

International case studies on the MMPI-A: An objective approach

by

Butcher, J. N., Ellertsen, B., Ubostad, B., Bubb, E., Lucio, E., Lim, J., Ophir, M., Almagor, M.,
Kokkevi, A., Gillet, I., Castro, D., Cheung, F., Tsang, M., Pongpanich, L. O., Atlis, M. M.,
Atlas, M., Derksen, J., Scott, R., Mamani, W., Aroztegui Valez, J., Parabera, S., Sirigatti, S.,
Massai, V., Graziani, G., Tanzella, M. & Elsbury, S.

Compiled by MMPI-2/MMPI-A Workshops, Department of Psychology,
University of Minnesota, Minneapolis, Minnesota.

Contributors

Moshe Almagor
Department of Psychology
University of Haifa
Mount Carmel
Haifa, Israel 31905

Mera Atlis
Department of Psychology
University of Minnesota
75 East River Road
Minneapolis, MN 55455

Myron Atlis
Advisor for the University Presidential
Committee
International Pedagogical University
Magadan, Russia

Eleanor Bubb
67 Marathan Street
Kensington 2094
Johannesburg, South Africa

James N. Butcher
Department of Psychology
University of Minnesota
75 East River Road
Minneapolis, MN 55455

Dana Castro
C/o Isabelle Gillet
Center Medico-Psychologique de Courbevoie
ECPA
25 Rue de la Plaine
75020 Paris, France

Fanny Cheung
Chinese University of Hong Kong
Shatin, N.T. Hong Kong
China

Jan J. J. L. Derksen
Twaalf Apostelenweg 2
6523 LW Nijmegen
Nijmegen, The Netherlands

Bjorn Ellertsen
University of Bergen
Dept of Clinical Neuropsychology
Aarstadveien 21
N-5009 Bergen, Norway

Isabelle Gillet
ECPA
25 rue de la Plaine
75980 Paris, Cedex 20

Graziano Graziani
C/o Saulo Sirigatti
Dep. Psicologia
Vis A. Niccolo, 93 Italy

Silvia Guinea
Hospital de Dia de Madrid
Spain

Anna Kokkevi
University Mental Health Research Institute
Eginitioin Hospital
72-74 Vas. Sophias Avenue
11529 Athens, Greece

Jeeyoung Lim
Jeongdun-Maul
193 Jeongia-Dong, Boondang-Gu
Sungnam-City, Kyunggi-Do, South Korea

Emilia Lucio G.M.
National University of Mexico
School of Psychology
Av. Universidad No. 3004, Mexico 04510

Veronica Massai
Department of Psychology
University of Florence
Florence, Italy

Menachem Ohier
C/o Msohe Almagor
University of Haifa
Haifa, Israel 31905

William Mamani Pampa
Universidad Nacional de San Agustin
Arequipa, Peru

Silvia Parabera
Hospital de Dia de Madrid
Spain

La-Or Pongpanich
Department of Psychiatry
Pramongkut Klao Hospital
Rajvidhi Road
Bangkok 10400
Thailand

Ron Scott
Chapman University
Dept of Psychology
Orange, CA 92666

Saulo Sirigatti
University of Florence
Department of Psychology
Florence, 50125, Italy

Marco Tanzel
C/o Saulo Sirigatti
University of Florence
Department of Psychology
Florence, 50125, Italy

Michael Tsang
C/o Fanny Cheung
Chinese University of Hong Kong
Shatin, N.T. Hong Kong
China

Bente Ubostad
University of Bergen
Bergen, Norway

Javier Aroztegui Valez
Hospital de Dia de Madrid
Spain

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Introduction
James N. Butcher

There is a long history of using personality tests to assess clients in cultures different from the one in which a test was developed. The original MMPI was translated into languages other than English and used in countries outside the United States shortly after it was published in 1943. It rapidly became the most widely used personality measure world-wide (Butcher & Pancheri, 1976). When the MMPI-2, the revision of the original MMPI, was published in 1989, it was adapted for use in many countries (Butcher, 1996). Research has shown it to be an effective instrument for clinical assessment in international settings. Computer-derived interpretive reports for patients in clinical settings in other countries have been found to aptly describe the symptoms and behavior of those tested. Settings (Butcher, Berah, Ellertsen, Miach, Lim, Nezami, Pancheri, Derksen, & Almagor, 1998)

The MMPI-A, the first MMPI instrument specifically developed for adolescents, was published in 1992. Since that time, thirteen translation projects have been initiated. The cases reported here were collected to determine how well the MMPI-A predicts symptomatic behavior in other countries and whether it can serve as an effective clinical tool for the assessment of adolescents outside the United States.

Of the translations administered in the cases reported, four have been published following standard translation/adaptation and norming procedures conducted by bilingual psychologists native to the target country (French, Spanish versions for Mexico, Spain, and the United States). The remaining nine are in various stages of development.

The Value of Case Studies in Psychological Assessment

What information do individual case studies provide in substantiating or verifying the effectiveness of a psychological test? In one sense, this is precisely why we employ personality tests -- to provide a description of a person's symptoms and behavior. A personality measure should provide pertinent and heuristic information about a client's problem situation. There is precious little reason for administering tests in clinical contexts if an objective interpretation does not add to or clarify pertinent aspects of the client's problem. The case approach in personality assessment can add greatly to our appraisal of the operation and worth of a psychological assessment procedure.

The use of case interpretation in teaching psychological assessment procedures is invaluable as well. Students learning about personality assessment techniques can gain a better understanding of how a test works if they see how the instrument depicts personality in a variety of contexts (Ben-Porath & Davis, 1996).

The Value of Individual Case Studies Analyzed by Computer

Objective personality assessment is based on the premise that the most likely actuarial and descriptive information for a given set of test scores is being applied without the clinician having to make judgments about that information. The use of the computer to "look up and combine" the most pertinent personality descriptions is the ultimate in objective interpretation. The most likely and most valid personality descriptions are stored in memory, and the computer is programmed to print out the descriptions for each range or combination of scores available. When practitioners employ a computer-derived report for a particular client, they are removing subjectivity from the analysis because the same descriptions for a given set of scores will be printed out regardless of whether the patient is friendly or surly, ingratiating or uncooperative, or whether the clinician is having a bad day.

Procedures Followed in Obtaining the Case Material

If one wants to examine whether a test interpretation applies across cultural boundaries, the most useful thing to do is to analyze the responses of the test-taker. The cases collected here make this possible.

Psychologists from a number of countries were invited to provide case material. They gave the MMPI-A to an adolescent patient in her or his home country and summarized the individual's problems and the information obtained. No specifications were given regarding the type of case to provide. The contributors were simply asked to administer the MMPI-A to any adolescent being evaluated in a clinical or school counseling context.

The psychologist was asked to send the case information and the MMPI-A profile to James Butcher, who processed the MMPI-A results and obtained a Minnesota Report, a computer-based report distributed by National Computer Systems, Minnetonka, MN. Case summaries and scored protocols are provided for each case, along with the computer-based narrative report. It should be noted that all protocols were scored on U.S. norms, even

though "in country" norms are available for several of the MMPI-A translations administered. If the computer interpretation had incorporated indigenous norms, the interpretation would likely have been more pointed.

What the Cases Show

Examination of the cases provides considerable clinical support for using the MMPI-A across a broad range of populations and applications -- even though U.S. interpretations and norms were used. Adolescents from diverse cultures and settings were assessed. Settings included school counseling, medical, and inpatient psychiatric.

One general conclusion that can be reached by examining the cases is that the MMPI-A interpretation provides valuable and accurate information about adolescents assessed in diverse cultures and clinical contexts. No efforts were made to select "strong" cases. Yet, in virtually all of them, the adolescent's problems were found to be consistent with the case information provided, an impressive finding especially since the interpretive reports are based on norms and interpretive strategies developed in and for the United States.

A second conclusion is that the MMPI-A results provided pertinent clinical information in a credible test performance. That is, the clients appeared to take the task seriously and responded in a cooperative manner. This is an important finding given that true-false tests like the MMPI-A may not be a means typically used to obtain self-report information in other countries. For example, a person taking the original MMPI in Israel (Gur & Butcher, 1974) referred to true-false tests as "American tests."

The validity profiles of the adolescents suggested that, generally, they cooperated with the evaluation. Scores on the validity indicators varied appropriately according to circumstances. For example, in cases where more serious disturbance was likely (the Korean adolescent), the F scale was more elevated. In the second testing for the case from Israel, the individual had more elevated L and K scale scores than in the first testing. This often occurs in follow-up evaluations of successful treatment cases -- individuals who improve in psychological therapy (as this young woman apparently had) tend to present themselves more positively in post-treatment assessment (Butcher, 1990). The elevated L scale score for Federico, a young man from Italy who was hospitalized after an unsuccessful suicide attempt, indicated the clinical phenomenon of denial. The elevation suggests that the youth was in a defensive state at the time of testing, that he had difficulty dealing with the immediate circumstances and appeared to be projecting an "I'm OK" attitude. The staff psychiatrists were aware of his tenuous state and provided appropriate follow-up.

Information Presented on Each Case

The case material is composed of the following:

- A description of the adolescent and his or her problem situation. The contributors were provided a suggested outline for developing the case information. Therefore, the cases are presented in a similar fashion, although not all the recommended information is available for each case.
- MMPI-A validity, clinical, and content scale profiles.
- The computerized MMPI-A narrative report, providing what would most likely be the personality description for the adolescent's MMPI-A profile.
- Final follow-up comment. The psychologists were sent copies of the MMPI-A computerized report and asked to comment on whether the narrative provided useful information.
- Additional scale scores.

SOUTH AFRICA

MMPI-A Version Administered: English

Case: Jenny

Setting: The client was evaluated in a private educational psychological practice that specializes in children with problems.

Identifying Information

Age: 15 years, 10 months

School: Grade 10

Gender: Female

Reason for Referral

Her parents brought her for therapy because of behavioral problems that had been displayed in the home and at school during the last six months. The school referred the child for an evaluation. The assessment was done after three sessions of therapy. During the initial interview with her parents, concerns were raised about her behavior, mood swings, lying, rejection of authority at home and at school, her unpredictability and in general her unacceptable behavior. They were also worried because of the rapid decline in her school performance, which was resulting in school failure.

The final decision for the evaluation was when she was caught skipping school and had pre-planned it by stealing a letterhead from the school on which she wrote a letter to parents of other children so that they could all play truant. The school was considering expelling her. Part of the conditions for staying on was that she was in therapy and that a report was provided.

The assessment included an intelligence test, the Senior South African Individual Scale-Revised (SSAIS-R). This test is standardized on South African children between the ages of 7 and 16 years whose home language is English or Afrikaans. Her verbal scale was in the superior range and her performance scale was in the average range, a significant discrepancy.

Family Structure and Background

She is an adopted child. Her biological mother is her adoptive mother's sister. Very little is known about the biological father, as the biological mother is reluctant to share information. She was very young when she became pregnant with the client. The adoptive parents were unable to have children and decided to adopt the child. The client was aware that she was adopted but was not aware of who her biological mother was. (While in therapy she guessed who her biological mother was and after that would treat her with disdain.)

Her adoptive father used to abuse alcohol and would often come home late and drunk. This would upset her because she hated him being drunk and also because she felt it was unfair to her mother. This behavior of her father improved during the time the child was in therapy. Both parents are volatile in nature and appear to have little inner control. Her parents would often threaten to separate. When not fighting her parents have a positive relationship, but there is very little consistency in the relationship. Both of her parents have demanding jobs and often work long hours.

Living Arrangements

At the time of the assessment she lived with her parents in a house in which she had a large area set aside for her personal use, somewhat like a small apartment.

Kind of Environment

She lives in an affluent area and as an only child has been spoiled on a material level. Discipline appears to have been applied inconsistently by both parents. Her parents also disagree on what behavior needs to be disciplined and the type of discipline required. It would also appear that since she entered puberty her father has become much stricter than previously. Generally discipline was carried out by gating (grounding) her. She would then sneak out without her parents knowing, or play the two against each other to get her own way, or would throw a tantrum until her parents gave in to her.

Her father brought her for a single session approximately a year before the evaluation where he reported that she and her mother were hitting him. At that time it was recommended that he go into therapy and that she

also attend therapy. He continued in therapy for a short period with another therapist but she did not return to continue therapy.

The family presents as dysfunctional and both parents will at times resort to physical violence in an attempt to control her. Their frustration tolerance is poor. The mother at times will also attack the father physically. There are constant arguments between her and her parents and between her parents. Her parents both threaten to leave home and often blame her for the problems in the home. When provided with parental guidance they may carry out instructions, or one parent may carry out the guidance resulting in conflicting discipline.

In the incomplete sentences, she wrote to the sentence stem When I was younger "I was extremely good and never did anything wrong. I always listened to my parents. I was a perfect child." She also wrote to the item I failed "to please my parent (sic) in what I did and am doing."

Educational Background and Experience

The client was attending an exclusive private girl's school at the time of the assessment. She was in Grade 10, and until the six months prior to the assessment had achieved extremely well. Her marks had fallen during this period of time up to 40% in some subjects and her overall aggregate for all her subjects had fallen by 16%. The school was concerned about her progress.

She appears to be artistic and good in languages, but struggles somewhat with mathematics and physical science.

Presenting Problem

Behavioral problems had developed within the school and home setting particularly in the six months prior to the evaluation. Her marks had dropped significantly within those six months. Her parents also reported outbursts of aggression and severe mood swings. They had very little control over her behavior and she was defiant toward all authority.

Description of Client's Symptoms and Behavior

She appeared to be very angry with her parents and would be rude and disrespectful when talking with them. Her relationship with her parents was generally poor. She related better to her mother than to her father. In the incomplete sentences, she noted that her father was a kind and loving man but that he irritated her and that her mother "makes me feel uncomfortable as I feel the need to impress." She was defiant and would only do things if it suited her. She would lose her temper if she did not get her own way and would use her anger to manipulate her parents to give in to her. She used emotional blackmail on her parents. She could be spiteful and vindictive when she was crossed or did not get her own way. She was aware of her temper and wrote to the sentence stem I suffer on the incomplete sentences, "from bad temper tantrums in which afterwards I cry (sic)."

She was very impulsive and would only think of the consequences of her behavior much later. This would then often lead to further misbehavior as she felt she was already in the wrong. She would disappear over weekends and would refuse to tell her parents where she had been. She was beginning to miss full days of school. At night, if she were not allowed to go out, she would make arrangements for friends older than herself to come and fetch her. She would then sneak out without her parents knowing. She had stolen her parents' car one night and had an accident on the highway. She was found by the police and taken to the hospital. Injuries were light but the car was a total loss.

She was lying excessively and was showing no respect for authority at school or at home. She would go to school and then disappear during the day and no one would know where she had been.

Sleeping patterns were very poor and erratic. When she disappeared for a weekend she would spend the whole day on Monday sleeping instead of going to school. She stated on the incomplete sentences that At bedtime "I cannot get to sleep because of bad experiences that flash through my mind."

Her behavior was very manipulative with the school, her parents and friends. She would blame others for her misbehavior and actions. She had insight into her behavior and reported remorse and regret. But once having shown this remorse she would easily repeat the misbehavior when angered. She exhibited poor frustration tolerance. On the incomplete sentences she indicated that she was unable to control her feelings.

Her feelings toward men were very confused. At one stage she did not want her father to touch her. In therapy she admitted that she was sexually involved with boys, but that sex held very mixed feelings for her. She reported that she was not promiscuous. She also had close friendships with a number of boys that were platonic in nature. On the incomplete sentences she reported conflicting feelings in relation to men or boys. She was fearful of men (boys) but also liked them. She stated on the incomplete sentences that Boys "irritate me and sometimes frighten me." She would become involved in relationships with boys for a couple of weeks and then the

relationship would break up. These relationships were very intense and she would often threaten suicide in their company when things were not going her way or if she was arguing with her parents. Her parents were concerned about her relationships with boys as they thought she might be sexually active, especially because she was disappearing for a number of days at a time.

It was very important for her to be accepted by her peer group. She would form sudden friendships, but these tended to last for very short periods of time. Upon meeting people she would tell them her life story and they would be very sympathetic. She would play on these feelings to get her own way in the relationship. She would often threaten suicide, which would result in her friends becoming very upset, as she normally did it while with them after she had fought with her parents. When she ran away it was often to her friends' houses. This would often cause conflict in these families. She would also lie to the parents of these children telling them that her parents knew where she was or telling them that she could not live at home because of the treatment. Within a few days, her disturbing behavior would surface and her parents would be contacted to remove her and take her back home. Some of these parents also contacted the practice because she told them this was where she was attending therapy and they were not sure how to cope with her. She reported intense feelings of loneliness and an almost compulsive need to be with her friends. On the incomplete sentences she made many remarks about her friends, including, I need "my friends to make me happy."

Some of her friends indicated that at times she would almost have an excessive energy that would scare them. On the incomplete sentences there are indications of a constant need to be occupied and to be with people.

The client presented as emotional and depressed with low self-esteem. Even though a very attractive teenager, she thought she was ugly. There was a possibility of an eating disorder, and her mother questioned whether she was bulimic. She was exceptionally thin but felt ugly and fat. She denied any form of eating disorder but admitted that she needed to eat more. She noted on the incomplete sentences that other children "seem so much more happier than I am." She was very touchy and easily annoyed by others. Her parents and friends reported excessive mood swings. She would resort to physical aggression with her parents when she was unable to get her own way. She would scream to the extent that neighbors were concerned about what was going on. Large amounts of money and some jewelry had disappeared from the home during this period.

There had been a sudden change in her achievement and interest levels at school. She was failing at school, even though she was clearly intelligent and did not have a learning disability.

While in therapy, and before the assessment, she revealed that she had been raped around about the time that her behavior and school marks deteriorated. This appeared to have been done by placing drugs in her drink while at a club. She remembered that during the rape she was unable to move which most probably indicates use of a hypnotic type of drug. This was the first time her parents reported she had stayed out the whole night. She also reported that she discovered she was pregnant and that she took herself for an abortion by herself. No one knew of the rape, pregnancy, or abortion until it was revealed during therapy.

During therapy, after the assessment, she overdosed one evening on anti-depressants. She was also hospitalized on two occasions as a result of psychological problems, once to remove her from her parents as the relationships in the family were very volatile and the second time because of suicidal threats.

Use of Drugs or Alcohol

She denied the use of drugs and alcohol at the time of the assessment. During therapy she later admitted having used Ecstasy quite extensively and had also taken LSD. She also indicated that her use of drugs had essentially started in the last six months. This may account for the sudden energy levels reported and sleeping patterns noted. She was smoking quite heavily and at times would become drunk. In general she did not like drinking but admitted to becoming drunk on one or two occasions.

Confrontation with the Law

The night she stole her parents' car the police contacted them after the accident. There was no prosecution, probably because no one else was involved. Her father kept on threatening to charge her friends with kidnapping as she was staying with them without his permission. She charged her father with assault after he hit her at her part-time work one evening. She later withdrew the charge.

DSM-IV Diagnosis

The psychologist did not make an official DSM-IV diagnosis, as it is not the normal procedure in the practice. The consulting psychiatrist, who was called in for hospitalization and medication, also did not provide an official diagnosis. The client did, however, present with many symptoms of an Oppositional Defiant Disorder, but at the same time much of her behavior had developed since the rape, indicating a Chronic Adjustment Disorder

with disturbance of conduct and depressed mood. Some indications of Post-Traumatic Stress symptoms were indicated during therapy as well.

Treatment and Intervention

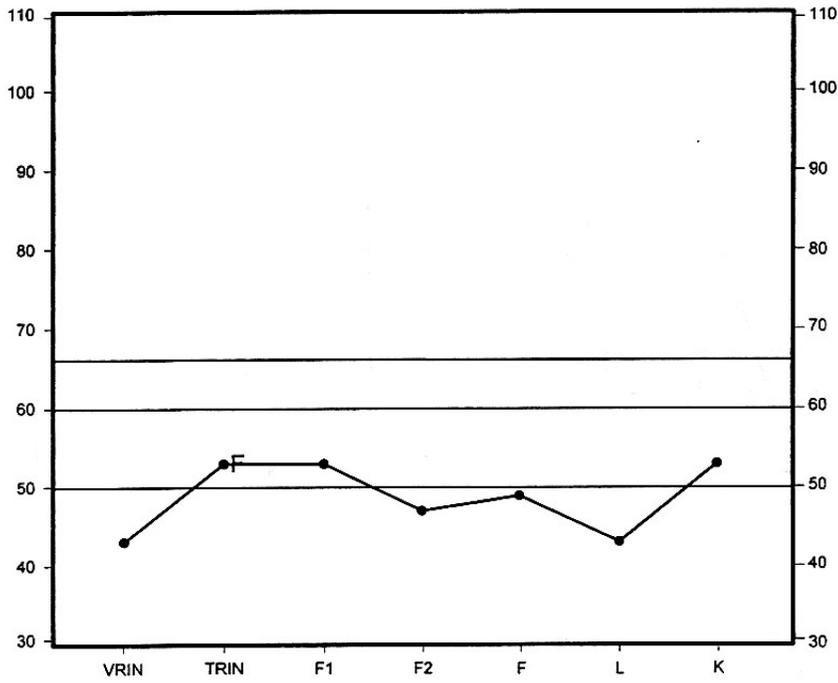
Medication

She was placed on anti-depressants and would take them irregularly.

Psychological Treatment

Therapy was continued. A combination of hypnotherapy and cognitive therapy was used. Much intervention was crisis management in nature because of the ongoing conflict in the family. Some family therapy did occur, but often one of the parents would not be able to attend or was too angry about the situation to attend. While in therapy her behavior was more controllable until her parents would deny her something. This normally ended in confrontation and then she would run away. Therapy was thus irregular. Therapy is officially still continuing but it is on a very irregular basis and normally occurs when there is a confrontation between her and her parents. Limits have recently been placed on her for the conditions under which therapy will continue. In general the relationship between her and her parents appears to be more consistent and positive. Her parents' relationship also presents as better functioning. She has also indicated that she no longer uses drugs, but this is not a certainty. Recent events indicate that she still may be using them on occasion. Thus, at present her behavior seems to be more controlled especially during school terms. She has changed schools and her attitude toward her schoolwork is much more positive. She is reported as attending school regularly and working well. There is no facility available in South Africa for girls representing her level of functioning and nature of behavior displayed. Facilities for more severe behavioral problems do exist, but because of her age she would not be readily accepted. The possibility of suitable placement for a short time was thus not feasible. When it was felt that she would harm herself or other family members, she was hospitalized. This occurred on two occasions. The first time for a week and the second time for two weeks. These experiences generally had a positive influence on her behavior. While in the hospital she attended group therapy sessions.

MMPI-A VALIDITY PATTERN



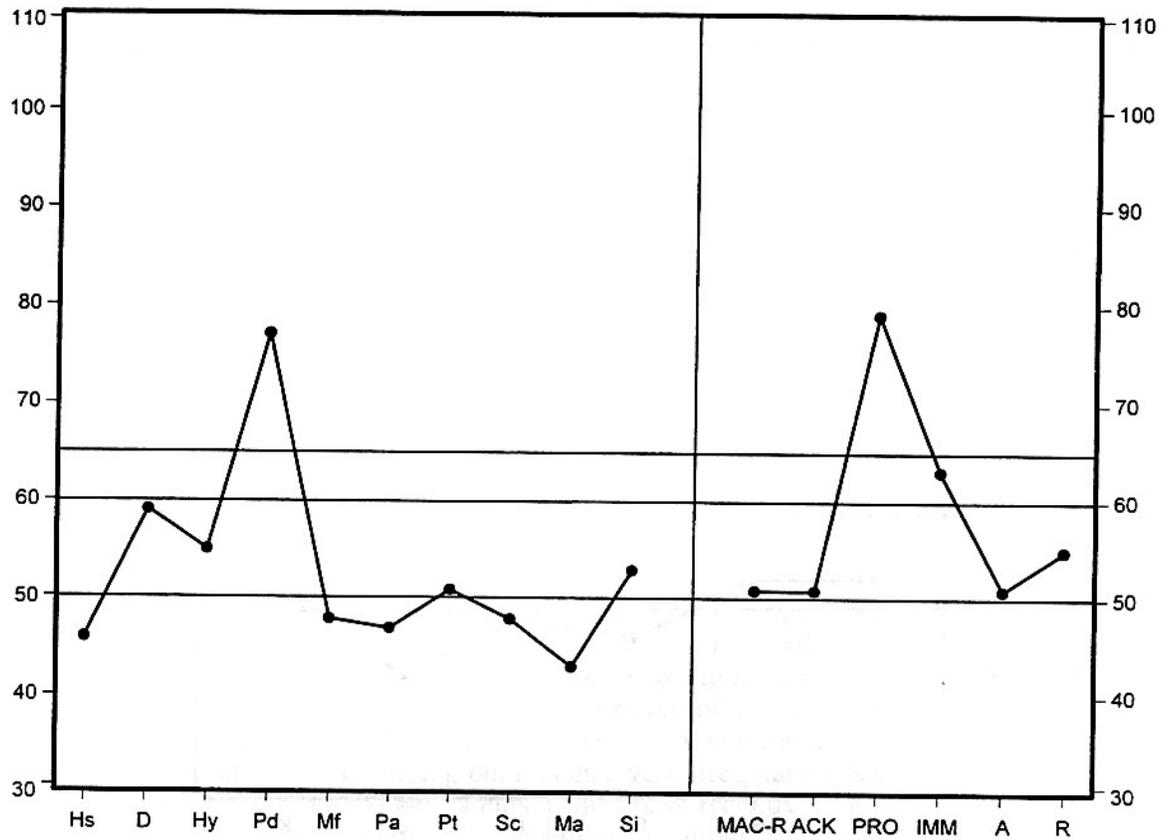
Raw Score:	2	9	4	3	7	1	13
T-Score:	43	53	53	47	49	43	53
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 0

Percent True: 47

Percent False: 53

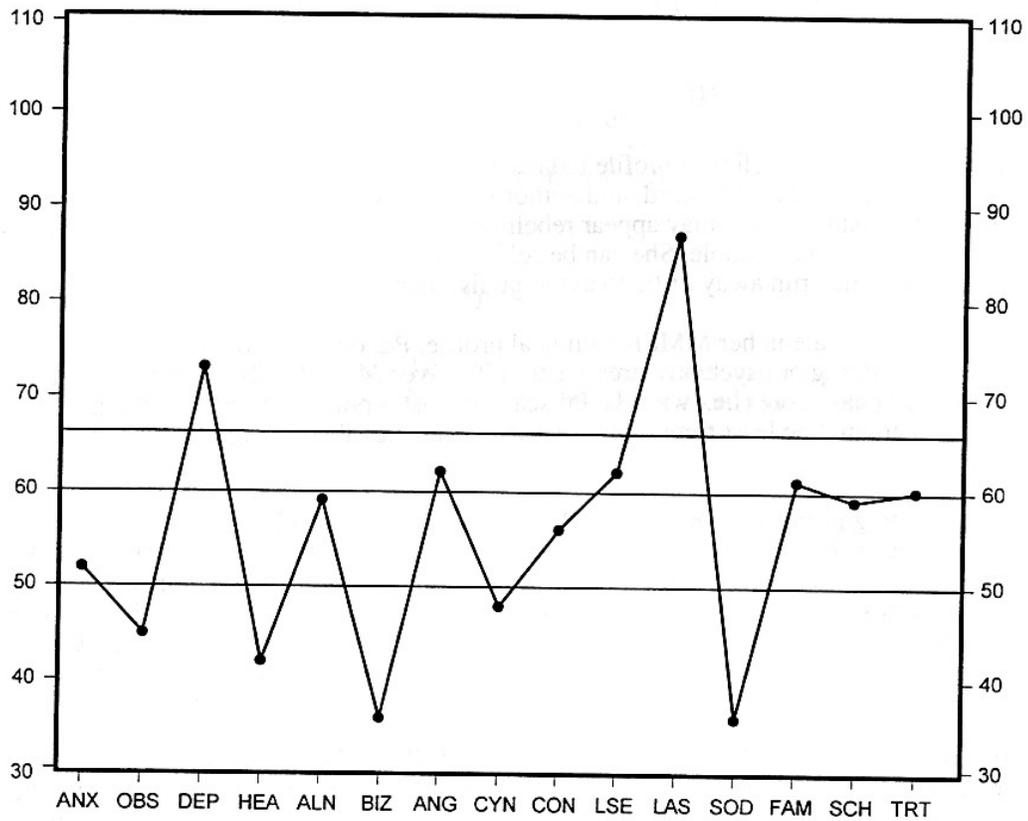
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	7	26	26	33	29	12	23	22	19	29	20	4	29	20	18	15
T-Score:	46	59	55	77	48	47	51	48	43	53	51	51	79	63	51	55
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 4'+-2307/58619: K/FL:
 Mean Profile Elevation: 53.30

MMPI-A CONTENT SCALES PROFILE



Raw Score:	11	7	20	4	9	0	12	13	11	10	14	1	19	9	14
T-Score:	52	45	73	42	59	36	62	48	56	62	87	36	61	59	60
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MINNESOTA REPORT NARRATIVE

VALIDITY CONSIDERATIONS

This adolescent's approach to the MMPI-A was open and cooperative. The resulting MMPI-A is valid and is probably a good indication of her present level of personality functioning. This may be viewed as a positive indication of her involvement with the evaluation.

SYMPTOMATIC BEHAVIOR

This adolescent's MMPI-A clinical profile indicates multiple serious behavior problems including school maladjustment, family discord, and authority conflicts. She can be moody, resentful, and attention-seeking. At times she may appear rebellious, impulsive, and argumentative. Her poor judgment may get her into trouble. She can be self-centered and may show little remorse for her bad behavior. She may run away or lie to avoid punishment.

The highest clinical scale in her MMPI-A clinical profile, Pd, occurs with very high frequency in adolescent alcohol/drug or psychiatric treatment units. Over 24% of girls in treatment settings have this well-defined peak score (i.e., with the Pd scale at least 5 points higher than the next scale). The Pd scale is among the least frequently occurring peak elevations in the normative girls' sample (about 3%).

Extreme responding is apparent on her MMPI-A Content Scales profile. She endorsed at least 90% of the items on A-Ias in the deviant direction, indicating that the following is quite important in understanding her problem situation. She has very little interest or investment in succeeding in school, and she has little expectation of success. She does not like to read or study, and she is probably described as lazy. It is difficult for her to start projects. She gives up easily and tends to let others take charge. Poor academic performance, limited involvement in school activities, and multiple problems in school are likely.

In addition to the extreme endorsements found in her MMPI-A Content Scales profile, she also described other important problem areas. Symptoms of depression are quite prominent in her responses to the MMPI-A. She reports sadness, fatigue, crying spells, and self-deprecatory thoughts. Her life may seem uninteresting and not worthwhile. Feelings of loneliness, pessimism, and uselessness are prominent.

She may be overly interested in violence and aggression, with occasional aggressive outbursts and other problems with anger control. She endorsed several items that are indicative of low self-esteem. She has some very negative attitudes about herself, including feeling unattractive and useless.

INTERPERSONAL RELATIONS

She may seem initially likable and may make a good impression on others; however, her relationships tend to be very troubled. Her behavior is primarily hedonistic and self-centered, and she is quite insensitive to the needs of other people, exploiting them and feeling no guilt about it.

She has an average interest in being with others and is not socially isolated or withdrawn. She appears able to meet and talk with other people and does not seem overly anxious in social gatherings. However, her personal relationships may be somewhat superficial. She may be manipulative at times.

The MMPI-A Content Scales profile provides some additional information about her interpersonal relationships. She indicated several family problems and may be experiencing increasing discord with her parents and other family members. She reported some irritability and impatience with others. She may have problems controlling her anger.

BEHAVIORAL STABILITY

The relative elevation of the highest scale (Pd) in her clinical profile shows very high profile definition. Her peak scores are likely to remain very prominent in her profile pattern if she is retested at a later date. Adolescents with this clinical profile may have a history of acting-out behaviors and relationship problems.

DIAGNOSTIC CONSIDERATIONS

More information is needed about her behavior problems before a definitive diagnosis can be made. Her Pd elevation suggests that behavior problems should be considered. Her endorsement of a significant number of depressive symptoms should be considered when arriving at a diagnosis.

Academic underachievement, a general lack of interest in any school activities, and low expectations of success are likely to play a role in her problems.

Adolescents with very high scores on the PRO scale typically report being involved with a peer group that uses alcohol or other drugs. This adolescent's involvement in an alcohol- or drug-using lifestyle should be further evaluated. Problems at home or in school are likely considering her involvement with alcohol or other drugs.

However, she has not acknowledged through her item responses substantial problematic use of alcohol or other drugs. She is not willing to admit to problems with alcohol or other drugs or she may be unaware of the extent to which her use interferes with her ability to meet her responsibilities.

TREATMENT CONSIDERATIONS

Her conduct disturbance should figure prominently in any treatment planning. Her clinical scales profile suggests that she is a poor candidate for traditional, insight-oriented psychotherapy. A behavioral strategy is suggested. Clearly stated contingencies that are consistently followed are important for shaping more appropriate behaviors.

Her very high potential for developing alcohol or drug problems requires attention in therapy if important life changes are to be made. However, her relatively low awareness of or reluctance to acknowledge problems in this area might impede treatment efforts.

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

There are some symptom areas suggested by the Content Scales profile that the therapist may wish to consider in initial treatment sessions. Her endorsement of internalizing symptoms of depression could be explored further.

She endorsed some items that indicate possible difficulties in establishing a therapeutic relationship. She may be reluctant to self-disclose, she may be distrustful of helping professionals and others, and she may believe that her problems cannot be solved. She may be unwilling to assume responsibility for behavior change or to plan for her future.

GREECE

MMPI-A Version Administered: Unpublished Greek translation

Case: Athanasios (Sakis) V.

Setting: Date of First Visit to Byronas Mental Health Center, 12/21/94

Identifying information

Date of Birth, 2/12/82

School: 1st year secondary school student

Gender: Male

Reason for Visit

Learning difficulties were reported as his primary problem. Although he does his homework with his mother, he does not work alone. He has difficulty in oral expression and is hyperactive. The family is seeking help for the first time, and identified the existence of a problem about one year ago. They visited the Mental Health Centre with a request for psychological assessment of the child. They described him as a sociable boy who takes initiatives. He was described as enjoying playing with older children and of wanting to be the leader. The family, too, presents itself as sociable, with many friends.

Family

The family describes itself as "close" and as taking a real interest in the child. The request for assessment comes from both parents. Three or four years ago, Sakis's family lived with the maternal grandparents, with whom Sakis has strong emotional bonds. All the family relationships are described as harmonious and the grandparents share with the mother the responsibility for bringing up the child. The family moved to a house of its own 7-8 years ago. Their economic situation is described as middle class and Sakis has a room of his own.

The father

The father, aged 35, completed secondary education and works as a press technician in a printing-works. He is the eldest of three siblings (one brother, one sister). No report of psychopathology or serious organic pathology was found in the family history. The paternal grandfather died seven years ago and the paternal grandmother underwent a chest operation at about the same time. No history of psychiatric problems was found in the family.

The mother

The mother, aged 34, completed secondary education and is a homemaker, although six years ago she ran a shop selling lingerie. No indications of psychopathology or serious organic pathology were reported. Before giving birth to Sakis, the mother had thyroid problems and hypothyroidism was diagnosed six years ago. She was born in Canada, to which country her parents had emigrated, and returned to Greece in 1973. She is an only child.

The pregnancy

The pregnancy was normal with no problems being reported other than a period of one week during the last ten weeks before birth in which Sakis's mother hemorrhaged and had to take medication. The pregnancy was unplanned but welcomed by both parents, and the mother's emotional state throughout the pregnancy was good.

Birth

Sakis was a full-term baby and was born by natural childbirth. His mother's labor lasted seven hours. His birth weight was normal (3650 gr.). The baby cried immediately, and there were no observable problems with the delivery.

Development

Sakis was breast-fed for 32 months. His mother reported his health history. His physical development was normal and he walked at 12-14 months, used a comforter until 2 years, and acquired sphincter control at 2 years. There was no reported enuresis. He spoke his first words (mama-dada) at 12 months, beginning to form complete sentences at 2 years. During the first year of life, Sakis contracted spastic bronchitis, which lasted for a year (until he was two years old), and infectious mononucleosis.

Diseases of Childhood

Among the diseases of childhood, the parents reported the following illnesses: scarlet fever, chickenpox, and mumps at 5-6 years. When Sakis was in the second grade (aged about 7 years), he was hospitalized after receiving a blow on the head, which caused him to feel giddy and vomit. During hospitalization he was given an ultrasound scan but not an ECG.

Sleep

Until the age of 11, Sakis slept in his mother's bed when the father was away from home. He slept with both parents until he was 2 years old.

Schooling

Sakis first attended a nursery school when he was 2 years old and adapted well. He began primary school at less than 6 years old, and learning difficulties appeared there. During primary school, his class frequently changed teachers. The class was taught by three different teachers in Primary Four and by two in Primary Three. Sakis's behavior at school is normal, he is sociable, and his out-of-school hobby is basketball.

Child Psychiatric Interview

Appearance and behavior

Sakis was a pleasant adolescent boy whose appearance is compatible with his chronological age. He made good emotional contact in the interview, and there were no disorders in motor functions.

Speech

He spoke spontaneously, expressing himself and comprehending questions well. His vocabulary was satisfactory and he seemed to be capable of verbalizing his thoughts and emotions clearly. He was equally good at non-verbal communication.

