MMPI®-A
Minnesota Multiphasic Personality Inventory®— ADOLESCENT

SAMPLE REPORT

Case Description: José — Correctional Interpretive Report

José, a 15-year-old Mexican-American, was arrested after a gang-related incident in which city property was destroyed. He was being detained at a state juvenile detention facility awaiting a hearing. His history includes multiple previous arrests, with the first when he was 11 years old and arrested for shoplifting in a department store. Another arrest for destroying property occurred at the same shopping center 12 months later when José and two friends were caught on a surveillance camera breaking car antennas and stealing. Considerable restraint was required during his most current arrest because José became verbally aggressive and threatened the arresting officer.

José lives with his parents, both of whom are employed as janitors at a local hotel. He has four younger siblings. On two occasions when he was entrusted with taking care of his two youngest brothers, he left them unattended and went out with his friends. His parents also learned that José gave alcohol to his nine-year-old brother another time when they were both working. As a result, his parents no longer trust him to baby-sit and have tried to arrange their work schedules so that one of them is always home.

A psychological evaluation was ordered, and during the interview, José acknowledged extensive alcohol and drug use in addition to his other behavior problems. José also reported a number of physical symptoms including headaches and neck pain, frequently requesting medications from authorities.

Jose's Minnesota Report is not unexpected for a young person with a history of delinquency being detained after his most recent arrest. There are numerous indications of serious behavior problems from the three profiles (i.e., Clinical and Supplementary Scales, Content Scales, and PSY-5 Scales). His elevations on the PSY-5 DISC and NEGE Scales added information about his risk-taking, impulsivity, and irresponsibility, as well as suggesting his overall pessimistic take on the world. Vague somatic complaints are also described in the narrative, and given his very high score on the Alcohol/Drug Problem Proneness Scale (and moderate elevation on MAC-R), requests for medication for headaches and the like should be carefully evaluated and regulated.

Case descriptions do not accompany MMPI-A reports, but are provided here as background information. The following report was generated from Q-global™, Pearson's web-based scoring and reporting application, using José's responses to the MMPI-A. Additional MMPI-A sample reports, product offerings, training opportunities, and resources can be found at PearsonClinical.com/mmpia.

Case Description *(continued)*: José — Correctional Interpretive Report

Interestingly, although José was forthcoming about his alcohol/drug use during the interview, he only endorsed 3 of the possible substance use items found on p. 13 of the Item Level Indicators, and did not produce an elevation on ACK, suggesting that he does not view his reported significant use as problematic. Jose's high A-Fam score, and elevated Familial Discord Content Component Scale (p. 11 from the Additional Scales section) suggests further assessment of his views of his family would be helpful. Although he reported significant discord within his family, his Familial Alienation Content Component Scale score was not elevated, suggesting that he may still feel connected with his family.

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Correctional Interpretive Report

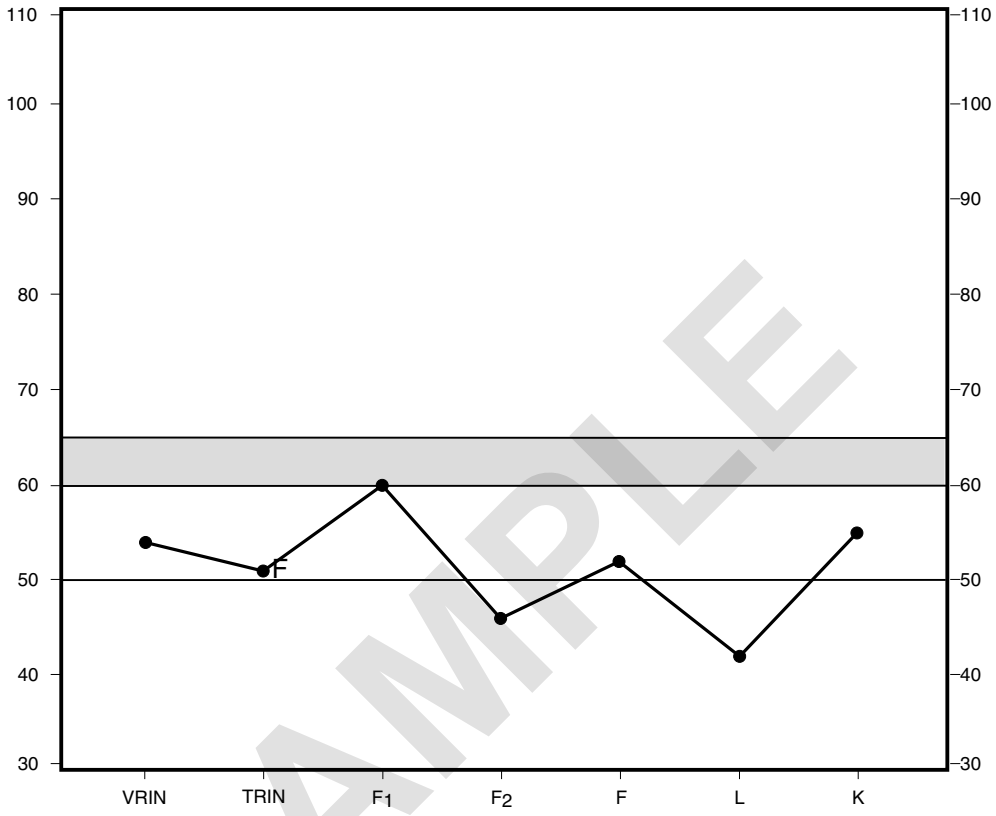
MMPI®-A
The Minnesota Report™: Adolescent Interpretive System, 2nd Edition
James N. Butcher, PhD, & Carolyn L. Williams, PhD

