



SAMPLE REPORT

Case Description: John G.— General Medical Interpretive Report

John G., a 55-year-old employee of an automobile manufacturing firm, was seen for a medical evaluation of severe gastrointestinal complaints. The medical examination was negative, and he was referred to a health psychologist to determine if his frequent medical visits and chronic “weak stomach” complaints were psychological in origin.

Mr. G. has a history of stomach problems in recent months, for which he has sought medical attention on two occasions. His medical history includes two hospitalizations: the first resulted from injuries he received in a farming accident when he was 19; the second occurred when he had an appendectomy at age 21. His current symptoms include severe pain in his left side, constipation, low energy, and lack of interest in activities that he used to enjoy.

In the initial interview, Mr. G. was cooperative and open about his medical symptoms but was reluctant to discuss possible psychological factors. He stated that his symptoms have intensified over the past few months. He reported that he drinks socially but denies having problems with alcohol use. He denied drug use. He takes over-the-counter medication for relief of his stomach distress.

Mr. G. is a high school graduate. He has been married for 30 years and has two adult children who are currently living in other states. His wife is employed in a floral shop. Mr. G. currently receives unemployment benefits because he has been on temporary layoff for the past six months as a result of company reorganization. A number of younger employees in his department have been laid off permanently, but because of his seniority he remains on temporary layoff. He is pessimistic about being called back to work and has thought about seeking other employment, but he considers his age and limited experience outside the field of automobile assembly a hindrance. After he graduated from high school, he worked for several years on a family farm, but the farm was sold several years ago.

Case descriptions do not accompany MMPI-2 reports, but are provided here as background information. The following report was generated from Q-global™, Pearson’s web-based scoring and reporting application, using Mr. G.’s responses to the MMPI-2. Additional MMPI-2 sample reports, product offerings, training opportunities, and resources can be found at PearsonClinical.com/mmpi2.



General Medical Interpretive Report

MMPI®-2

The Minnesota Report™: Adult Clinical System-Revised, 4th Edition

James N. Butcher, PhD

Name:	John G.
ID Number:	2514
Age:	55
Gender:	Male
Marital Status:	Married
Years of Education:	12
Date Assessed:	1/31/14



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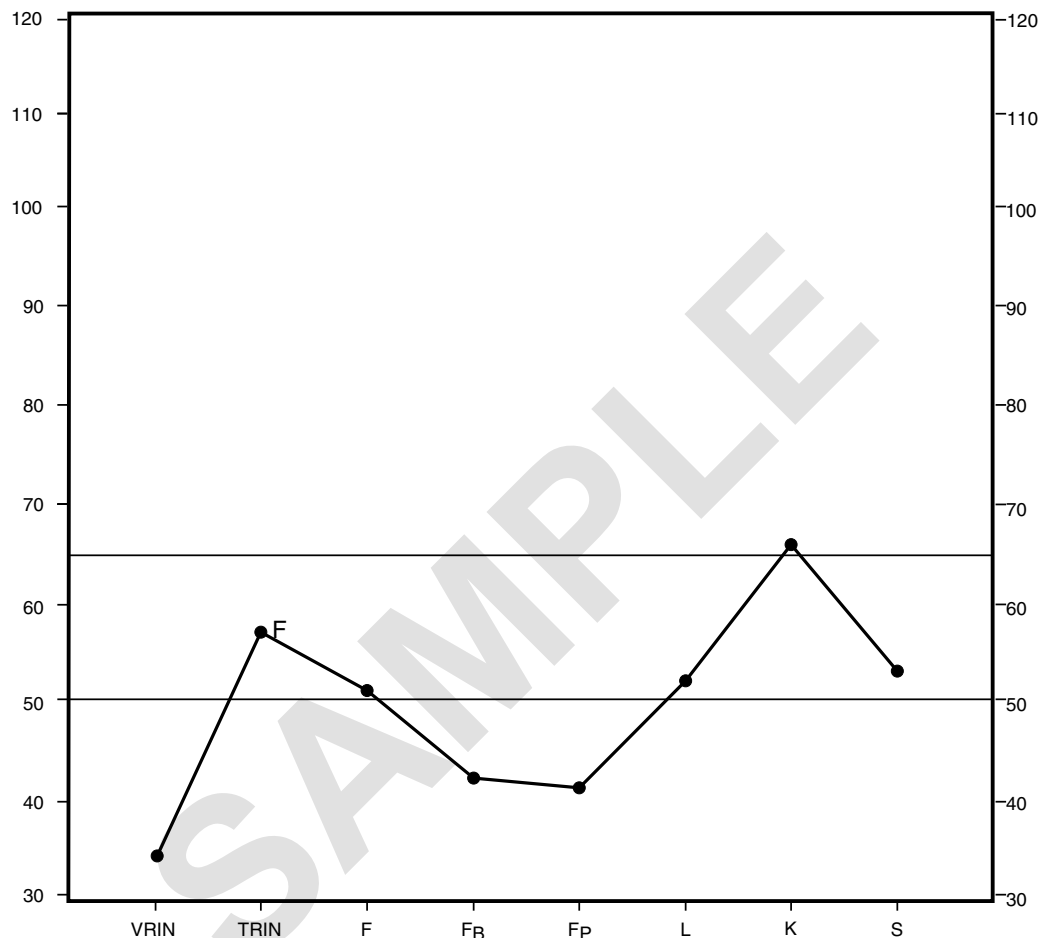
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[9.5 / 1 / QG]