Thought content

No disturbances were observed in the flow, structure and content of his thinking and no disturbances of perception were observed. He made no reference to emotionally charged conversational topics. He described his learning difficulties, expressing his concern over the system of examinations in senior high school. He also reported anxiety generated by homework and his school performance. He has no emotional investment in school, unlike his parents, who appear to wish their son to receive a university education. He has many extra-curricular activities in sport, in which he has invested and where he distinguishes himself. He believes his most serious problem is that of headaches (tantamount to migraines). He describes them adequately: frequency, intensity, duration, warning signs, dissipating factors, ways of coping. He reported a reduction in the frequency of headaches over time. He connects them with periods of anxiety, but does not see their causality as psychological.

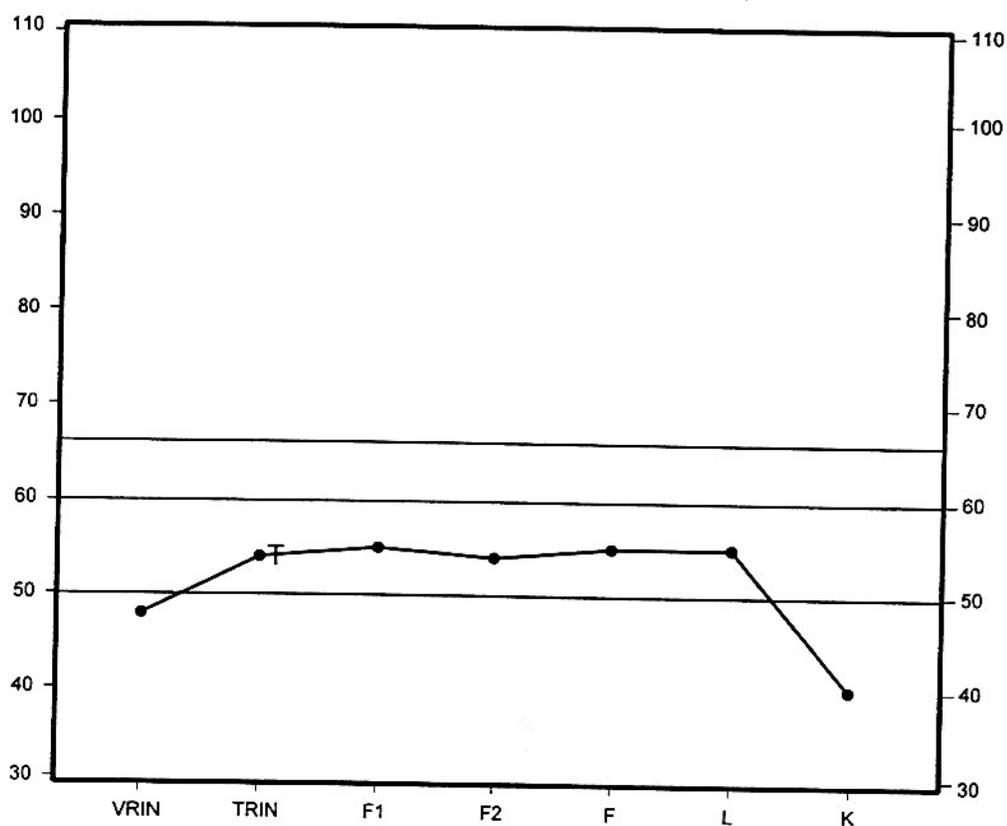
Affect

He appeared to be slightly constrained during the interview. He reported periods of anxiety, especially when external reality clashes with his desires. The ways in which he copes with anxiety do not appear to interfere with his ability to derive satisfaction.

Conclusion

The diagnostic impressions include: Dyslexia, migraines, mild anxiety syndrome.

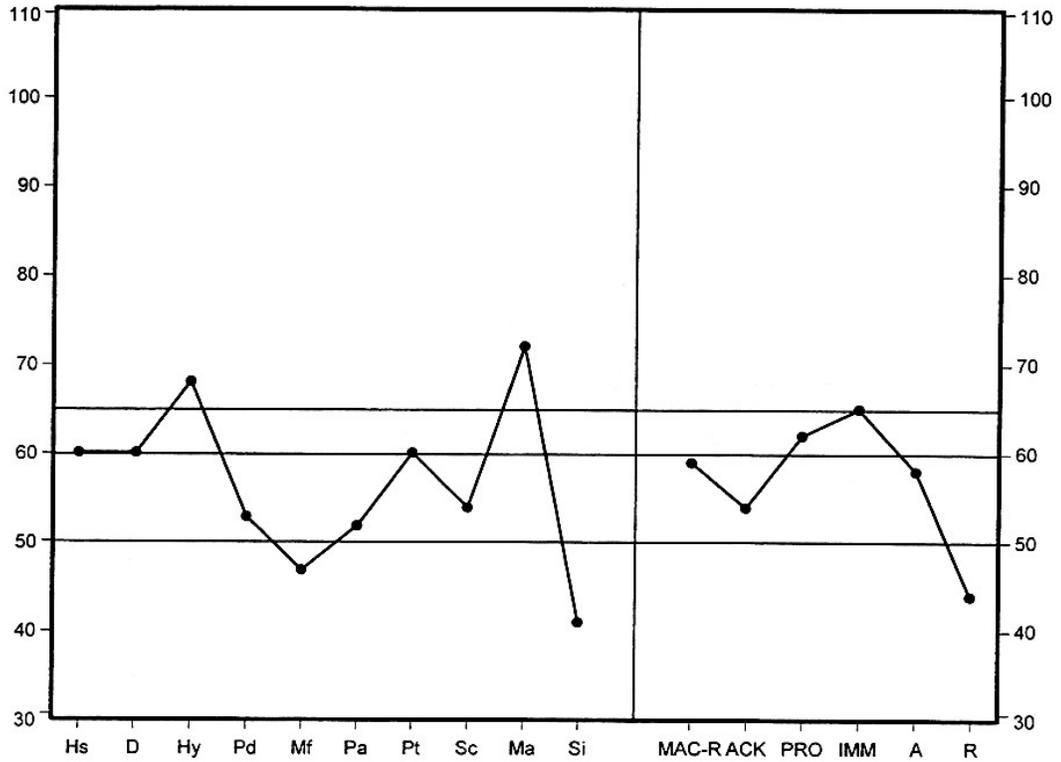
MMPI-A VALIDITY PATTERN



Raw Score:	4	10	6	7	13	4	8
T-Score:	48	54	55	54	55	55	40
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 2 Percent True: 55 Percent False: 45

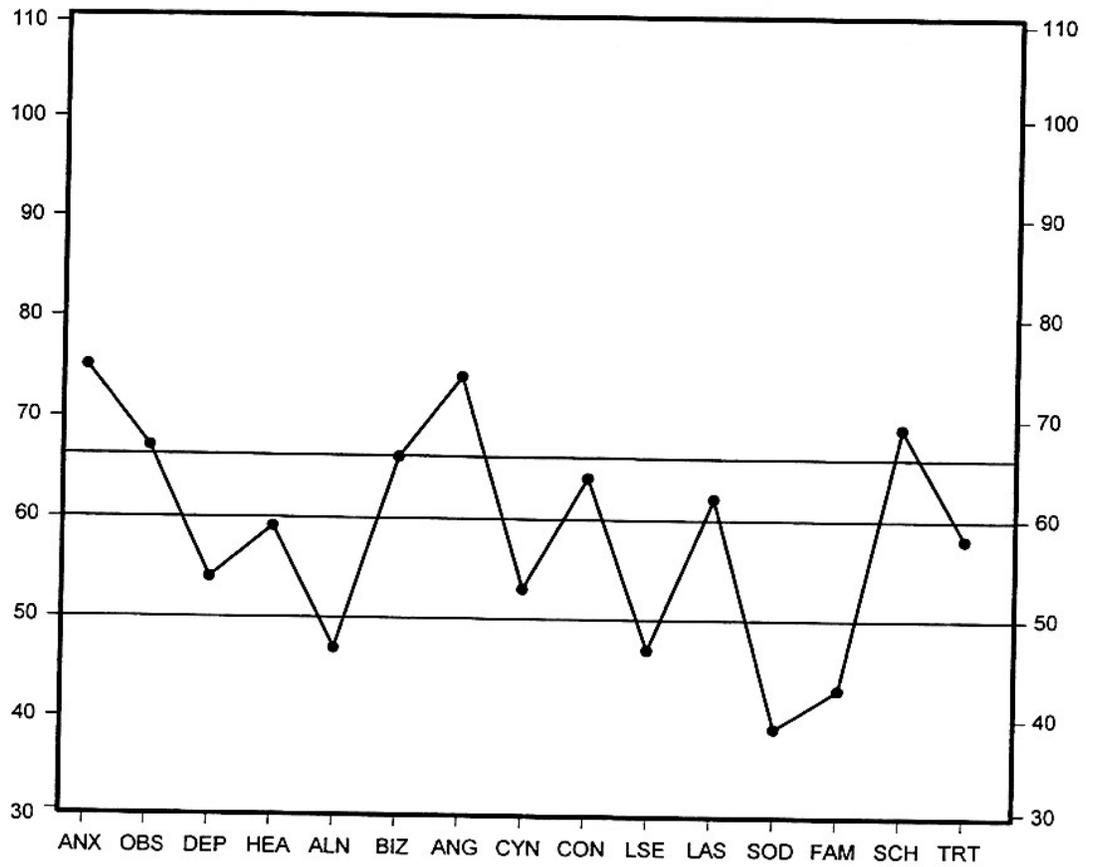
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	13	25	31	22	20	14	26	28	30	19	25	5	22	23	20	11
T-Score:	60	60	68	53	47	52	60	54	72	41	59	54	62	65	58	44
Response %:	100	100	100	100	98	100	100	100	100	100	96	100	100	100	100	97

Welsh Code: 9'3+127-846/50: FL/K:
 Mean Profile Elevation: 59.90

MMPI-A CONTENT SCALES PROFILE



Raw Score:	17	12	10	14	5	9	14	15	15	4	9	3	7	12	13
T-Score:	75	67	54	59	47	66	74	53	64	47	62	39	43	69	58
Response %:	100	100	100	100	100	100	100	95	100	100	100	100	100	100	100

MINNESOTA REPORT NARRATIVE

VALIDITY CONSIDERATIONS

The MMPI-A was developed for adolescents between the ages of 14 and 18 inclusive. Because he has reported his age to be below 14, it is important to keep in mind that the information provided here may not be appropriate for this client. The clinician needs to determine if the adolescent can read and comprehend the item content and is sufficiently mature to answer appropriately. Caution should be exercised in applying MMPI-A correlates to adolescents below age 14 because younger adolescents were not represented in the normative sample.

This adolescent responded to the items in a cooperative manner, producing a valid MMPI-A. His profiles are likely to be a good indication of his current personality functioning.

SYMPTOMATIC BEHAVIOR

This individual appears to be overactive, according to his clinical scales profile. He may have unrealistic plans and agitated behavior, and he may be unable to complete tasks. He tends to be disorganized and has little patience for details.

Such individuals appear overly self-confident, and when things do not go their way, they become frustrated, irritable, and moody. In addition, this adolescent is easily bored and will act impulsively, sometimes showing poor judgment and behaving in ways that create difficulties for himself or others. He is a risk-taker.

Adolescent boys with this MMPI-A clinical profile configuration have one of the most frequent high-point scales, the Ma score, among treatment populations. Over 16% of boys in treatment programs have this prime scale score in their profile. It should be noted that this high-point score is also the most frequent peak score in the normative population (21%), although it usually has a lower level of elevation than in treatment samples. In clinical samples, the Ma score is elevated above a T score of 65 in 18% of the cases, while almost 11% of the normative sample have this scale elevated above a T score of 65.

His MMPI-A Content Scales profile reveals important areas to consider in his evaluation. Assaultive or aggressive acting-out behavior might be present given his report of considerable problems in controlling his anger. He may appear overly interested in violence and aggression.

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. He may have some anxiety or fears about going to school.

He reports many symptoms of anxiety, including excessive worries and sleep disturbances. He may have difficulties with concentration and attending, sometimes becoming confused. Life is probably a strain for him and he may believe that his problems are so great that he will not be able to solve them.

He reports several strange thoughts and experiences, which may include hallucinations, persecutory ideas, or ideas of reference. He reported a tendency toward obsessional thinking and worries.

INTERPERSONAL RELATIONS

He is likely to use others, which results in difficult interpersonal problems. He might be experiencing strained relationships owing to his poor judgment and acting-out behaviors. He may need a lot of interpersonal stimulation; he tends to become easily bored and irritated with others.

His social behavior might be punctuated with periods of moodiness and open expression of negative feelings.

Some interpersonal issues are suggested by his MMPI-A Content Scales profile. Anger-control problems are significant in his clinical picture. He reports considerable irritability, annoyance, and impatience with others. Temper tantrums and aggressive behavior may characterize his interactions.

BEHAVIORAL STABILITY

The relative scale elevation of his highest clinical scale (Ma) 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. Adolescents with this clinical profile are often emotionally labile and may have high moods for no apparent reason and downswings that serve as marked contrasts.

DIAGNOSTIC CONSIDERATIONS

Adolescents with this clinical profile should be evaluated for a mood disorder. Possible authority problems and impulsivity should also be considered.

He reported several bizarre thoughts and behaviors. If these experiences cannot be explained by alcohol or other drug intoxication, organic problems, a misunderstanding of the items, or an intentional exaggeration of psychopathology, a psychotic process should be considered.

Given his elevation on the School Problems scale, his diagnostic evaluation could include assessment of possible academic skills deficits and behavior problems. His endorsement of several anxiety-based symptoms should be considered in his diagnostic work-up. Recurrent obsessions, including obsessive brooding, may be a part of his diagnostic picture.

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. Adolescents with moderate scores on the PRO scale may be involved with a peer group that uses alcohol or drugs. Their involvement in an alcohol- or drug-using lifestyle should be further evaluated. This adolescent may be encountering problems at home or in school because of this. However, he has not acknowledged through his item responses that he has problems with alcohol or other drugs.

TREATMENT CONSIDERATIONS

Adolescents with high scores on Ma are typically unwilling to explore feelings in therapy and tend to be insensitive to feedback. They may overuse denial, and they do not like to discuss details of personal problems. Because they are not introspective, they are not good candidates for insight-oriented psychotherapy. Behavioral approaches designed to increase self-control may prove more fruitful.

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.

There are some symptom areas suggested by the Content Scales profile that the therapist may wish to consider in initial treatment sessions. His endorsement of several anxiety-based symptoms could be explored further.

Conditions in his environment that may be contributing to his aggressive and hostile behaviors could be explored. Adolescents with anger-control problems may benefit from modeling approaches and rewards for appropriate behaviors. Stress-inoculation training or other cognitive-behavioral interventions could be used to teach self-control. Angry outbursts during therapy sessions can provide opportunities for him to learn about his impulse-control problems and to practice new skills.

ISRAEL

MMPI-A Version Administered: Unpublished Hebrew translation

Case: Galit

Setting: Paramilitary Naval Academy (Senior High level with three main directions: Marine, Marine Engineering and Electronics).

Identifying Information

Galit (not her real name) is a second year 15 1/2-year-old. She lives in the school dormitory. Galit began her study at the academy at the second year while most of the students begin at the first year of senior high. Her academic achievement was poor and she failed most of her courses. Her teachers' evaluations of her were the lowest of her class. Her parents reported that she had difficulties in school adjustment beginning at a much younger age.

Reason for Referral

The school counselor whose impression was that Galit has difficulties adjusting to living in the dorm referred her at the beginning of the school year to the school psychologist for further evaluation and assessment.

The Presenting Problem

Galit demonstrated what appeared to be strange behaviors; she was not able to maintain a coherent conversation. She made up stories (such as membership in a Satanic cult, or putting a band-aid on her mouth saying "I want to die" etc.). She had aggressive outbursts and acting-out and provocative behavior such as slipping out to a beach at 2 am, attention seeking, promiscuity, projecting blame onto others for her behavior, disobedience of school rules. She did not find a comfortable place with her peers who rejected her. A sociometric measure revealed her as an extremely disliked student. School staff was seriously considering dropping her from school.

The MMPI-A was administered twice: the first time on March 3, 1997 and the second on February 2, 1998 at the end of therapy.

Symptoms

1. Severe distress; mood swings from depression and helplessness to energetic, grandiose states.
2. Low self-esteem and poor body image; she characterized herself as ugly, obese, and retarded.
3. Feeling rejected and lacking social skills.
4. Attention- and affection-seeking in disinhibitory and provocative ways.
5. Oversensitivity, suspiciousness, feeling of persecution (everybody is against me), projecting blame, feeling misunderstood and that there is nobody there for her on whom she can depend.
6. She was not experiencing alcohol or drug abuse or any problems with the law.

Diagnosis

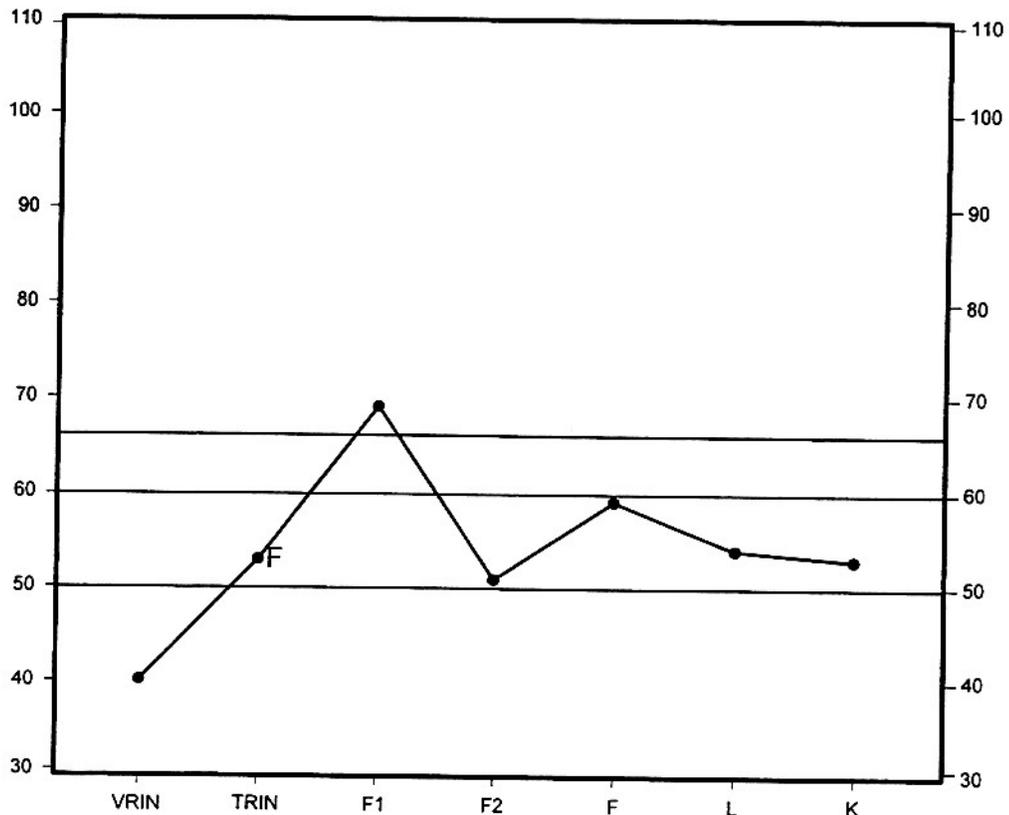
Formal DSM-IV diagnosis would be: Oppositional defiant behavior, and/or Reactive attachment disorder of infancy or early childhood. However, a systemic view of Galit's situation would lead to a diagnosis of Parent-child relational problem.

Background

Galit is the youngest child of a family including two older sisters (23 and 22 years old). The elder sister completed her high school education and is currently a second-year student in a college in the Tel-Aviv area. The second sister also completed her high-school education and she is currently an officer in the IDF. The father, 61, was born in Morocco, immigrated to Israel when he was 13, completed 10 years of education, and works as a taxi driver. The mother, 56, was born in Morocco, immigrated to Israel when she was 11, completed 10 years of education. She used to be an assistant kindergarten teacher, but now she is a housewife. The family lives in the Tel-Aviv area and their socioeconomic status can be described as medium-low. In the interview with the family it was apparent that the relationship between the parents is quite tense and argumentative. They have separate bedrooms (in a three-bedroom apartment) and Galit reports rarely seeing any expressions of fondness between them. The mother appears to be the dominant person in the family, especially when it comes to child rearing. The father was quite passive. When he tried voicing his opinion, he was shut up and ridiculed by both his wife and daughters. It was quite clear that the mother and the two older siblings form a coalition against father and Galit.

The mother did not seem to appreciate Galit and appeared to be rejecting her. She refused to have her back home despite pleas by Galit and the professional staff. Galit appeared to be the family “Black Sheep”, and that was probably the reason for sending her to this particular school. Galit does not get along with her mother and sisters.

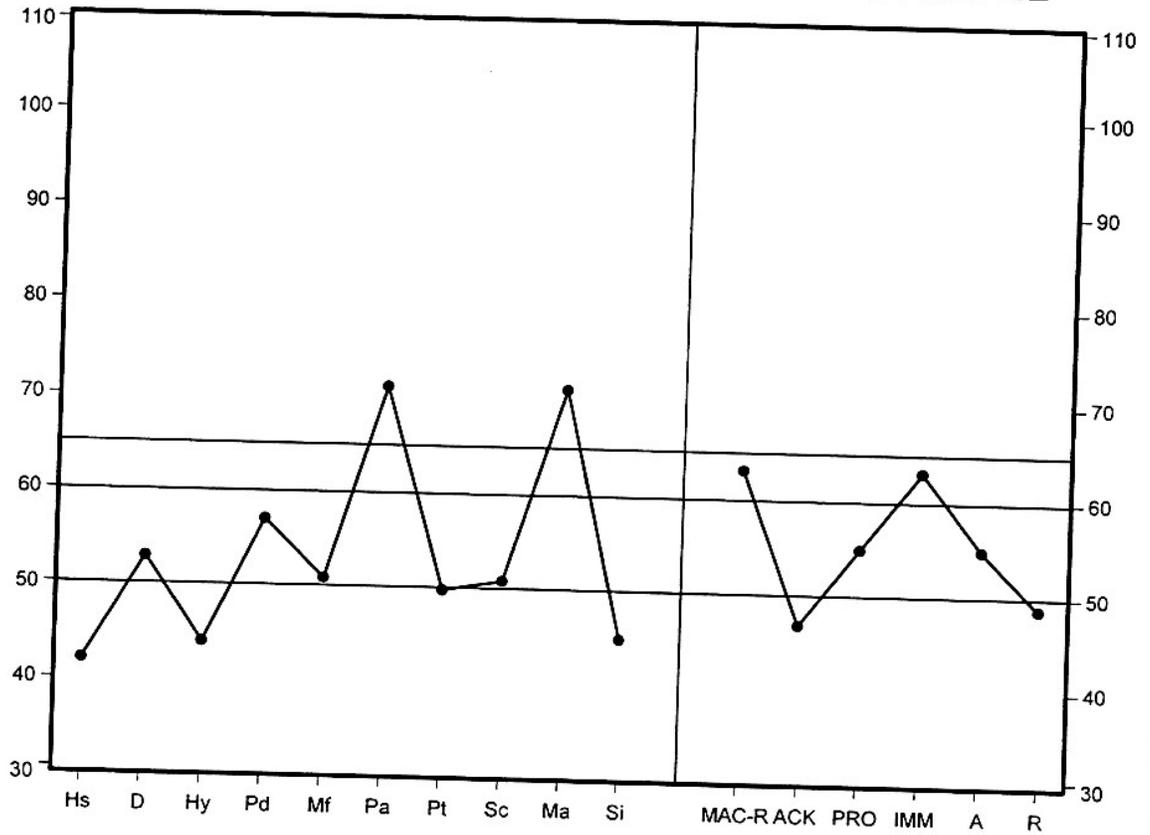
MMPI-A VALIDITY PATTERN



Raw Score:	1	9	9	5	14	3	13
T-Score:	40	53	69	51	59	54	53
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 0 Percent True: 52 Percent False: 48

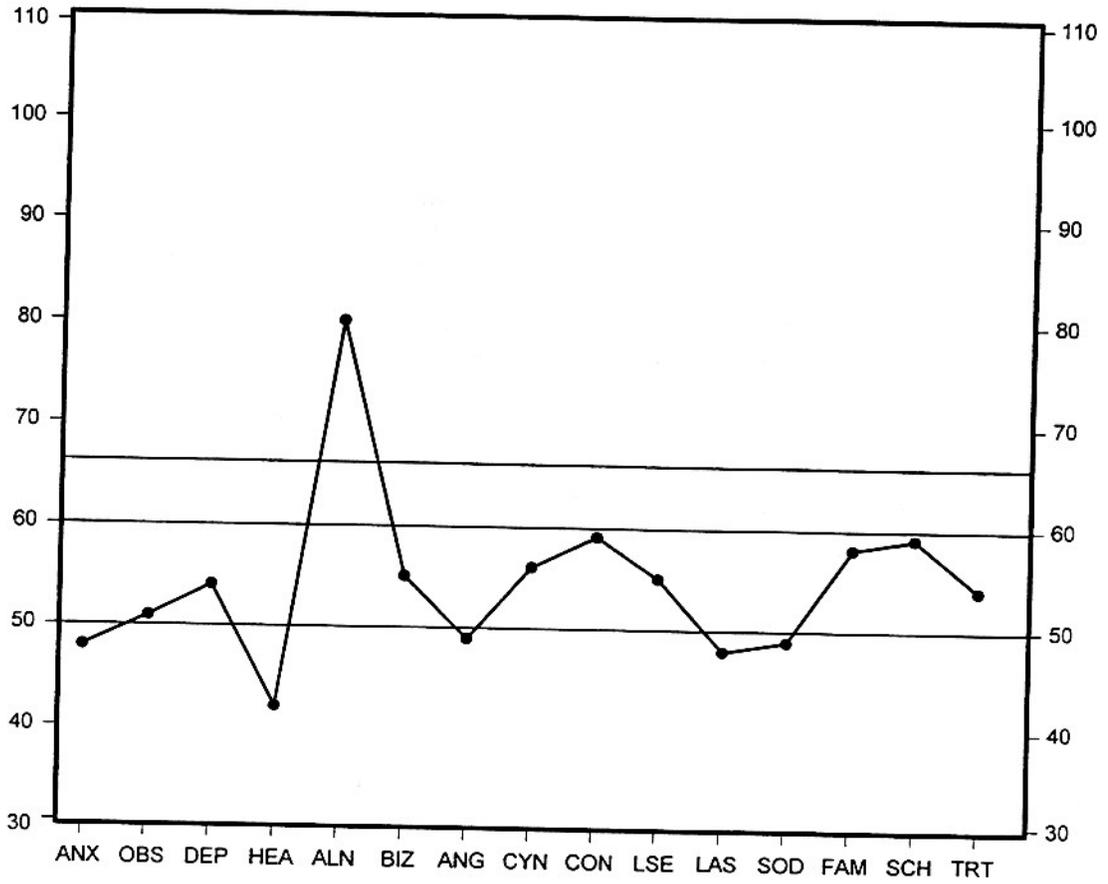
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	5	23	20	25	28	21	22	27	30	23	25	3	19	20	21	13
T-Score:	42	53	44	57	51	71	50	51	71	45	63	47	55	63	55	49
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 69'+-42587/031: FLK/
 Mean Profile Elevation: 54.90

MMPI-A CONTENT SCALES PROFILE



Raw Score:	9	9	12	4	15	6	9	16	12	8	6	7	18	9	12
T-Score:	48	51	54	42	80	55	49	56	59	55	48	49	58	59	54
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MINNESOTA REPORT NARRATIVE (FIRST MMPI-A)

VALIDITY CONSIDERATIONS

This adolescent responded to the items in a cooperative manner, producing a valid MMPI-A. Her profiles are likely to be a good indication of her current personality functioning.

SYMPTOMATIC BEHAVIOR

This MMPI-A clinical profile is frequently found among adolescents who have problems controlling their behavior and may have intense emotional outbursts. In addition, their suspicious, mistrustful behavior can create social problems. This adolescent probably has trouble expressing emotions in a modulated way. She is likely to overreact to environmental events and may frighten those close to her. She may have grandiose plans and could be delusional. She tends to be confused and disoriented and blames others for her problems instead of accepting responsibility herself. The strong possibility of irrational thinking and poor impulse control make adolescents like her difficult to manage because they may act out their self-centered beliefs.

Her high-point MMPI-A score, Pa, is not a very frequent peak score among adolescent girls in treatment centers. Only 6% of girls in treatment programs have this peak scale elevation in their clinical profile. It should be noted that this high-point score occurs with somewhat greater frequency (10%) as a peak score for girls in the normative population but at a lower level of elevation than in treatment program samples.

INTERPERSONAL RELATIONS

Adolescents with this clinical profile tend to have disrupted interpersonal relationships. They frequently act out against others, especially when demands are placed on them, and they are not very sensitive to the needs of other people. Their pervasive lack of trust and wariness of other people's motivations make them difficult to relate to. This individual's lack of trust may prevent her from developing warm, close relationships. When she feels frustrated, she may be aggressive toward others.

Some interpersonal issues are suggested by her MMPI-A Content Scales profile. She feels considerable emotional distance from others. She may believe that other people do not like, understand, or care about her. She reports having no one, including parents or friends, to rely on.

BEHAVIORAL STABILITY

The relative elevation of the highest scales (Pa, Ma) in her clinical profile shows very high profile definition. Her peak scores are likely to remain very prominent in her profile pattern if she is retested at a later date. This MMPI-A clinical profile probably reflects some personality problems as well as a possible intense reaction to a perceived situational threat.

DIAGNOSTIC CONSIDERATIONS

The possibility of paranoid features in her diagnosis should be evaluated, given her clinical profile. Alternatively, some adolescents with this profile may be diagnosed as having some features of a bipolar disorder.

She has some personality characteristics that are associated with the development of alcohol- or other drug-use problems. An evaluation of her use of alcohol or other drugs is recommended. She may be a risk-taker and she may enjoy being the center of attention. However, she has not acknowledged through her item responses that she has problems with alcohol or other drugs.

TREATMENT CONSIDERATIONS

Because adolescents with this clinical profile often have trouble controlling their impulses, they may require a controlled environment if their behavior is erratic or explosive. Externalization of blame, hostility, mistrust, and lack of introspective abilities make these patients generally unresponsive to insight-oriented psychotherapy. A behavioral approach aimed at developing self-control is suggested.

Her potential for developing alcohol or drug problems requires attention in therapy if important life changes are to be made. However, her lack of acknowledgment of problems in this area might interfere with treatment efforts. This adolescent's emotional distance and discomfort in interpersonal situations must be considered in developing a treatment plan. She may have difficulty self-disclosing, especially in groups. She may not appreciate receiving feedback from others about her behavior or problems.

She 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.

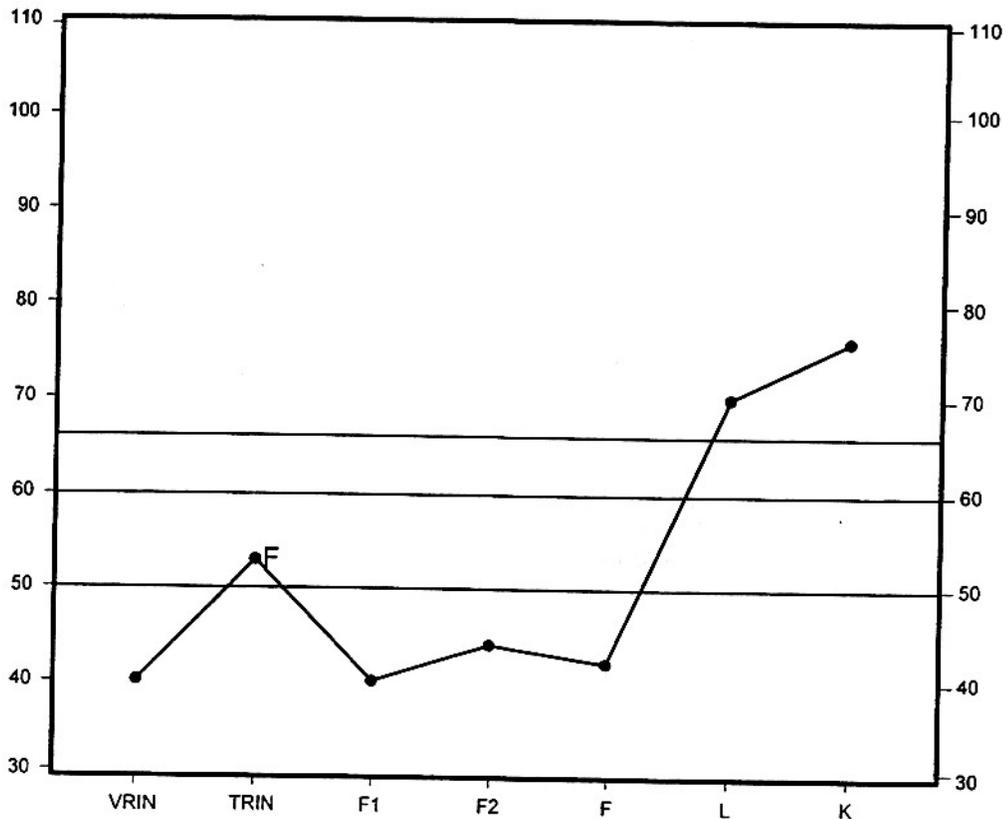
Treatment

Once or twice weekly sessions of individual psychotherapy were provided. The therapy focused on her family and peer relationships. The first step was an attempt to build rapport with Galit by accepting her in a nonjudgmental manner and trying to represent her to staff and parents. Gaining her trust made it possible to deal with issues of self-esteem and social skills. Galit showed remarkable insight and cooperation in therapy. The therapist (M.O.) met with the family several times because they lived far away from school and were not able to travel there regularly.

Meetings were held with all or some family members with the goal of improving relations between Galit and her mother. Following improvement in this relation, the sisters were able to improve their own relations with Galit. Improved relations with peers and the class-social guide were an important objective for therapy. The guide, who left school by the end of the year, manifested negative attitudes and behavior toward her, stigmatizing her, loudly expressing his wish that she drop out of the program. Following discussions with the guide during which he was able to talk about his own issues and Galit's place in that, he changed his attitude toward her. Sociometric measures administered several times during that period clearly demonstrated the improvement in her relationship with her peers and the gradual adjustment to school.

Outcome: Academically, Galit has greatly improved in many ways. Her GPA was much higher and she failed only one class. Socially she became much more accepted by her peers. The sexually provocative behavior and tendency to project blame on others stopped and she became socially involved. Her changed behavior appeared to gain her the appreciation of staff. She has a steady boyfriend at this time. Her relations with her mother have improved and are being described now as warm and that they have become best friends. Her relations with her sisters have improved and so has the atmosphere at home. Galit feels good about herself and is quite satisfied with the changes she has undergone.