Name:	Jose SampleCase
ID Number:	5555
Age:	15
Gender:	Male
Date Assessed:	1/27/14

PsychCorp

[4.4 / 1 / QG]

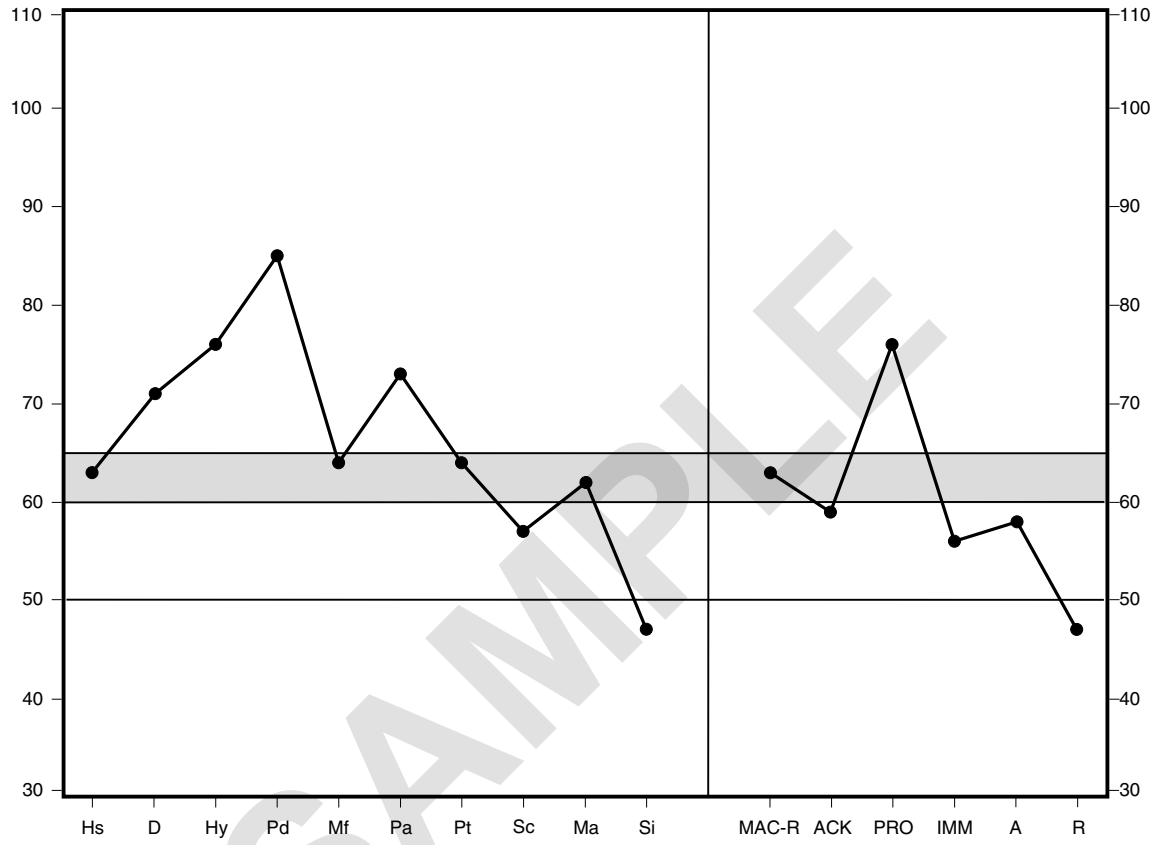
MMPI-A VALIDITY SCALES PROFILE



	VRIN	TRIN	F_1	F_2	F	L	K
Raw Score:	6	9	8	3	11	1	15
T Score:	54	51	60	46	52	42	55
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw):	0
Percent True:	49
Percent False:	51