MMPI-2 VALIDITY PATTERN

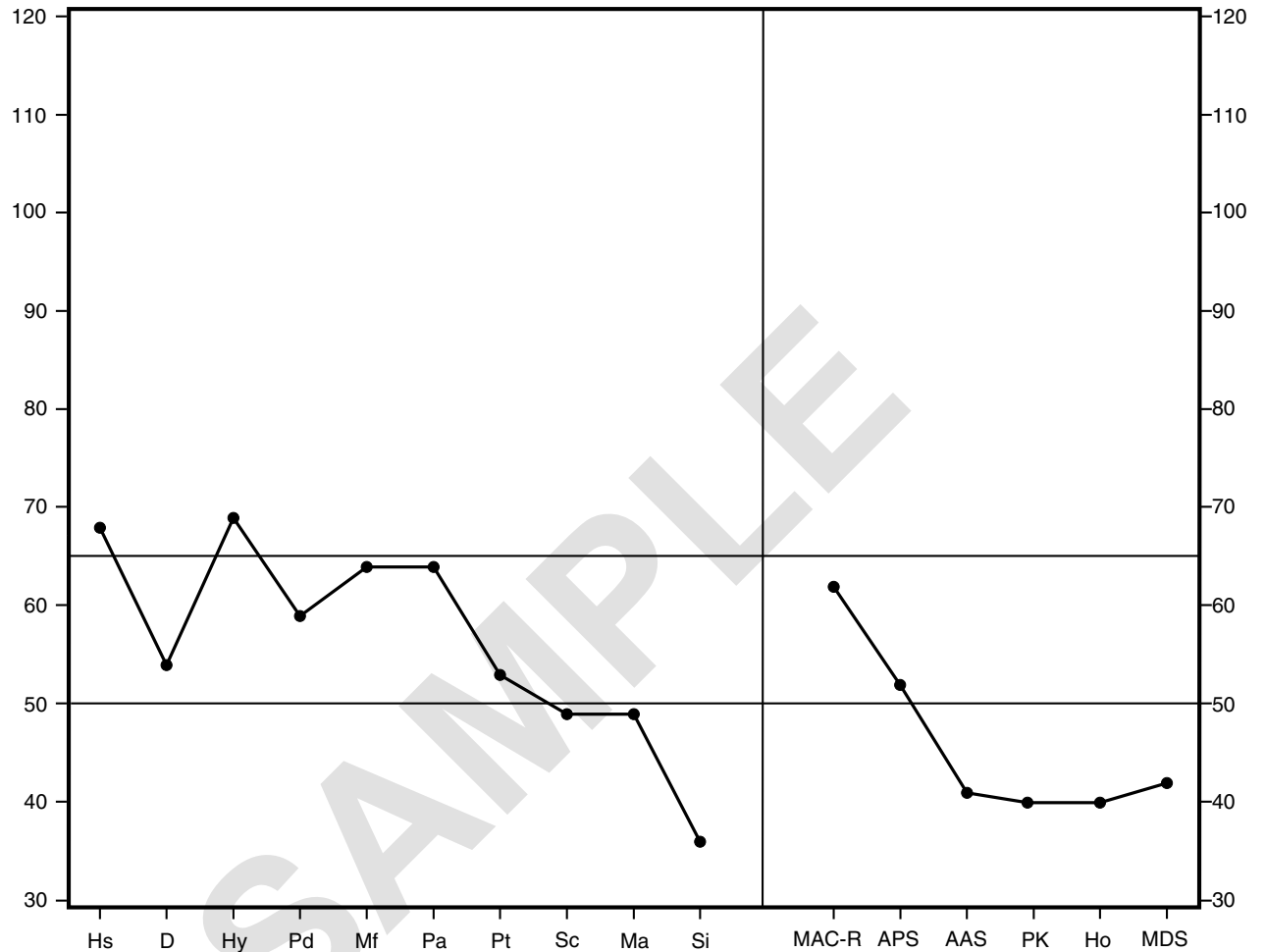


Raw Score:	1	8	5	0	0	4	23	28
T Score:	34	57F	51	42	41	52	66	53
Response %:	100	100	98	100	100	100	100	96

Cannot Say (Raw): 6
Percent True: 31
Percent False: 69

	Raw Score	T Score	Resp. %
S1 - Beliefs in Human Goodness	8	52	93
S2 - Serenity	9	61	100
S3 - Contentment with Life	2	40	100
S4 - Patience/Denial of Irritability	4	49	88
S5 - Denial of Moral Flaws	5	65	100