MMPI-A VALIDITY PATTERN



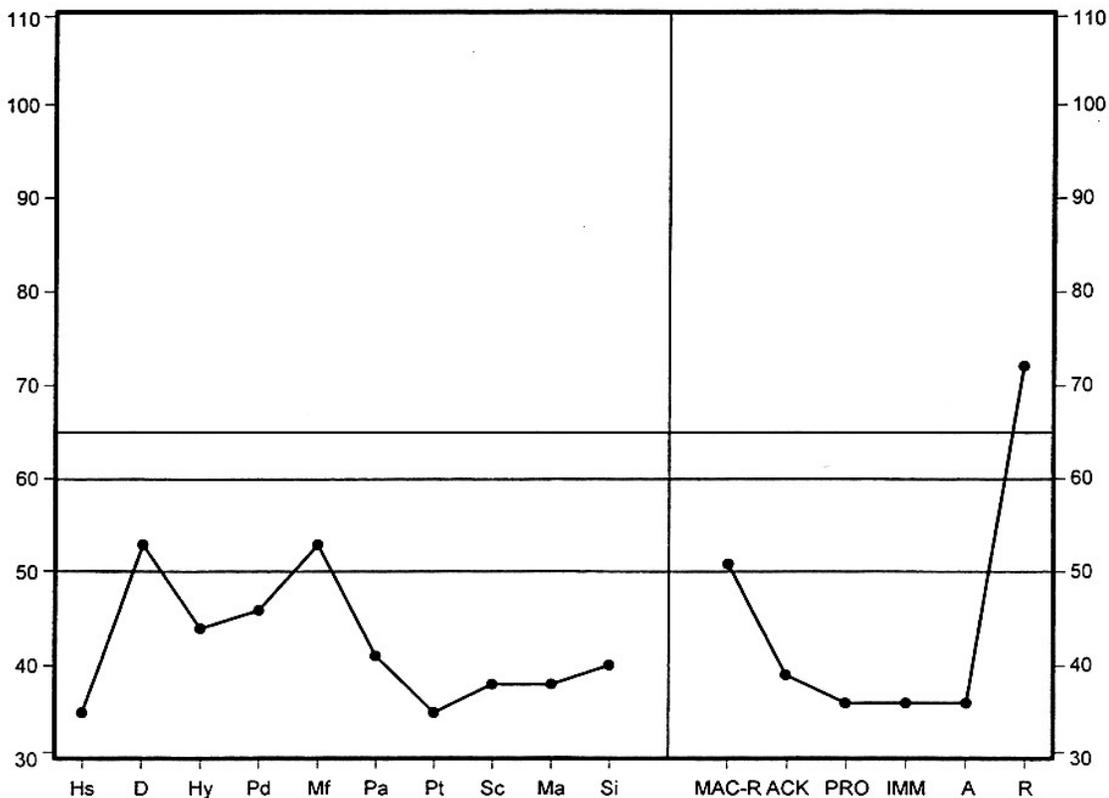
Raw Score:	1	9	0	2	2	6	23
T-Score:	40	53	40	44	42	70	76
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 0

Percent True: 33

Percent False: 67

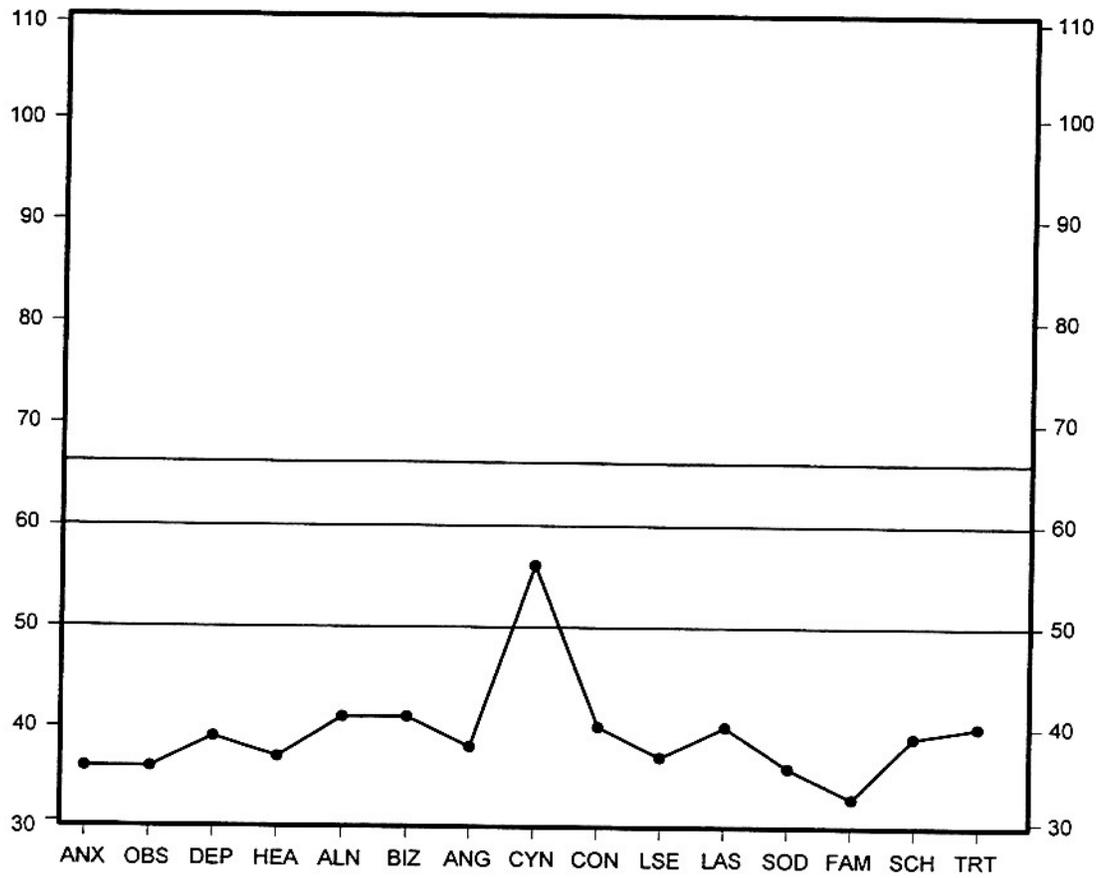
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	2	23	20	18	27	9	7	9	15	19	20	1	11	3	6	21
T-Score:	35	53	44	46	53	41	35	38	38	40	51	39	36	36	36	72
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 25/4360:89 17# KL'+-/F:
 Mean Profile Elevation: 41.30

MMPI-A CONTENT SCALES PROFILE



Raw Score:	2	2	3	2	2	1	4	16	4	1	3	1	2	2	4
T-Score:	36	36	39	37	41	41	38	56	40	37	40	36	33	39	40
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MINNESOTA REPORT NARRATIVE (SECOND TESTING)

VALIDITY CONSIDERATIONS

She responded to the MMPI-A items by claiming to be unrealistically virtuous. This test-taking attitude weakens the validity of the test and shows an unwillingness or inability on the part of the individual to disclose personal information. The resulting MMPI-A is unlikely to provide much useful information about the individual because she was too guarded to cooperate in the self-appraisal.

Her efforts to present herself with an overly positive self-image produced MMPI-A profiles that may underestimate her psychological maladjustment. The test interpretation should proceed with the caution that the clinical picture reflected in the MMPI-A profiles may be overly positive and not provide sufficient information for evaluation.

SYMPTOMATIC BEHAVIOR

These MMPI-A profiles are within normal limits. Unlike most adolescents being seen in mental health settings, this adolescent does not report psychological conflicts or situational stresses that are producing great difficulty for her at this time. She appears to be dealing effectively with her life situation, and she seems to be getting sufficient satisfaction out of life at this point.

She reported no more problems in school than average. This could be an accurate characterization of her behavior in school or it could reflect denial, unawareness, or a simple lack of concern about school-related difficulties.

INTERPERSONAL RELATIONS

She enjoys being around people. She likes social attention and prefers to spend time with others rather than being alone.

The MMPI-A Content Scales profile provides some additional information about her interpersonal relationships. She reported no more problems in her family than other adolescents. This may be an accurate characterization of her family life, or it may reflect denial or a lack of awareness of problems in this area.

DIAGNOSTIC CONSIDERATIONS

No diagnosis is suggested by her moderately elevated MMPI-A clinical profile.

TREATMENT CONSIDERATIONS

She did endorse content suggesting a desire to succeed in life. School may have some positive aspects for her. This could be an asset to build on during treatment.

Final Follow-up Comment

In a meeting with the girl's personal counselor and the chief counselor for her age group held in 1999 it was found that G. is now 17:8 years of age and studying in her senior grade. She is currently preparing to take her matriculation examinations. Her academic achievements have been generally above average but could have been higher if she had spent more time studying rather than socializing.

Her personal adjustment had improved and there was an improvement in her self-esteem and body image. She does not consider herself ugly but not as very beautiful either. She reported that she feels "beautiful on the inside." There was a significant improvement in self-confidence, coping ability, mature attitude, and assertiveness.

Her most significant improvement was in the interpersonal sphere. She has changed from a rejected and unpopular girl to one who is very well liked and who is the center of her class and age group. She initiates and contributes to social activities and takes a number of roles upon herself. She was second in elections for chairperson of student council. She is a member of the school's boating team (the only

girl). She has a steady relationship with a boyfriend. During their friendship he dated another girl and was dumped by G. who later renewed the relationship after he begged her to come back.

The MMPI-A profile reflected accurately G.'s main problems as presented in the "presenting problems" and "Symptoms".

The computerized report is very accurate and describes almost every behavioral syndrome. However, the reference to self-image is not emphasized clearly enough. There is also too much emphasis on chemical abuse. G. had some characteristics such as risk-taking, self-centeredness but there is no evidence for drug use or abuse.¹

¹ We found that for the MMPI-A, the interpretation concerning drug use and abuse is not accurate for the Israeli population in contrast to the interpretation of personality characteristics. The computerized interpretation provided useful clinical information in describing behavior, symptoms, and evaluation. The treatment recommendation (no insight-oriented therapy) was found to be misleading since G. was quite insightful and this insight was quite instrumental in her change. We think that treatment recommendations should not be given. In clinical reports we do not provide diagnostic impressions according to Almagor's policy that, for children and adolescents in Israel, this may be misleading and inaccurate in light of the lack of Israeli solid empirical data in this regard.

NORWAY

MMPI-A Version Administered: Unpublished Norwegian translation

Case: Victoria

Setting: Victoria was an out-patient at the Biofeedback Unit at the Department of Clinical Neuropsychology, University of Bergen, Norway when she completed the MMPI-A.

Identifying Information: At the time of evaluation she was 15 years old and in the 9th grade.

Presenting Problem

Victoria suffers from severe migraine symptoms which had a pre-pubertal onset. She was initially referred for biofeedback treatment by a pediatrician at The University Hospital. The pediatrician had been seeing her regularly from early childhood. The pediatrician wanted to see whether biofeedback could serve as an alternative to the use of analgesics and migraine medication. After 1 year of treatment, it became obvious that there was a relatively modest treatment effect. At this point, her therapist decided that an extensive neuropsychological evaluation was indicated. The therapist suspected that psychological/relational factors played an important role in maintaining the patient's presenting pain problems. Over the course of the treatment it had also become evident that she experienced various other pain problems in addition to the migraine. She and her family were about to make important decisions regarding her future educational and vocational plans. Her therapist therefore wanted to get a general picture of her overall functioning with regard to cognitive abilities, psychosocial functioning, personality factors and psychological symptoms in general.

In addition to the MMPI-A the assessment included the extended Halstead Reitan test battery, supplementary neuropsychological tests, as well as the Personality Inventory for Children (PIC) completed by the patient's mother.

At the time of the evaluation Victoria was living with her mother and her sister who is 2 years younger. The socioeconomic status of the family is best described as upper middle class with her mother teaching at a secondary school and her father being a highly successful businessman. After 10 years of marriage the parents had divorced 6 years ago. The father has remarried and lives in the neighborhood, which allows him to keep in contact with his former family. Victoria's mother, however, describes the contact between Victoria and her father as sporadic and at times of great convenience to her father.

History

Victoria was born 3 months pre-term with a birth-weight of 1 kilogram. There were postnatal complications consisting of breathing problems and infections that led to several periods of hospitalization. Victoria has impaired hearing and is dependent on a hearing aid. She also suffers from a light cerebral palsy mostly affecting the left side of her body. The mother reported that Victoria reached the developmental milestones somewhat later than most children do. During her first 6 school years she attended an ordinary primary school, but she became a student at a school for children with hearing problems in the 7th to 9th grade. She is experiencing learning problems at school and is also described as having problems with psychosocial functioning. She has few, mainly younger, friends in the neighborhood. At home she frequently throws temper tantrums, and her relationship to her younger sister is characterized by jealousy. Her sister is reported to be successful in most respects. The family experiences Victoria's behavior as somewhat immature, highly conflict provoking and as representing a problem for family life. The mother described herself as very tired and wary about the future and in great need of counseling.

Symptoms

Victoria's most prominent symptom at the time of the assessment was a relatively extensive pain problem. She suffered from tension headache as well as migraine. In addition, she reported more diffuse pain manifestations in different body systems. Victoria seemed to have a limited awareness of the relational problems in the family. As the biofeedback sessions proceeded the part of the sessions that involved talking to the therapist tended to overshadow the more technical, biofeedback-training part of the treatment. The therapist therefore decided to initiate a shift of focus and offered psychotherapeutic contact on a regular basis to try to sort out some of the problems Victoria and her family were struggling with. The mother took an active part in the therapy and

came to see the psychologist with Victoria. In addition, both the patient and her mother had single sessions with the therapist during the course of treatment. The broad assessment of Victoria's functioning took place during the first phase of the above mentioned shift of focus from biofeedback to traditional psychotherapeutic interventions. The results from the assessment yielded valuable information which could serve as a basis for further clinical work with the family.

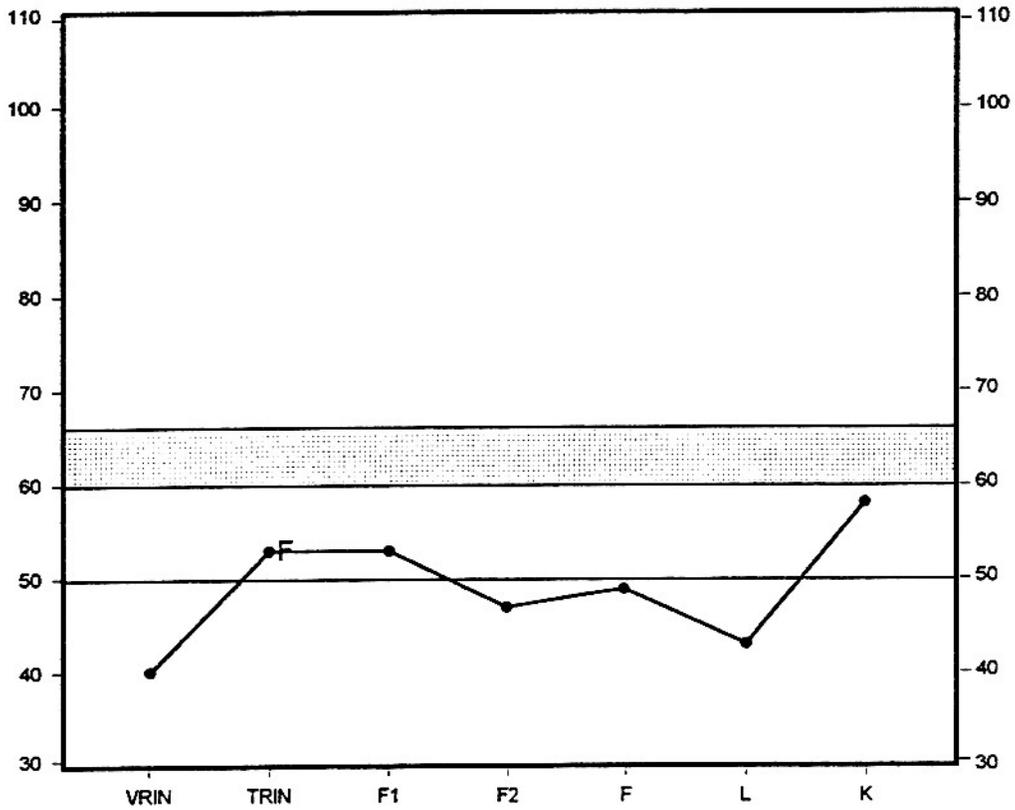
Neuropsychological Evaluation

The extensive neuropsychological evaluation provided an opportunity to elaborate her strengths and weaknesses in cognitive functioning. Her WAIS results showed an IQ near 1 standard deviation below the mean. She obtained a somewhat better result on verbal tasks which gave reason to believe that she would be able to complete the MMPI-A in a valid manner. The main impression from the neuropsychological evaluation was that her test profile shows some similarities with a cluster of problems often labeled Nonverbal learning Disability. She seemed to have limited capacity for theoretical school performance, and to be in need of extensive supervision to complete her additional years of education after the elementary school.

Treatment

The different aspects of her MMPI-A protocol were discussed with the patient in the feedback session shortly after the completion of testing. Her therapist found it particularly useful to use her self-descriptions as a means of discussing her present symptoms and possible strategies to change her coping-style. The fact that some of her pain symptoms were related to muscular tension that could be indirectly caused by her CP led to a decision to start a treatment program with a physical therapist. Social services provided a personal assistant who once a week took Victoria out to do things that girls her age normally like to do. The assistant is a female student aged 19 who hopefully will assist the patient further in finding ways of coping with the different aspects of being a young girl with minor handicaps. Victoria and her mother are still seeing the therapist who initiated the assessment. A main focus of the therapy is to help the two of them find positive ways to relate to each other, as well as to prepare them for new ways of relating as Victoria grows toward a life of her own.

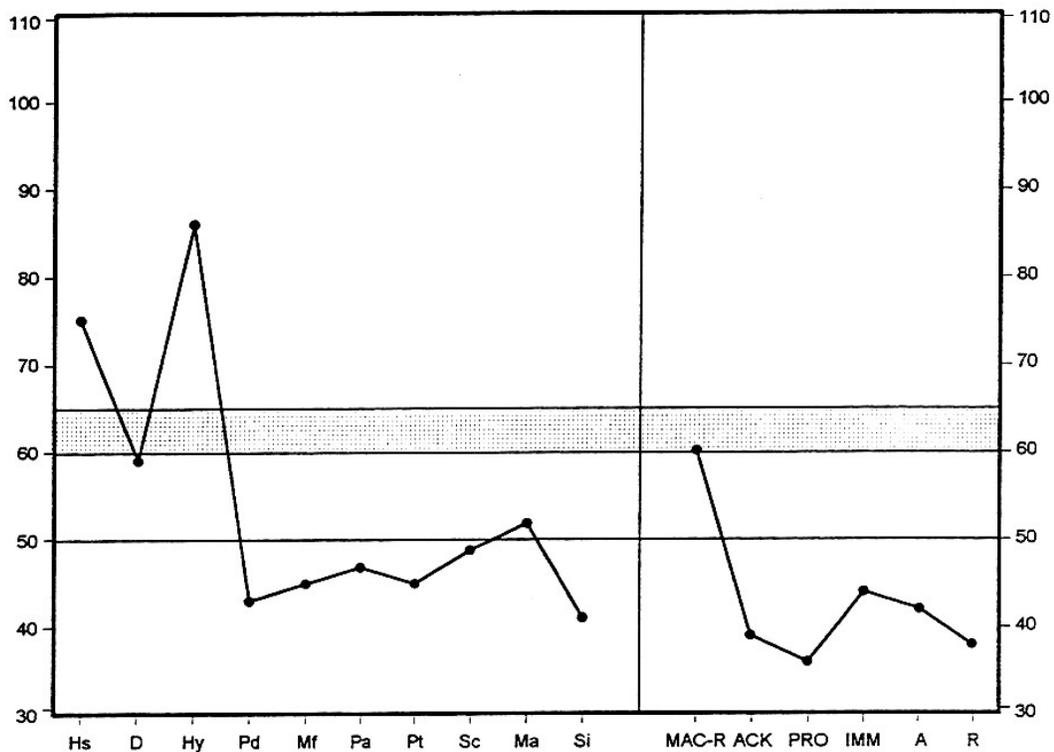
MMPI-A VALIDITY PATTERN



Raw Score:	1	9	4	3	7	1	15
T-Score:	40	53	53	47	49	43	58
Response %:	86	81	91	100	95	93	100

Cannot Say (Raw): 17 Percent True: 46 Percent False: 54

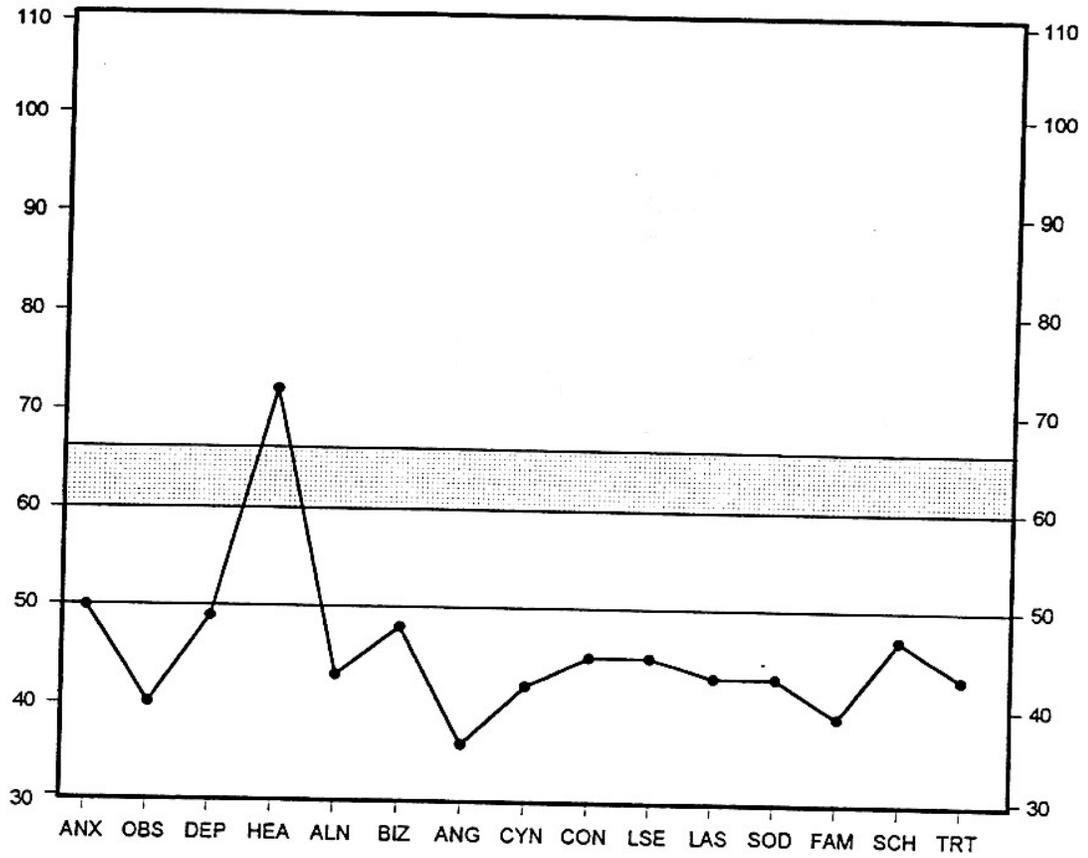
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	21	26	39	16	30	12	17	24	24	20	24	1	11	8	11	9
T-Score:	75	59	86	43	45	47	45	49	52	41	60	39	36	44	42	38
Response %:	94	98	98	94	98	93	96	95	96	97	98	100	92	95	97	94

Welsh Code: 3*1+/-29/865740: K/FL:
 Mean Profile Elevation: 57.00

MMPI-A CONTENT SCALES PROFILE



Raw Score:	10	4	9	21	3	3	3	8	6	4	4	4	5	5	6
T-Score:	50	40	49	72	43	48	36	42	45	45	43	43	39	47	43
Response %:	100	100	96	92	90	100	100	100	96	89	94	92	97	100	100

MINNESOTA REPORT NARRATIVE

VALIDITY CONSIDERATIONS

She omitted 17 items on the MMPI-A. Although this is not enough to invalidate the resulting MMPI-A profiles, some of her scale scores may be artificially lower because of these omissions. It may be helpful to discuss her item omissions with her to determine the reasons for her omissions. Many clinicians prefer to readminister the omitted items (listed at the end of this report) to ensure the most accurate interpretation possible.

The pattern of her item omissions should be carefully evaluated. She omitted from 10 to 15 percent of the items on the following scales: VRIN, A-aln, A-lse, Pd1, Pa1, Pa2, Sc1, and Ma4. Omitting items may result in an underestimate of the problems measured by the affected scale(s). Scale elevations above a T score of 60 should be interpreted even though item omissions may have had some slight effect on her total score. She omitted from 16 to 25 percent of the items from the following scales: TRIN and Pd4. Omitting this many items will probably result in a considerable underestimate of the problems or characteristics measured by the affected scale(s). Caution should be exercised in interpreting the affected scale(s) because full scale scores are clearly attenuated by this degree of item omission. Of course, any scale elevations above a T score of 60 should be interpreted, but it should be understood that the score probably underestimates problems reflected by the scale.

This adolescent's approach to the MMPI-A was open and cooperative. The resulting MMPI-A is valid and is probably a good indication of her present level of personality functioning. This may be viewed as a positive indication of her involvement with the evaluation.

SYMPTOMATIC BEHAVIOR

This individual's MMPI-A clinical profile presents a pattern of symptoms in which somatic reactivity under stress is a primary difficulty. She presents a pattern of physical problems and a reduced level of psychological functioning. Her physical complaints may be vague, may have appeared suddenly after a period of stress, and may not be traceable to actual organic causes. She may be manifesting fatigue, pain, weakness, or unexplained periods of dizziness. Adolescents with this pattern may not appear greatly anxious or depressed about their symptoms and may show "la belle indifference." Apparently sociable and possibly exhibitionistic, this individual seems to manage conflict by excessive denial and repression.

The highest clinical scale in her MMPI-A clinical profile, Hy, occurs with relatively low frequency in adolescent alcohol/drug or mental health treatment units. Only about 4% of girls in treatment settings have this well-defined peak score (i.e., with the Hy scale at least 5 points higher than the next scale). The Hy scale is the second most frequently occurring well-defined peak score among girls in the normative sample, with almost 9% of the profiles having this peak score.

Her MMPI-A Content Scales profile reveals important areas to consider in her evaluation. She reports numerous somatic symptoms, including gastrointestinal difficulties, neurological problems, sensory deficits, cardiovascular symptoms, pain, or respiratory problems.

INTERPERSONAL RELATIONS

Adolescents with similar clinical profiles tend to be somewhat passive-dependent and demanding in interpersonal relationships. This individual may attempt to manipulate others by complaining of physical symptoms.

She enjoys being around people. She likes social attention and prefers to spend time with others rather than being alone. Her personal relationships are likely to be somewhat superficial. She appears to be rather spontaneous and expressive and may manipulate others, especially to gain social recognition.

BEHAVIORAL STABILITY

The relative elevation of the highest scales (Hs, Hy) in her clinical profile shows very high profile definition. Her peak scores are likely to remain very prominent in her profile pattern if she is retested at a later date. This adolescent may be developing a hysteroid adjustment to life, and may experience periods of exacerbated symptoms under stress.

DIAGNOSTIC CONSIDERATIONS

Adolescents with this clinical profile typically show a pattern of adjustment in which somatic complaints are prominent. Conversion disorder or somatization disorder should be considered.

She has some personality characteristics that are associated with the development of alcohol- or other drug-use problems. An evaluation of her use of alcohol or other drugs is recommended. She may be a risk-taker and she may enjoy being the center of attention. However, she has not acknowledged through her item responses that she has problems with alcohol or other drugs.

TREATMENT CONSIDERATIONS

This adolescent may be resistant to mental health treatment because she has little psychological insight and seeks medical explanations for her problems. She is probably reluctant to engage in self-exploration. In addition, she seems to experience little anxiety over her situation and may have little motivation to change her behavior. Some individuals with this clinical profile respond to placebos or mild suggestion, or to stress-inoculation therapy if it is not too threatening. They will probably require long-term commitment to therapy before their personality will change substantially. However, individuals with this clinical profile often terminate treatment early.

Unless a medical evaluation determines otherwise, daily school attendance should be encouraged. Brief visits to the nurse's office during times of symptom expression might be helpful, but she should be encouraged to return to class as soon as feasible. Her attention should be directed away from her somatic complaints. Assessment of her school friendships might be helpful, and if the school has a friendship-building class or other social skills programs, a referral might also facilitate her adjustment.

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

MEXICO

MMPI-A Version Administered: Published Spanish translation by Lucio-G.M. et al.

Case: Alejandro

Identifying Information: Alejandro, an 18-year-old man, recently finished high school and was waiting to be admitted to college. He recently failed to obtain admission to a public university and he was greatly depressed. This adolescent comes from a high middle social class in Mexico City, his reading comprehension is very good, his family is well educated and Alejandro has a good cultural background. It is important to emphasize that in this social class the MMPI-A is very useful, but perhaps it does not work as well in lower class adolescents when education is low and reading level marginal.

Reason for the Referral

He entered psychological treatment for his depressed mood and was referred for an evaluation by his psychotherapist to obtain a picture of his current mood and behavior. Currently there is a great problem getting a placement at public universities in Mexico. This situation makes adolescents and their parents very anxious. He sought counseling to explore what career he should follow at the University.

Family Structure and Background

His mother teaches art history in college and is from a high social class family; she is 50 years old. His father is a surgeon, from a middle class family; he is 57 years old. He has two younger sisters, one is 15 years old and the other is 13. His parents were divorced when he was 10 years old.

He currently lives with his father. However, some months before the evaluation he lived with his mother, his two sisters and his stepfather. His mother was remarried 6 years ago and she has no children with her present husband.

Educational Background

At the time of the evaluation he was not attending school. He finished high school (preparatory) at a private school. Before he failed the exams for admission first to a public university, and then to a private university, he was a very good student, his marks were always high.

Presenting Problem

He was referred for the assessment because he did not know what career to choose and also because he was depressed, so his psychotherapist wanted to know what his aptitudes and interests were. The psychologist who carried out the assessment decided to administer the MMPI-A because she thought that sometimes personality traits and symptoms interfere with the decision about which career to choose. On the WAIS he attained an I.Q. score of 119.

Symptoms and Behavior

Alejandro was depressed and had no interest in anything. His symptoms are: sleep disturbances such as hypersomnia, feelings of worthlessness, diminished ability to think or concentrate, and indecisiveness. At the present time, he has lost an interest in everything. He has also been rejected by the girl with whom he was involved. He thinks that his friends treat him differently now because he failed the admission exam to the university.

He is trying to choose between Medicine and Chemistry. His mother does not want him to study Medicine because she thinks it is a very long career; his father does not tell him what to study. Alejandro thinks that his father would like him to study Medicine, but he does not say anything, which makes matters worse. He thinks he would also like to study Literature, but he is undecided. He thinks he really likes Chemistry, but he is not enthusiastic about it. He thinks perhaps he is not good enough to study anything.. He had a lot of quarrels with her mother because he thinks she is very strict, and she makes many comparisons between him and his sisters, she treats his sisters better. He has a lot of quarrels with his father because his father wants him to do something, while he is waiting for the admission exam at the university again. At present he is neither studying nor working. His father thought he was depressed because he gets up very late in the morning.

This adolescent does not use alcohol or drugs, he has never been arrested or confined in prison.

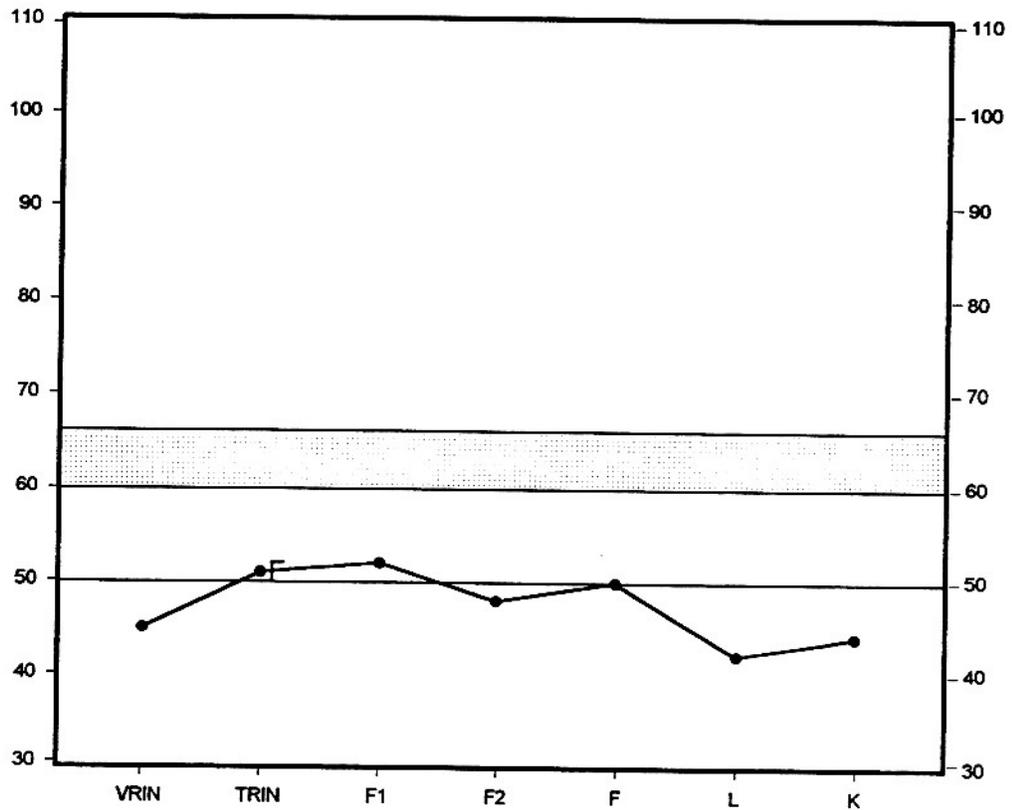
Diagnosis

According to the DSM IV the diagnosis would be an Adjustment disorder with depressed mood.

Treatment or Intervention

This adolescent was being treated in psychotherapy with a psychodynamic orientation. At the time of the assessment he was not taking any medication, but some months ago he was taking antidepressive medication. During the course of psychotherapy Alejandro came to some resolution about his career plans and was determined to pursue Chemistry when he entered college.

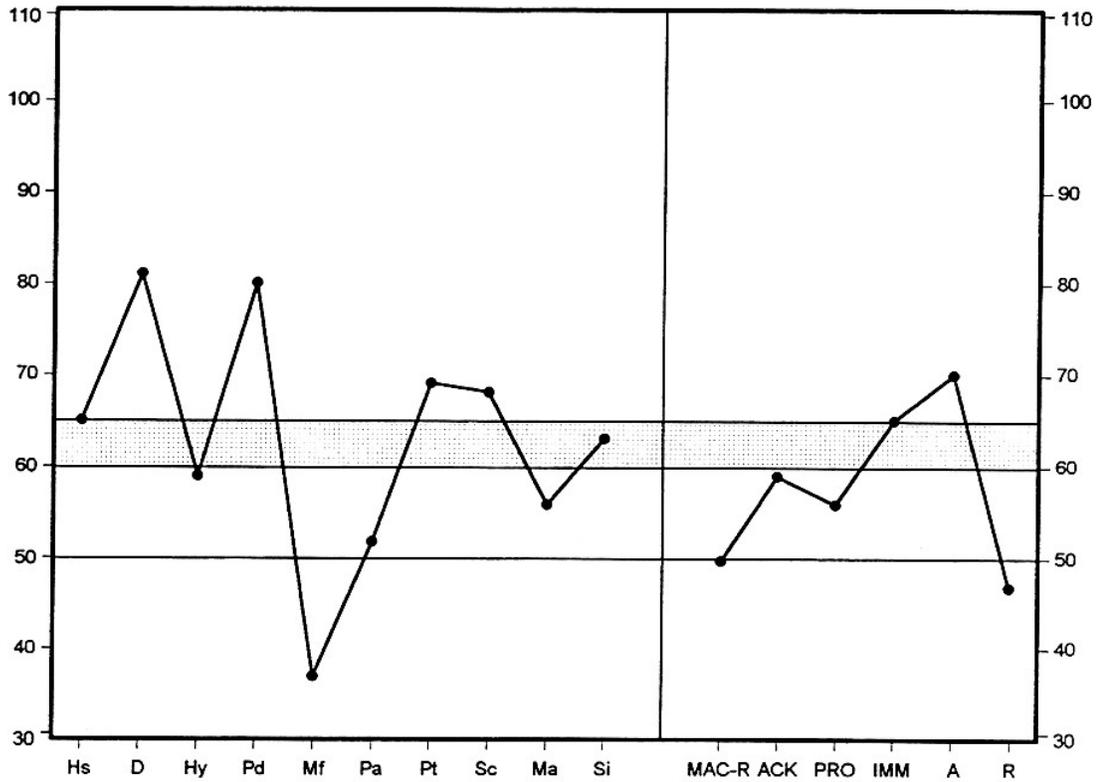
MMPI-A VALIDITY PATTERN



Raw Score:	3	9	5	4	9	1	10
T-Score:	45	51	52	48	50	42	44
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 0 Percent True: 54 Percent False: 46

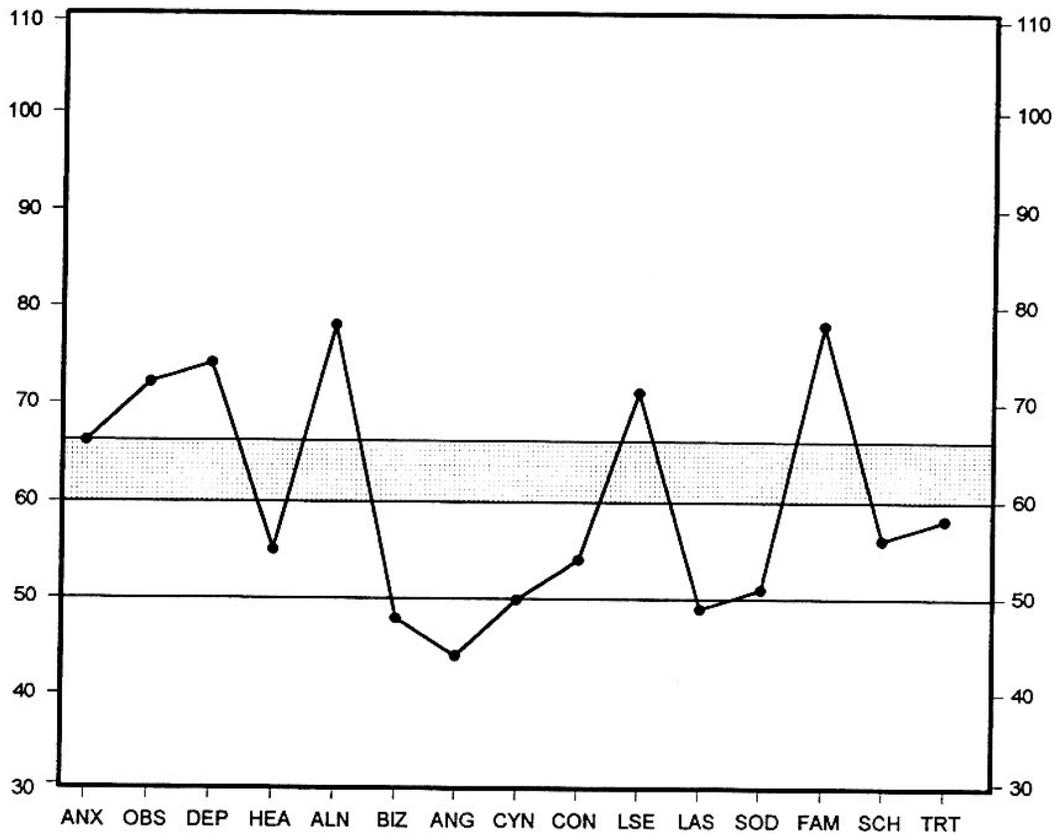
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	15	35	26	33	16	14	31	39	25	36	21	6	19	23	29	12
T-Score:	65	81	59	80	37	52	69	68	56	63	50	59	56	65	70	47
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 24**781+0-396/:5# F/KL:
 Mean Profile Elevation: 66.30

MMPI-A CONTENT SCALES PROFILE



Raw Score:	14	13	18	12	14	3	6	14	12	11	6	9	24	9	13
T-Score:	66	72	74	55	78	48	44	50	54	71	49	51	78	56	58
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MINNESOTA REPORT NARRATIVE

VALIDITY CONSIDERATIONS

This is a valid MMPI-A. He is neither denying problems nor claiming an excessive number of unusual symptoms. His low K score suggests an overly frank self-appraisal, possibly presenting a more negative picture than is warranted. This may reflect a need to get attention for his problems.