MMPI-A CLINICAL AND SUPPLEMENTARY SCALES PROFILE

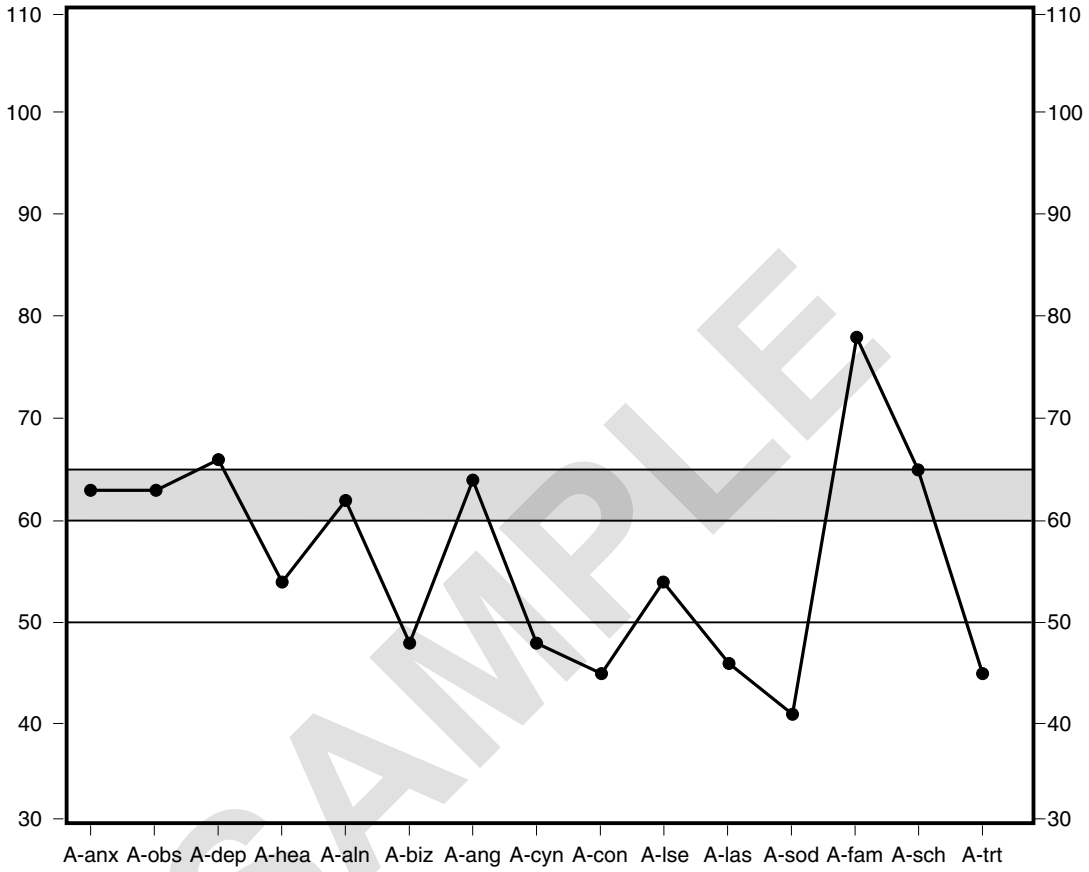


	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	MAC-R	ACK	PRO	IMM	A	R
Raw Score:	14	30	36	35	27	21	28	31	27	24	27	6	28	17	20	12
T Score:	63	71	76	85	64	73	64	57	62	47	63	59	76	56	58	47
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 4"362'+5719-8/0: KF/L:

