CALDWELL REPORT
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April 2, 2013

NAME: Sherry Wickman

AGE: 24

SEX: Female

EDUCATION: 18 years

MARITAL STATUS: Single

REFERRED BY: Dale C. Godby, Ph.D.

DATE TESTED: April 1, 2013

TEST ADMINISTERED: Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

TEST TAKING ATTITUDE

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

Attitude and Approach: Considering scales L, F, and K, her approach to the inventory was generally straightforward without being unduly self-favorable or self-critical. The profile appears valid by the usual criteria for these scales.

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

Socio-cultural Influences vs. Conscious Distortion: The supplemental validity scales showed an average to below average score on the scale (Ss) measuring her level of currently attained, recently experienced, or self-perceived socioeconomic status. She did not show any significant amount of

conscious defensiveness; her score on K was not distorted by any intentionally self-favorable slanting of her responses. Her K score was slightly higher than would have been expected for her Ss score; that is, this level of socioeconomic status identification is frequently associated with a lower level of sophistication on K.

In contradiction to her relatively self-favorable responding on K, she obtained a somewhat elevated score on the scale (Ds) measuring intentional overstatement or exaggeration. Although this latter could be increased (and perhaps substantially accounted for) by any current mental confusion and especially by any psychotic trends if present, it may also represent a conflict between pressures to present well and "save face" in some areas and conscious needs to emphasize or mildly exaggerate her disturbance in other areas. The level of severity reflected in the following actuarial interpretation may need to be evaluated in relation to these oddly contradictory biases.

SYMPTOMS AND PERSONALITY CHARACTERISTICS

The profile indicates a vulnerability to a psychotic decompensation if not currently a borderline condition. Patients with this pattern have often shown emotional flatness and inappropriateness along with unusual ways of thinking if not looseness of associations. Distressed by her recurrent fears, anxieties, and nervousness, she appears self-preoccupied and prone to worry about her inadequacies, insecurities, and feelings of inferiority. Depression and pessimism are suggested. Introverted and shy, she tests as lacking in poise, assurance, and social confidence. She would be fearful of emotional closeness and quick to withdraw socially. Her ego strength score predicts adequate functioning and immediate practical self-sufficiency in most areas.

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

Seclusiveness, secretiveness, and suspicions would reflect a long history of hurt feelings and deep resentments. She is apt to lack awareness of how her hostility is expressed and how it alienates others. Anger and intense internal reactions may be controlled by marked outward passivity, withdrawal from involvement, and emotional isolation. Irritability and disagreeableness could come out sharply at unexpected moments.

Her fears of emotional vulnerability are apt to handicap her in developing sexual role maturity. Her balance of interests is markedly feminine, emphasizing esthetic, cultural, and verbal interests and sensitivities. There may be a strong rejection of masculine insensitivities and aggressive male activities along with a general hypersensitivity to

sexual roles.

She obtained the "inferior sibling" life style profile. Often with this pattern such childhood traits as food finickiness, speech problems, and temper tantrums had contributed to feelings of inferiority and had provoked unfavorable comparisons with siblings. Typically, the behavior of these patients forced their families to baby them with resulting ambivalences that involved many mutually negative feelings. Often these family backgrounds were notably adverse and ambivalent with a deficiency of normally socializing and maturing experiences. The pattern predicts chronic and severe dependency-independency conflicts with painful difficulties around breaking away from resented family protection and dominance. Employed women with similar profiles showed an immature idealism in their jobs, readily identifying with the underdog and dissatisfied with the supervision over themselves. Usually they avoided jobs requiring sustained intellectual concentration.

DIAGNOSTIC IMPRESSION

The pattern has been associated with borderline psychotic states and with incipient and overtly schizophrenic disorders; latent schizophrenia would be a typical diagnosis. Some of these patients showed schizo-affective elements and in other cases the histories suggested cyclothymic personality disorders.

TREATMENT CONSIDERATIONS

She tests as needing continuing and positive psychological support from her family or possibly from hospitalization.

The usual prognosis with this profile is guarded. Apathy, social withdrawal, and longterm schizoid trends would be prognostically negative signs. A history of seclusiveness and suspiciousness would also be adverse. Her rigidity and problems in relating to others would severely handicap psychotherapy, as would the likely difficulties in drawing out her feelings in general and hostile feelings in particular. Treatment goals might have to be limited to a regaining of her previous level of functioning. She is likely to require longterm contact to let go of odd ideas and negative self-identifications. She would need support and encouragement in order to take initiative and to act assertively in her close personal relationships.