SYMPTOMATIC BEHAVIOR

This adolescent's MMPI-A clinical profile reflects a high degree of psychological distress at this time. He appears rather tense and depressed and may be feeling agitated over problems in his environment. He may be experiencing a great deal of stress following a period of acting-out behavior, possibly including problem use of alcohol or other drugs.

He appears to be developing a pattern of poor impulse control and a lack of acceptance of societal standards. This individual may also be angry about his present situation and may blame others for his problems. He may be seeking a temporary respite from situational stress. He may attempt to manipulate others through his symptoms in order to escape responsibility for the problems he has created.

His two highest MMPI-A clinical scales, D and Pd, which are clearly elevated above other scales, constitute the third most frequent well-defined two-point scale combination among adolescents in mental health and alcohol/drug treatment settings. Over 3% of boys in treatment programs have this clearly defined profile pattern. It should be noted that this well-defined high-point pair is less common in the normative sample, where it occurs in less than 1% of the sample.

Extreme responding is apparent on his MMPI-A Content Scales profile. He endorsed at least 90% of the items on A-obs in the deviant direction, indicating that the following is quite important in understanding his problem situation. He reports worrying beyond reason, often over trivial matters. He may be troubled by intrusive thoughts (for example, "bad words") or by counting unimportant things. His sleep may be disturbed by worries. Decision making is problematic and he approaches changes with dread.

In addition to the extreme endorsements found in his MMPI-A Content Scales profile, he also described other important problem areas. 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.

He reported several symptoms of anxiety, including tension, worries, and difficulties sleeping. He endorsed several very negative attitudes about himself and his abilities.

INTERPERSONAL RELATIONS

His relationships may be somewhat superficial. He may use others for his own gratification. He is somewhat hedonistic and may act out impulsively without due concern for the feelings of friends or relatives. He has probably been experiencing strained interpersonal relationships.

He is somewhat shy, with some social anxiety 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 toward others. He may try to avoid crowds, parties, or school activities.

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 feels considerable emotional distance from others. He may believe that other people do not like, understand, or care about him. He reports having no one, including parents or friends, to rely on.

BEHAVIORAL STABILITY

The relative elevation of the highest scales (D, Pd) in his clinical profile shows very high profile definition. His peak scores are likely to remain very prominent in his profile pattern if he is retested at a later date.

This clinical profile reflects some maladaptive characteristics that could develop into personality problems. Although he appears to be experiencing much acute distress, his personality problems may continue even after current stresses subside and he feels more comfortable.

DIAGNOSTIC CONSIDERATIONS

An adolescent with this clinical profile may receive a diagnosis of oppositional or conduct disorder with some depressive features. His extreme endorsement of multiple anxiety-based symptoms should be considered in his diagnostic work-up. Recurrent obsessions, including obsessive brooding, may be a part of his diagnostic picture.

Although the alcohol- and other drug-problem scales are not elevated, he has some other indicators of possible problems in this area. An evaluation of his alcohol or other drug use is suggested.

TREATMENT CONSIDERATIONS

He views himself as having so many problems that he is no longer able to function effectively in day-to-day situations. His low mood and pessimistic outlook on life weigh heavily on him and seemingly keep him from acting to better his situation. His low frustration tolerance and negative attitudes about himself may be very detrimental to progress in treatment and may require attention and support early in therapy to prevent him from becoming discouraged.

Some individuals with this MMPI-A pattern attempt to manipulate others through suicidal gestures when their needs are not being met.

Because substance abuse is a strong possibility among individuals with this clinical profile, any use of medications should be cautiously monitored.

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. This adolescent's emotional distance and discomfort in interpersonal situations must be considered in developing a treatment plan. He may have difficulty self-disclosing, especially in groups. He may not appreciate receiving feedback from others about his behavior or problems.

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.

Final Follow-up Comment:

Alejandro continued in psychological treatment for a while and showed clear improvement. The results of the MMPI-A were provided to him and he thought they were useful to him. Now he has been admitted to a public university. He decided to apply for the Chemistry program and passed the entrance exam. This diminished the negative attitudes he had about himself. He is getting along better with his peers since he does not feel that he is going to fail in everything.

The MMPI-A detected Alejandro's major problems, which were his low self-esteem which did not correspond to his abilities, the significant anxiety he was experiencing and the identity crisis which he was passing through, which was shown in the elevation of the alienation scale.

The computerized report described most of the symptoms and behavior. However, it was not accurate in suggesting that he could present acting-out behavior and problems with alcohol use or drugs. He has not acted impulsively in the past. In fact he was shy, pessimistic, and rigid.

He was really worried and decision making was problematic for him. The high 4 was related to his family problems, which he was exaggerating because he is sensitive and was really depressed when he took the MMPI-2. The elevation of 4 might also be because he judged himself and his father, who was really supportive, very strictly. The depressive features were more important than the oppositional conduct. He was disappointed when he failed the admission exam and was feeling very different from his peers. There are some small differences between the Mexican and U.S. norms, and perhaps the report would be more accurate if the Mexican norms were used.

KOREA

MMPI-A Version Administered: Unpublished Korean translation

Case: Jo

Setting/Identifying Information: The patient, 16-year-old girl, was admitted to an inpatient psychiatric unit for mental health problems she was experiencing.

Presenting Problem: She reportedly missed a lot of school, was a frequent runaway, was dissatisfied with her life, had frequent troubles with friends, had difficulties in close relationships with others, and frequently showed unstable moods.

Reason for Referral: Her psychiatrist referred her for psychological evaluation to provide information about the severity and possible causes of her present problems.

Symptoms: The following problems have been noted as characterizing her behavior: Runaway from home, missing school, engaging in sexual relationships with boys, having anger-control problems, impulsive behavior, impatience, variable moods, and assaultive behaviors.

Family Structure and Background

Jo was born to an unwed teenage mother and adopted 5 months after birth. She presently lives with her adoptive parents and one older sibling, a brother. Her adoptive father owns a small shop; her mother is a homemaker.

Educational Background and Experience

She has completed a total of 8 years of education. Jo is not currently attending the 2nd year of middle school. Her behavior problems (missing school, runaway, impulse-control difficulties) started about a year ago.

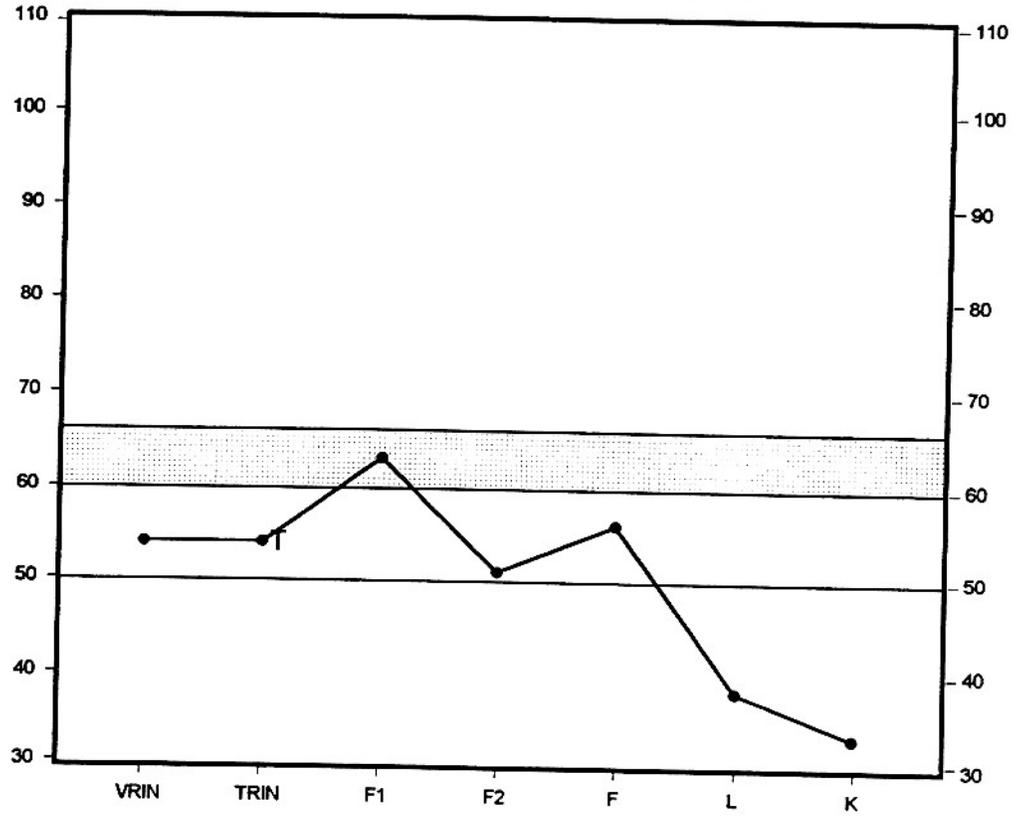
DSM-IV Diagnosis

Jo has been diagnosed as having Borderline personality disorder, Conduct disorder, and Depression.

Treatment or Intervention

Her treatment program to date has involved both psychotropic medication and psychotherapy. She has been prescribed the following medications: Magnesium Oxide, Fluoxetine, and Lorazepam. She has also been involved in individual psychotherapy during the past year.

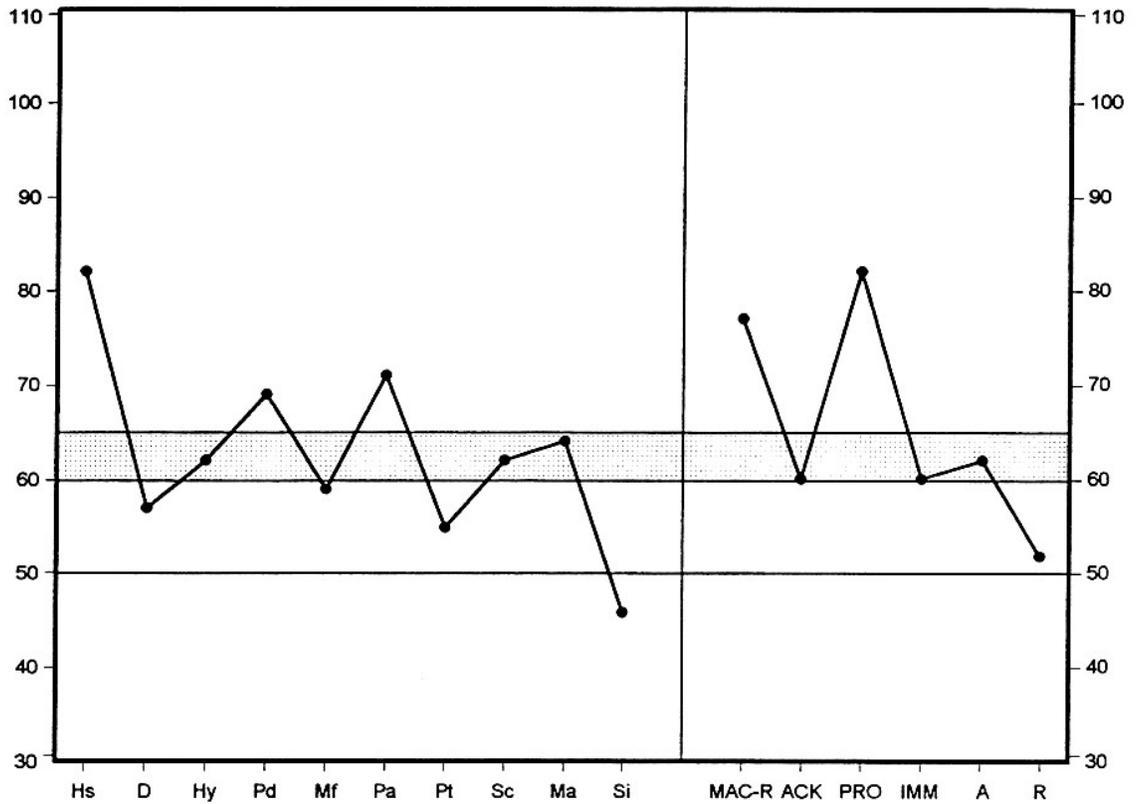
MMPI-A VALIDITY PATTERN



Raw Score:	5	10	7	5	12	0	4
T-Score:	54	54	63	51	56	38	33
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 0 Percent True: 57 Percent False: 43

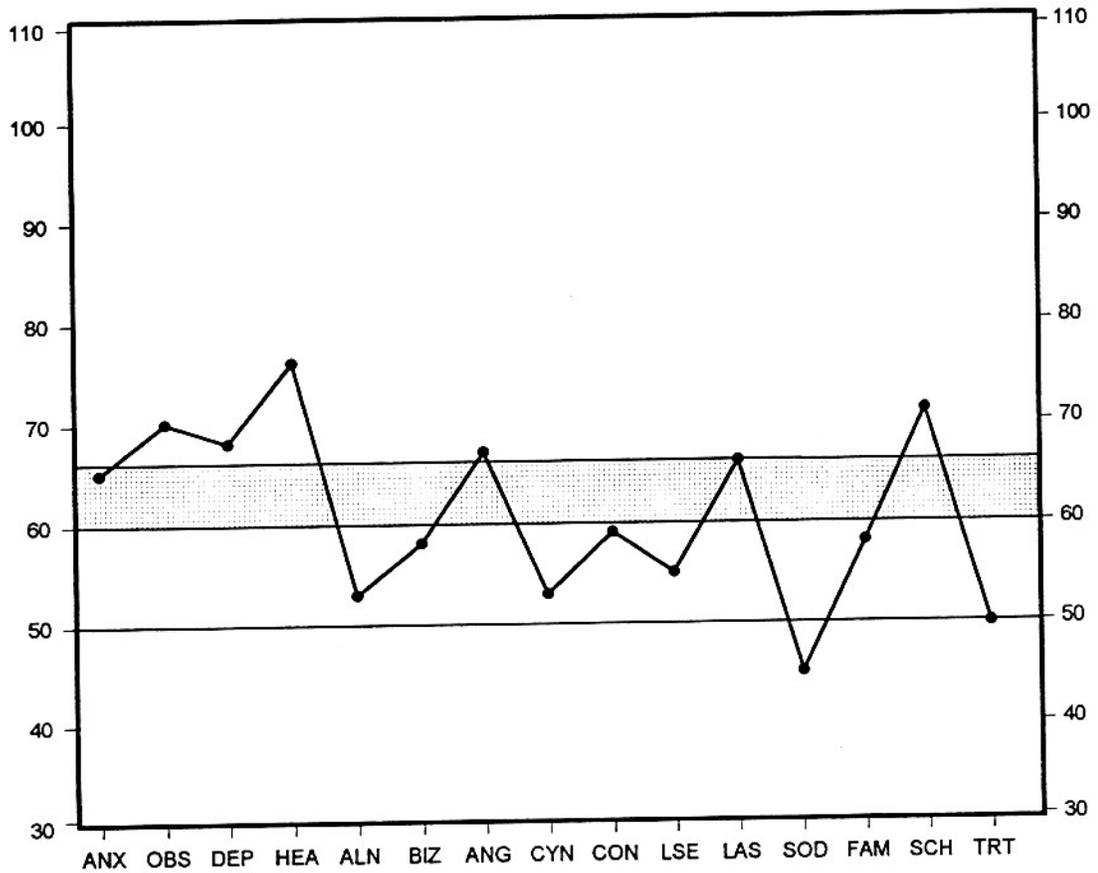
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	24	25	29	30	25	21	26	36	28	24	31	6	30	18	26	14
T-Score:	82	57	62	69	59	71	55	62	64	46	77	60	82	60	62	52
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 1*6'4+938-527/0: F/:LK#
 Mean Profile Elevation: 65.30

MMPI-A CONTENT SCALES PROFILE



Raw Score:	15	13	18	23	7	7	13	15	12	8	10	5	18	12	10
T-Score:	65	70	68	76	53	58	67	53	59	55	66	45	58	71	50
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MINNESOTA REPORT NARRATIVE

VALIDITY CONSIDERATIONS

This adolescent responded to the items in a cooperative manner, producing a valid MMPI-A. Her profiles are likely to be a good indication of her current personality functioning.

SYMPTOMATIC BEHAVIOR

Adolescents with this MMPI-A clinical profile tend to show a pattern of psychological maladjustment. This individual is feeling intense stress and complains of physical problems. The physical symptoms may be vague or unusual but are rigidly maintained even in the absence of organic findings. Thus, the possibility of delusional symptoms should be evaluated.

She appears to be rather rigid, stubborn, and angry at others. She feels that she is presently unable to function well through no fault of her own. In addition, she feels that others do not understand her physical problems and do not give her enough support.

She may be suspicious, believing that others are largely responsible for her problems. She may become angry at physicians or other health care providers for not helping her enough.

Her high-point MMPI-A score, Hs, is the least frequently occurring well-defined peak score among adolescent girls in alcohol/drug or psychiatric treatment units. Approximately 2% of girls in treatment programs have this peak scale elevation in their clinical profile. It should be noted that this high-point score also occurs with relatively low frequency (almost 4%) as a peak score for girls in the normative sample but at a lower level of elevation than in treatment program samples.

Extreme responding is apparent on her MMPI-A Content Scales profile. She endorsed at least 90% of the items on A-obs in the deviant direction, indicating that the following is quite important in understanding her problem situation. She reports worrying beyond reason, often over trivial matters. She may be troubled by intrusive thoughts (for example, "bad words") or by counting unimportant things. Her sleep may be disturbed by worries. Decision making is problematic and she approaches changes with dread.

In addition to the extreme endorsements found in her MMPI-A Content Scales profile, she also described other important problem areas. This young person reports numerous difficulties in school. She probably has poor academic performance and does not participate in school activities. She may have a history of truancy or suspensions from school. She probably has very negative attitudes about school, possibly reporting that the only positive aspect of school is being with her friends. She may have some anxiety or fears about going to school.

She reports numerous somatic symptoms, including gastrointestinal difficulties, neurological problems, sensory deficits, cardiovascular symptoms, pain, or respiratory problems.

She may be assaultive or aggressive when she is angry, and she may be overly interested in violence. She may be sexually active, flirtatious, or provocative. She has limited expectations of success in school and is not very interested or invested in succeeding. She reported several symptoms of anxiety, including tension, worries, and difficulties sleeping. Symptoms of depression were reported.

INTERPERSONAL RELATIONS

She is probably experiencing great turmoil. She may be angry at others, feeling that they do not understand her. She is very resentful and mistrustful.

Some interpersonal issues are suggested by her MMPI-A Content Scales profile. She reports being irritable and impatient with others, and she may throw temper tantrums to get her way.

BEHAVIORAL STABILITY

The relative elevation of her highest clinical scales (Hs, Pa) suggests that her profile is not as well defined as many other profiles. That is, her highest scale(s) are very close to her next scale score elevations. There could be some shifting of the most prominent scale elevations in the profile code if she is retested at a later date.

DIAGNOSTIC CONSIDERATIONS

Adolescents with this clinical profile tend to have hypochondriacal problems. A possible diagnosis is somatoform disorder. The presence of somatic delusions and a more severe psychotic process should be considered, however.

Given her elevation on the School Problems scale, her diagnostic evaluation could include assessment of possible academic skills deficits and behavior problems. Academic underachievement, a general lack of interest in any

school activities, and low expectations of success are likely to play a role in her problems. Her extreme endorsement of multiple anxiety-based symptoms should be considered in her diagnostic work-up. Recurrent obsessions, including obsessive brooding, may be a part of her diagnostic picture.

She obtained extremely high scores on MAC-R and PRO, indicating a high potential for developing alcohol or other drug problems. She probably engages in risk-taking behaviors and tends toward exhibitionism. She probably belongs to a peer group that uses alcohol or other drugs. Her involvement in an alcohol- or drug-abusing lifestyle should be further evaluated. Problems at home or school are likely given her problems with alcohol or other drugs.

She has endorsed items that confirm her increasing involvement with alcohol or other drugs. She acknowledges that her use is problematic and reports being criticized for it. She may feel that alcohol or other drugs facilitate social interactions, thus serving as a coping strategy.

TREATMENT CONSIDERATIONS

Adolescents with this MMPI-A pattern view themselves as being physically ill and feel that others are not sympathetic to their problems. This individual tends to view herself as being "put upon" or mistreated by others and often feels that her somatic problems are misunderstood or minimized by health professionals.

This individual is likely to be suspicious about the treatment she receives. She may not comply with recommended treatment because of a mistrust of professionals. Adolescents with this clinical profile also tend to feel bitter about "unjust" or "unfair" treatment. Anger toward physicians is a common outcome. This individual has a generally hostile manner of interacting with others, which is liable to carry over into treatment and reduce the chance that therapeutic gain can be made. Adolescents with this personality style are not very receptive to suggestions from others.

Although psychological problems are evident and referral to a psychologist or psychiatrist is indicated, she is likely to strongly resist this. Adolescents with this clinical profile are quite rigid and opinionated and not very insightful; they tend to resist psychological interpretation. She is likely to be somewhat petulant and argumentative in therapeutic situations. Approaching her problems in a stress-management framework may prove more acceptable to her.

Her very high potential for developing alcohol or drug problems requires attention in therapy if important life changes are to be made. She has acknowledged some problems in this area, which is a valuable first step for intervention.

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

There are some symptom areas suggested by the Content Scales profile that the therapist may wish to consider in initial treatment sessions. Her endorsement of internalizing symptoms of anxiety and depression could be explored further.

Conditions in her environment that may be contributing to her aggressive and assaultive behaviors could be explored. Adolescents with anger-control problems may benefit from modeling approaches and rewards for appropriate behaviors. Stress-inoculation training or other cognitive-behavioral interventions could be used to teach self-control. Observations of her behavior around her peers may provide opportunities to intervene and prevent aggressive actions toward others.

During the course of her treatment, it may be important to discuss her sexual behavior. Her knowledge about sexuality and protecting herself against sexually transmitted diseases could be assessed and information provided, if needed. Perhaps in a trusting therapeutic relationship, she will be able to discuss the extent of her sexual activity and its meaning in her life. Alternatives to risky, promiscuous behavior could be discussed and promoted. If she is flirtatious and provocative, a greater awareness of this on her part may prevent unwanted sexual advances or possible victimization. Social skills training may be helpful in changing possibly inappropriate behaviors.

Final Follow-up Comment

New information from interview with the client's parents

In an interview with the clinician Jo's parents said that she has often asked them whether they loved her as much as her big brother, their legitimate son. Jo was pretty much occupied by the fact that she was adopted and wanted to keep this secret, especially to her friends. Jo's parents experienced a lot of disciplinary difficulties since she believed that she was mistreated. Jo tended to attribute most of the conflict with her family to the fact that she was adopted.

Comment upon the utility of the MMPI-A profiles and the accuracy of the computerized report

Jo's MMPI-A descriptors seem to present a fairly consistent pattern of behavior problems she is experiencing. Many of the diagnostic hypotheses appear to be probable since they have been verified by the client's MMPI-A scales and by extra-test data from Jo's parents and school records. Jo's MMPI-A content scales profile demonstrates how it can be used to provide richer inferences about a troubled adolescent's symptoms and behavior.

Although Jo denied any use of alcohol or drugs when having an intake interview, her MMPI-A (elevated MAC-R) indicates the possibility of developing problems with alcohol or other drugs, which can guide the clinician to further evaluation.

Jo's FAM score was only moderately elevated at a T-score of 61. This means that she did not report having many more family problems than many other adolescents. However, her other elevations and extra-data information from the interview with her parents suggest that even though she did not use the MMPI-A item content to fully describe possible significant family discord, her home life is unlikely to be problem free.

The computer-based narrative report incorporates a discussion of having home problems. Overall, the narrative report appears to point to several major problem areas in Jo's test performance that could guide the clinician into fruitful areas to explore in therapy.

FRANCE

MMPI-A Version Administered: Published French translation by Isabelle Gillet

Case: Carroll

Identifying Information

Carroll was a 17-year-old pregnant woman at the time of her referral for psychological assessment. She lived in a state residence for single mothers. Although she completed 9th grade she had a very poor academic record and by the time of the assessment had already left the academic system.

Reason for Referral

The referral was made by the educational team, concerned by her recent changed behavior, emotional and social problems.

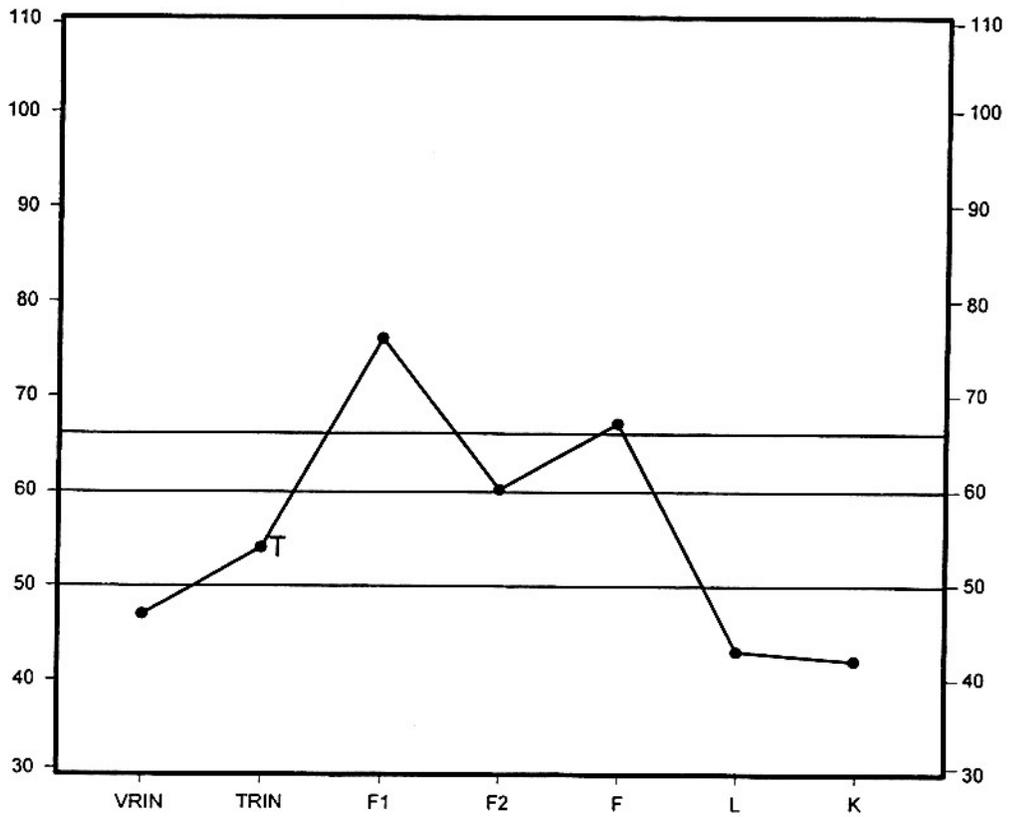
Her mother is an unemployed 40-year-old woman who has two younger children, born to different fathers. She now lives with an artisan, belonging to another ethnic group and father of two adult unemployed young men living in the same household. She is described by the educational team as a very cold, angry, self-centered, greedy woman. Every cupboard in the house is heavily locked, while the whole set of keys is constantly attached to her belt. Her biological father was tried and convicted of murder, is presently confined in prison for a twenty-year sentence. When Carroll was 2-years-old he shot a neighbor who was making too much noise. By the age of 15, Carroll was sexually abused by the elder son of her mother's partner. The family had decided not to bring the case to court.

By the age of 16, she met a young violent, alcohol dependent young man, with whom she wishes to build her life and who is the father of her child. The Juvenile Services have placed her in the state residence for single mothers.

Carroll is a plump young woman in her eighth month of pregnancy. She now presents with defiant behavior, bursts into tears very frequently, is erratic, sucks her thumb when left alone, and is unable to keep a job for more than two weeks. Severe sleep disorders (hypersomnia or insomnia) are reported by the educational team. She smokes 40 cigarettes a day, even during the pregnancy. Her social relations are poor and immature. She constantly seeks the attention of the educational team, displaying frequent feelings of jealousy. She has few social interactions with the other residents. No psychiatric assessment has been accomplished prior to the psychological evaluation.

Carroll has never been medicated, and has overall good health.

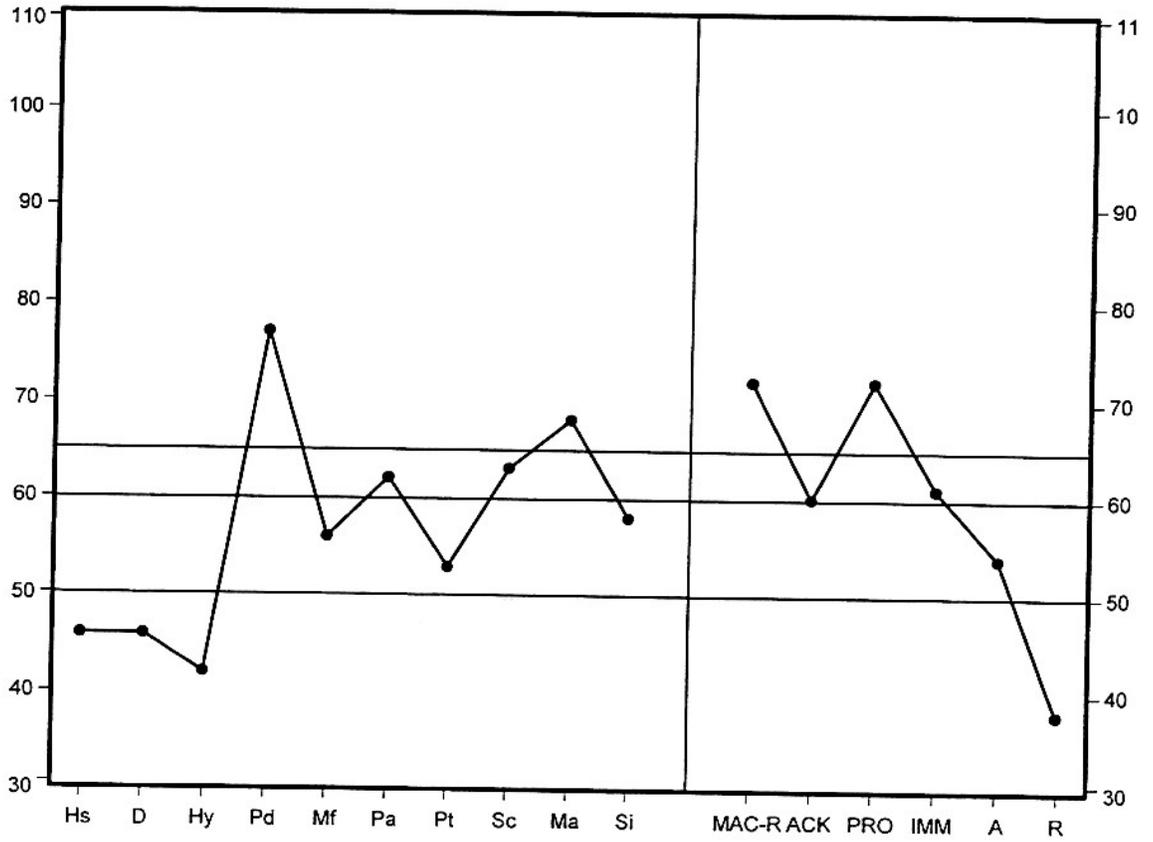
MMPI-A VALIDITY PATTERN



Raw Score:	3	10	11	9	20	1	8
T-Score:	47	54	76	60	67	43	42
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 2 Percent True: 58 Percent False: 42

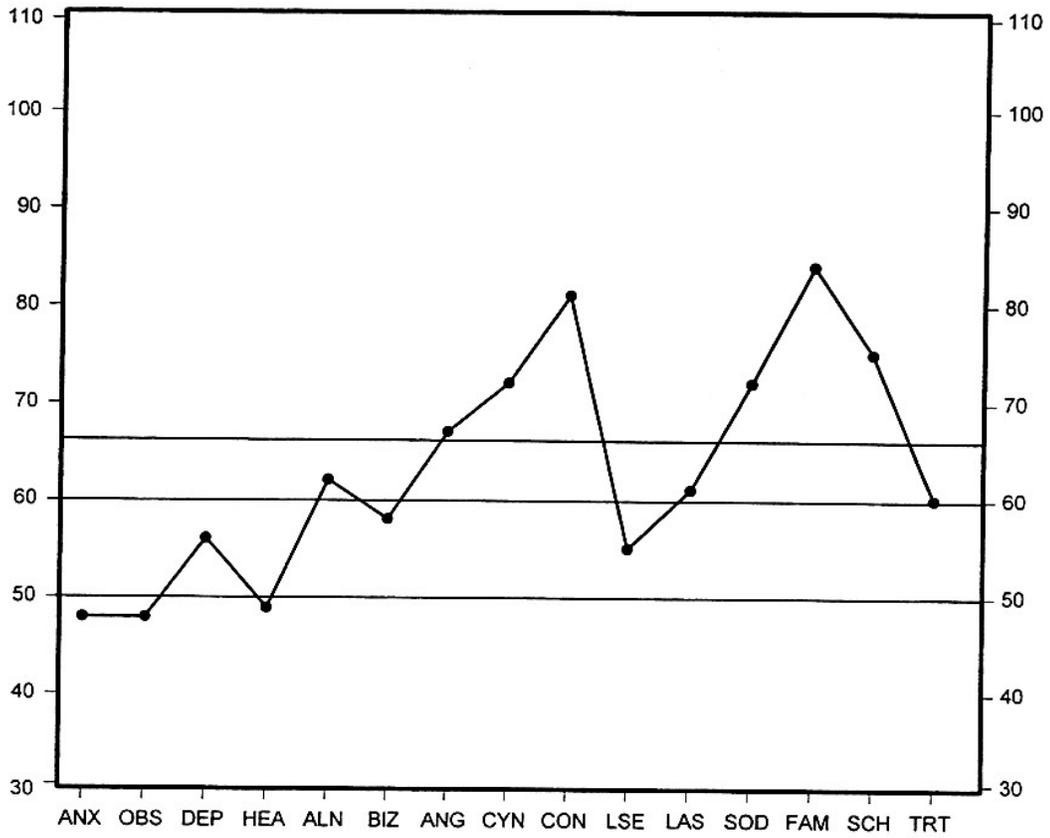
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	7	19	19	33	26	18	25	37	29	33	29	6	26	19	20	9
T-Score:	46	46	42	77	56	62	53	63	68	58	72	60	72	61	54	38
Response %:	100	98	100	100	100	100	98	100	100	100	100	92	100	100	100	100

Welsh Code: 4'9+86-057/123: F+/LK:
 Mean Profile Elevation: 57.10

MMPI-A CONTENT SCALES PROFILE



Raw Score:	9	8	13	8	10	7	13	20	18	8	9	16	27	13	14
T-Score:	48	48	56	49	62	58	67	72	81	55	61	72	84	75	60
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MINNESOTA REPORT NARRATIVE

VALIDITY CONSIDERATIONS

This individual has a number of problems reflected in a somewhat exaggerated response to the test items. Her endorsement of a wide range of symptoms makes her appear "defenseless" at this time. She may be experiencing a great deal of stress and she may feel that she cannot manage her life very well. The MMPI-A is valid and suggests that the individual probably feels a need to discuss her problems. A tendency toward self-deprecation is suggested and should be taken into consideration in the clinical interpretation.

SYMPTOMATIC BEHAVIOR

This adolescent's MMPI-A clinical profile indicates multiple serious behavior problems including school maladjustment, family discord, and authority conflicts. She can be moody, resentful, and attention-seeking. At times she may appear rebellious, impulsive, and argumentative. Her poor judgment may get her into trouble. She can be self-centered and may show little remorse for her bad behavior. She may run away or lie to avoid punishment.

She probably engages in risk-taking behaviors. She seeks immediate gratification of her wishes, even if it is at the expense of others. Sensation-seeking activities are likely. Alcohol and other drug problems are common. Her high elevation on A-con suggests that antisocial behaviors are likely to be prominent in her symptomatic pattern.

Her MMPI-A clinical profile configuration, which includes high points on Pd and Ma, is the most frequent well-defined two-point scale pair among girls in mental health and alcohol/drug treatment units. Approximately 8% of adolescent girls in treatment programs have this clinical profile. It should be noted that this high-point pair occurs somewhat less frequently in the normative population (1%) and at a lower level of elevation than in clinical samples.

Her MMPI-A Content Scales profile reveals important areas to consider in her evaluation. She reports many behavioral problems including stealing, shoplifting, lying, breaking or destroying property, being disrespectful, swearing, or being oppositional. She may belong to a peer group that is frequently in trouble and encourages deviant behavior. Poor academic performance and behavioral problems in school are also possible, as are behavior problems at home.

