby he avoids conflict and therefore negative feedback, and also tries to obtain the approval of others. Accompanied with the anxiety in this whole process, is a strong depressive mood. He often expresses physical complaints which can be a result of the anxiety and depression sprouting from his ineffective interpersonal style. He may also experience fatigue, hypersomnia, poor concentration and feelings of despair. Any anger accompanying his depressed mood may be directed inwards, hence some of the somatic complaints and suicidal tendencies. Alcohol and narcotics can be a means to help him relieve anxiety, or as a means of facilitating his interpersonal interactions.