MMPI-2 CLINICAL AND SUPPLEMENTARY SCALES PROFILE

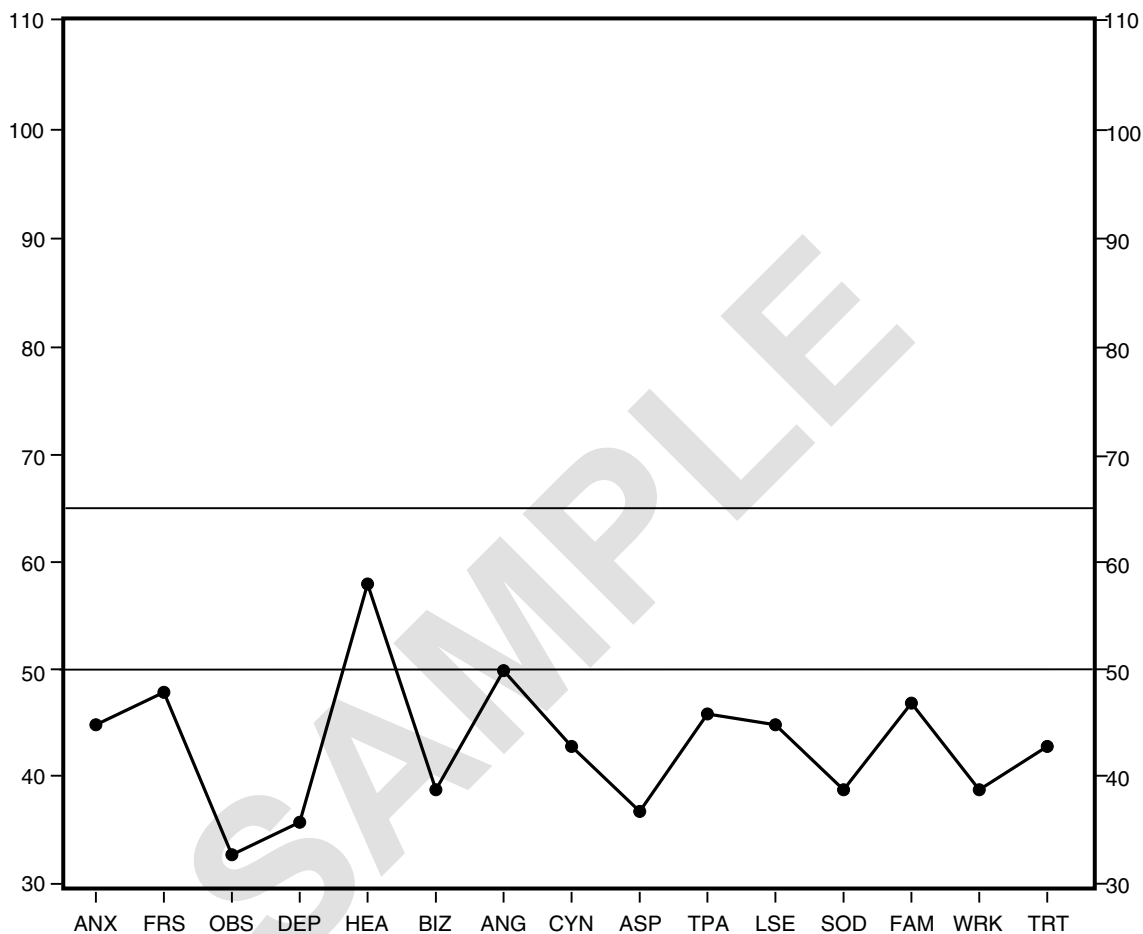


Raw Score:	8	20	29	18	33	14	5	3	15	12	26	24	1	2	10	1
K Correction:	12			9			23	23	5							
T Score:	68	54	69	59	64	64	53	49	49	36	62	52	41	40	40	42
Response %:	100	98	100	98	100	100	98	99	98	97	100	100	100	98	98	93

Welsh Code: 31+56-427/89:0# K+-LF/

Profile Elevation: 58.1

MMPI-2 CONTENT SCALES PROFILE



Raw Score:	3	3	0	0	8	0	6	5	2	7	2	2	4	2	2
T Score:	45	48	33	36	58	39	50	43	37	46	45	39	47	39	43
Response %:	100	100	100	100	97	96	94	96	100	95	100	100	96	97	100

PROFILE VALIDITY

The client omitted 6 items on the MMPI-2. Although this is not enough to invalidate the resulting MMPI-2 clinical profile, some of his scale scores may be lower than expected because of these omissions. It may be helpful to talk with him to determine the reasons for his item omissions. Many clinicians prefer to readminister the omitted items (listed at the end of this report) to ensure the most complete and accurate interpretation possible.

The pattern of his item omissions should be carefully evaluated. He omitted from 10 to 15% of the items on Scales Pd1, BIZ2, and ANG2. Omitting items may result in an underestimate of the problems measured by the affected scales. He omitted from 16 to 25% of the items on Scale TPA1. Caution should be exercised in interpreting the affected scales because 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 if there are omitted items, the score probably underestimates problems reflected by the scale.

The client approached the items in a rather defensive manner. His overcautious and evasive manner suggests that he is quite concerned with his social image and is reluctant to disclose much about his personal adjustment. He appears to be rather intolerant of others' weaknesses and is generally unaccepting of others' unconventional beliefs.

In a medical setting, individuals with this validity profile are often not willing to view their problems as psychological. They have a low degree of "psychological-mindedness" and not much insight into their problems. They are inclined to view their personal problems as physical. Individuals with this profile also may be presenting a favorable social image so that the evaluation will not center on their conscious motivation to deny psychological problems. The patient's MMPI-2 profile should be interpreted with care because evasive performances like this usually result in profiles that underestimate problems. Medical patients with this validity profile are usually resistant to a referral for psychological treatment.