This young person reports numerous difficulties in school. She probably has poor academic performance and does not participate in school activities. She may have a history of truancy or suspensions from school. She probably has very negative attitudes about school, possibly reporting that the only positive aspect of school is being with her friends.

She may be assaultive or aggressive when she is angry, and she may be overly interested in violence.

INTERPERSONAL RELATIONS

She may seem initially likable and may make a good impression on others; however, her relationships tend to be very troubled. Her behavior is primarily hedonistic and self-centered, and she is quite insensitive to the needs of other people, exploiting them and feeling no guilt about it.

Her social behavior might be punctuated with periods of moodiness and open expression of negative feelings.

Some problems with her relationships are evident from her extreme endorsement of items on A-cyn. This young person has numerous misanthropic attitudes. The world is a very hostile place to her and she believes that others are out to get her. She looks for hidden motives whenever someone does anything nice for her. She believes that it is safer to trust no one because people make friends in order to use them. Because she believes that people inwardly dislike helping each other, she reports being on guard when people seem friendlier than she expects. She feels misunderstood by others and thinks they are very jealous of her.

In addition to her extreme endorsements on the MMPI-A Content Scales, she reported other significant interpersonal issues. Family problems are quite significant in this person's life. She reports numerous problems with her parents and other family members. She describes her family in terms of discord, jealousy, fault finding, anger, serious disagreements, lack of love and understanding, and very limited communication. She looks forward to the day when she can leave home for good, and she does not feel that she can count on her family in times of trouble. Her parents and she often disagree about her friends. She indicates that her parents treat her like a child and frequently punish her without cause. Her family problems probably have a negative effect on her behavior in school. She reports many problems in social relationships. She finds it difficult to be around others and much

prefers to be alone. She reports being irritable and impatient with others, and she may throw temper tantrums to get her way. She may feel distant from others, believing that they do not understand or care about her. She may feel that she has no one to rely on.

BEHAVIORAL STABILITY

The relative scale elevation of the highest scale (Pd) in her clinical profile reflects high profile definition. If she is retested at a later date, the peak scores on this test are likely to retain their relative salience in her profile pattern. Adolescents with this clinical profile usually have a history of acting-out behaviors and relationship problems that may continue over time.

DIAGNOSTIC CONSIDERATIONS

A diagnosis of one of the disruptive behavior disorders should be considered given her elevations on Pd and A-con.

Her highly elevated Conduct Problems scale may indicate the presence of an oppositional-defiant disorder or a conduct disorder. She may meet the criteria for the solitary, aggressive type of conduct disorder.

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

She obtained extremely high scores on MAC-R and PRO, indicating a high potential for developing alcohol or other drug problems. She probably engages in risk-taking behaviors and tends toward exhibitionism. She probably belongs to a peer group that uses alcohol or other drugs. Her involvement in an alcohol- or drug-abusing lifestyle should be further evaluated. Problems at home or school are likely given her problems with alcohol or other drugs.

She has endorsed items that confirm her increasing involvement with alcohol or other drugs. She acknowledges that her use is problematic and reports being criticized for it. She may feel that alcohol or other drugs facilitate social interactions, thus serving as a coping strategy.

TREATMENT CONSIDERATIONS

Her conduct disturbance should figure prominently in any treatment planning. Her clinical scales profile suggests that she is a poor candidate for traditional, insight-oriented psychotherapy. A behavioral strategy is suggested. Clearly stated contingencies that are consistently followed are important for shaping more appropriate behaviors.

Her very high potential for developing alcohol or drug problems requires attention in therapy if important life changes are to be made. She has acknowledged some problems in this area, which is a valuable first step for intervention.

Her family situation, which is full of conflict, should be considered in her treatment planning. Family therapy may be helpful if her 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 her treatment to explore her considerable anger and disappointment in her 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.

There are some symptom areas suggested by the Content Scales profile that the therapist may wish to consider in initial treatment sessions. Her behavior problems may respond best to behavior management strategies such as contracting.

Conditions in her environment that may be contributing to her aggressive and hostile behaviors could be explored. Adolescents with anger-control problems may benefit from modelling approaches and rewards for appropriate behaviors. Stress-inoculation training or other cognitive-behavioral interventions could be used to teach self-control. Angry outbursts during therapy sessions can provide opportunities for her to learn about her impulse-control problems and to practice new skills.

She endorsed some items that indicate possible difficulties in establishing a therapeutic relationship. She may be reluctant to self-disclose, she may be distrustful of helping professionals and others, and she may believe that her problems cannot be solved. She may be unwilling to assume responsibility for behavior change or to plan for her future. Her cynical attitudes and beliefs about others and their hidden motivations may create difficulties in therapy. Her therapist should be aware of her general mistrust of others.

Final Follow-up Comment

Carroll has had a little girl who is now two months old. Because of her pregnancy, she was not medicated, nor was she during the breast-feeding period. Her behavior did not change; the educational team still worries

about her conduct. Her attitude toward her daughter is unstable, at moments she looks at her and bursts into tears, while at others she just does not want to take care of her baby. She seeks, very often, the presence of her boyfriend, and does not have future expectations. Within a few weeks, Carroll will be offered a therapeutic behavioral program, aiming mainly to develop her social skills.

MMPI-A Profile

The MMPI-A provided a good overall view of Carroll's major problems in terms of diagnosis (conduct disorder), psychological functioning (interpersonal relations and behavioral stability), and indications about the origin of the troubles (significant family conflicts). It also pin-pointed to the educational team several aspects of Carroll's behavior, such as her self-centeredness and acting out, that seemed important to work through. It also enabled the educational team to understand the meaning of these features in terms of severe feelings of loneliness and inability to sense other people's needs.

Accuracy of the Report Description of Client's Symptoms and Behavior

One possible drawback of a computerized report is that in order to fit many similar cases, it may be too broad. If so, all assertions are not relevant to the specific case. In Carroll's case, a positive feature of the computerized report is that most of the presentations fit the clinical observations formulated by the diagnosis team, and, as such, furnished elements of objective clinical validation. Besides, a comprehensive report may also assist the clinician with a good thesaurus useful to a practical and realistic description of the case under study.

Clinical Information about the Client

The most valuable clinical information included in the MMPI-A computerized description of the case lie in the focus on the existence of risk behaviors. The MMPI-A suggested a psychological characteristic, the addictive possible risk profile, which was not clearly detected through the clinical interview. In this way the MMPI-A brought a major contribution to essential follow-up decisions and sets of therapeutic priorities.

PEOPLES REPUBLIC OF CHINA (HONG KONG)

MMPI-A Version Administered: Unpublished Chinese translation

Case: K.H.

Setting: K.H. was referred to the Adolescent Unit of a general hospital where a clinical psychologist provided outpatient services for children who came through the hospital and required psychological consultations. Both K.H. and his mother had given consent for this case study.

Identifying Information

Date of Birth (age): Sept. 8, 1984 (14)

Gender: Male

School: Form I (=7)

Date of Exam: October 7, 1998

Reasons for Referral

K.H. is a 14-year-old Chinese male who is repeating Grade 7 at a government subsidized secondary school in Hong Kong. He was referred for a psychological assessment by his family doctor because of suicidal threats and impulsive sexual tendencies. Reportedly, he had hid his younger sister's underwear and had touched her genitals on several occasions while she was lying in bed.

Family Structure and Background

K.H. is the older of two children in the family. His parents have been married for over fifteen years. His father has a primary school education and works as a waiter in a Chinese restaurant. He reportedly works long hours and comes home very late at night. He also travels and does business in mainland China and frequently stays there for days before coming home. His wife described him as aloof and uninvolved. She also suspected that he might have a mistress in China but she has been reluctant to confront him. She indicated that she is not happy with her marriage but has settled with putting all her hopes on raising her two children. She has some high school education and has been working irregularly part-time. Currently, she works for a cleaning company.

K.H. lives with his parents and his 10-year-old sister in a 2-bedroom flat owned by the family. He and his sister used to share the same room but slept in separate beds. According to his mother, after K.H. was found by his family to have molested the sister, the family has partitioned the room and the children now sleep in separate rooms. Financially, the family is fine and there have not been particular stressors. They live in an old neighborhood where the homes are old but "nice and spacious". Besides their flat, the children can also play on the roof-top where they used to ride their bicycles. Reportedly, the family had been living with K.H.'s grandmother until about six years ago when she died. He does not remember much about his grandmother and he also speaks very little about his sister. His mother, on the other hand, observed that K.H. tends to be somewhat mean to his sister. In addition, K.H. does not get along with his father reportedly because his father would "spank him whenever he disobeyed."

Educational Background and Experience

K.H. appeared to have a poor start in his early years. According to his mother, he had breathing problems and had asthma attacks off and on when he was six or seven years old. As a result, he missed many days of school and had to repeat the first grade. K.H. reported that he was teased by his fellow school-mates and would often get into fights in which he would frequently be beaten. He disliked school. and his school grades had always been poor throughout his primary school. He was often ranked last among the students in his grade. There was one year during which he passed mathematics and science on a couple of tests and had become slightly more interested in school. He attributed that to having a more considerate teacher. Reportedly, K.H. failed almost all his classes last year and has to repeat seventh grade at the same school. In addition, the school which K.H. is attending is considered to be in the "band 4 or band 5" range (1 being the best and 5 being the worse).

Presenting Problem

According to his mother, K.H. has always been an overly active and difficult to manage child. His problems seem to have increased since the beginning of this summer. Reportedly, he would push or hit others when he couldn't get his way. There has been a constant struggle between his mother and him on his studying and

indulgence in computer games. In July, he made several suicidal threats with kitchen knives when his mother tried to disconnect his computer. On several other occasions, he had reportedly stood by the window and threatened to jump off the building.

What also prompted his mother to seek help was K.H.'s impulsive sexual tendencies. According to his mother, she discovered that K.H. had hid some of his younger sister's underwear. On a few occasions in July and early August, he had allegedly gone into the room and touched his sister's genitals while she was lying in bed. There were also times that he would pull down his pants in front of his sister and ask her to look at his genitals. His mother also complained that he would masturbate indiscriminately even when watching a TV series in the presence of the other family members. She had also found him with some pornographic computer games that he claimed to have bought for a school friend. She found it difficult to tolerate his behavior and had consulted their family doctor who referred K.H. to the Adolescent Unit of the hospital for an assessment and follow-up intervention.

Symptoms

K.H. denied any major problems in his behavior. However, he admitted to feeling depressed and had suicidal ideation on occasions. He was described by his mother as irritable, loud, and having a bad temper. His mother also reported that K.H. tended to get into fights at school and had repeatedly been beaten by his classmates "usually not because he had provoked them." He had difficulty concentrating on any of his work except when playing computer games when he would become very persistent. He appeared increasingly impulsive sexually. He had no history of alcohol and/or drug abuse. There had also been no history of problems with the law.

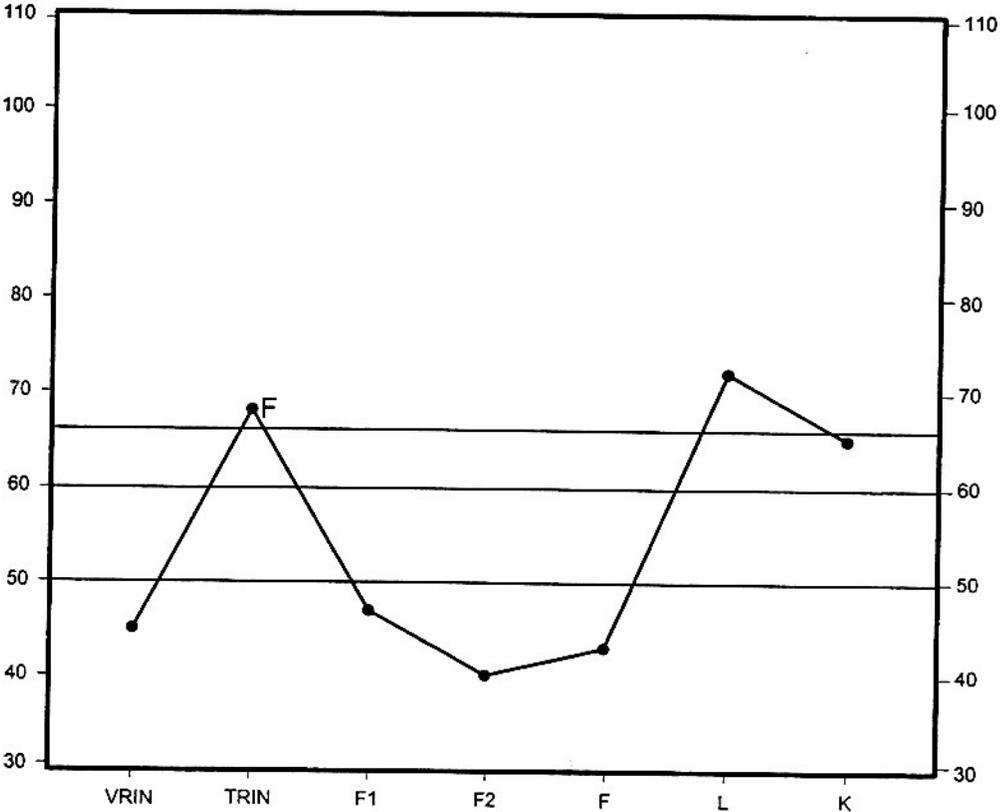
Diagnosis

Axis I: Deferred (799.90)

Treatment or Intervention

K.H. had been seen once for an intake interview by the hospital clinical psychologist prior to this assessment. He was not prescribed any medication. Follow-up individual and family interventions would be implemented by the clinical psychologist on the unit.

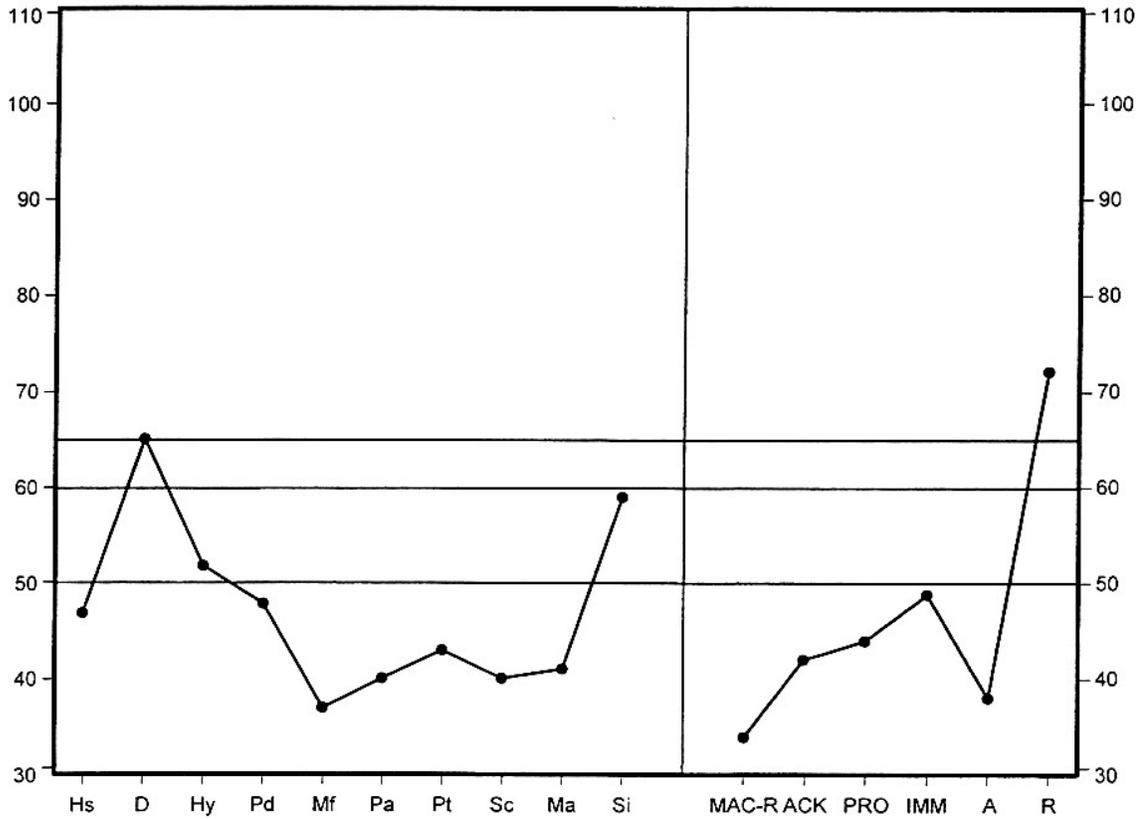
MMPI-A VALIDITY PATTERN



Raw Score:	3	6	3	0	3	8	20
T-Score:	45	68	47	40	43	72	65
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 0 Percent True: 28 Percent False: 72

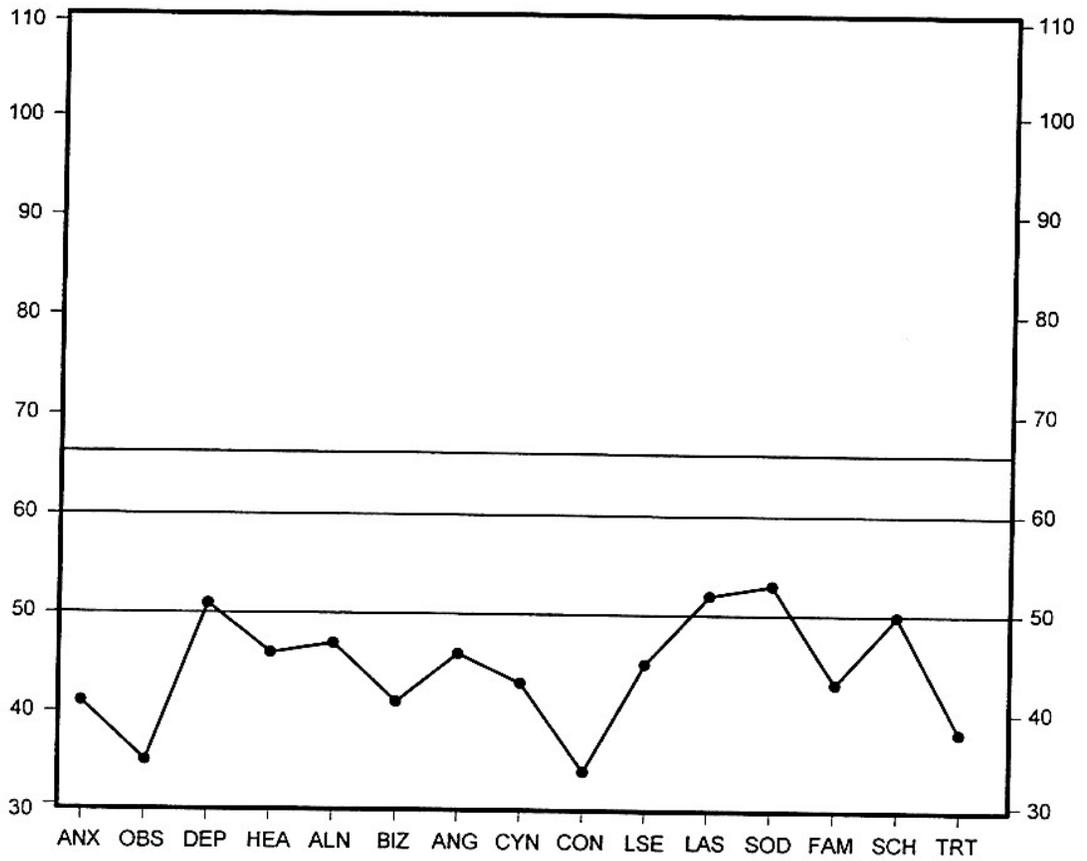
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	6	27	22	19	16	8	12	10	16	33	14	2	14	13	6	23
T-Score:	47	65	52	48	37	40	43	40	41	59	34	42	44	49	38	72
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 2+-03/417968:5# L'K+/-F:
 Mean Profile Elevation: 47.00

MMPI-A CONTENT SCALES PROFILE



Raw Score:	4	1	8	5	5	1	7	10	2	3	7	10	7	7	3
T-Score:	41	35	51	46	47	41	46	43	34	45	52	53	43	50	38
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MINNESOTA INTERPRETIVE REPORT

VALIDITY CONSIDERATIONS

He responded to the MMPI-A items by claiming to be unrealistically virtuous. This test-taking attitude weakens the validity of the test and shows an unwillingness or inability on the part of the individual to disclose personal information.

SYMPTOMATIC BEHAVIOR

He feels inadequate and tends to view the future with uncertainty and pessimism. He tends to lack confidence in himself, is somewhat moody, is rather sensitive to criticism, and may tend to blame himself for things that go wrong. He seems to worry excessively, has low energy, has a slow personal tempo, and is dissatisfied with his life. His low moods and vulnerability to feelings of inadequacy and despair may make him guilt-prone. Sleep disturbance is possible.

This MMPI-A clinical profile contains one of the least frequent high-point scores in clinical samples, the D score. Only 2% of boys in treatment programs have this well-defined profile (i.e., with the D scale at least 5 points higher than the next scale). However, 6% of boys in the normative population have this well-defined high-point profile.

INTERPERSONAL RELATIONS

Adolescents with similar clinical profiles tend to be hesitant and pessimistic about personal relationships and may feel rather inadequate in social situations. They tend to be dependent and clingy at times.

BEHAVIORAL STABILITY

The relative elevation of the highest scale (D) in his clinical profile shows very high profile definition. His peak scores are likely to remain very prominent in his profile pattern if he is retested at a later date.

This clinical profile may result from a stressful environment or a recent traumatic experience. The possibility of such circumstances should be evaluated.

DIAGNOSTIC CONSIDERATIONS

This adolescent's tendency toward depressive episodes should be evaluated. The MMPI-A clinical profile does not provide sufficient information to suggest a diagnosis based on the clinical scales; however, his low mood and feelings of insecurity are likely to be important symptoms in his clinical picture.

TREATMENT CONSIDERATIONS

He may be motivated to seek and respond to therapy because of his low mood and high level of distress. Response to psychological treatment is usually good for individuals with similar clinical profiles.

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.

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.

Final Follow-up Comment

Case Update: A follow-up contact with K.H.'s mother one month after the assessment revealed that K.H. had become more compliant at home and his impulsive sexual problem seemed to have gradually receded. Unfortunately, he was attacked by a fellow school-mate with whom he had fought in the past. Reportedly, K.H. was knocked over and his head was banged against the floor several times by this school-mate. He suffered a head injury and was hospitalized for one week. According to K.H., he had not resumed any psychological treatment since the injury.

Comment on his MMPI-A profile: Local norms (Cheung & Ho, 1997) show that T-scores for Scales L, D, and Pt are generally higher among Hong Kong Chinese adolescents than the US standardization group. K.H.'s T-scores on these scales are high but the discrepancies are significantly lowered when compared to local youngsters: scales L=62, D=55, and Pt=61. When local norms are used, those scales which have a T-value at or above 60 are L (T=62), K (T=68), Hs (T=60), Pd (T=64), and Pt (T=61).

K.H.'s MMPI-A profile appears consistent with his psychological state during the assessment. He is apparently reluctant to acknowledge any problem and tries to see himself in the best possible light. His immaturity makes one wonder whether this test-taking behavior also reflects a psychological naivete, and his inability to relate problems to any of his discomforts. He acts out his impulses, feels inadequate and is insecure while at the same time, has an inordinate need for attention. He struggles between emotional dependency and a disregard of other's needs or wishes. His suicidal threats appear more indicative of such struggle in his relationship with his mother than simply a depressive symptom. K.H.'s test profile does adequately capture his major problems and is reflective of his presenting difficulties.

Comment on the computerized report: The computerized report is based on K.H.'s test results as compared to the US norms. High scores have not been corrected and the emphasis on the "high" D score has to be viewed in the context of the local norm and should not be over-interpreted. On the other hand, part of the report appears consistent with K.H.'s clinical picture. Overall, the computerized report does provide some useful clinical information. In particular, his view of himself and a tendency to be clingy are helpful in the formulation of his family and sexual problems as well as treatment delivery. The inclusion of his strengths also helps the clinician plan the treatment.

THAILAND

MMPI-A Version Administered: Unpublished Thai translation

Date tested: March 15, 1999

Case: T.P.

Setting: Hospital

Identifying Information: The patient, T. P. is a 14-year-old girl who is currently in the 9th grade.

Reason for Referral

She was referred from the outpatient department for psychological assessment and counseling for psychological problems she was experiencing. She was initially brought to the hospital by her aunt because she had been complaining of severe headache for about 2-3 hours a day for several weeks. She has reportedly been worrying a great deal over fights she has been having with one of her friends. In addition, she reported that she has often heard some girls talking about her but she could not see them and did not know what they were talking about. The possibility of auditory hallucinations was being considered. During her psychological treatment, she has not been attending school but has been showing some improvement in her behavior. At the present time she returns to the hospital for follow-up sessions on a monthly basis and shows good cooperation in psychological assessment and counseling.

The patient is the second daughter and has two siblings—an older sister and a younger sister. Her parents are both from working class families and both have a secondary school education. The family earns a living by feeding dogs, fishes, and birds that they then sell. Their income from this activity is not good but they are able to get by. No family problems were noted.

The patient was viewed by the staff as immature, selfish, and demanding. She becomes angry easily when she cannot get what she wants. Her parents always try to please her and tend to give in to her wishes. Reportedly, she does not get along well with her sisters. When her mother gets angry at her, she often releases her anger at her sisters.

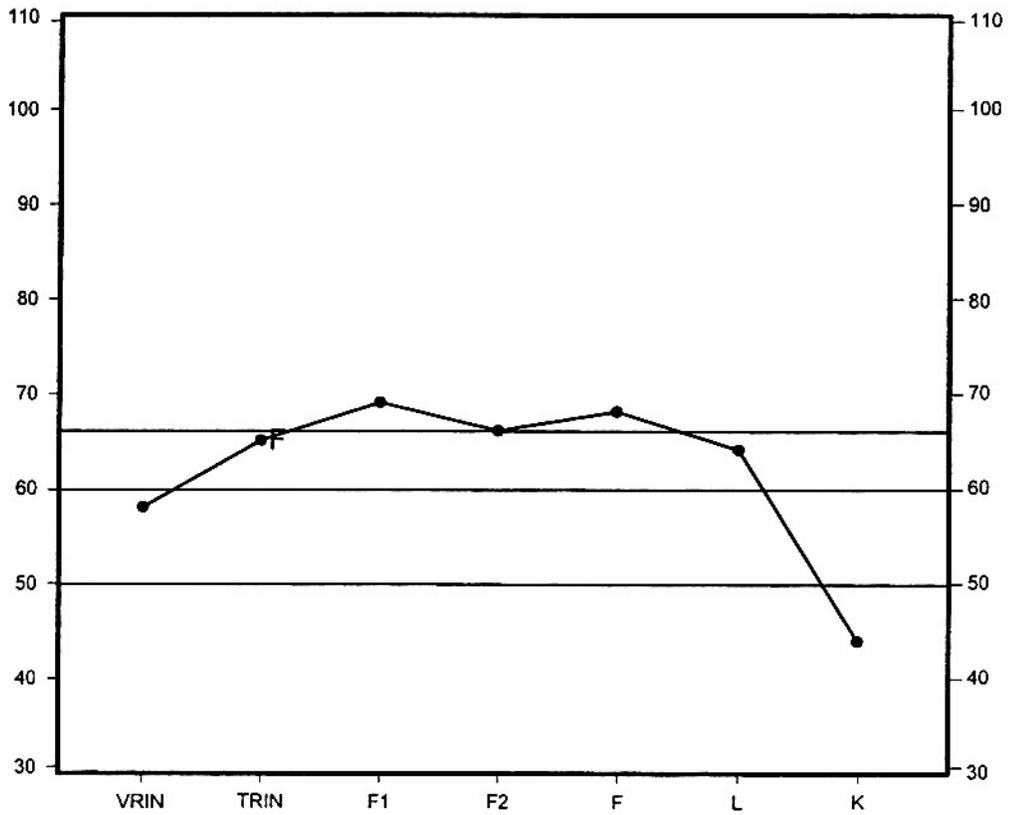
The patient has shown some improvement after medication and counseling and has been getting along better with her friends. No auditory hallucinations were noted at the follow-ups conducted monthly.

Diagnosis: From DSM-IV - Hysterical neurosis

Treatment: Counseling and medication

Result: Improved

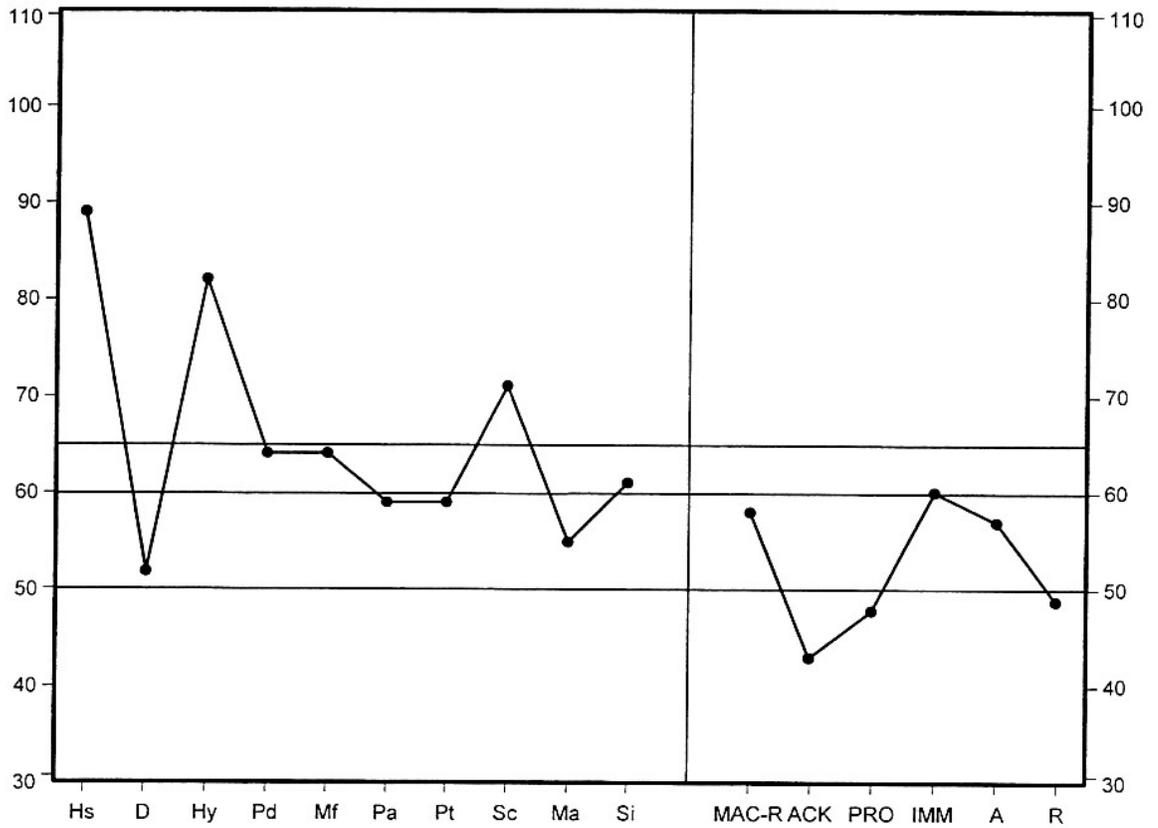
MMPI-A VALIDITY PATTERN



Raw Score:	6	7	9	12	21	5	9
T-Score:	58	65	69	66	68	64	44
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 0 Percent True: 52 Percent False: 48

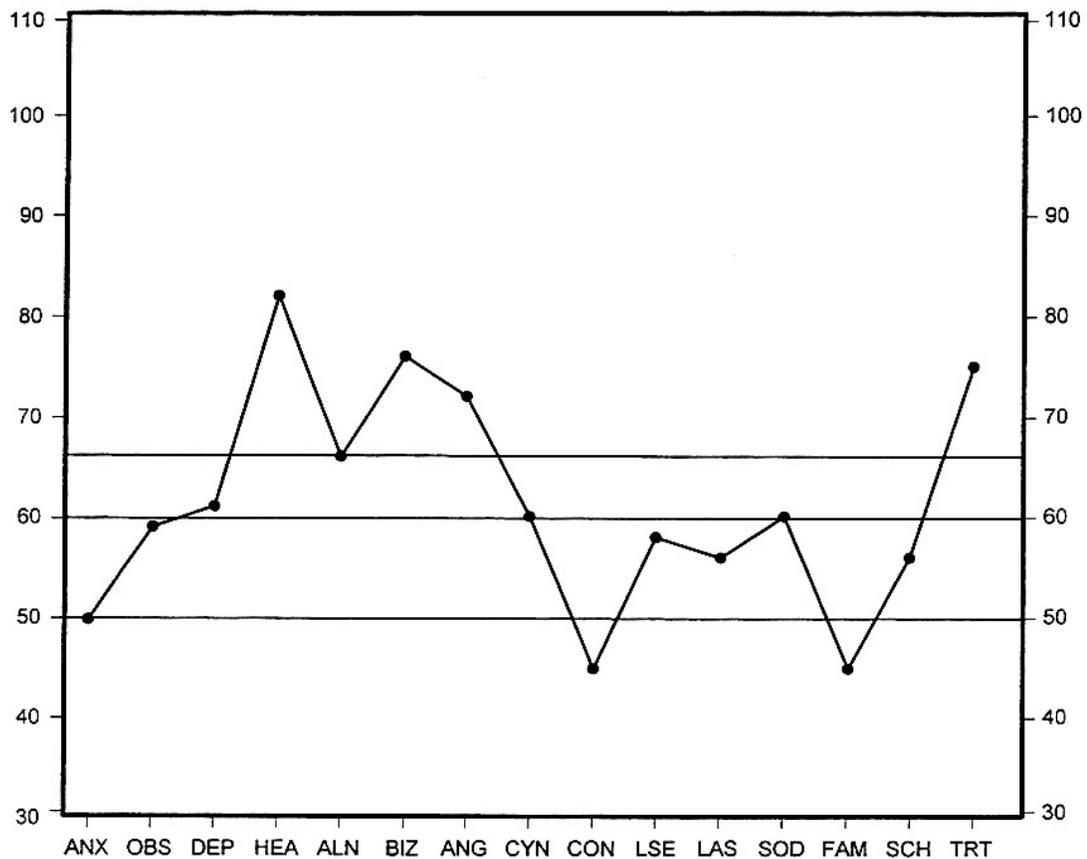
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	27	22	37	28	23	17	29	42	25	36	23	2	16	18	22	13
T-Score:	89	52	82	64	64	59	59	71	55	61	58	43	48	60	57	49
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 13"8'+450-6792/ F+L-/K:
 Mean Profile Elevation: 66.40

MMPI-A CONTENT SCALES PROFILE



Raw Score:	10	11	15	26	11	12	14	17	6	9	8	12	10	8	18
T-Score:	50	59	61	82	66	76	72	60	45	58	56	60	45	56	75
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

THE MINNESOTA INTERPRETIVE REPORT

VALIDITY CONSIDERATIONS

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

SYMPTOMATIC BEHAVIOR

Adolescents with this MMPI-A clinical profile tend to show a pattern of psychological maladjustment. Internalization of conflict is characteristic of many adolescents with this clinical pattern. This adolescent is probably experiencing severe personality deterioration and is likely to have problems with intense anxiety, somatic distress, and agitation. She may also have many problems because of her general ineffectiveness in dealing with life.

She is likely to demand much attention for her somatic complaints, which may have a bizarre quality, and she may be delusional about her health. She may appear somewhat suspicious and mistrustful.

Her high-point MMPI-A score, Hs, is the least frequently occurring well-defined peak score among adolescent girls in alcohol/drug or psychiatric treatment units. Approximately 2% of girls in treatment programs have this peak scale elevation in their clinical profile. It should be noted that this high-point score also occurs with relatively low frequency (almost 4%) as a peak score for girls in the normative sample but at a lower level of elevation than in treatment program samples.

Her MMPI-A Content Scales profile reveals important areas to consider in her evaluation. She reports several strange thoughts and experiences, which may include hallucinations, persecutory ideas, or feelings of being controlled by others. She may worry that something is wrong with her mind. School and family problems are possible.

She reports numerous somatic symptoms, including gastrointestinal difficulties, neurological problems, sensory deficits, cardiovascular symptoms, pain, or respiratory problems.

She may be assaultive or aggressive when she is angry, and she may be overly interested in violence.

INTERPERSONAL RELATIONS

Her interpersonal relationships are probably disturbed, and she tends to manipulate others by developing physical symptoms.

She is somewhat shy, with some social anxiety and inhibitions. She is a bit hypersensitive about what others think of her and is occasionally concerned about her relationships with others. She appears to be somewhat inhibited in personal relationships and social situations, and she may have some difficulty expressing her feelings toward others. She may try to avoid crowds, parties, or school activities.

Some interpersonal issues are suggested by her MMPI-A Content Scales profile. She reports being irritable and impatient with others, and she may throw temper tantrums to get her way.

This young person reports feeling distant from others. Other people seem unsympathetic toward her. She feels unliked and believes that no one understands her. She reports several problems in social relationships. She finds it difficult to be around others, and she prefers to be alone. She reported some misanthropic attitudes, indicating distrust of others and their motivations. She may be on guard when people seem friendlier than she thinks they should be.

BEHAVIORAL STABILITY

The relative scale elevation of the highest scales (Hs, Hy, Sc) in her clinical profile reflects high profile definition. If she is retested at a later date, the peak scores on this test are likely to retain their relative salience in her profile pattern.