The profile anticipates that she would be quite cautious in interviews about any possibly improper reactions she felt she was being asked to reveal if not at times a bit concrete or morally simplistic. Underneath this there may be a fear of moral judgment. This fear of being shamed or judged by the interviewer may have to be relieved before therapy can proceed in any other areas. Any public occasions in the past when she seriously lost self-control or otherwise openly violated her own moral self-expectations could contribute to her vulnerability to shame. In general her emotional constrictions and her tendency to declare certain topics "off limits" could

necessitate careful handling and patience in therapy.

In many similar cases the precipitating circumstances involved increasing social withdrawal along with personal "binds" that were partly due to the patients' ambivalences and indecisiveness and to their avoidance of decisions and responsibility. Often this was aggravated by their negativism to decisions made for them by others. The ego weakness suggests arrangements to minimize the longterm demands and stresses on her. Her awareness of the intensity of her hurt and angry feelings and of the indirectness of her ways of expressing them appears seriously distorted. Discovery of her personal ways of keeping others at a distance---perhaps especially as she uses them on the therapist---is apt to be of direct benefit in treatment.

Thank you for this referral.

Alex B. Caldwell, Ph.D.

Alex B. Caldwell, Ph.D.
Diplomate in Clinical Psychology

The preceding analysis is basically actuarial and probabilistic in nature in that the symptoms and personality characteristics presented in the report have been identified as disproportionately frequent among individuals obtaining similar scores and patterns of scores on the MMPI-2 (tm). The diagnosis of any individual, however, needs to be based on the integration of information from personal contacts, the person's history, other test results, and whatever independent data are relevant and available.

This report has an overall focus on psychotherapy intake, differential diagnosis, treatment planning, and related personality-dependent determinations. It provides assistance in the diagnostic process by providing an extended set of clinical hypotheses, the largest part of the basis for which is data from traditional psychiatric settings. The application of these hypotheses to an individual requires independent confirmation of them by the clinician and an allowance for the specific context of testing if it differs substantially from the primarily psychotherapeutic database.

This report was prepared for our professional clientele. In most cases this is confidential information and legally privileged. The ongoing protection of this privilege becomes the responsibility of the professional person receiving the attached material from Caldwell Report.

THE ADAPTATION AND ATTACHMENT HYPOTHESES SUPPLEMENT:

The following paragraphs present my current hypotheses as to etiologic and developmental factors that likely contribute to the behaviors associated with the codetype to which this profile best conforms. The following description characterizes a relatively serious if not severe level of disturbance. Typically an individual with a moderate although not severely elevated profile will show an intermediate level of sensitization so that the adaptive responses to the aversive shaping experiences described below are demanding of but not overwhelming of the person's attentional energy and somewhat less disruptive of day-to-day functioning. THIS DESCRIPTION IS NOT MODIFIED OR ADJUSTED TO THE LEVEL OF DISTURBANCE OR SECONDARY VARIATIONS OF THIS PERSON'S PROFILE: IT IS AN ETIOLOGIC PROTOTYPE FOR ANYONE WITH THIS GENERAL PATTERN TYPE. It is intended to generate hypotheses as to how the individual "got this way". This prototype material will always be the same for any profile corresponding to her code type. At least three fourths of the reports currently processed will have these paragraphs--the other quarter are of more or less rarely occurring codes, and for want of code-specific data they will not have these paragraphs at this time.

My belief is that all behaviors are adaptive given the person's biologic/constitutional makeup and life experiences. An awareness of adaptational benefits is potentially helpful: (1) in understanding the origins and adaptive self-protections of the person's present behaviors, (2) in providing test-result feedback to the client as well as in explaining the person's conduct to judges and any other parties appropriately involved, and (3) in guiding psychotherapeutic intervention. These inductive hypotheses are based on an extensive searching for developmental information on pattern-matched cases. Some interpretations are supported by published data (e.g., Gilberstadt & Duker, 1965, Hathaway & Meehl, 1951, Marks & Seeman, 1963), etc., and others are based on clinically examining any cases I have been able to access on whom pertinent information has been available. Your feedback to me will be much appreciated regarding: (1) whatever in the material that follows is clearly a misfit to this individual, (2) more precisely targeted word choices, phrasing, and especially the person's own words for crucial experiences, and (3) behavioral characteristics that are likely to generalize to the code type but are missing here. For everyone's sakes, don't hesitate to send me a note.