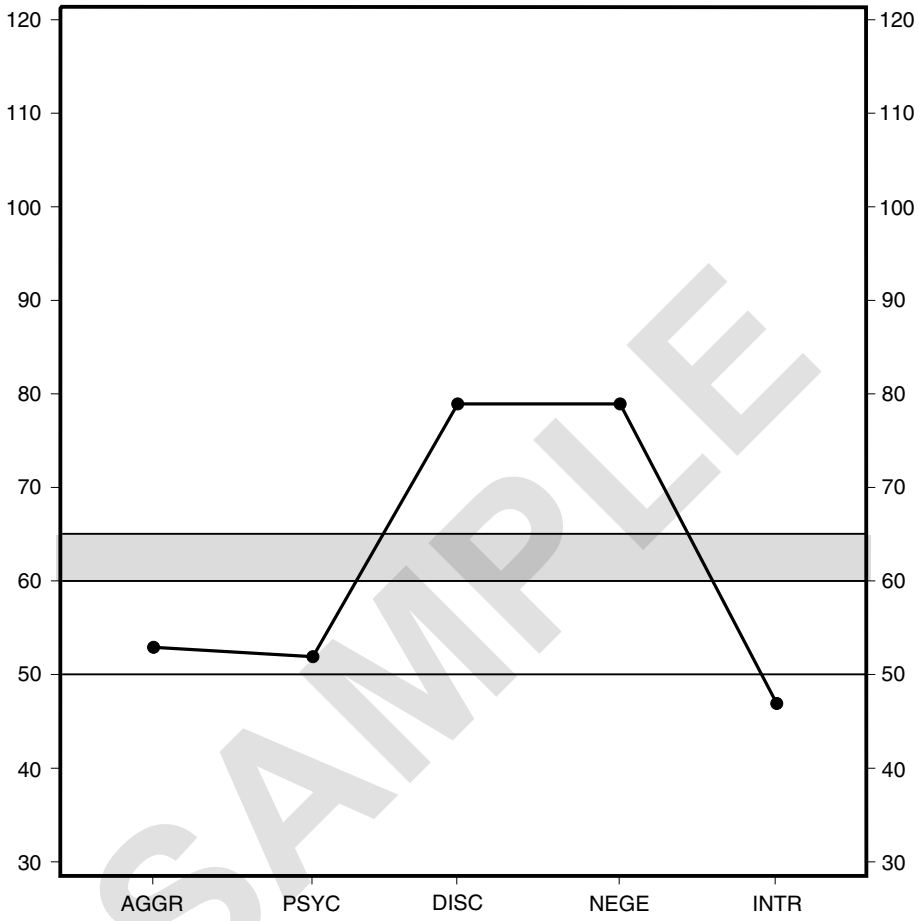
Mean Profile Elevation: 68.9

MMPI-A CONTENT SCALES PROFILE



Raw Score:	13	11	15	11	10	3	12	13	8	7	5	4	24	11	7
T Score:	63	63	66	54	62	48	64	48	45	54	46	41	78	65	45
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MMPI-A PSY-5 SCALES PROFILE



	AGGR	PSYC	DISC	NEGE	INTR
Raw Score:	11	6	18	19	6
T Score:	53	52	79	79	47
Response %:	100	100	100	100	100

VALIDITY CONSIDERATIONS

This is a valid MMPI-A. His responses to the MMPI-A validity items suggest that he cooperated with the evaluation enough to provide useful interpretive information. The resulting profiles are an adequate indication of his present personality functioning.

SYMPTOMATIC BEHAVIOR

This adolescent's MMPI-A clinical scales profile shows problems with acting-out behaviors, social naivete, and lack of insight. His self-control may be tenuous. He probably blames others for his difficulties, and is moody, argumentative, and resentful. Runaway behaviors are possible. Poor impulse control and low tolerance for frustration may contribute to suicidal gestures under stress.

He may develop vague somatic complaints as a defensive style when he encounters pressure, perhaps as a result of rule violations on his part. These somatic complaints are likely to be used to manipulate others and to help him avoid responsibility for his actions.

His two highest MMPI-A clinical scales, Hy and Pd, are among the most frequent two-point scale elevations of adolescents in psychiatric or alcohol/drug treatment settings. Over 8% of boys in treatment programs have these two scales prominent in their clinical profile. It should be noted that this high-point pair is somewhat less frequent in the normative sample, where it occurs in only 3% of the sample. Pd and Hy scale elevations in the normative sample are usually lower in adolescent treatment samples.