Adolescents with this clinical profile often develop persistent adjustment problems. This adolescent's present extreme pattern of physical symptoms may have been precipitated by environmental stress. Her premorbid adjustment may have been poor, however, and the present agitated state is likely to be only an intensification of previous problems.

DIAGNOSTIC CONSIDERATIONS

Her clinical profile suggests consideration of a serious mental disorder, such as schizophrenia or severe anxiety disorder.

She reported several bizarre thoughts and behaviors. If these experiences cannot be explained by alcohol or other drug intoxication, organic problems, a misunderstanding of the items, or an intentional exaggeration of psychopathology, a psychotic process should be considered.

TREATMENT CONSIDERATIONS

Adolescents with this MMPI-A clinical profile tend to be experiencing unusual or unexplained physical symptoms for which they are seeking attention. They tend to be somewhat eccentric and to have unusual thinking about bodily processes. This individual is likely to be uninsightful about possible psychological factors involved in her problems, and insight-oriented or nondirective therapy would probably be unproductive in her case. Behavior modification procedures may be used to alter her unusual symptom pattern. Treatment of her serious psychological disorder may enhance her ability to learn by reducing her confused and disorganized thinking. It is important that her school provide as consistent, supportive, and stable an environment as possible during the course of her treatment.

Conditions in her environment that may be contributing to her aggressive and hostile behaviors could be explored. Adolescents with anger-control problems may benefit from modelling approaches and rewards for appropriate behaviors. Stress-inoculation training or other cognitive-behavioral interventions could be used to teach self-control. Angry outbursts during therapy sessions can provide opportunities for her to learn about her impulse-control problems and to practice new skills.

She may have several attitudes and beliefs that could interfere with establishing a therapeutic relationship. These may include very negative opinions about mental health professionals, an unwillingness to self-disclose, and beliefs that her problems are unsolvable. She may be unwilling to accept responsibility for her behaviors or to plan for her future. She may doubt that others care enough to help her or that they are capable of understanding her.

This adolescent's emotional distance and discomfort in interpersonal situations must be considered in developing a treatment plan. She may have difficulty self-disclosing, especially in groups. She may not appreciate receiving feedback from others about her behavior or problems.

RUSSIA

MMPI-A Version Administered: Experimental unpublished Russian translation by Atlas

Case: Iliya

Identifying Information

Chronological age: 15-years old (DOB: July 31, 1983)

School: Grade 10

Gender: Male

Procedures

Information for this report was collected in February of 1999 by a psychiatrist, Dr. Natalia A. Zhukova, of Magadan, Russia, as part of the client's current inpatient admission at the regional psychiatric hospital. The MMPI-A, patient's self-report, inpatient chart review, and an outpatient polyclinic chart were used in this evaluation. Mera M. Atlas translated and organized the information as well as provided the DSM-IV and ICD-10 diagnoses.

Reason for Referral

Iliya is a 10th grade student in an evening school in the Magadan region, Russia. He was referred for admission due to behavioral problems and trouble with the law. In particular, in October of 1998 he committed an aggressive sexual act toward a 9-year-old boy (see Presenting Problem section). Prior to the current admission, Iliya has never been referred to a psychiatrist or a neurologist. This admission was initiated by Iliya's mother but was voluntary on his part.

Family History

Iliya's mother, currently age 42, is a high school graduate. She also has a certificate from an art school. She has never worked as an artist but her paintings are quite good. According to Iliya, she has worked as a postal worker for many years. She has three children from different fathers, none of whom express any interest in their children's lives. Currently, the family lives in a small village and their material/financial situation is strained. Iliya's biological father abused alcohol. He also physically and verbally abused Iliya, frequently saying that Iliya's place is only in prison. He moved to central Russia when Iliya was 11 years old. The family has heard nothing from him since then. Iliya's brother is 5 years older. As a teenager his brother moved to central Russia to live with his grandmother. This was difficult for Iliya because he liked to spend time with his brother who used to teach him how to draw. They haven't been in touch for over a year. Iliya's sister is 3 years younger. About 4 years ago she also moved to live with the grandmother. He hasn't been in touch with his sister since then. The grandmother refused to take Iliya to live with her because of his bad behavior.

School

Iliya started school at the age of 7. His grades have always been mediocre. He explained that his poor academic performance was at first due to lack of interest, then to shyness and fear that others will tease him if he brought attention to himself. He reported that at home he loves to read, including books like Homer's "Odyssey" (although he never finished this one, finding the text too difficult). In reading, he identifies with characters and draws parallels with his own life. He considers himself a good storyteller, though at school he prefers to keep silent because he believes people will "pick on him." He said, with some satisfaction, boys and girls of his circle enjoy listening to his stories and that without him they get bored and "have nothing to talk about."

Between the 5th and 7th grade he actively broke rules, was very irritable, didn't do his homework, skipped school, and cursed his teachers. During this period, he inhaled super glue fumes and on several occasions experienced intoxication delirium with visual hallucinations. He stopped inhaling glue after about a month because he felt that his peers started to dislike him for his drug use.

Iliya dropped out of school after the 8th grade. He decided to work during the day and take evening classes. He indicated another reason for leaving high school was his teachers' attitude that he is a weak student. Iliya's school record states: "His abilities are below average. He has difficulties with concentration, his memory is poor, and cognitive abilities are delayed. He rarely skips school, yet, does not do his homework assignments. He has difficulties with acquiring educational material, which he tends to instantly forget. His study habits are poor.

His behavior is for the most part satisfactory. He can sometimes be rude in response to a teacher's comments or criticism. His behavior is unstable, indifferent, sometimes irritable, overly sensitive and demanding."

Psychosocial Development

According to Iliya, he has been shy and unsociable since kindergarten. He explains this by the fact that, as long as he remembers, he has believed he is not as good as other people. He has had few friends. He got along better with children who misbehaved because he thought he was "of the same breed." He occasionally stole things, broke rules, but his antisocial behaviors did not seem to have a consistent pattern. He tended to initiate break ups with his friends because "other people thought about me even worse than I did." He has always been reserved, touchy, and passive. He remembers that, when he was little, his parents took away the sweets from him but gave them to his brother and sister. He explained his parents' behavior as another confirmation of him being "worse than others."

He reported that at the age of 7, to alleviate some of his interpersonal discomfort, he started smoking cigarettes. At about the same age he also began stealing money from his parents. He spent the money on candy and gum in spite of being found out and severely punished repeatedly by his father. Deep inside he really needed his mother's care but she didn't pay much attention to him. Throughout his life, he has never been particularly close to anyone but always felt the need. He hung out with a bunch of kids who lived on his street. They were all of different ages. In his interactions within a group he usually had a subordinate role. He submitted to group pressure in spite of disliking the people. He never tried to leave or oppose them, even when he had an opportunity.

When Iliya was 7 years old, in a group of boys (both older and younger than himself) he was sexually abused by a 15-year-old boy, who beat him and forced him to perform oral sex in front of other boys. This experience was quite distressing for Iliya. Afterwards he felt ashamed and was so afraid of publicity that he never told his mother or brother. This episode never became public. He denies having any suicidal thoughts during that time. He continued going to school and hung out with the same group of boys. A while later he had a girlfriend (2 years older than he). In 2-3 months she left him for another boy. Iliya took the breakup as something inevitable since he is "worse than others."

At the age of 14, after threats and beatings, Iliya was forced to perform oral sex by an older man who was intoxicated. Iliya didn't fight, just cried and begged the man not to do it. Again he never told his mother about the incident. Several months later in the company of the same group of boys he participated in the beating of another teenager who was forced to perform oral sex on an 18-old man. Iliya didn't seem to express much remorse about what happened: "Everybody was doing it...they did the same to me."

After Iliya turned 14, he noticed that the houses of other kids are "clean and tidy" and his house is dirty and unattractive. He started cleaning his house regularly. He continues doing so because he likes to have a "cozy and neat" house. He commented that, if he had lot of money, he would put up new wallpaper and would buy them a new TV set and a teapot. Iliya's mother never seemed to notice his efforts. He very much would like to earn her gratitude and recognition.

Presenting Problem

In October of 1998 on his way home Iliya saw a 9-year-old boy. He reported feeling angry and wanting to cause someone the same suffering he experienced in the past. He called the boy, brought him behind a garage, and forced the boy to take his penis into his mouth. Iliya never completed the act and let the boy go because he immediately got scared of publicity and punishment. Before forcing the boy, he indicated experiencing conflicting motives, but the desire to commit an aggressive act turned out to be stronger. He also reported feeling pleasurable arousal the moment before physical contact with the boy's mouth. Later when Iliya saw the boy at school, every time he felt shame and fear, and tried to avoid looking at him. Two weeks after the incident, the boy told his mother what had happened and she went to the police. Eventually this became known in the village. Iliya believes that the publicity is the reason why his friends became hostile and stopped talking to him. The detective who was investigating the case recommended to his mother that Iliya see a psychiatrist.

It is worth mentioning that shortly after the incident he tattooed a black dot between the thumb and index finger of his left hand. He stated that he doesn't know the meaning of the black dot. He wanted to make the first letter of his name, just like the others have, but it didn't turn out.

Medical History

Iliya's birth weight was normal. Early physical development was normal. His medical history is significant for a respiratory infection (severe cold) before the age of 1, otitis media around age 2, and measles at the age of 3. He also tested negative for TB for which preventive treatment was completed.

According to Iliya, until age 10, he was physically like his peers (not the shortest among his classmates), then ceased to grow. Currently, he lags behind in physical development, which has entered into his negative perception of himself as an "ugly duckling." Prior to current admission, reasons for cessation of physical growth were never evaluated. A medical exam indicated that his physical development is below his age norm. His height is 150 cm. and weight is 37 kg. His constitution is normal and harmonious but corresponds to that of an 11-12-year-old child. His secondary sexual characteristics are not expressed. Signs of neurological damage or pathology of the internal organs was not observed.

The EEG revealed a pronounced left hemisphere dominance (as expressed via discrepancy in alpha rhythms). There appears to be an overall intracranial change of organic nature with a moderate dysfunction of brain stem structures. During the light stimulation, singular paroxysms of interlunar waves and the hyperventilation in the left parietal-temporal areas were observed (could not rule out the possibility of a latent epileptic-like center between left T4-T5). Epileptic activity was not present. A PET scan revealed poor arterial inflow and slowed venal outflow on the left side in the area of the carotid and spinal arteries.

Mental Status/Behavioral Observations

During assessment interviews and therapy sessions, Iliya was oriented and accessible. He tends to speak reluctantly, hesitates, gets ashamed, and hides his eyes. His mood is somewhat low and anxious. In his conversations with the doctor, he maintains emotional control but can be irritable in interactions with other patients. He appears to have difficulty talking about himself. This is often expressed in nervous body movements. It is possible to talk about his feelings with Iliya, but only for brief periods of time. It is difficult to go beyond the formal interactions. When the conversation becomes more personal, he tends to get visibly tense and anxious. At the end of the conversation he appears tired. His speech is at the normal rate, without structural disturbances. His thought and judgment are consistent with his age and educational background. Imagination is developed, he draws well, but tends to hide his abilities. He denied hallucinations and delusions. Volitional processes are immature. He is easily swayed and persuaded. He does not have much self-sufficiency and is dependent on others for behavioral clues. He understands various life events on an abstract intellectual level; however, the personal meaning that he gets out of these events is somewhat distorted by his subthreshold depression and low self-esteem. He acknowledges his achievements only indirectly ("but I am a good story-teller"). His ability to objectively evaluate his behaviors and take responsibility for them is insufficiently developed.

On the ward Iliya follows the rules, volunteers to assist with cleaning and other janitorial activities, and is very sensitive to praise. During his free time he reads stories by Shukshin (Russian classical writer). In interactions with other patients he tries to stay away from patients who may potentially hurt or offend him (this is an all male ward). He prefers to join more active patients who are likely to offer him protection. He is not particularly critical of his "protectors." In conflicts he does not try to defend himself or walk out of the situation. Several days after a therapy session, he showed active resistance in a conflict with another patient. Plans or goals for the future are absent, tends to "drift with the flow." During therapy sessions, he appears receptive to suggestions but does not seem to feel them through, which suggests that he might go back to the same patterns of behavior once he goes back to his usual setting.

DSM IV Diagnoses

Axis I.

Developmental Delay (possibly fetal alcohol syndrome)

Physical and Sexual Abuse of Child (V61.21)

Adolescent Antisocial Behavior (v71.02)

r/o Conduct Disorder, Childhood-onset vs. Adolescent-onset Type (321.81 vs. 321.82)

r/o Major Depressive Disorder (296.2x vs. 296.3x)

r/o Mood Disorder due to General Medical Condition (293.83)

r/o Acute Stress Disorder (308.3) Nicotine Dependence (305 10)

Hallucinogen Intoxication Delirium, by history (292.81)

Axis II. Deferred (799.9)

Axis III. Sexual Development and puberty, delayed (ICD-9-CM code 259.0)

TB negative, by history

Axis IV. Pending criminal charges, sexual abuse of a minor

Axis V. GAF 52 (current)

ICD- 10 Diagnoses

F91.1 (F92.2?)

F92.0 an/or F94.8

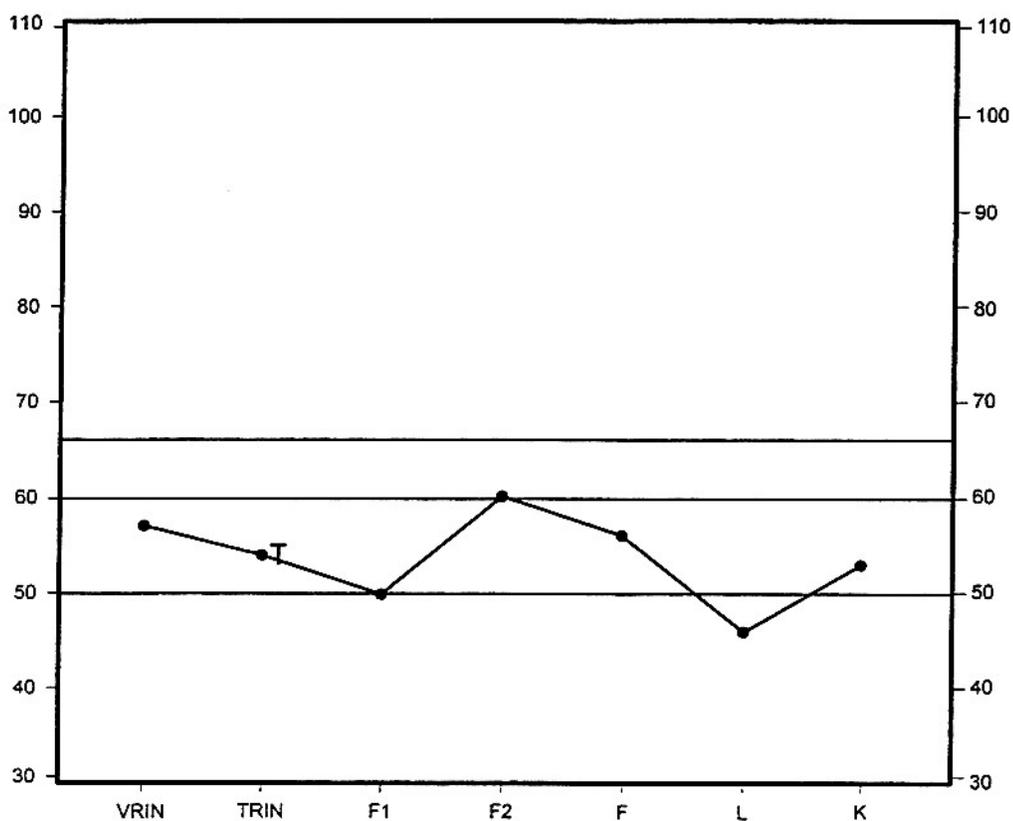
r/o (F43.2) vs. Acute Stress Reaction (F43.0)

(F66.0) vs. (F66.9)

Treatment Approach

On this inpatient unit the traditional approach to treatment consists of the supervision by the psychologist and the psychiatrist, regular individual psychotherapy sessions, short term pharmacotherapy, and family therapy directed toward reorganization of intrafamilial relationships, overcoming conflicts, and improving communication between family members. In this case family therapy is impossible due to his family living far away. Inability to work with the family creates an additional uncertainty in Iliya's recovery process. His current treatment involves individual psychotherapy (with elements of transactional analysis) and pharmacotherapy. Sonapax (20mg per day) is prescribed to alleviate some of his subthreshold depression and anxiety as well as to improve his adaptation to the inpatient setting.

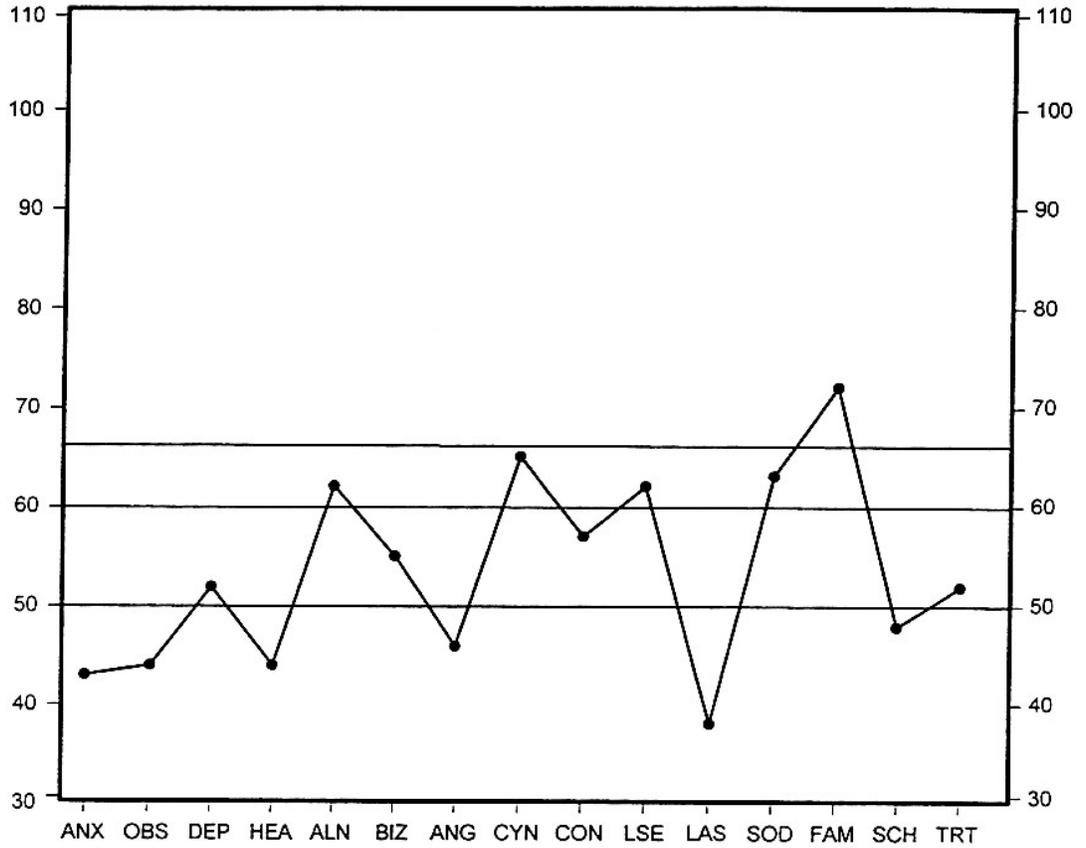
MMPI-A VALIDITY PATTERN



Raw Score:	7	10	4	10	14	2	14
T-Score:	57	54	50	60	56	46	53
Response %:	100	100	100	100	100	100	100

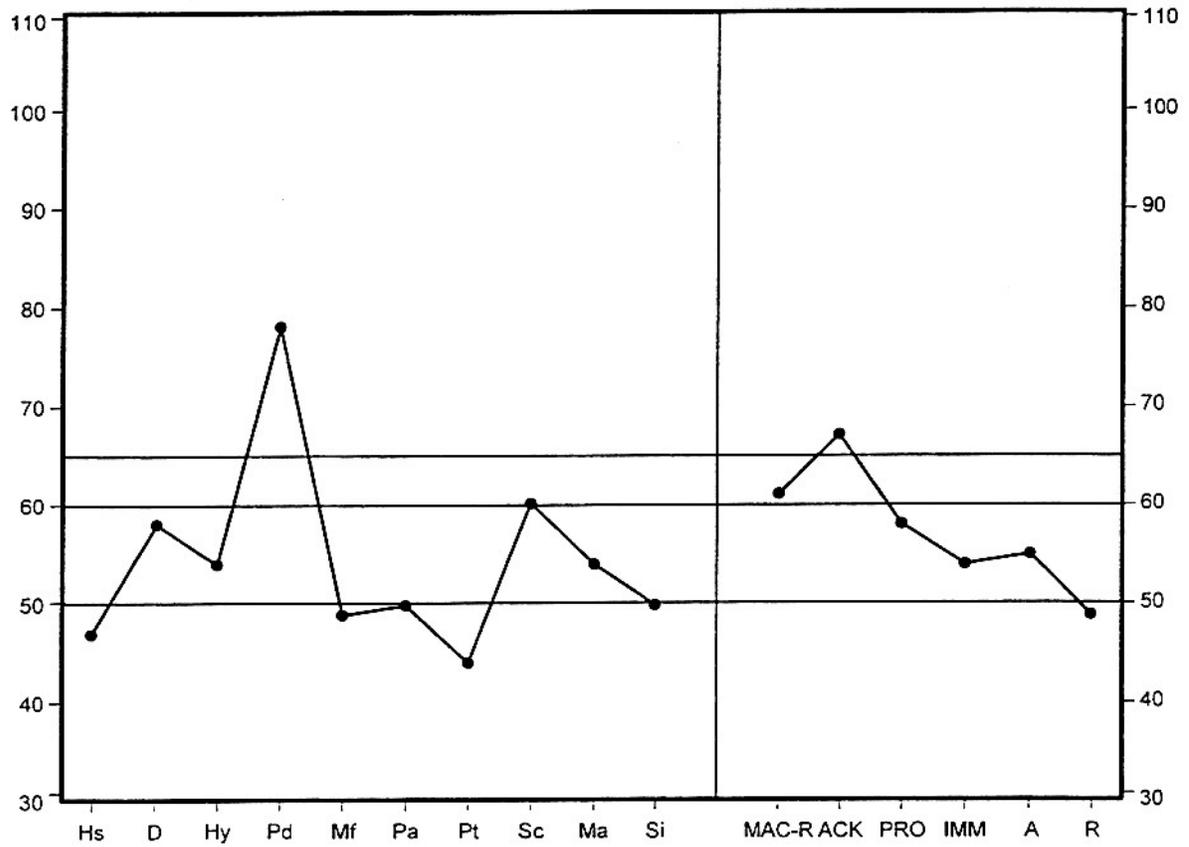
Cannot Say (Raw): 0 Percent True: 50 Percent False: 50

MMPI-A CONTENT SCALES PROFILE



Raw Score:	5	5	9	4	10	6	7	18	13	9	2	14	22	6	11
T-Score:	43	44	52	44	62	55	46	65	57	62	38	63	72	48	52
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	6	24	23	32	21	13	13	33	24	26	26	8	20	16	18	13
Scale Score:	47	58	54	78	49	50	44	60	54	50	61	67	58	54	55	49
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

T-Score Code: 4+8-239 60/517: FK/L:
 Mean Profile Elevation: 55.60

THE MINNESOTA INTERPRETIVE REPORT

VALIDITY CONSIDERATIONS

This adolescent responded to the items in a cooperative manner, producing a valid MMPI-A. His profiles are likely to be a good indication of his current personality functioning.

The clinical setting in which this MMPI-A was taken has not been indicated on the answer form. The report has been processed as though "Outpatient Mental Health Program" has been indicated. The report may not be as specific as it would have been if the actual assessment setting had been designated.

SYMPTOMATIC BEHAVIOR

This adolescent's MMPI-A clinical profile indicates multiple serious behavior problems including school maladjustment, family discord, and authority conflicts. He can be moody, resentful, and attention-seeking. At times he may appear rebellious, impulsive, and argumentative. His poor judgment may get him into trouble. He can be self-centered and may show little remorse for his bad behavior. He may run away or lie to avoid punishment.

This MMPI-A clinical profile contains the most frequent high point, the Pd score, among clinical samples. Over 25% of boys in treatment have this well-defined profile (i.e., with the Pd scale at least 5 points higher than the next scale). Less than 4% of boys in the normative sample have this well-defined high-point profile.

INTERPERSONAL RELATIONS

He may seem initially likable and may make a good impression on others; however, his relationships tend to be very troubled. His behavior is primarily hedonistic and self-centered, and he is quite insensitive to the needs of other people, exploiting them and feeling no guilt about it.

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.

This young person has very misanthropic attitudes. He believes that others are out to get him and will use unfair means to gain advantage. He is distrustful, looking for hidden motives when people do nice things. He feels that it is safer to trust no one. He is on guard when people seem friendlier than he expects. He often reports being misunderstood by others and sees others as being quite jealous of him. He reports several problems in social relationships. He finds it difficult to be around others, and he prefers to be alone. 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 elevation of the highest scale (Pd) in his clinical profile shows very high profile definition. His peak scores are likely to remain very prominent in his profile pattern if he is retested at a later date. Adolescents with this clinical profile may have a history of acting-out behaviors and relationship problems.

DIAGNOSTIC CONSIDERATIONS

More information is needed about his behavior problems before a definitive diagnosis can be made. His Pd elevation suggests that behavior problems should be considered.

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.

He has endorsed items that confirm his increasing involvement with alcohol or other drugs. He recognizes that his use is problematic, and he may be aware that others are critical of it. Using alcohol or other drugs may be a coping strategy for him.

TREATMENT CONSIDERATIONS

His conduct disturbance should figure prominently in any treatment planning. His clinical scales profile suggests that he is a poor candidate for traditional, insight-oriented psychotherapy. A behavioral strategy is suggested. Clearly stated contingencies that are consistently followed are important for shaping more appropriate behaviors.

His potential for developing alcohol or drug problems requires attention in therapy if important life changes are to be made. He has acknowledged some problems in this area, which is a valuable first step for intervention.

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.

His cynical attitudes and beliefs about others and their hidden motivations may create difficulties in therapy. His therapist should be aware of his general mistrust of others.

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.

Final Follow-Up Comment

The correspondence between the MMPI-A computerized interpretive report and impressions obtained from interviews and medical records is striking. Moreover, the computer printout provided additional information about the dangers associated with Iliya's likely substance abuse. This information was not emphasized by the treating clinician and is highly relevant to Iliya's treatment.

On May 3, 1999 Dr. Miron Atlis conducted an interview with Iliya and his mother in their home. It turns out that both Iliya's mother and his maternal uncle have serious problems with alcohol abuse. The uncle attempted an alcohol treatment once. During the interview, Iliya appeared somewhat less "pathological" than described in the computer output although all the key characterological elements were highlighted correctly.

Based on family photographs, there is a very high resemblance between Iliya and his biological father. From these photographs it was apparent that the father had slowed hypotrophic growth but then proceeded to develop normally after he turned 16-17.

For Iliya the only consequence of his sexually deviant behavior was changing from day school to evening classes. The police are not interested in Iliya's case just as they are not interested in most delinquent adolescents from "difficult" families. His mother talked him into getting psychiatric services. There was no pressure from the police or the community. Their village has very high crime and a high unemployment rate. Iliya's mother has been out of work for over a year. She lost her job due to downsizing and has been unable to find a new one. The family survives mostly because of help from friends and neighbors.

The maternal grandmother appears not to like Iliya probably because of his bad behavior and physical resemblance to his biological father. His brother is close to being discharged from the army. He is not planning on coming back to Magadan. Iliya's maternal grandmother, uncle, and sister are living in the rural area near the Black Sea where they own a small house with a garden, which is their main source of income. Iliya and his mother would like to move there.

THE NETHERLANDS

MMPI-A Version Administered: Unpublished Dutch/Flemish translation

Case: Ellen

Setting: Ellen and her parents contacted an outpatient private practice of several primary health care psychologists in a rural area in the Netherlands. Before this step Ellen had three sessions at the regular mental health service. There she was advised to become involved in a combination of family therapy and individual therapy. Ellen was not happy with this advice and she did not think it was well thought through.

Identifying Information: Ellen is a 7-year-old girl and in the fourth year of a regular secondary high school.

Reason for Referral

Ellen complains about “attacks” in which she becomes unconscious and harms herself. These attacks vary in time between 15 minutes and three hours and take place at school and also at her work. These attacks have occurred for about four years. Neurological examination did not identify an organic cause. The neurologist referred her to the mental health institution for psychological treatment. Her functioning at school is impaired by this problem and she has lots of attacks and misses lessons. Also the other pupils are influenced by her attacks.

After finishing secondary school Ellen would like to continue her education at a school for cooks, but this seems to be impossible because of these complaints. Also Ellen is not able to pass the exam for her drivers license because of these attacks. Contact with her friends and going out with them also is severely impaired. Ellen’s mother frequently accompanies her and she was also there at the first consultation in the private practice. Also, at the moment of the consultation her mother impresses the staff as having a very supportive and caring attitude toward her daughter.

Family Structure and Background

Ellen’s parents divorced when she was 8 years old and her brother was 4 years old. Her father left her mother after developing a relationship with a neighbor woman. Her mother became involved with another man who brought three children with him, two sons, ages 12 and 15, and one daughter, 8 years old. Ellen’s relationship with her mother is described as very good and tight. She is also positive about her relation with her stepfather. She considers him as her real father. She has little contact with her biological father and she has the feeling that he does not understand her. Ellen has been a great support for her mother during difficult times also. Earlier her mother received psychological help at the same private practice where she is taking her daughter now. That help centered around her divorce and problems with her former husband, Ellen’s father.

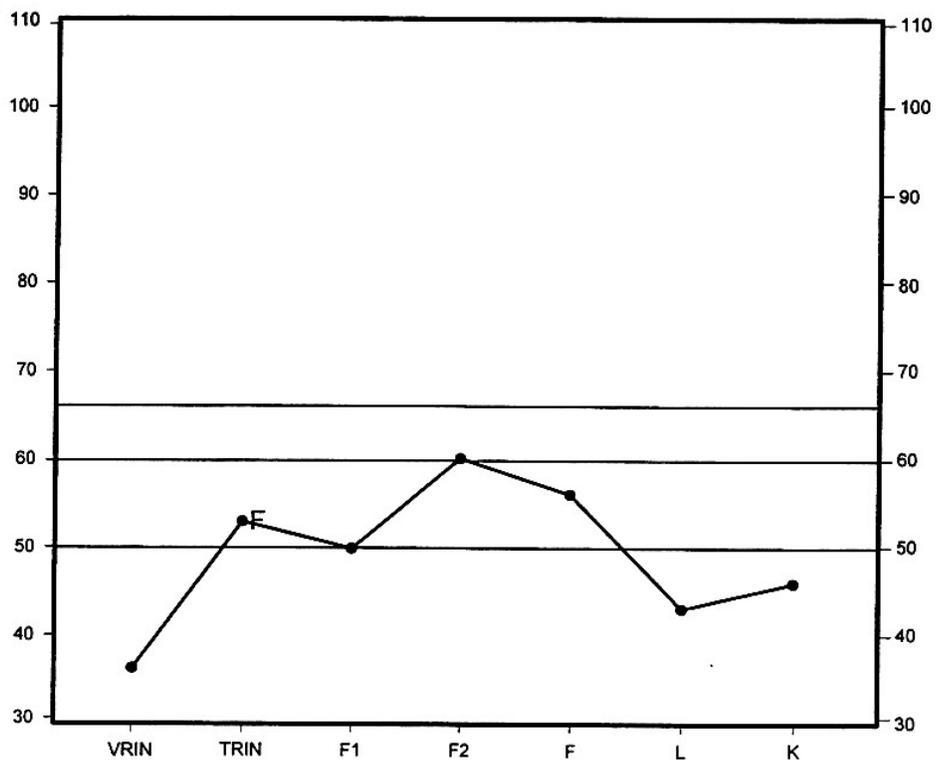
In primary school Ellen was not accepted by her peers, she was teased by them and because of this she once changed schools. During recent years these problems do not exist; at her current school her adaptation is very good.

Psychological Evaluation

After the intake session Ellen was assessed further by means of interview and several psychological tests. During these sessions Ellen began to talk more and for the first time she reported that she feels very confused. She starts to talk about her stepbrothers and stepsisters and then she confesses that she was abused sexually by her younger stepbrother between the ages 9 and 13. During these years she had intercourse with him several times. First Ellen felt good about all the special attention she got from him, especially because this was during the time that she did not feel accepted by her peers. But more and more she felt uncomfortable about it and more and more her stepbrother forced her to submit to his wishes. Ellen also thought that she might have been pregnant once because her period was delayed for two months and after that she had a great deal of bleeding. The sexual abuse stopped when her stepbrother got a girlfriend.

Her dysphoria and the development of somatic symptoms are congruent with the clinical picture. Also the symptoms of anxiety, tension and worry probably result from the secret that she has been hiding. Talking about the sexual abuse brought a great relief, lowering her anxiety and dysphoria. At the moment treatment is still going on.

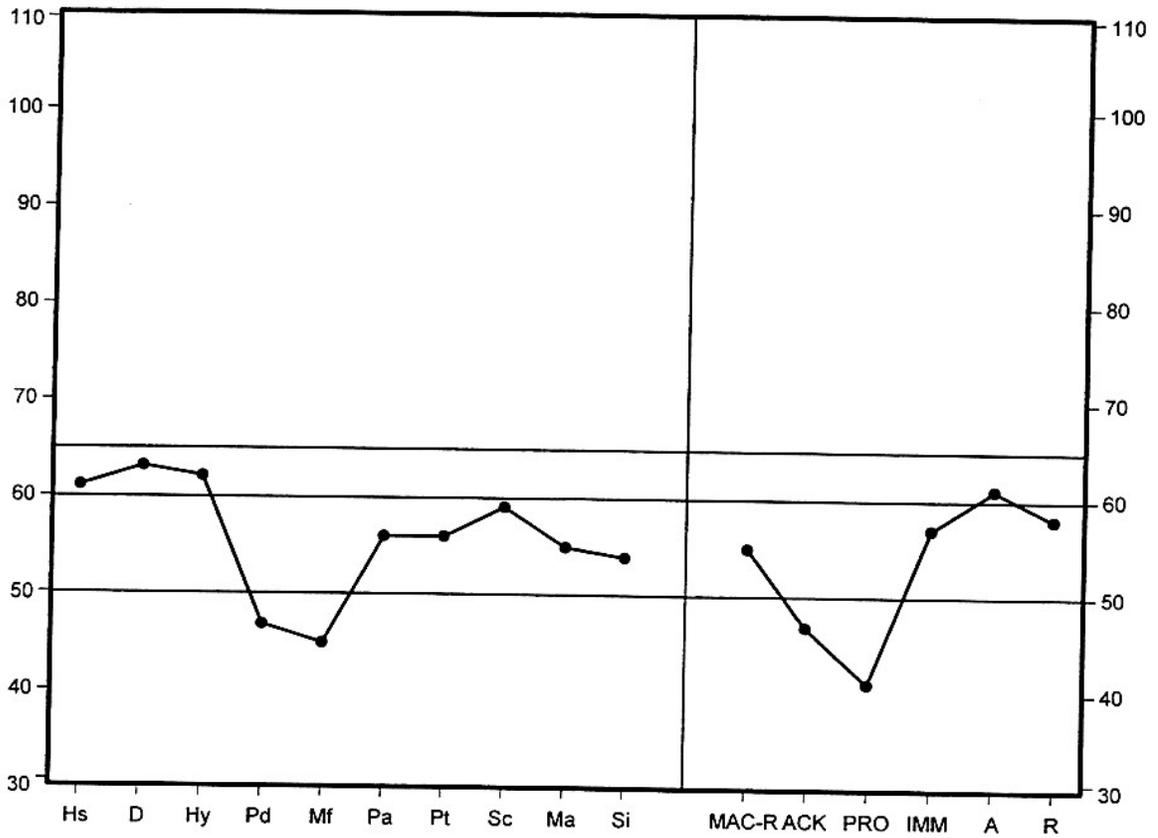
MMPI-A VALIDITY PATTERN



Raw Score:	0	9	3	9	12	1	10
T-Score:	36	53	50	60	56	43	46
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 0 Percent True: 50 Percent False: 50

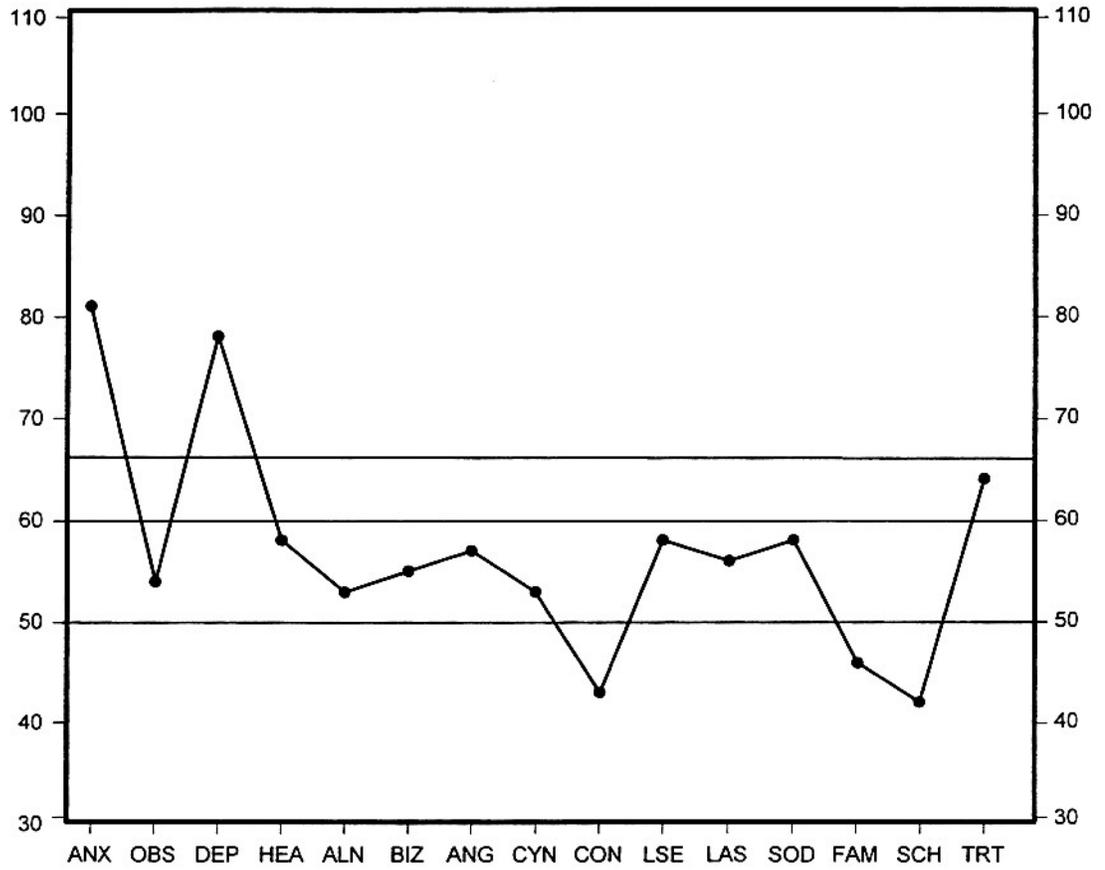
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	15	28	29	19	30	16	27	34	25	30	22	3	13	16	25	16
z-Score:	61	63	62	47	45	56	56	59	55	54	55	47	41	57	61	58
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

T-Score Code: 231-86790/45: F/KL:
 Mean Profile Elevation: 57.40

MMPI-A CONTENT SCALES PROFILE



Raw Score:	19	10	22	14	7	6	11	15	5	9	8	11	11	3	15
T-Score:	81	54	78	58	53	55	57	53	43	58	56	58	46	42	64
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

THE MINNESOTA INTERPRETIVE REPORT

VALIDITY CONSIDERATIONS

This adolescent responded to the items in a cooperative manner, producing a valid MMPI-A. Her profiles are likely to be a good indication of her current personality functioning.