SYMPTOMATIC PATTERNS

The clinical scale prototype used in the development of this narrative included prominent elevations on Hs and Hy. His MMPI-2 clinical profile presents a rather mixed pattern of symptoms in which somatic reactivity under stress is a primary difficulty. The client presents a picture of physical problems and a reduced level of psychological functioning. The client is likely to have a hysteroid adjustment to life and may experience periods of exacerbated symptom development under stress. Some individuals with this profile develop patterns of "invalidism" in which they become incapacitated and dependent on others. His physical complaints may be vague, may have appeared suddenly after a period of stress, and may not be traceable to actual organic changes. He may be manifesting fatigue, vague pain, weakness, or unexplained periods of dizziness. He may view himself as highly virtuous and he may show a "Pollyannish" attitude toward life. Such clients may not appear greatly anxious or depressed about their symptoms and may exhibit "la belle indifférence." Apparently sociable and rather exhibitionistic, this individual seems to manage conflict by excessive denial and repression.

In addition, the following description is suggested by the client's scores on the content scales. He appears to have good social skills and tends to deny that he has any problems interacting with other

people.

PROFILE FREQUENCY

It is usually valuable in MMPI-2 clinical profile interpretation to consider the relative frequency of a given profile pattern in various settings. The client's MMPI-2 high-point clinical scale score (Hy) was found in 12.1% of the MMPI-2 normative sample of men. However, only 3.8% of the normative men had Hy as the peak score at or above a T score of 65, and only 2.3% had well-defined Hy spikes. This elevated MMPI-2 profile configuration (1-3/3-1) is rare in samples of normals, occurring in 1.8% of the MMPI-2 normative sample of men.

The relative frequency of his profile in various medical settings is informative. In the Pearson medical sample, Hy was the most frequent MMPI-2 high-point clinical scale score, occurring in 20.7% of the men. In addition, 16.3% of the men had the Hy scale spike at or above a T score of 65, and 9.3% had a well-defined Hy high point in that range. His elevated MMPI-2 profile configuration (1-3/3-1), in this elevation range, is very common in samples of medical patients. It occurred in 16.4% of the men in the Pearson medical sample.

PROFILE STABILITY

The relative elevation of his highest clinical scale scores suggests some lack of clarity in profile definition. Although his most elevated clinical scales are likely to be present in his profile pattern if he is retested at a later date, there could be some shifting of the most prominent scale elevations in the profile code. The difference between the profile type used to develop the present report (involving Hs and Hy) and the next highest scale in the profile code was 4 points. So, for example, if the client is tested at a later date, his profile might involve more behavioral elements related to elevations on Pa. If so, then on retesting, externalization of blame, mistrust, and questioning the motives of others might become more prominent.

INTERPERSONAL RELATIONS

Individuals with similar profiles tend to be somewhat passive-dependent and demanding in interpersonal relationships. The client may attempt to control others by complaining of physical symptoms. He is likely to experience low sexual drive and may have problems in his marriage because of this. He seems to require an excessive amount of emotional support from his spouse. His physical complaints are likely to be used to gain attention for his perceived illness.

Quite outgoing and sociable, he has a strong need to be around others. He is gregarious and enjoys attention. Personality characteristics related to social introversion-extraversion tend to be stable over time. The client is typically outgoing, and his sociable behavior is not likely to change if he is retested at a later time.

DIAGNOSTIC CONSIDERATIONS

Individuals with this profile typically exhibit a neurotic pattern of adjustment and would probably receive a clinical diagnosis of Conversion Disorder or Somatization Disorder. They might also receive an Axis II diagnosis of Dependent Personality.

TREATMENT CONSIDERATIONS

The client will probably be resistant to mental health treatment because he has little psychological insight and seeks medical explanations for his disorder. He is probably defensive and reluctant to engage in self-exploration. In addition, he seems to experience little anxiety over his situation and may have little motivation to change his behavior. Some individuals with this profile respond to placebos or mild suggestion or to stress inoculation training 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 profile often terminate treatment early.