Moreover, in a large archival sample from Pearson Assessments (n = 19,048), the elevated high points Hy and Pd shown by this adolescent occurred for only 2.6% of the adolescent boys, using well-defined criteria (i.e., each scale score being 65 or above, and more than 5 points higher than the third highest scale).

His MMPI-A Content Scales profile reveals important areas to consider in his evaluation. This young person reports numerous difficulties in school. He probably has poor academic performance and does not participate in school activities. He may have a history of truancy or suspensions from school. He probably has very negative attitudes about school, possibly reporting that the only positive aspect of school is being with his friends.

Symptoms of depression are quite prominent in his responses to the MMPI-A. He reports sadness, fatigue, crying spells, and self-deprecatory thoughts. His life may seem uninteresting and not worthwhile. Feelings of loneliness, pessimism, and uselessness are prominent.

An examination of the adolescent's underlying personality factors with the PSY-5 scales might help explain any behavioral problems he might be presently experiencing. He shows a pattern of disinhibition given his elevation on the Disconstraint scale that can be manifest through high risk-taking, impulsivity, and irresponsibility. He appears to be less bound by moral restraints than other people and shows callous disregard for others. He may also view the world in a negative manner and may develop a worst-case scenario to events affecting him. His somewhat self-critical nature prevents him from viewing relationships in a positive manner.

INTERPERSONAL RELATIONS

He appears to have skill in interpersonal situations, although he may lack genuine warmth and may manipulate others for his own gains, possibly through intimidation.

Some interpersonal issues are suggested by his MMPI-A Content Scales profile. Family problems are quite significant in this person's life. He reports numerous problems with his parents and other family members. He describes his family in terms of discord, jealousy, fault finding, anger, serious disagreements, lack of love and understanding, and very limited communication. He looks forward to the day when he can leave home for good, and he does not feel that he can count on his family in times of trouble. His parents and he often disagree about his friends. He indicates that his parents treat him like a child and frequently punish him without cause. His family problems probably have a negative effect on his behavior in school. He reported some irritability and impatience with others. He may have problems controlling his anger. He may feel distant from others, believing that they do not understand or care about him. He may feel that he has no one to rely on.

BEHAVIORAL STABILITY

The relative scale elevation of his highest clinical scales (Hy, Pd) suggests clear profile definition. His most elevated clinical scales are likely to be present in his profile pattern if he is retested at a later date.

This pattern of acting-out behavior and poor impulse control may continue over time in the absence of intervention.

DIAGNOSTIC CONSIDERATIONS

He is likely to be viewed as developing maladaptive personality features.

Given his elevation on the School Problems scale, his diagnostic evaluation could include assessment of possible academic skills deficits and behavior problems.

He has some personality characteristics that are associated with the development of alcohol- or other drug-use problems. An evaluation of his use of alcohol or other drugs is recommended. He may be a risk-taker and he may enjoy being the center of attention. However, his ACK score indicates his unwillingness to acknowledge significant problems with alcohol or other drugs.

TREATMENT CONSIDERATIONS

His MMPI-A clinical scales profile suggests that this adolescent is not a good candidate for traditional psychotherapy. Rather, he may be more responsive to a behavior management approach. Any vague somatic complaints may be secondary to his possible conduct problems. Secondary gain from his illness behavior should be carefully evaluated and reduced.

His potential for developing alcohol or drug problems requires attention in therapy if important life changes are to be made. However, his lack of acknowledgment of problems in this area might interfere with treatment efforts.

He should be evaluated for the presence of suicidal thoughts and any possible suicidal behaviors. If he is at risk, appropriate precautions should be taken.

His family situation, which is full of conflict, should be considered in his treatment planning. Family therapy may be helpful if his parents or guardians are willing and able to work on conflict resolution. However, if family therapy is not feasible, it may be profitable during the course of his treatment to explore his considerable anger at and disappointment in his family. Alternate sources of emotional support from adults (e.g., foster parent, teacher, other relative, friend's parent, or neighbor) could be explored and facilitated in the absence of caring parents.

He did endorse content suggesting a desire to succeed in life. There may be some positive aspects about school that could be reinforced. This could be an asset to build on during treatment.

ADDITIONAL SCALES

A subscale or content component scale should be interpreted only when its corresponding parent scale has an elevated T score of 60 or above. Subscales and content component scales printed below in bold meet that criterion for interpretation.