PROPOSED DIAGNOSIS: INFERIORITY IDENTITY SYNDROME
ADAPTATION TO: familial treatment as inferior, deficient, defective
Traditional diagnoses: (1) obsessive-compulsive (predominantly obsessive), or (2) marginally schizophrenic, in a few severe cases overtly schizophrenic with markedly obsessive ideation

PROTOTYPIC CHARACTERISTICS: repetitive, obsessive preoccupations and a troubling if not pervasive sense of inferiority with feelings of inadequacy

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

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

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

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MMPI-2 CRITICAL ITEMS

Only the items shown in boldface were answered in the critical direction.

Distress and Depression

5. I am easily awakened by noise. (TRUE)
24. Evil spirits possess me at times. (True)
73. I am certainly lacking in self-confidence. (TRUE)
130. I certainly feel useless at times. (TRUE)
140. Most nights I go to sleep without thoughts or ideas bothering me. (FALSE)
146. I cry easily. (TRUE)
165. My memory seems to be all right. (False)
170. I am afraid of losing my mind. (TRUE)
180. There is something wrong with my mind. (True)
233. I have difficulty in starting to do things. (TRUE)
299. I cannot keep my mind on one thing. (TRUE)
301. I feel anxiety about something or someone almost all the time. (TRUE)

Suicidal Thoughts

71. These days I find it hard not to give up hope of amounting to something. (True)
75. I usually feel that life is worthwhile. (False)
150. Sometimes I feel as if I must injure either myself or someone else. (True)
215. I brood a great deal. (True)
234. I believe I am a condemned person. (True)
246. I believe my sins are unpardonable. (True)
303. Most of the time I wish I were dead. (True)
454. The future seems hopeless to me. (True)
506. I have recently considered killing myself. (True)
520. Lately I have thought a lot about killing myself. (True)
524. No one knows it but I have tried to kill myself. (True)

Ideas of Reference, Persecution, and Delusions

42. If people had not had it in for me, I would have been much more successful. (True)
99. Someone has it in for me. (True)
138. I believe I am being plotted against. (True)
144. I believe I am being followed. (True)
162. Someone has been trying to poison me. (True)
228. There are persons who are trying to steal my thoughts and ideas. (True)
314. I have no enemies who really wish to harm me. (False)
333. People say insulting and vulgar things about me. (True)
336. Someone has control over my mind. (True)
361. Someone has been trying to influence my mind. (True)
466. Sometimes I am sure that other people can tell what I am thinking. (TRUE)

Peculiar Experiences and Hallucinations

32. I have had very peculiar and strange experiences. (True)
60. When I am with people, I am bothered by hearing very queer things. (True)
96. I see things or animals or people around me that others do not see. (True)
198. I often hear voices without knowing where they come from. (True)
298. Peculiar odors come to me at times. (True)
311. I often feel as if things were not real. (True)
316. I have strange and peculiar thoughts. (True)
319. I hear strange things when I am alone. (True)
355. At one or more times in my life I felt that someone was making me do things by hypnotizing me. (True)

Aggressive Impulses

37. At times I feel like smashing things. (True)
85. At times I have a strong urge to do something harmful or shocking. (True)
134. At times I feel like picking a fist fight with someone. (True)
213. I get mad easily and then get over it soon. (True)
389. I am often said to be hotheaded. (True)

Authority Problems and Poor Control

35. Sometimes when I was young I stole things. (True)
50. I have often had to take orders from someone who did not know as much as I did. (True)
84. I was suspended from school one or more times for bad behavior. (True)
105. In school I was sometimes sent to the principal for bad behavior. (True)
240. At times it has been impossible for me to keep from stealing or shoplifting something. (True)
266. I have never been in trouble with the law. (False)

Sexual Difficulties

12. My sex life is satisfactory. (FALSE)
34. I have never been in trouble because of my sex behavior. (False)
62. I have often wished I were a girl. (or if you are a girl) I have never been sorry that I am a girl. Male: (True) Female: (False)
121. I have never indulged in any unusual sex practices. (False)
166. I am worried about sex. (TRUE)
268. I wish I were not bothered by thoughts about sex. (True)

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MMPI-2 CRITICAL ITEMS

Only the items shown in boldface were answered in the critical direction.