ADDITIONAL SCALES

	Raw Score	T Score	Resp %
Personality Psychopathology Five (PSY-5) Scales			
Aggressiveness (AGGR)	10	54	100
Psychoticism (PSYC)	1	40	96
Disconstraint (DISC)	13	46	97
Negative Emotionality/Neuroticism (NEGE)	5	43	100
Introversion/Low Positive Emotionality (INTR)	12	52	100
Supplementary Scales			
Anxiety (A)	0	36	100
Repression (R)	12	43	100
Ego Strength (Es)	41	58	100
Dominance (Do)	19	58	100
Social Responsibility (Re)	22	55	100
Harris-Lingoes Subscales			
Depression Subscales			
Subjective Depression (D ₁)	4	42	100
Psychomotor Retardation (D ₂)	4	43	100
Physical Malfunctioning (D ₃)	5	67	91
Mental Dullness (D ₄)	2	48	100
Brooding (D ₅)	0	40	100
Hysteria Subscales			
Denial of Social Anxiety (Hy ₁)	6	61	100
Need for Affection (Hy ₂)	11	67	100
Lassitude-Malaise (Hy ₃)	4	57	100
Somatic Complaints (Hy ₄)	3	52	100
Inhibition of Aggression (Hy ₅)	3	48	100
Psychopathic Deviate Subscales			
Familial Discord (Pd ₁)	1	45	89
Authority Problems (Pd ₂)	4	53	100
Social Imperturbability (Pd ₃)	6	63	100
Social Alienation (Pd ₄)	4	50	100
Self-Alienation (Pd ₅)	2	43	100
Paranoia Subscales			
Persecutory Ideas (Pa ₁)	3	58	100
Poignancy (Pa ₂)	3	55	100
Naivete (Pa ₃)	8	65	100

	Raw Score	T Score	Resp %
Schizophrenia Subscales			
Social Alienation (Sc ₁)	1	43	95
Emotional Alienation (Sc ₂)	1	50	100
Lack of Ego Mastery, Cognitive (Sc ₃)	1	48	100
Lack of Ego Mastery, Conative (Sc ₄)	1	44	100
Lack of Ego Mastery, Defective Inhibition (Sc ₅)	0	40	100
Bizarre Sensory Experiences (Sc ₆)	0	41	100
Hypomania Subscales			
Amorality (Ma ₁)	2	50	100
Psychomotor Acceleration (Ma ₂)	6	53	100
Imperturbability (Ma ₃)	4	53	100
Ego Inflation (Ma ₄)	1	37	100
Social Introversion Subscales (Ben-Porath, Hostetler, Butcher, & Graham)			
Shyness/Self-Consciousness (Si ₁)	0	36	100
Social Avoidance (Si ₂)	2	45	100
Alienation--Self and Others (Si ₃)	0	35	94
Content Component Scales (Ben-Porath & Sherwood)			
Fears Subscales			
Generalized Fearfulness (FRS ₁)	0	44	100
Multiple Fears (FRS ₂)	3	50	100
Depression Subscales			
Lack of Drive (DEP ₁)	0	40	100
Dysphoria (DEP ₂)	0	42	100
Self-Depreciation (DEP ₃)	0	41	100
Suicidal Ideation (DEP ₄)	0	45	100
Health Concerns Subscales			
Gastrointestinal Symptoms (HEA ₁)	3	83	100
Neurological Symptoms (HEA ₂)	0	40	100
General Health Concerns (HEA ₃)	2	56	100
Bizarre Mentation Subscales			
Psychotic Symptomatology (BIZ ₁)	0	44	100
Schizotypal Characteristics (BIZ ₂)	0	41	89
Anger Subscales			
Explosive Behavior (ANG ₁)	2	52	100
Irritability (ANG ₂)	2	46	86
Cynicism Subscales			
Misanthropic Beliefs (CYN ₁)	2	39	93
Interpersonal Suspiciousness (CYN ₂)	3	48	100