SYMPTOMATIC BEHAVIOR

Her clinical profile is moderately elevated, suggesting a tendency towards dysphoria and the development of somatic symptoms in times of stress. Her clinical profile is not as extreme as one would expect in a treatment setting. Her other MMPI-A profiles or additional assessment techniques may provide more information about her current situation.

Her MMPI-A clinical profile configuration, which includes D and Hy, is the fifth most frequently occurring two-point scale pair among adolescent girls in treatment settings. Approximately 7% of girls in treatment have this clinical profile. It should be noted that this high-point pair occurs with similar frequency among girls in the normative population (over 5%) but usually at a lower level of elevation than in clinical samples.

Extreme responding is apparent on her MMPI-A Content Scales profile. She endorsed at least 90% of the items on A-anx in the deviant direction, indicating that the following is quite important in understanding her problem situation. She reported many symptoms of anxiety, tension, and worry. She may have frequent nightmares, fitful sleep, and difficulties falling asleep. Life is very much a strain for her and she may feel that her problems are insurmountable. A feeling of dread is pervasive as are difficulties with concentration and staying on task.

In addition to the extreme endorsements found in her MMPI-A Content Scales profile, she also describing other important problem areas. Symptoms of depression are quite prominent in her responses to the MMPI-A. She reports sadness, fatigue, crying spells, and self-deprecatory thoughts. Her life may seem uninteresting and not worthwhile. Feelings of loneliness, pessimism, and uselessness are prominent.

INTERPERSONAL RELATIONS

She has an average interest in being with others and is not socially isolated or withdrawn. She appears able to meet and talk with other people and does not seem overly anxious in social gatherings.

BEHAVIORAL STABILITY

The relative elevation of her highest clinical scales (D, Hy) suggests that her profile is not as well defined as many other profiles. That is, her highest scale(s) are very close to her next scale score elevations. There could be some shifting of the most prominent scale elevations in the profile code if she is retested at a later date.

DIAGNOSTIC CONSIDERATIONS

The relatively low elevation of her MMPI-A clinical scales does not provide sufficient information to formulate a clinical diagnosis. Additional information from other sources is needed to arrive at a diagnosis. Her extreme endorsement of a significant number of depressive symptoms should be considered when arriving at a diagnosis.

TREATMENT CONSIDERATIONS

She may be experiencing some symptoms of depression that might respond to traditional psychotherapy or cognitive-behavioral techniques. This could be considered unless other MMPI-A profiles or assessment techniques identify further areas for intervention.

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

There are some symptom areas suggested by the Content Scales profile that the therapist may wish to consider in initial treatment sessions. Her endorsement of internalizing symptoms of anxiety and depression could be explored further.

She endorsed some items that indicate possible difficulties in establishing a therapeutic relationship. She may be reluctant to self-disclose, she may be distrustful of helping professionals and others, and she may believe that her problems cannot be solved. She may be unwilling to assume responsibility for behavior change or to plan for her future.

PERU

MMPI-A Version Administered: Published Hispanic translation by Garcia-Peltoniemi et al.

Case: Adriana D.

Setting: Outpatient mental health

Identifying Information

Age: 17

Gender: Female

Reason for Referral: Adriana was born on December 23, 1981 and was an only child. Her parents got divorced when she was three years old. At present, she lives with her mother and stepfather. Her mother remarried when Adriana was five.

She was referred to therapy because she became violent toward her mother, and broke her arm. Reportedly, she has been demonstrating many aberrant behaviors—she is very aggressive, has bulimia, and problems with drugs and alcohol. Her mother has also been in therapy for many years and has been admitted to a hospital several times for depression and constant insomnia. Her (biological) father has always been an alcoholic. He always drank and was very abusive toward Adriana's mother. This was the reason her parents got their divorce. The father married again and had another baby girl. He has continued to drink until recently.

When Adriana was 15 she displayed many symptoms of bulimia. She would eat in excess and then would vomit immediately afterward. In recent times, she is experiencing voluntary or reflective bulimia attack at least twice a week.

At 16, Adriana started drinking and smoking – about 3 glasses of rum and coke and several bottles of beer over a weekend. She acknowledged that she gets drunk easily and becomes aggressive at times. She also started using marijuana at public parks but she stopped four months ago. She's been in trouble with the police and she has been accused of being a small drug dealer. She is currently under police scrutiny. She currently smokes four cigarettes per day.

She reportedly has been experiencing a great deal of difficulty at school. She has reported problems with some of her classes, especially math, chemistry and physics. Her school failures required that she repeat the 7th grade. She was kicked out of school for aggressiveness and smoking. She's been in two other middle schools so far. She is currently in 11th grade and performing poorly.

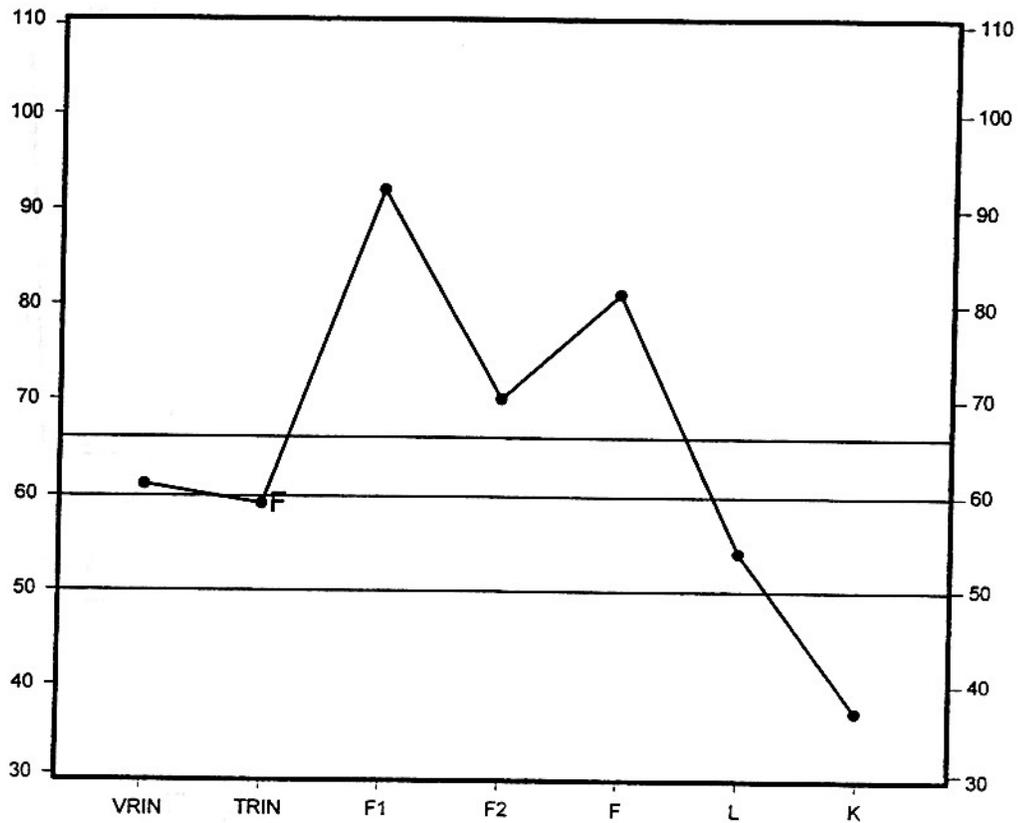
Family Structure

Her present relationship with her father is reportedly not particularly problematic, in part, because there is not much communication. Most of the time her father has been “borracho” (drunk) and continues to act aggressively toward Adriana's mother—often calling her names. Adriana only lives with her father sporadically and he was never very nice to her. He would also call her names and insult her but he never hurt her physically. In recent times, her father has tried to change his behavior; he stopped drinking 20 months ago saying he wants to have a good relationship with his daughter and his ex-wife. Her relationship with her stepfather seems to be better. She seems to respect him more. He's very strict with her and always insists on her being truthful. He reprimands her when she drinks, smokes or behaves inappropriately.

Her current relationship with her mother is not particularly good. They are always arguing because of Adriana's behavior, especially related to the drinking and the bulimia. In spite of that, Adriana says that she loves her mother and she doesn't mean to hurt her—it is just that sometimes she loses control. She doesn't remember breaking her mother's arm—she says she was drunk.

She also promises her mother that she will change but never fulfills her promise because she feels her mother is always over controlling. She said the bulimia started as a way to get her mother's attention. She also caused problems because she wouldn't clean up the mess after the vomiting incidents that she would initiate by putting her finger in her throat. When her mother wouldn't let her go out with her friends she would tell her that she was going to kill herself and it would be her fault.

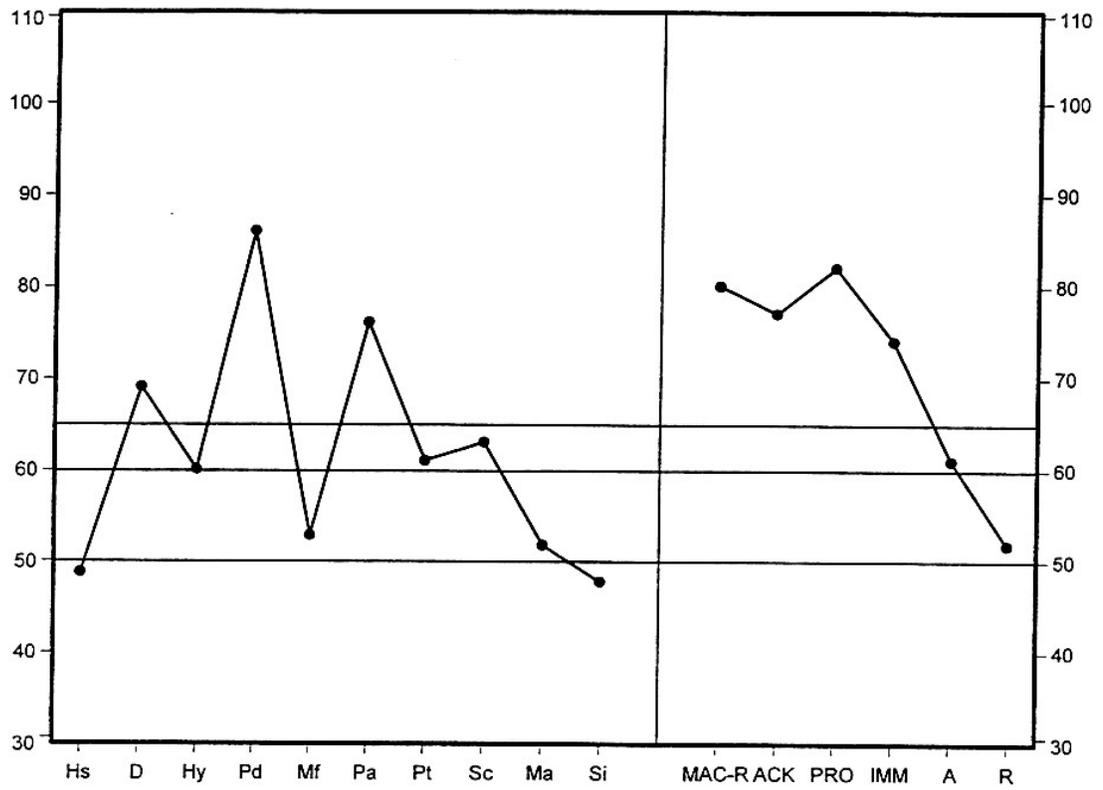
MMPI-A VALIDITY PATTERN



Raw Score:	7	8	16	14	30	3	6
T-Score:	61	59	92	70	81	54	37
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 1 Percent True: 62 Percent False: 38

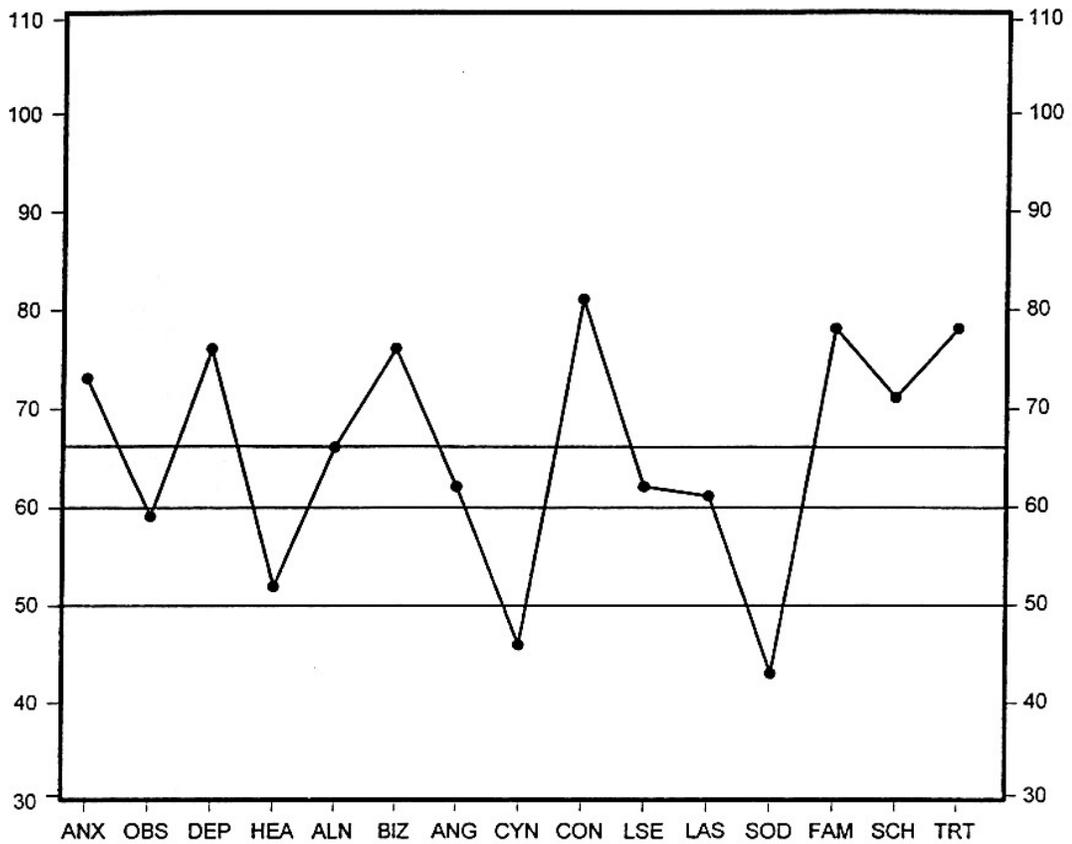
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	9	31	28	37	27	23	30	37	24	25	32	10	30	27	25	14
T-Score:	49	69	60	86	53	76	61	63	52	48	80	77	82	74	61	52
Response %:	100	100	100	100	100	100	100	100	100	98	100	100	100	100	100	100

Welsh Code: 4"6'2+873-59/10: F""+L/:K#
 Mean Profile Elevation: 64.50

MMPI-A CONTENT SCALES PROFILE



Raw Score:	17	11	21	10	11	12	12	12	18	10	9	4	25	12	19
T-Score:	73	59	76	52	66	76	62	46	81	62	61	43	78	71	78
Response %:	100	100	100	100	100	100	100	100	100	94	100	100	100	100	100

THE MINNESOTA REPORT

VALIDITY CONSIDERATIONS

This is a valid MMPI-A. She is neither denying problems nor claiming an excessive number of unusual symptoms. Her low K score suggests an overly frank self-appraisal, possibly presenting a more negative picture than is warranted. This may reflect a need to get attention for her problems.

SYMPTOMATIC BEHAVIOR

Adolescents with this clinical scales profile show an extreme pattern of psychological maladjustment that combines acting-out problems with more neurotic and dependent behaviors. This individual tends to be quite oppositional, resistant, sneaky, and underhanded. She can be overemotional when things don't go her way. Her behavior is unpredictable and she is very moody. She may tease, bully, or dominate her peers. Anger-control problems may be pronounced. She may have problems with alcohol or other drugs, and she may have difficulties in school. More serious antisocial problems, including acting out sexually, are possible.

She can also be very clinging and dependent on adults (e.g., seeking their help, wanting to be around them). She may be troubled by beliefs that she is evil or deserves severe punishment. These ideas may take on an obsessional quality. Paradoxically, she also tends to externalize blame.

The highest clinical scale in her MMPI-A clinical profile, Pd, occurs with very high frequency in adolescent alcohol/drug or psychiatric treatment units. Over 24% of girls in treatment settings have this well-defined peak score (i.e., with the Pd scale at least 5 points higher than the next scale). The Pd scale is among the least frequently occurring peak elevations in the normative girls' sample (about 3%).

Her MMPI-A Content Scales profile reveals important areas to consider in her evaluation. She reports several strange thoughts and experiences, which may include hallucinations, persecutory ideas, or feelings of being controlled by others. She may worry that something is wrong with her mind.

She reports many behavioral problems including stealing, shoplifting, lying, breaking or destroying property, being disrespectful, swearing, or being oppositional. She may belong to a peer group that is frequently in trouble and encourages deviant behavior. Poor academic performance and behavioral problems in school are also possible, as are behavior problems at home. She may be sexually active, flirtatious, provocative, or promiscuous.

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

She reported numerous problems in school, both academic and behavioral. She reported several symptoms of anxiety, including tension, worries, and difficulties sleeping.

INTERPERSONAL RELATIONS

She has a great deal of difficulty in her social relationships. She feels that others do not understand her and do not give her enough sympathy. She is somewhat aloof, cold, nongiving, and uncompromising, attempting to advance herself at the expense of others. She tends to be hostile, resentful, and irritable.

Some interpersonal issues are suggested by her MMPI-A Content Scales profile. Family problems are quite significant in this person's life. She reports numerous problems with her parents and other family members. She describes her family in terms of discord, jealousy, fault finding, anger, serious disagreements, lack of love and understanding, and very limited communication. She looks forward to the day when she can leave home for good, and she does not feel that she can count on her family in times of trouble. Her parents and she often disagree about her friends. She indicates that her parents treat her like a child and frequently punish her without cause. Her family problems probably have a negative effect on her behavior in school. This young person reports feeling distant from others. Other people seem unsympathetic toward her. She feels unliked and believes that no one understands her. She reported some irritability and impatience with others. She may have problems controlling her anger.

BEHAVIORAL STABILITY

The relative scale elevation of the highest scales (Pd, Pa) in her clinical profile reflects high profile definition. If she is retested at a later date, the peak scores on this test are likely to retain their relative salience in her profile pattern. This adolescent's acting-out behaviors and extreme dependency needs may produce periods of intense interpersonal difficulty.

DIAGNOSTIC CONSIDERATIONS

An individual with this MMPI-A clinical scales profile may be viewed as developing characteristics of a personality problem. Externalizing behaviors are likely to be prominent in her clinical pattern.

She admits to having some symptoms of eating disorders (e.g., bingeing, purging, or laxative use for weight loss).

She reported several bizarre thoughts and behaviors. If these experiences cannot be explained by alcohol or other drug intoxication, organic problems, a misunderstanding of the items, or an intentional exaggeration of psychopathology, a psychotic process should be considered.

Her highly elevated Conduct Problems scale may indicate the presence of an oppositional-defiant disorder or a conduct disorder.

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

She obtained extremely high scores on all three of the alcohol- and drug-problem scales, indicative of serious problems in this area. She probably engages in risk-taking behaviors and tends toward exhibitionism. She probably belongs to a peer group who uses alcohol or other drugs. Her involvement in an alcohol- or drug-using lifestyle should be further evaluated. She has acknowledged having alcohol- or drug-abuse problems in her responses to the MMPI-A. Problems at home or school are likely given her problems with alcohol or other drugs.

TREATMENT CONSIDERATIONS

The MMPI-A clinical scales profile suggests that this individual has serious problems that require intervention. She will probably be a difficult therapy patient because of her distrust, moodiness, and potential for acting out. A supportive, consistent approach may be helpful. A directive strategy focusing on behavioral change may prove more beneficial than insight-oriented techniques. Her dependency needs may be an asset in building a therapeutic relationship. However, the relationship may be stormy at times, with the therapist being inundated with unrealistic demands.

Her very high potential for developing alcohol or drug problems requires attention in therapy if important life changes are to be made. She has acknowledged some problems in this area, which is a valuable first step for intervention.

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

Her family situation, which is full of conflict, should be considered in her treatment planning. Family therapy may be helpful if her 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 her treatment to explore her considerable anger at and disappointment in her 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.

There are some symptom areas suggested by the Content Scales profile that the therapist may wish to consider in initial treatment sessions. Her endorsement of internalizing symptoms of anxiety and depression could be explored further.

During the course of her treatment, it may be important to discuss her sexual behavior. Her knowledge about sexuality and protecting herself against sexually transmitted diseases could be assessed and information provided, if needed. Perhaps in a trusting therapeutic relationship, she will be able to discuss the extent of her sexual activity and its meaning in her life. Alternatives to risky, promiscuous behavior could be discussed and promoted. If she is flirtatious and provocative, a greater awareness of this on her part may prevent unwanted sexual advances or possible victimization. Social skills training may be helpful in changing possibly inappropriate behaviors.

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She may have several attitudes and beliefs that could interfere with establishing a therapeutic relationship. These may include very negative opinions about mental health professionals, an unwillingness to self-disclose,

and beliefs that her problems are unsolvable. She may be unwilling to accept responsibility for her behaviors or to plan for her future. She may doubt that others care enough to help her or that they are capable of understanding her.

This adolescent's emotional distance and discomfort in interpersonal situations must be considered in developing a treatment plan. She may have difficulty self-disclosing, especially in groups. She may not appreciate receiving feedback from others about her behavior or problems.

SPAIN

MMPI-A Version Administered: Published Spanish translation by Avila-Espada et al.

Case: Juan M.

Setting: The patient was seen at the Hospital de Dia de Madrid (HDM) in Madrid. This program is a day stay clinical center that is a private program. Patients are expected to pay for their treatment on a private basis but most of them are funded by public health or educational public administration. The center uses individual and group psychoanalytic therapy, medical therapy, and educational guidance as treatment approaches.

Identifying Information: A 17-year-old male who currently lives with his grandmother, an aunt, and a cousin. For the past month he has spent days at the day treatment center.

Evaluators

Silvia Parabera and Javier Aroztegui are the psychologists and psychotherapists.

Test Administration

The patient completed the MMPI-A under standard conditions. He was seated in an office and tested at a table along with two other adolescents. A ten-minute rest period was permitted mid-way through the testing to reduce the subjects' fatigue. The test was completed in one hour and filled out anonymously.

Family Background

His family has many problems. His aunt works as a prostitute and his cousin is a heroin addict. His father abandoned the family some time ago, although he appears from time to time to try and obtain money from them in a very manipulative way. He is typically in trouble with the law.

Juan's mother and grandmother are among the more structured and healthy people in his family. They try to help him, but he is very distant and alienated from others. His mother works as a cleaner, and is making a great effort trying to help him. She has tried to protect him from the consequences of his behavior but now she is tired and has concluded that he must handle the consequences of his own behavior.

Clinical Symptoms and Problems

Juan comes from a dysfunctional family and in many ways can be viewed as being reared on the streets. He has had very little supervision. He reports occasional soft drug (marijuana) consumption. His behavior is considered to be manipulative. He has no record of violence and is solitary in terms of his activities. He does not hang out with a group, he receives no pleasure from hobbies, and he is not interested in sexual relations. He spends what money he has available on electronic role games which seem to be related to a fantasy way of forming his personal identity. He has not performed well at school and at this time is not attending school.

The psychological evaluation found no psychotic symptoms such as hallucinations or delusions.

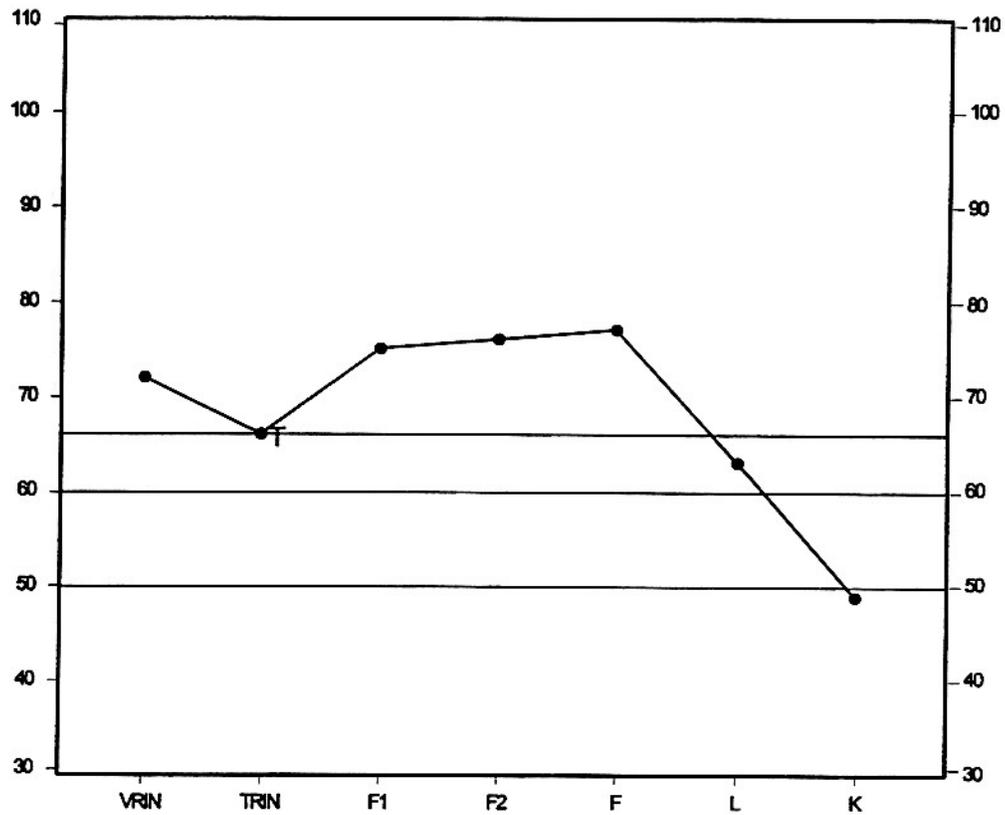
Diagnosis

Schizoid personality disorder

Treatment or Intervention

Currently Juan is being seen in individual psychotherapy and is taking neuroleptic medications in low dosage to reduce his symptoms.

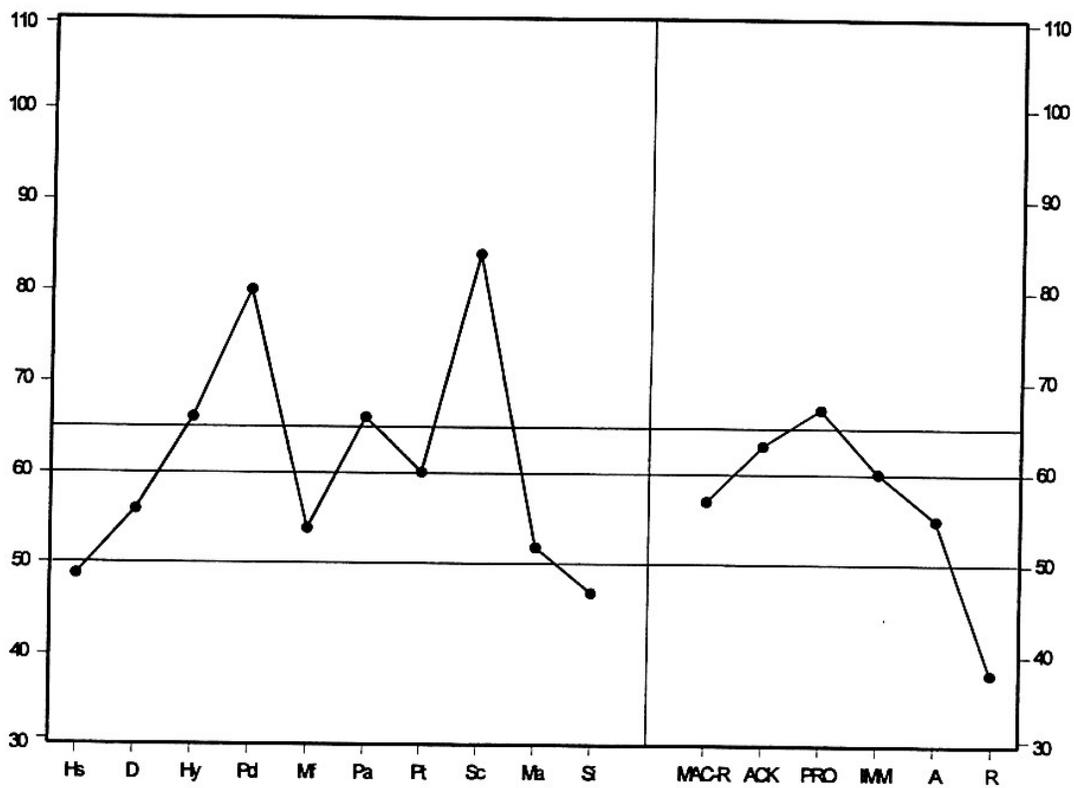
MMPI-A VALIDITY PATTERN



Raw Score:	12	12	14	18	32	6	12
T-Score:	72	66	75	76	77	63	49
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 0 Percent True: 54 Percent False: 46

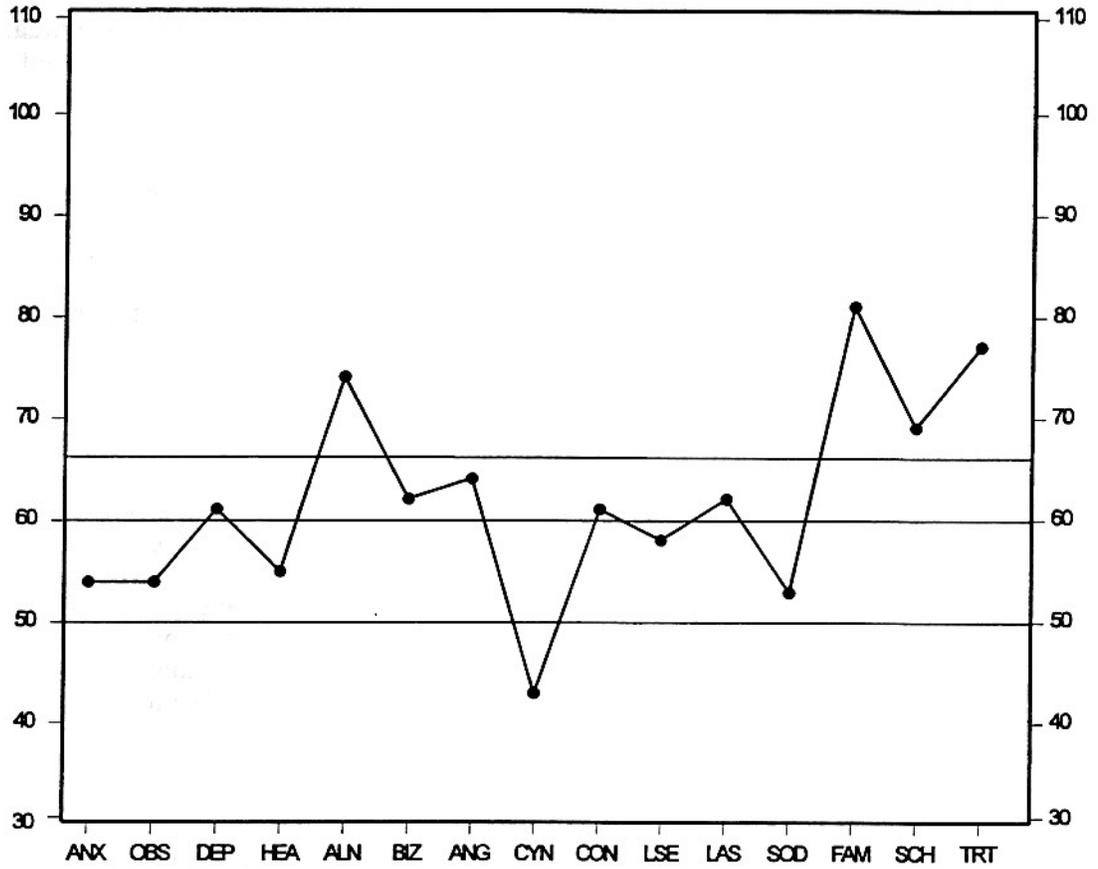
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	7	23	30	33	23	19	26	50	23	24	24	7	24	20	18	8
T-Score:	49	56	66	80	54	66	60	84	52	47	57	63	67	60	55	38
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 84136-7-25910 P+L/K
 Mean Profile Elevation: 64.10

MMPI-A CONTENT SCALES PROFILE



Raw Score:	10	9	13	12	13	8	12	10	14	8	9	10	25	12	18
T-Score:	54	54	61	55	74	62	64	43	61	58	62	53	81	69	77
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

MINNESOTA REPORT NARRATIVE

VALIDITY CONSIDERATIONS

This adolescent responded to the MMPI-A items in an unusual manner. He claimed an unrealistic amount of virtue while also endorsing a great number of psychological difficulties. This infrequent response pattern reflects some unconventional and possibly extreme beliefs.

Careful evaluation of this individual's response attitudes should be undertaken to explain this unusual validity scale pattern. He may be consciously distorting the test responses to create a particular impression or he may be generally unsophisticated. In addition, he may be somewhat inconsistent in his responses to the MMPI-A items. Therefore, caution should be used in interpreting his test results.

This is a valid MMPI-A. The individual's scores on the validity scales suggest that he was cooperative enough with the evaluation to provide useful clinical scale information. The resulting MMPI-A protocol should be interpreted with caution although it is likely to be valid.

SYMPTOMATIC BEHAVIOR

This adolescent's MMPI-A clinical scales profile indicates severe psychological problems. He has unusual thinking and may exhibit strange behavior. Others may see him as odd or different.

Severe emotional problems and lack of control are likely. He appears to be angry and alienated, and he tends to act out impulsively and unpredictably. He may engage in dangerous or extremely pleasure-oriented behavior just for the thrill of it. He may have maladaptive sexual behaviors. He is likely to be viewed as immature and irresponsible. Poor achievement and problems with authority are likely. His acting-out behavior may involve drug or alcohol use.

INTERPERSONAL RELATIONSHIPS

He appears to have problems with social skills, and although he is insecure in relationships, he may manipulate others through aggression and intimidation. He is overly sensitive and frequently misunderstands the motives of others.

Severe family discord is an important part of his problem situation. His family is characterized by jealousy, fault finding, anger, serious disagreements, lack of love and understanding, and limited communication. He does not believe he can count on his family in times of trouble. He looks forward to the day when he can leave home for good. He often feels as if his parents punish him without cause, treating him as if he were a child. His parents may dislike and complain about his peer group. Problems within his family may spill over into school and may be related to poor academic performance and school-behavior problems.

He may have a history of delinquent, hostile, or aggressive behavior. He may also display neurotic behavior such as internalizing, dependency, and withdrawal.