Alcohol and Drugs

168. I have had periods in which I carried on activities without knowing later what I had been doing. (True)
229. I have had blank spells in which my activities were interrupted and I did not know what was going on around me. (True)
264. I have used alcohol excessively. (True)
487. I have enjoyed using marijuana. (True)
489. I have a drug or alcohol problem. (True)
511. Once a week or more I get high or drunk. (True)
527. After a bad day, I usually need a few drinks to relax. (True)
540. I have gotten angry and broken furniture or dishes when I was drinking. (True)

Family Discord

21. At times I have very much wanted to leave home. (TRUE)
83. I have very few quarrels with members of my family. (False)
125. I believe that my home life is as pleasant as that of most people I know. (FALSE)
190. My people treat me more like a child than a grown-up. (TRUE)
195. There is very little love and companionship in my family as compared to other homes. (True)
217. My relatives are nearly all in sympathy with me. (FALSE)
288. My parents and family find more fault with me that they should. (True)

Somatic Concerns

2. I have a good appetite. (FALSE)
10. I am about as able to work as I ever was. (False)
18. I am troubled by attacks of nausea and vomiting. (True)
47. I am almost never bothered by pains over the heart or in my chest. (False)
101. Often I feel as if there were a tight band about my head. (True)
111. I have a great deal of stomach trouble. (True)
141. During the past few years I have been well most of the time. (False)
164. I seldom or never have dizzy spells. (False)
175. I feel weak all over much of the time. (True)
176. I have very few headaches. (False)
224. I have few or no pains. (False)