	Raw Score	T Score	Resp %
Antisocial Practices Subscales			
Antisocial Attitudes (ASP ₁)	1	35	100
Antisocial Behavior (ASP ₂)	1	45	100
Type A Subscales			
Impatience (TPA ₁)	2	45	83
Competitive Drive (TPA ₂)	2	44	100
Low Self-Esteem Subscales			
Self-Doubt (LSE ₁)	2	49	100
Submissiveness (LSE ₂)	0	41	100
Social Discomfort Subscales			
Introversion (SOD ₁)	2	42	100
Shyness (SOD ₂)	0	36	100
Family Problems Subscales			
Family Discord (FAM ₁)	2	45	92
Familial Alienation (FAM ₂)	1	49	100
Negative Treatment Indicators Subscales			
Low Motivation (TRT ₁)	0	42	100
Inability to Disclose (TRT ₂)	1	45	100

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

CRITICAL ITEMS

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

The percentages of endorsement for each critical item by various reference groups are presented in brackets following the listing of the item. The endorsement percentage labeled "N" is the percentage of the MMPI-2 normative sample of 1,138 men who endorsed the item in the scored direction. Endorsement percentages for the normative sample are reported for all critical items. When available, endorsement percentages for the setting are also reported. The designation "Ms" refers to a group of 3,290 men from a sample of medical patients (Pearson, 1993).

Acute Anxiety State (Koss-Butcher Critical Items)

Of the 17 possible items in this section, 2 were endorsed in the scored direction:

- 5. Item Content Omitted. (True) [N = 41; Ms = 56]
- 15. Item Content Omitted. (True) [N = 37; Ms = 48]

ITEMS
NOT
SHOWN

Special Note:

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

Threatened Assault (Koss-Butcher Critical Items)

Of the 5 possible items in this section, 1 was endorsed in the scored direction:

- 37. Item Content Omitted. (True) [N = 39; Ms = 41]

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

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

- 502. Item Content Omitted. (True) [N = 28; Ms = 27]

Persecutory Ideas (Koss-Butcher Critical Items)

Of the 16 possible items in this section, 1 was endorsed in the scored direction:

- 314. Item Content Omitted. (False) [N = 12; Ms = 19]

Antisocial Attitude (Lachar-Wrobel Critical Items)

Of the 9 possible items in this section, 1 was endorsed in the scored direction:

105. Item Content Omitted. (True) [N = 31; Ms = 41]

Somatic Symptoms (Lachar-Wrobel Critical Items)

Of the 23 possible items in this section, 4 were endorsed in the scored direction:

- 18. Item Content Omitted. (True) [N = 1; Ms = 9]
- 47. Item Content Omitted. (False) [N = 19; Ms = 32]
- 57. Item Content Omitted. (False) [N = 27; Ms = 47]
- 111. Item Content Omitted. (True) [N = 6; Ms = 16]



Special Note:

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Anxiety and Tension (Lachar-Wrobel Critical Items)

Of the 11 possible items in this section, 1 was endorsed in the scored direction:

- 15. Item Content Omitted. (True) [N = 37; Ms = 48]

Sleep Disturbance (Lachar-Wrobel Critical Items)

Of the 6 possible items in this section, 1 was endorsed in the scored direction:

- 5. Item Content Omitted. (True) [N = 41; Ms = 56]

Deviant Thinking and Experience (Lachar-Wrobel Critical Items)

Of the 10 possible items in this section, 1 was endorsed in the scored direction:

- 122. Item Content Omitted. (True) [N = 80]

Deviant Beliefs (Lachar-Wrobel Critical Items)

Of the 15 possible items in this section, 1 was endorsed in the scored direction:

- 314. Item Content Omitted. (False) [N = 12; Ms = 19]

OMITTED ITEMS

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

- 21. Item Content Omitted.
- 181. Item Content Omitted.
- 222. Item Content Omitted.
- 302. Item Content Omitted.
- 466. Item Content Omitted.
- 538. Item Content Omitted.



Special Note:

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

End of Report

NOTE: This MMPI-2 interpretation can serve as a useful source of hypotheses about clients. This report is based on objectively derived scale indices and scale interpretations that have been developed in diverse groups of patients. The personality descriptions, inferences, and recommendations contained herein need to be verified by other sources of clinical information because individual clients may not fully match the prototype. The information in this report should only be used by a trained and qualified test interpreter. The report was not designed or intended to be provided directly to clients. The information contained in the report is technical and was developed to aid professional interpretation.

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