	Raw Score	T Score	Resp %
Harris-Lingoes Subscales			
Depression Subscales			
Subjective Depression (D_1)	**19**	**75**	**100**
Psychomotor Retardation (D_2)	4	46	100
Physical Malfunctioning (D_3)	**6**	**68**	**100**
Mental Dullness (D_4)	**6**	**60**	**100**
Brooding (D_5)	**8**	**76**	**100**
Hysteria Subscales			
Denial of Social Anxiety (Hy_1)	**6**	**66**	**100**
Need for Affection (Hy_2)	**9**	**67**	**100**
Lassitude-Malaise (Hy_3)	**12**	**81**	**100**
Somatic Complaints (Hy_4)	4	50	100
Inhibition of Aggression (Hy_5)	2	44	100
Psychopathic Deviate Subscales			
Familial Discord (Pd_1)	**6**	**64**	**100**
Authority Problems (Pd_2)	**5**	**60**	**100**
Social Imperturbability (Pd_3)	**5**	**61**	**100**
Social Alienation (Pd_4)	**12**	**83**	**100**
Self-Alienation (Pd_5)	**8**	**65**	**100**
Paranoia Subscales			
Persecutory Ideas (Pa_1)	**8**	**64**	**100**
Poignancy (Pa_2)	**6**	**67**	**100**
Naivete (Pa_3)	3	45	100
Schizophrenia Subscales			
Social Alienation (Sc_1)	12	68	100
Emotional Alienation (Sc_2)	1	43	100
Lack of Ego Mastery, Cognitive (Sc_3)	5	59	100
Lack of Ego Mastery, Conative (Sc_4)	6	57	100
Lack of Ego Mastery, Defective Inhibition (Sc_5)	3	48	100
Bizarre Sensory Experiences (Sc_6)	5	50	100
Hypomania Subscales			
Amorality (Ma_1)	2	45	100
Psychomotor Acceleration (Ma_2)	8	57	100
Imperturbability (Ma_3)	3	49	100
Ego Inflation (Ma_4)	**7**	**64**	**100**

	Raw Score	T Score	Resp %
Social Introversion Subscales			
Shyness / Self-Consciousness (Si_1)	2	36	100
Social Avoidance (Si_2)	1	43	100
Alienation--Self and Others (Si_3)	10	57	100
Content Component Scales			
Adolescent Depression			
Dysphoria (A-dep$_1$)	**5**	**78**	**100**
Self-Depreciation (A-dep$_2$)	**5**	**74**	**100**
Lack of Drive (A-dep$_3$)	2	47	100
Suicidal Ideation (A-dep$_4$)	0	42	100
Adolescent Health Concerns			
Gastrointestinal Complaints (A-hea$_1$)	1	59	100
Neurological Symptoms (A-hea$_2$)	3	46	100
General Health Concerns (A-hea$_3$)	5	71	100
Adolescent Alienation			
Misunderstood (A-aln$_1$)	**4**	**64**	**100**
Social Isolation (A-aln$_2$)	2	54	100
Interpersonal Skepticism (A-aln$_3$)	**3**	**64**	**100**
Adolescent Bizarre Mentation			
Psychotic Symptomatology (A-biz$_1$)	1	43	100
Paranoid Ideation (A-biz$_2$)	2	64	100
Adolescent Anger			
Explosive Behavior (A-ang$_1$)	**6**	**66**	**100**
Irritability (A-ang$_2$)	6	59	100
Adolescent Cynicism			
Misanthropic Beliefs (A-cyn$_1$)	8	51	100
Interpersonal Suspiciousness (A-cyn$_2$)	5	52	100
Adolescent Conduct Problems			
Acting-Out Behaviors (A-con$_1$)	2	40	100
Antisocial Attitudes (A-con$_2$)	3	46	100
Negative Peer Group Influences (A-con$_3$)	1	51	100
Adolescent Low Self-Esteem			
Self-Doubt (A-lse$_1$)	5	56	100
Interpersonal Submissiveness (A-lse$_2$)	2	53	100
Adolescent Low Aspirations			
Low Achievement Orientation (A-las$_1$)	4	53	100
Lack of Initiative (A-las$_2$)	0	36	100

	Raw Score	T Score	Resp %
Adolescent Social Discomfort			
Introversion (A-sod$_1$)	3	46	100
Shyness (A-sod$_2$)	1	36	100
Adolescent Family Problems			
Familial Discord (A-fam$_1$)	**18**	**76**	**100**
Familial Alienation (A-fam$_2$)	4	58	100
Adolescent School Problems			
School Conduct Problems (A-sch$_1$)	**3**	**69**	**100**
Negative Attitudes (A-sch$_2$)	4	57	100
Adolescent Negative Treatment Indicators			
Low Motivation (A-trt$_1$)	1	40	100
Inability to Disclose (A-trt$_2$)	3	47	100

Uniform T scores are used for Hs, D, Hy, Pd, Pa, Pt, Sc, Ma, the content scales, the content component scales, and the PSY-5 scales. The remaining scales and subscales use linear T scores.