F
Female

Female
MMPI-2 code: 7 8 0 6 ' 2 - 1 3 9 / 4 : 5 #

MMPI-2™

The Minnesota Multiphasic Personality Inventory-2™

Starke R. Hathaway and J. Charnley McKinley

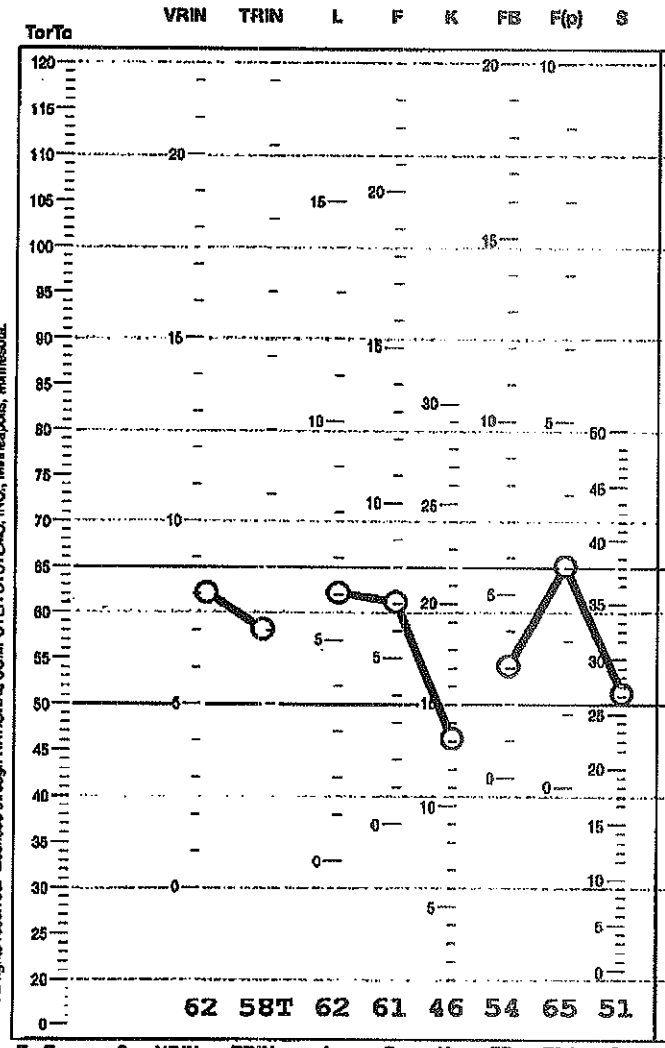
Name Sherry Wickman Age 24

Marital Status Single Education 18 years

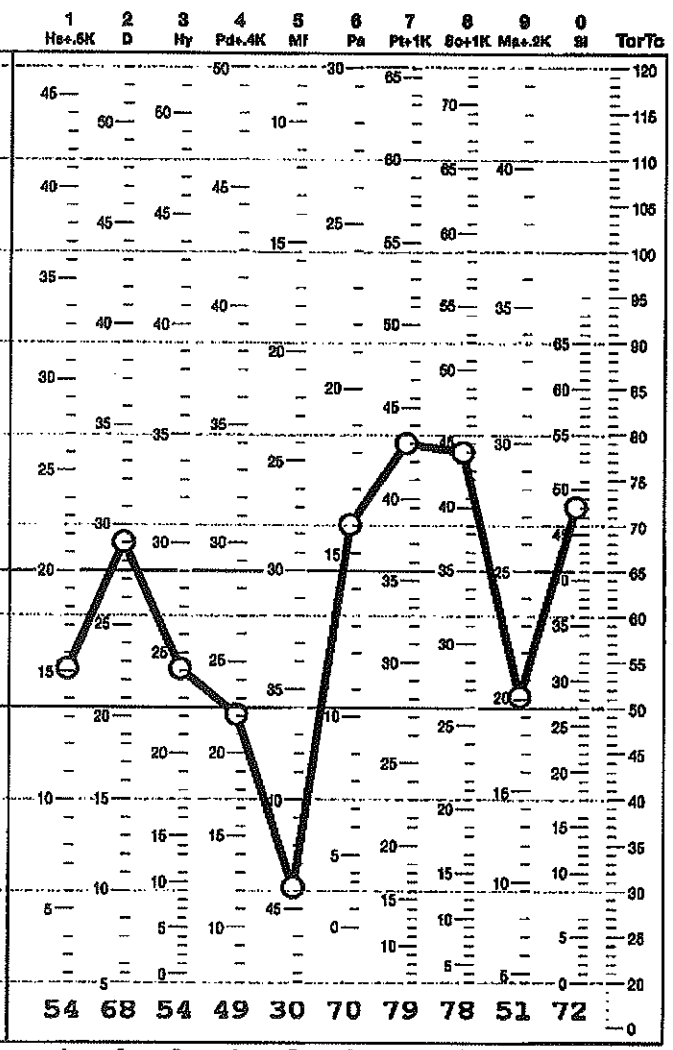
Date Tested 04/01/13 Date Processed 04/02/13

Referred By Dale C. Godby, Ph.D.

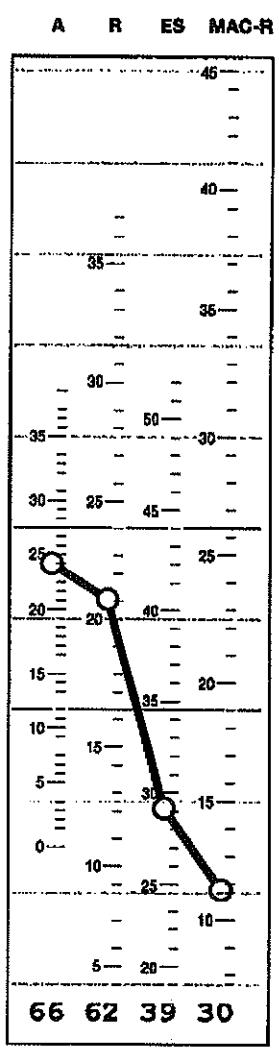
Validity



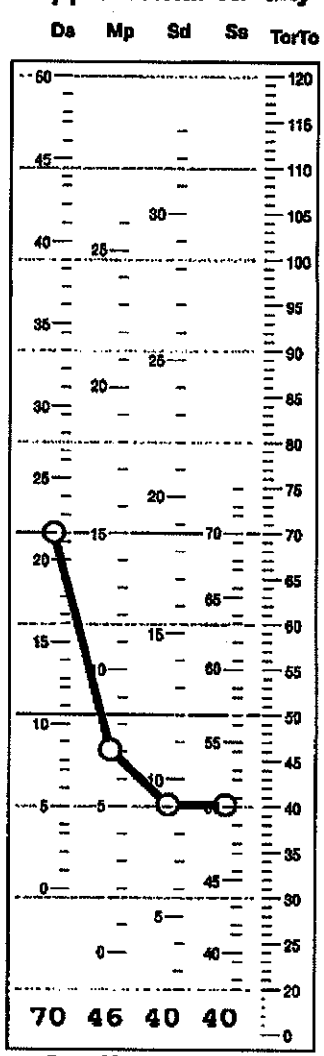
MMPI-2 Basic Scale Profile



Major Variables



Supplemental Validity



	?	VRIN	TRIN	L	F	K	FB	F(p)	S
Raw Score	0	8	10	6	7	13	3	3	26
K to be added									
Raw Score with K									