BEHAVIORAL STABILITY

His clinical profile shows very high profile definition. His peak scores are likely to remain very prominent in his profile pattern if he is retested at a later date. This is a pattern of maladjustment likely to include periods of "chaotic" situational problems.

DIAGNOSTIC CONSIDERATIONS

The possibility of a psychotic process should be ruled out, given his clinical scales profile. Developing personality problems should also be considered. His MMPI-A pattern suggests the possibility of a schizoid life adjustment. This adolescent's extreme elevation on the School Problems scale suggests that an evaluation of academic skills deficits, as well as disruptive behavior disorders such as attention-deficit hyperactivity disorder, should be included in his diagnostic assessment.

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.

TREATMENT CONSIDERATIONS

The MMPI-A clinical scales profile indicates a need to rule out a possible thought disorder before definitive treatment plans can be formulated. This young person is likely to be emotionally distant and alienated from others, including his therapist. The therapist will probably have trouble establishing a relationship. Considerable reassurance may be helpful. A psychiatric consultation is advised to determine if medications are appropriate.

ITALY

MMPI-A Version Administered: Unpublished Italian translation

Case: Federico

Setting: The patient, Federico (not his real name), was evaluated in a public facility, the Service of Counseling for Adolescence, which specializes in psychological disorders of adolescents and where two psychiatrists carry out diagnosis, counseling, and pharmacological and psychological therapy.

Identifying Information

Age: 17 years, 1 month

School: Grade 11

Gender: Male

Reason for Referral

The psychiatric counselor of the hospital, where Federico was admitted following his attempted suicide, referred him to the Service.

Presenting Problem

Ten days before the MMPI-A administration, Federico made a serious suicide attempt by hanging. After having tied a rope round his neck, he threw himself from the stair-well in his house. Then, when he realized the extent of the neck injuries, he changed his mind and managed to scramble up the stairs, to open a door (he said he had been able to do this because of the survival course he had attended) and call the Emergency Service. He then fainted.

In a cyanotic state, he was admitted to the neurological ward of the hospital for anoxia. While he was in the hospital (only a day), because of the risk of serious cerebral suffering, an EEG was administered which showed clear signs of subcortical dysfunction. Later, a follow-up EEG was administered with good results: the dysfunction was absent. Moreover, during the time spent in the hospital, a psychiatric counselor carried out an interview with Federico's parents, who seemed very distant and inclined to minimize the son's attempted suicide, and an interview with Federico himself.

Parental Report

They stated that, during the days before the attempted suicide, Federico's behavior had seemed completely normal. However he had actually for some time been planning the details of his attempted suicide with lucidity and rationality (in fact, he had been preparing the necessary equipment and he had been calculating his parents movements and absences).

Subject's Report.

Federico attributed his behavior to his scholastic problems, with particular reference to:

- the strong hate and aversion for the school he is attending (a commercial and business institute);
- the fear of getting bad marks;
- and, consequently, the dread of dropping in grades and so repeating a year in the same school.

Moreover, according to Federico's report, his family seemed to exert a significant pressure with regard to school. More exactly, they had high expectations of their son's scholastic performance and consequently Federico was afraid of disappointing his parents.

Note: Federico's psychiatrist also reported some depressive symptoms and sleeping problems.

Family Structure and Background

Federico's family consists of his parents and his elder brother, who is 25 years old. Both his father and his mother completed a high-school education. They are currently book-keepers/accountants and had had the same high school education that Federico is at the moment doing. His father had spent some time (unspecified) in further education.

His brother is attending University (commercial and business studies), has excellent marks and is about to get a degree in Economics. Federico and his family live in a textile town in the center of Italy, with a middle-high social and economical status even if with some small areas of deprivation.

Educational Background and Experience

The client is attending a technical high school (grade 11) and is doing commercial and business studies. He hates his school and the subjects he has to study, has bad marks and has had a course failure.

Social Experiences and Life Events

Interpersonal relationships. Federico has many friends and participates in peer groups; he is extroverted and bright; he establishes good relationships with his peers, both males and females, and he has had some relationships with girls.

Hobbies His psychiatrist told us that Federico takes part in some high risk activities, such as free-climbing, with fearlessness and exuberance; he often practices these hobbies without his parents' knowledge or against their wishes. Sometimes, during these activities, he has participated in some very dangerous episodes. Moreover, in the past, he attended a survival course. Finally, he participates in catholic service activities. Furthermore, on the *Biographical Form-Adolescent* the subject states that he takes part in some extra-scholastic activities, such as band/orchestra, clubs, drama, service. This seems to confirm his strong social orientation and engagement in social activities.

Events Federico's psychiatrist reported to us that in the last year the subject has had seven serious accidents, most of them while riding on a moped. The last of these was a car accident: he was with some of his friends and one of them was driving; he was the only person unhurt, he was able to get out of the car and call and organize aid.

On the *Life Events Form-Adolescent* Federico reports that in the last six months he has experienced many events which have had different effects on him. For example, in the area of interpersonal relationships, he has experienced the loss of loved people, such as a grandparent and a close friend, who have died, and has had arguments with his parents: these events have had a negative impact.

Moreover he reports some discipline and performance scholastic problems which he has appraised as having a positive effect on his own life. With regard to social context, he states that he has had some relationships with girls, that he is a member of some groups and organizations, and moreover that he has had some outstanding achievement (events with positive effects on himself): this confirms again his relevant social orientation and brightness.

Finally, we may note that the client reports that his referral to a counselor or psychotherapist has had a positive impact. This could be an important indication of a possible positive orientation toward the psychological treatment.

Psychiatrist's Notes

Federico's psychiatrist has highlighted the following characteristics which emerge especially from Hobbies and Events:

- strong sensation seeking;
- passion for high-risk experiences;
- attitude of challenge toward death.

DSM-IV Diagnosis

Formal DSM-IV diagnosis made by a psychiatrist and a psychologist would be:

- Axis I: *Impulse-Control Disorder Not Otherwise Specified (NOS)*, that is reason for visit, and *Mood Disorder Not Otherwise Specified (NOS)*
- Axis II: *None*
- Axis III: *None*
- Axis IV: *Problems with Primary Support Group (family) and Educational Problems (school)*. More exactly, the client has disagreements with his family (his parents are very demanding; with regard to school, the subject is

compared with his brother who is very good at school), has bad scholastic performances and hates the school he is attending.

Treatment or Intervention

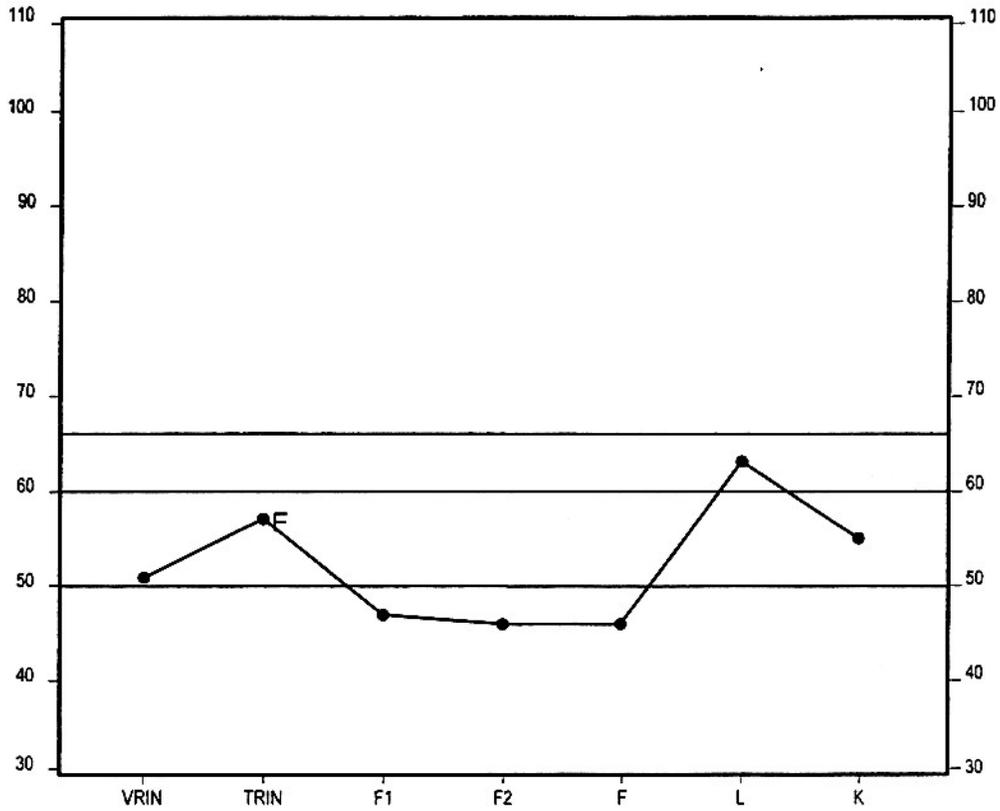
During the time spent in the hospital, he was placed on emergency light sedatives such as Valium. In the Service of Counseling for Adolescence, psychological treatment consists of two parallel sessions carried out by two different psychiatrists:

- sessions of individual counseling with the client to give the subject support and to investigate the degree of seriousness of his risk behavior;
- sessions of family counseling with his parents to explore and redefine their expectations toward Federico.

During the counseling with his parents, it was noted that they are not as distant as they seemed initially and that they seem to be less demanding and severe with regard to school. In October of this year, Federico had a follow-up counseling session with his psychiatrist who reported that he seems to be well, probably because his parents have moderated their attitude and he has changed schools. At the moment Federico is attending a private commercial and business school and is very pleased with it.

Nevertheless, his psychiatrist still underlines his high risk personality.

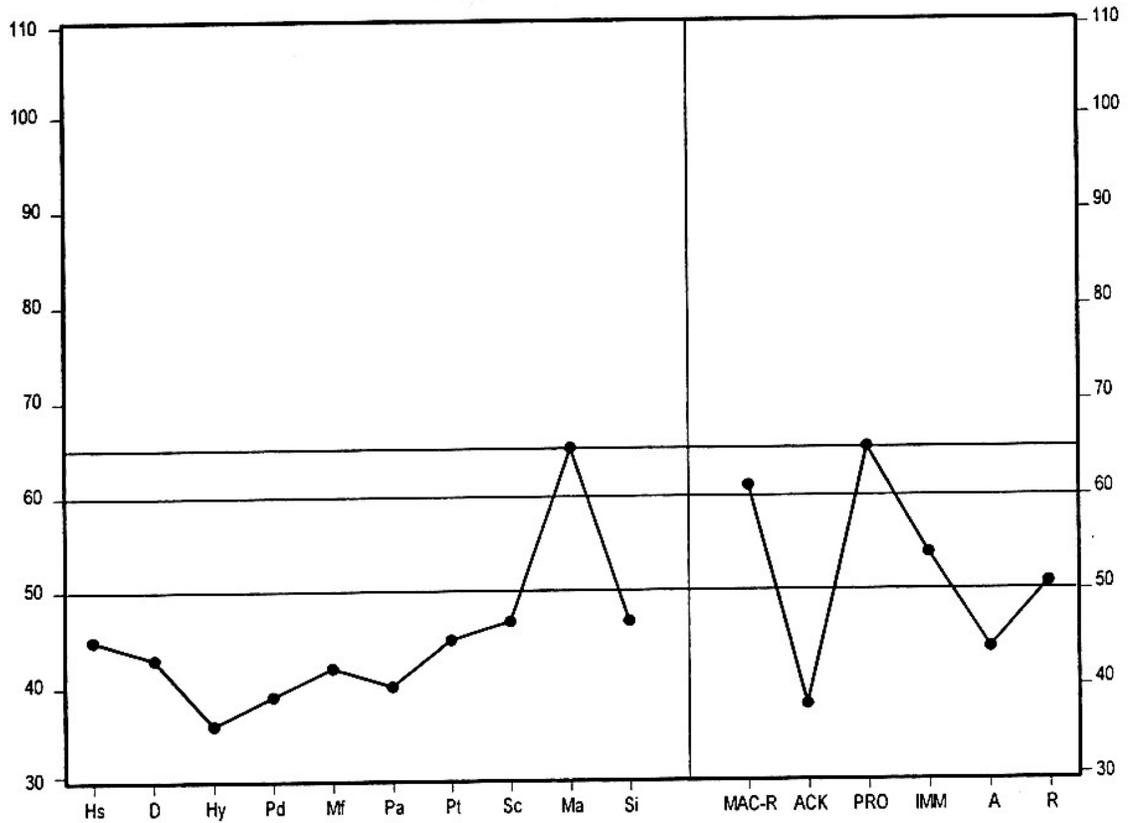
MMPI-A VALIDITY PATTERN



Raw Score:	5	8	3	3	6	6	15
T-Score:	50	57	47	46	46	63	55
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): Percent True: Percent False:

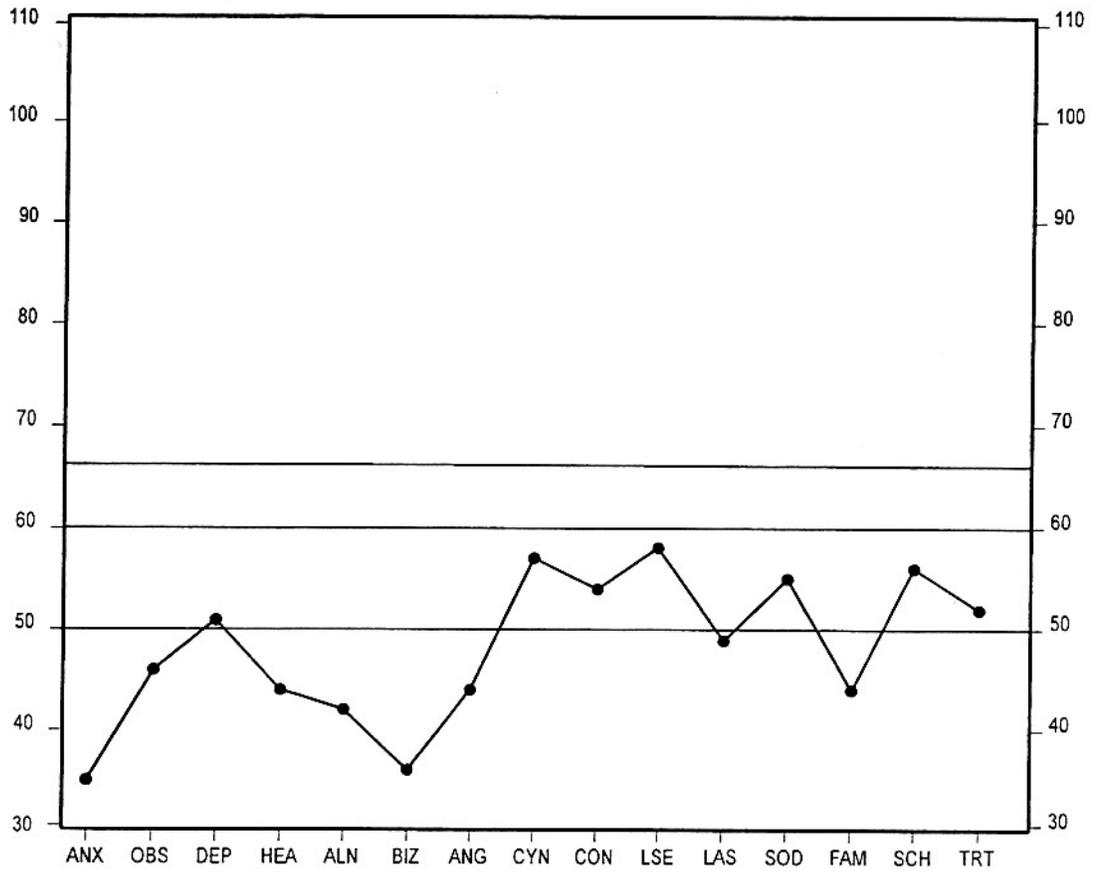
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	5	15	13	13	18	8	14	19	28	24	26	1	23	16	10	14
T-Score:	45	43	36	39	42	40	45	47	65	47	61	38	65	54	44	51
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: B-150 17 23 3 42 4 1 1 1
 Mean Profile Elevation: 45.71

MMPI-A CONTENT SCALES PROFILE



Raw Score:	1	6	8	4	3	0	6	16	12	8	6	11	8	9	11
T-Score:	35	46	51	44	42	36	44	57	54	58	49	55	44	56	52
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

THE MINNESOTA REPORT NARRATIVE

VALIDITY CONSIDERATIONS

He presented himself in a somewhat defensive manner, claiming more personal virtue than people generally do. This self-image might reflect membership in a subcultural group that values strong moral character. However, this pattern is also found among individuals who consciously distort their answers to project a favorable self-image or who have unrealistically positive views of their own virtue.

Although the MMPI-A profile configuration suggests some defensiveness, it is valid and probably provides a reasonably good appraisal of the individual's personality. It should be kept in mind, however, that the individual has attempted to present an overly virtuous image and that the MMPI-A profiles may underestimate problems. Adolescents who present themselves in this manner may have little insight into their psychological state.

SYMPTOMATIC BEHAVIOR

This client's MMPI-A clinical scales profile shows relatively few psychological problems at this time. He appears to be energetic, enthusiastic, and busy. He is involved in numerous activities. Although he appears to be very self-confident, he may overestimate his capabilities and overextend himself with projects that he has difficulty completing.

Although he has a natural tendency to deny problems, he may experience some difficulties in controlling his behavior. He may have problems with authority figures and he may resent their interference. Risk-taking behaviors, including problematic use of alcohol or other drugs, may occur.

Adolescent boys with this MMPI-A clinical profile configuration have one of the most frequent high-point scales, the Ma score, found in adolescent treatment units. Over 10% of boys in treatment programs have this well-defined high point in their profile. It should be noted that this high-point score is also the most frequent peak for well-defined profile configurations in the normative sample (over 12%), although it usually has a lower level of elevation than in treatment samples.

INTERPERSONAL RELATIONS

At times his self-centered behavior is likely to produce interpersonal conflict. He is not very open to considering his contribution to these difficulties.

He has an average interest in being with others and is not socially isolated or withdrawn. He appears able to meet and talk with other people and does not seem overly anxious in social gatherings.

BEHAVIORAL STABILITY

The relative elevation of the highest scale (Ma) in his clinical profile shows very high profile definition. His peak scores are likely to remain very prominent in his profile pattern if he is retested at a later date.

DIAGNOSTIC CONSIDERATIONS

No clinical diagnosis is provided for this MMPI-A clinical scales profile. However, possible authority problems and impulsivity should be evaluated.

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, he has not acknowledged through his item responses that he has problems with alcohol or other drugs.

TREATMENT CONSIDERATIONS

Adolescents with this clinical profile who are in inpatient treatment settings usually see no need for therapy. If the other MMPI-A profiles or additional assessments reveal no further problems, they may enter therapy only at the insistence of others. Under these circumstances, behavior change will be difficult to accomplish.

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 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.

GREAT BRITAIN

MMPI-A Version Administered: English

Case: Ashley

Setting: The client was evaluated in a Care and Educational environment combined. The organization specializes in caring for children who are behaviorally challenged, and have been excluded from mainstream education.

Identifying Information

Age: 15 yrs 11 months

School: Grade 10

Gender: Male

Reason for Referral

Ashley's progress was monitored while an evaluation of the care environment took place. The assessments were done as a pre- and post-treatment analysis. He has a history of malicious outbursts. Daily prodding, kicking and finger poking was normal behavior. There were incidents of criminal damage, lying, mood swings. He rejected authority at home and at school. He had been excluded from mainstream school and often absconded from care.

Recently, he had presented as angry and bewildered, he caused a great deal of damage to his foster parents' motor vehicle, showing no remorse whatsoever. He freely admitted that he had caused the damage. He appeared proud of his actions. His use of bad language and bad attitude increased as he refused point blank to attend usual therapy sessions.

The assessment included a Full Scale Intelligence Quotient, (88) above 21% of his age peers in Great Britain. Also, an MAC (Macmillan assessment) provided a Comprehension reading age of 10.4 yrs. and an accuracy age of 9.2 yrs.

Family Structure and Background

Ashley has limited contact with his birth mother and two younger sisters. His father received a custodial sentence early on. This was for neglect, Unlawful sexual Intercourse with a 13-year-old, and dishonesty. He was taken into the care of a Local Authority. He now lives with foster parents. He was placed upon a Child Protection Register. He was the subject of neglect, physical and sexual abuse at a very early age.

At a later date, he disclosed persistent sexual abuse by his father. He often reflects on the terrible childhood he experienced at the hands of his father, his family was dysfunctional and the mother was unloving and unconcerned.

Ashley revealed abuse by foster parents. Subsequently the boy was moved between foster placements by the local authority. There were eleven different families in twenty different towns. He has failed to make any significant attachments. This was despite the opportunities that have been presented to him.

Eventually, he was placed within the present care organization. He made contact with his mother and sisters for the first time in ten years.

Living Arrangements

At the time of the assessment, the young man had recently made the transition from a secure unit into a foster home once again. He lives as a member of the foster family. He has a room of his own and shares the daily routines of family life.

Kind of Environment

The young man lives in a structured environment, materially secure. An individual progress report is prepared periodically. The reports are worked with to provide a consistent care environment. In general he is disciplined using a reward and punishment design. There is a counselor and therapist available. Home, school and local authority work together to provide a consistent and secure environment.

Educational Background and Experience

Mainstream school is not a realistic option for this boy. His refusal to attend a mainstream school caused many problems. He was attending an exclusive one to one school environment at the time of the assessment. He was in grade 10 and remains an enthusiastic student within the school environment. He continues to work hard at his studies. He is much more able to work alone rather than craving teachers' attention. At the present time the boy is working hard toward his General Certificates of Secondary Education. He takes great pride in his work. He is not a keen sportsman, but enjoys swimming and has won swimming medals in the past.

Past negative behavior in the classroom setting has been due to his fear of failure. Also it may be attributable to his insistence that nothing should be wrong. He is now more able to make mistakes without viewing them as personal failure.

Presenting Problem

All persons involved with the boy expressed concerns regarding Ashley's recently deteriorating behavior. Also the potential he has for disruption and violence. He does not easily make friends. He gravitates toward much younger children, who find his childlike manner appealing. He seems unable to understand why these relationships may not be entirely appropriate.

Description of Client's Symptoms and Behavior

As a result of abuse, he presents as someone whose life and past experience is incoherent and incomprehensible to him. He has a friendly personality, but his temperament can be very changeable. His behavior when not contained by an adult is without boundaries. He is antagonistic to other children and inviting of attack. Also, he is given to "temper tantrums." Displaying a basic mistrust of adults presenting a (False Self). Ashley mixes only with younger children. He does not recognize any reason not to. He cannot distinguish right from wrong. He has poor social skills with inappropriate sexualized behaviors. This has most recently been brought to attention in reports from the care placement.

He refuses to attend an alternative therapy program. The foster parents are anxious that therapy continues for the boy. An individual's progress is closely monitored in the care organization, and all have expressed concern about the boy's recently deteriorating behavior. Also, his potential to 'play staff off against each other'

Ashley states that he thinks that if he continues to behave in this manner, he will be sent back to his home town. He appears confused as to what this actually means in practice. He is a slim dark haired young man. He is just starting to show signs of facial hair, he has a fairly clear complexion, with a 'modern' set of braces for his teeth. He is a moderately clean young man, with a tidy hair cut. He tells lies frequently about himself, even when he knows that the truth is probably known. At the time of the assessment he stated, "I've done three MMPI-A tests already." He appears to build a fantasy world around himself.

For example he stated, "When I go home I don't watch any T.V. at all. I go straight to bed and don't have any tea or breakfast!"

At the time of assessment the boy was 'manageable' he behaved well, paying attention to what was said. However, usually he has an extreme lack of social skills. He shows a marked difference from boys of a similar age. In social situations he tends to be targeted and becomes a 'misfit'.

He has very low self-esteem. He stated that he "felt nowhere near good enough for his foster parents" as "No one had ever believed in him before" The foster parents believe that his fabrications are his way of impressing them. Although, he appears to respond better to short term goals. These enable him to achieve his aims.

He can be belligerent and difficult. He is given to temper tantrums and self abuse. He becomes violent, often biting the adults who care for him. He has used play therapy extensively. It is thought that the present therapy program has been working for him. However, he has refused to attend recent sessions, or any alternative therapy. This is possibly because of his reluctance to fully disclose detail from his early abuse. His 'false self' personality is heavily defended against the feelings created by his traumatic life.

Use of Drugs and Alcohol

He denied the use of drugs and alcohol at the time of the assessment. There is no knowledge or evidence of controlled drug use. He admitted to drinking and reported that on occasion he gets drunk. He smokes cigarettes.

Confrontation with the Law

He had to be collected from school because of unmanageable behavior. When outside of the school grounds, he absconded. His foster parents followed in a car. He refused to get into the car. He then became violent

and hit the male foster parent. He caused damage to the motor vehicle. A passer-by summoned the police, thinking that the boy was being kidnapped. The young man eventually calmed down, breaking down on the pavement. The police came but no action was taken. Damage was caused to the motor vehicle's rear door and rear seats. The foster parents were bitten and his coat was torn.

DSM-IV Diagnosis

There has been no official psychiatric DSM-IV diagnosis. He does, however, present with symptoms of self-harming behavior and severe attachment problems.

Treatment or Intervention

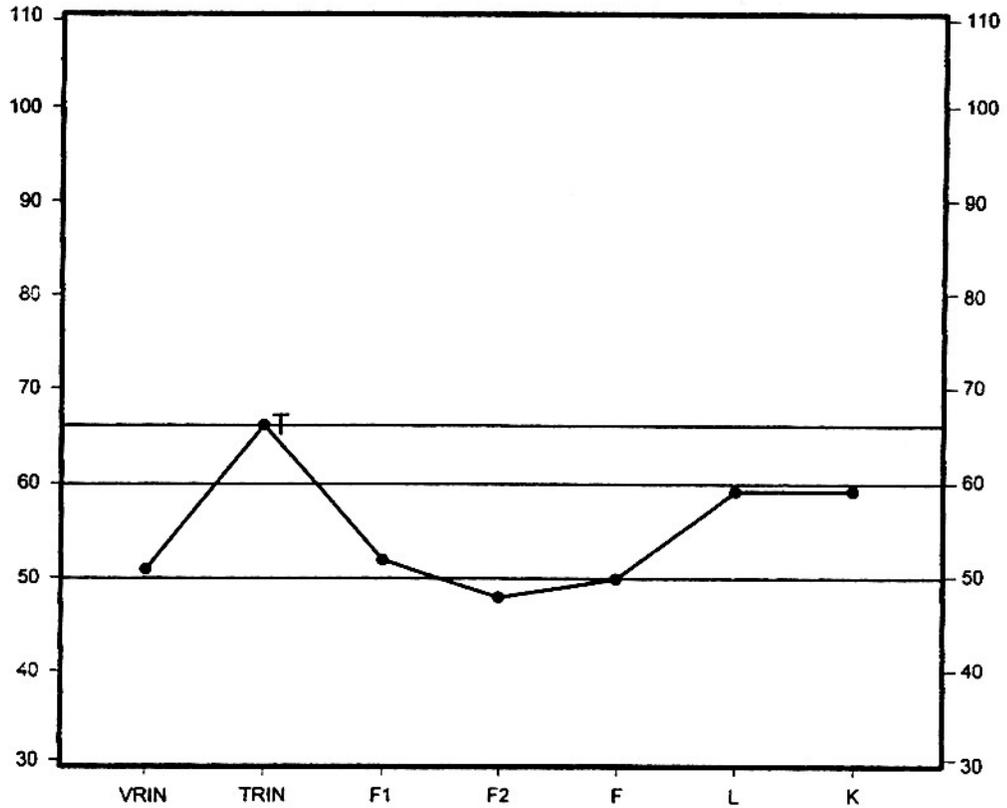
Feedback from pre-treatment assessments recommends he needs consistent long-term relationships. He needs to stay in one location for a significant time. He requires skilled vocational guidance so that he can be helped to make the maximum use of what abilities he has. He requires help and encouragement to make and create worthwhile things that he can take pride in. If he is to have further counseling or therapy, it must be long term and stick rigidly to the tenets of empathy, genuineness, warmth and unconditional positive regard.

Medication

He had no prescribed medication at the time of the assessment.

Play therapy has continued. Alternative therapy sessions are irregular and appointments are often broken. He has recently refused point blank to attend therapy sessions at the care center. The care therapist and young man do appear to have a good relationship and it is hoped that a change of attitude can be brought about in the future. It is felt that the sessions do help him challenge his anti-social behavior.

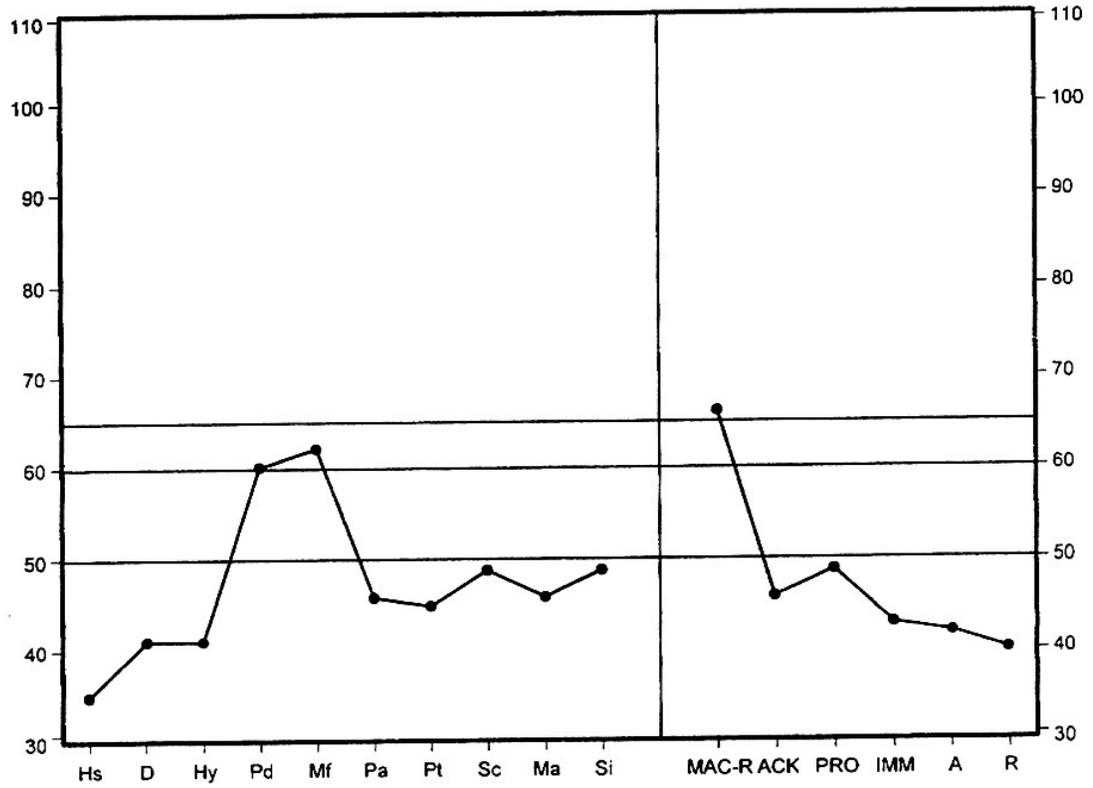
MMPI-A VALIDITY PATTERN



Raw Score:	5	12	5	4	9	5	17
T-Score:	51	66	52	48	50	59	59
Response %:	100	100	100	100	100	100	100

Cannot Say (Raw): 2 Percent True: 44 Percent False: 56

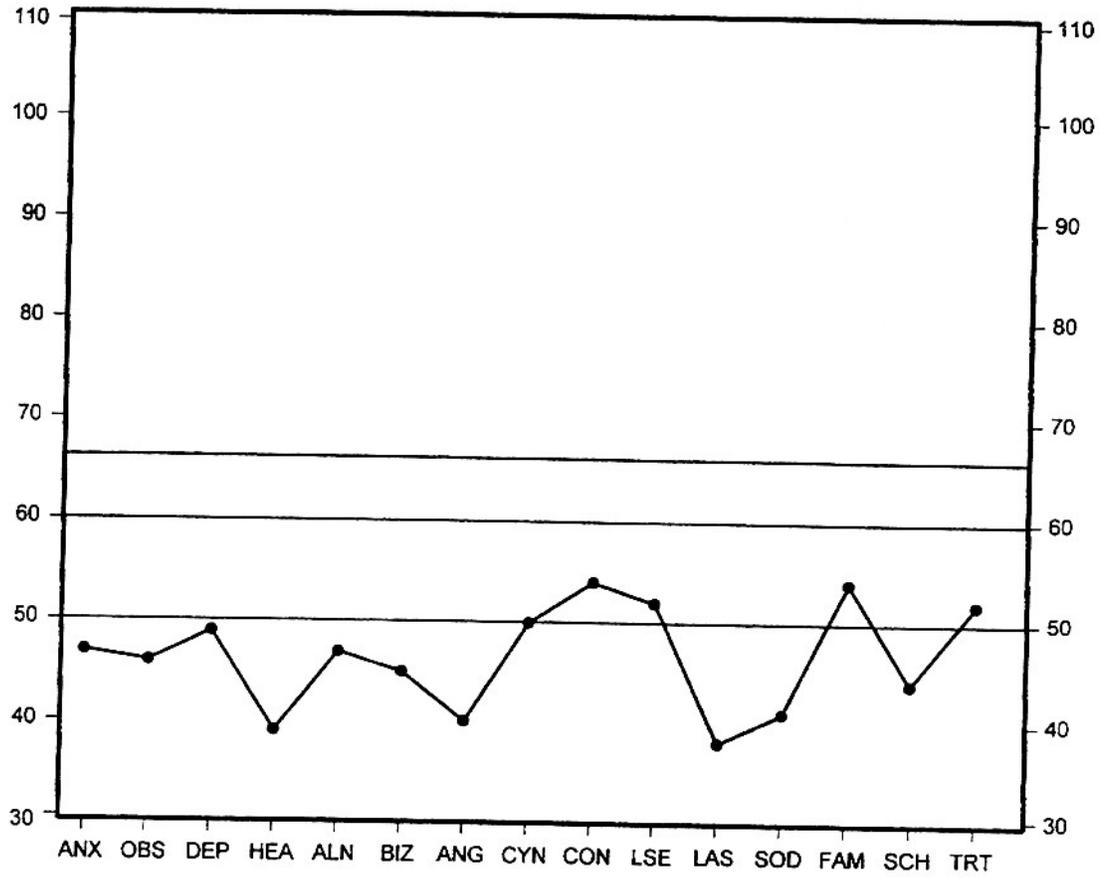
MMPI-A BASIC AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	1	14	16	25	26	11	14	22	20	25	28	3	16	9	9	9
T-Score:	35	41	41	60	62	46	45	49	46	49	66	46	49	43	42	40
Response %:	97	96	98	100	100	100	98	99	100	100	100	100	100	100	97	97

Welsh Code: 54-/80 697 23:1# LKF/
 Mean Profile Elevation: 45.40

MMPI-A CONTENT SCALES PROFILE



Raw Score:	7	6	7	2	5	2	4	14	12	6	2	4	15	4	11
T-Score:	47	46	49	39	47	45	40	50	54	52	38	41	54	44	52
Response %:	100	100	96	100	100	100	100	100	100	100	100	100	100	100	100

MINNESOTA REPORT NARRATIVE

VALIDITY CONSIDERATIONS

This adolescent's approach to the MMPI-A was open and cooperative. The resulting MMPI-A is valid and is probably a good indication of his present level of personality functioning. This may be viewed as a positive indication of his involvement with the evaluation.

SYMPTOMATIC BEHAVIOR

Adolescents with this MMPI-A clinical profile who are being evaluated in an outpatient setting are likely to have some behavior problems. These may include family discord, school-adjustment problems, risk-taking behaviors, or conflicts with authority figures. However, his clinical profile is only moderately elevated on Pd. This elevation is not as extreme as one would expect in a clinical setting. Only limited information is available from the clinical profile. The other MMPI-A profiles or additional assessment techniques may provide more information about his current situation.

This MMPI-A clinical profile contains the most frequent high point, the Pd score, among clinical samples. Over 25% of boys in treatment have this well-defined profile (i.e., with the Pd scale at least 5 points higher than the next scale). Less than 4% of boys in the normative sample have this well-defined high-point profile.

INTERPERSONAL RELATIONS

He has an average interest in being with others and is not socially isolated or withdrawn. He appears able to meet and talk with other people and does not seem overly anxious in social gatherings.

BEHAVIORAL STABILITY

The relative elevation of the highest scale (Pd) in his clinical profile shows very high profile definition. His peak scores are likely to remain very prominent in his profile pattern if he is retested at a later date.

DIAGNOSTIC CONSIDERATIONS

No diagnosis is suggested by his moderately elevated MMPI-A clinical profile.

He appears to be having difficulties that may involve the use of alcohol or other drugs. He probably enjoys risky activities and being the center of attention. However, he has not acknowledged through his item responses that he has problems with alcohol or other drugs.

TREATMENT CONSIDERATIONS

His clinical scales profile suggests that he views his adjustment as adequate and probably does not feel the need for mental health treatment at this time. If he is being considered for treatment, perhaps at someone else's insistence, his motivation to change his behavior may need to be discussed with him before treatment can proceed effectively.

His very high potential for developing alcohol or drug problems requires attention in therapy if important life changes are to be made. However, his relatively low awareness of or reluctance to acknowledge problems in this area might impede treatment efforts.

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.

References

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