ITEM-LEVEL INDICATORS

The MMPI-A contains a number of items whose content may indicate the presence of psychological symptoms when endorsed in the deviant direction. The MMPI-A critical item list includes 15 categories that may provide an additional source of hypotheses about this young person.

However, caution should be used when interpreting item-level indicators like the MMPI-A critical items because responses to single items are much less reliable than scores on full-length scales. An individual can easily mismark or misunderstand a single item, and not intend the answer given. Furthermore, many adolescents in the normative sample endorsed some of the MMPI-A critical items in the deviant direction. For this reason, the responses to the item-level indicators printed below include the endorsement frequency for the item in the normative sample to give the clinician an indication of how common or rare the response is in the general population.

Aggression
(Of the three possible items in this section, one was endorsed in the scored direction):

453. Item Content Omitted. (20.2% of the normative boys responded True.)

Anxiety
(Of the six possible items in this section, three were endorsed in the scored direction):

36. Item Content Omitted. (15.3% of the normative boys responded True.)
163. Item Content Omitted. (23.1% of the normative boys responded True.)
297. Item Content Omitted. (15.5% of the normative boys responded True.)

Conduct Problems
(Of the seven possible items in this section, four were endorsed in the scored direction):

249. Item Content Omitted. (29.3% of the normative boys responded False.)
345. Item Content Omitted. (24.6% of the normative boys responded True.)
440. Item Content Omitted. (26.2% of the normative boys responded True.)
460. Item Content Omitted. (25.6% of the normative boys responded False.)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Depression/Suicidal Ideation
(Of the seven possible items in this section, one was endorsed in the scored direction):

62. Item Content Omitted. (20.1% of the normative boys responded True.)

Family Problems
(Of the three possible items in this section, one was endorsed in the scored direction):

366. Item Content Omitted. (16.2% of the normative boys responded True.)

Paranoid Ideation
(Of the nine possible items in this section, two were endorsed in the scored direction):

95. Item Content Omitted. (19.2% of the normative boys responded True.)
428. Item Content Omitted. (14.1% of the normative boys responded True.)

School Problems
(Of the five possible items in this section, three were endorsed in the scored direction):

80. Item Content Omitted. (14.6% of the normative boys responded True.)
101. Item Content Omitted. (24.2% of the normative boys responded True.)
389. Item Content Omitted. (18.8% of the normative boys responded True.)

Sexual Concerns
(Of the four possible items in this section, one was endorsed in the scored direction):

159. Item Content Omitted. (33.7% of the normative boys responded True.)

Substance Use/Abuse
(Of the nine possible items in this section, three were endorsed in the scored direction):

429. Item Content Omitted. (28.9% of the normative boys responded True.)
431. Item Content Omitted. (23.8% of the normative boys responded False.)
467. Item Content Omitted. (22.9% of the normative boys responded True.)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

Unusual Thinking
(Of the four possible items in this section, one was endorsed in the scored direction):

291. Item Content Omitted. (36.5% of the normative boys responded True.)

This young person did not endorse any items from the following MMPI-A critical items categories:

Cognitive Problems
Eating Problems
Hallucinatory Experiences
Self-Denigration
Somatic Complaints

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.

End of Report

NOTE: This MMPI-A interpretation can serve as a useful source of hypotheses about adolescent clients. This report is based on objectively derived scale indexes and scale interpretations that have been developed with diverse groups of clients from adolescent treatment settings. The personality descriptions, inferences, and recommendations contained herein need to be verified by other sources of clinical information because individual clients may not fully match the prototype. Only a qualified, trained professional should use the information in this report.

This and previous pages of this report contain trade secrets and are not to be released in response to requests under HIPAA (or any other data disclosure law that exempts trade secret information from release). Further, release in response to litigation discovery demands should be made only in accordance with your profession's ethical guidelines and under an appropriate protective order.