	1 Hs+.5K	2 D	3 Hy	4 Pd+.4K	5 Mf	6 Pa	7 Pt+1K	8 Sc+1K	9 Ma+.2K	0 Si
Raw Score	8	29	24	17	44	16	30	31	17	48
K to be added	7			5			13	13	3	
Raw Score with K	15			22			43	44	20	

	A	R	ES	MAC-R
Raw Score	24	21	29	11

	Ds	Mp	Sd	Ss
Raw Score	22	7	9	50

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Page 1 (MMPI-2)
Subscales

2-D and Subscales

		RAW	T
D	(full scale)	29	68
D1	Subjective depression	17	72
D2	Indecision-retardation	11	79
D3	Health pessimism	4	56
D4	Mental dullness	8	75
D5	Brooding, loss of hope	6	68

3-Hy and Subscales

		RAW	T
Hy	(full scale)	24	54
Hy1	Denies social anxiety	0	29
Hy2	Need for affection	9	59
Hy3	Lassitude - malaise	5	59
Hy4	Somatic complaints	4	53
Hy5	Inhibits aggression	4	54

4-Pd and Subscales

		RAW	T
Pd	(full scale)	17	49
Pd1	Family discord	4	62
Pd2	Authority problems	0	30
Pd3	Social disinhibition	0	29
Pd4	Social alienation	7	65
Pd5	Self-alienation	3	48

5-Mf and Subscales

		RAW	T
Mf	(full scale)	44	30
GM	Gender masculine	19	34
GF	Gender feminine	41	59

6-Pa and Subscales

		RAW	T
Pa	(full scale)	16	70
Pa1	Persecutory ideas	3	57
Pa2	Poignant sensitivity	5	65
Pa3	Moral righteousness	7	60

8-Sc and Subscales

		RAW	T
Sc	(full scale)	31	78
Sc1	Social alienation	11	81
Sc2	Emotional alienation	4	76
Sc3	Ego defect, cognitive	4	67
Sc4	Ego defect, conative	9	85
Sc5	Defective inhibition	4	65
Sc6	Sensorimotor dissociation	3	54

9-Ma and Subscales

		RAW	T
Ma	(full scale)	17	51
Ma1	Opportunism	1	45
Ma2	Psychomotor acceleration	7	60
Ma3	Imperturbability	1	37
Ma4	Ego inflation	3	49

0-Si and Subscales

		RAW	T
Si	(full scale)	48	72
Si1	Shyness and self-consciousness	14	73
Si2	Social avoidance	7	69
Si3	Alienation - self and others	6	52

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Subscales

Major Clinical Variables

		RAW	T
ES	Ego strength	29	39
MAC-R	Potential alcoholism	11	30
SAP	Teen drugs/alcohol	6	42
AAS		1	44
Mt	College maladjustment	21	62
N-P	Neurotic-psychotic profile balance		77

Interpersonal Style Variables

		RAW	T
ER-S	Ego resiliency	14	39
EC-5	Ego control	20	70
ORIG	Need novelty	30	59
INT	Abstract interests	46	47
Do	Need for autonomy	13	39
Dy	Need reassurances	35	70
Pr	Intolerance	9	50
Re	Value rigidity	24	59
Et	Ethnocentrism	11	49
St	Status mobility	11	29
R-S	Repression-sensitization	64	65
Lbp	Low back pain	12	63
O-H	Overcontrolled hostility	12	44
Ho	Cynical hostility	14	46
Ba	Good teamworker	42	43

Distress-Control

		RAW	T
A	Level of distress	24	66
R	Emotional constriction	21	62
Ca	Caudality-distress	14	60
Cn	Control-facade	21	50
So-r	Life as desirable	20	33
Th-r	Tired housewife	18	60
Wb-r	Worried breadwinner	17	65
PK	PTSD	21	69

Validity & Stability

		RAW	T
VRIN	Response inconsistency	8	62
TRIN	T-F inconsistency	10	58T
F-back	Rare answers - back	3	54
F(p)	Psychiatric infrequency	3	65
S	Superlative self-presentation	26	51
Ds	Overemphasize-fake sick	22	70
Mp	Consciously fake good	7	46
Sd	Consciously fake good	9	40
Ss	SES identification	50	40
Ch	Correction for H	28	72
Rc	Retest-consistency	22	48
Ic	Retest-item change	30	59
Tc	Retest-score change	25	63

Content Scales

		RAW	T
HEA	Health concerns	7	53
DEP	Depression	9	57
FAM	Family problems	11	62
ASP	Antisocial practices	5	47
ANG	Anger	2	39
CYN	Cynicism	5	44
ANX	Anxiety	16	71
OBS	Obsessiveness	9	59
FRS	Fears - phobias	7	51
BIZ	Bizarre mentation	3	56
LSE	Low self-esteem	15	73
TPA	Type A	5	43
SOD	Social discomfort	21	80
WRK	Work interference	14	59
TRT	Negative treatment indicators	6	53

PSY-5 Personality Psychopathology Scales

	RAW	T
AGGR Aggressiveness	2	33
PSYC Psychoticism	6	59
DISC Disconstraint	22	59
NEGE Negative Emotionality/Neuroticism	15	57
INTR Introversion Low Positive Emotionality	22	47

Name or I.D.: Sherry Wickman Date Tested: 04/01/13

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ABBREVIATIONS FOR RATINGS
3 = SIGNIFICANT POTENTIAL
2 = POSSIBLE CONCERN
1 = MILD/OCCASIONAL TENDENCY
BLANK = NOT INDICATED

1. VALIDITY AND ACCEPTABILITY OF PERSONALITY PROFILE

3	2	1	
		X	denied common, trivial moral faults
			minimizing of psychological problems
			serious personal problems may have been covered over
		X	too many atypical and questionable responses

Valid 1 2 3 4 5 6 7 8 9 10 Unacceptable

2. POTENTIAL FOR PROBLEMATIC PSYCHOLOGICAL-EMOTIONAL REACTIONS

3	2	1	
		X	high level of concern about own health, potential for recurrent medical absences
			prone to pain and other body complaints without sufficient physical basis, overreactive to injuries
X			depressed, low morale would interfere with functioning
			slowed down pace, may not keep up
X			lacks emotional stability and self-regulation
X			could misinterpret the motives of others and act on wrong beliefs
X			insecure, fearful, lacks mature self-confidence
X			unable to handle hostility from others. may disorganize under intense hostility
			overexcitable and easily distracted
			unrealistic optimism, apt to get "carried-away"
		X	starter but non-finisher
	X		deficits of practical organization

Not Indicated 1 2 3 4 5 6 7 8 9 10 Serious Problems

3. JUDGMENT AND DEPENDABILITY

3	2	1	
			deficits of conscience and integrity
			potential for over-reactions and loss of judgment under stress
			problematic reactions to normal discipline
		X	impulsive, failures to anticipate consequences
			accident prone
			serious longterm risk of alcoholism and/or drug abuse

Stable 1 2 3 4 5 6 7 8 9 10 Undependable

4. SELF-CONTROL AND ANGER CONTROL

3	2	1	
		X	undercontrolled aggression under stress
X			could be dangerous to others
X			irritable, hasty reactions
X			"chip-on-the-shoulder" attitude
X			could be self-righteous and punitive
			rigid and brittle controls; potentially explosive

Under Control 1 2 3 4 5 6 7 8 9 10 At Risk

5. WORK FACTORS: POTENTIAL PROBLEMS ON-THE-JOB AND WITH CO-WORKERS

3	2	1	
X			risk of undue "time off sick"
X			moodiness, could drag others down
X			inhabited, lacks needed assertiveness
X			problems in handling criticism
	X		lacks flexibility, rule-bound
X			potentially irritating or disturbing of staff morale
	X		lacks longterm persistence, vocational stability
X			lacks warmth, sensitivity
X			distant and slow to trust others
			rationalizer, always has an excuse
		X	manipulative of others
X			lacks realistic self-appraisal
		X	overly ambitious, unrealistic expectations
			likely to seek responsibilities beyond training and experience
X			low overall effectiveness

Favorable 1 2 3 4 5 6 7 8 9 10 Unfavorable

OVERALL EVALUATION

	LEVEL 1 MOST ACCEPTABLE
	LEVEL 2
	LEVEL 3
	LEVEL 4
	LEVEL 5 LESS ACCEPTABLE
X	LEAST ACCEPTABLE

Alex McCaldwell, Ph.D.

CALDWELL REPORT

PERSONNEL EVALUATION FORM