



Personal Injury (Neurological) Interpretive Report

MMPI®-2

The Minnesota Report™: Reports for Forensic Settings

James N. Butcher, PhD

| | |
|---------------------|---------|
| Name: | Del C. |
| ID Number: | 2541 |
| Age: | 50 |
| Gender: | Male |
| Marital Status: | Married |
| Years of Education: | 12 |
| Date Assessed: | 1/31/14 |



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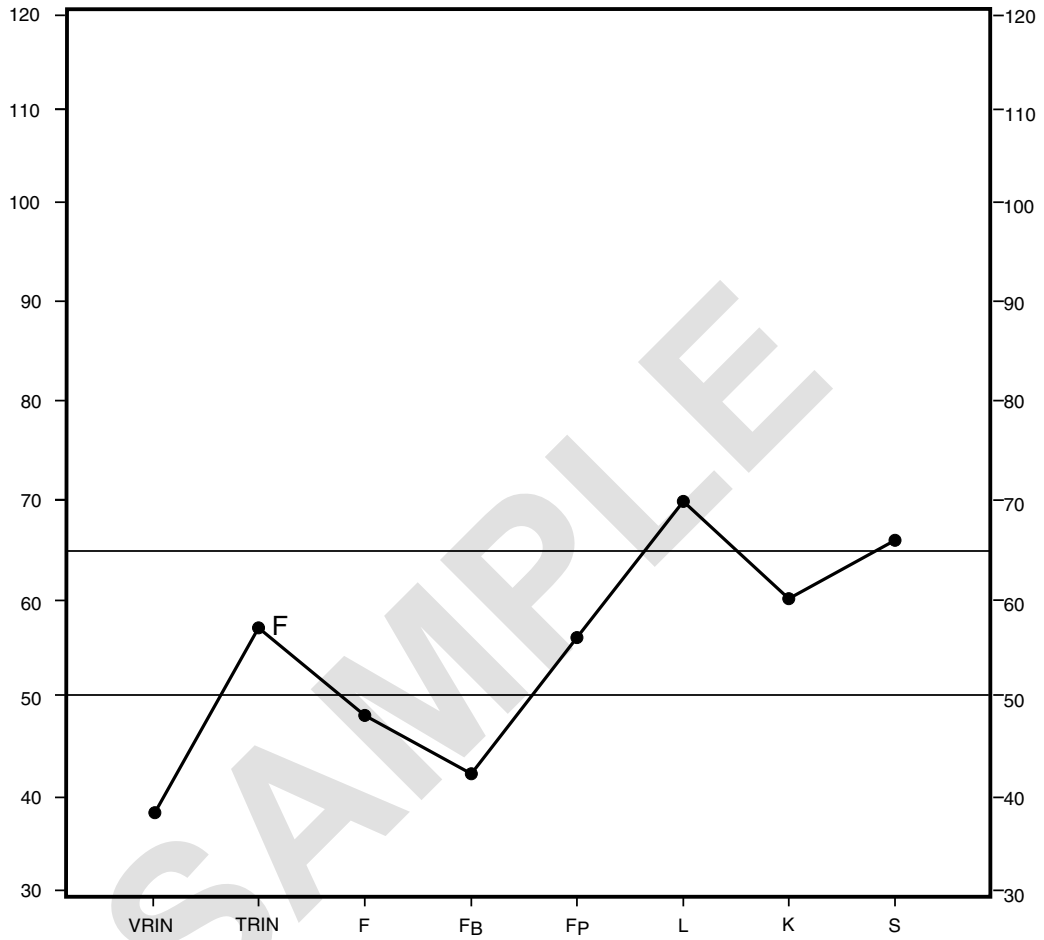
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MMPI-2 VALIDITY PATTERN



| | | | | | | | | |
|-----------------------|-----|-----|-----|-----|-----|-----|-----|-----|
| Raw Score: | 2 | 8 | 4 | 0 | 2 | 8 | 20 | 39 |
| T Score (plotted): | 38 | 57F | 48 | 42 | 56 | 70 | 60 | 66 |
| Non-Gendered T Score: | 38 | 57F | 50 | 42 | 57 | 70 | 60 | 66 |
| Response %: | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

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

| | Raw Score | T Score | Resp. % |
|--|-----------|---------|---------|
| S ₁ - Beliefs in Human Goodness | 8 | 52 | 100 |
| S ₂ - Serenity | 11 | 68 | 100 |
| S ₃ - Contentment with Life | 7 | 65 | 100 |
| S ₄ - Patience/Denial of Irritability | 7 | 63 | 100 |
| S ₅ - Denial of Moral Flaws | 5 | 65 | 100 |

PROFILE VALIDITY

Unrealistic claims of virtue, as shown in this profile, reflect conscious attempts to influence the outcome of litigation by giving the appearance of having extremely high moral virtue and honesty. This test-taking attitude weakens the validity of the test and shows an unwillingness or inability on the part of the client to disclose personal information. The resulting MMPI-2 profile is unlikely to provide much useful information about the client because he was too guarded to cooperate in the self-appraisal. Many reasons may be found for this pattern of uncooperativeness: conscious distortion to present himself in a favorable light, lack of psychological sophistication, or rigid neurotic adjustment.

The client's conscious efforts to influence the outcome of the evaluation and to project an overly positive self-image produced an MMPI-2 profile that substantially underestimates his psychological maladjustment. The test interpretation should proceed with the caution that the clinical picture reflected in the profile is probably an overly positive one and may not provide sufficient information for evaluation.

SYMPTOMATIC PATTERNS

Scales *Hs* and *Hy* were used as the prototype to develop this report. 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. He 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 exhibit a "Pollyannish" attitude toward life. Such clients may not appear greatly anxious or depressed about their symptoms and may exhibit "la belle indifference." 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 content of the client's item responses. He finds it difficult to manage routine affairs, and the items he endorsed suggest a poor memory, concentration problems, and an inability to make decisions. He appears to be immobilized and withdrawn and has no energy for life. He views his physical health as failing and reports numerous somatic concerns. He feels that life is no longer worthwhile and that he is losing control of his thought processes. He appears to have good social skills and reports that he has no problems interacting with other people. He complains about feeling quite uncomfortable and in poor health. The symptoms he reports include vague weakness, fatigue, and difficulty concentrating. In addition, he feels that others are unsympathetic toward his perceived health problems.

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) is found in 12.1% of the MMPI-2 normative sample of men. However, only 3.8% of the normative men have Hy as the peak score at or above a T score of 65, and only 2.3% have well-defined Hy spikes. His elevated MMPI-2 two-point 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 Assessments medical sample, this is the most frequent MMPI-2 high-point clinical scale score (Hy), occurring in 20.7% of the men. In addition, 16.3% of the men have the Hy scale spike at or above a T score of 65, and 9.3% have a well-defined Hy high point in that range. His elevated MMPI-2 two-point profile configuration (1-3/3-1), in this elevation range, is very common in samples of medical patients. It occurs in 16.4% of the men in the Pearson Assessments medical sample.

This MMPI-2 profile peak score on the Hy scale occurs with very high frequency among individuals involved in personal injury litigation. This is the most frequent profile peak (30.6%). Moreover, 17.2% of the cases have well-defined scores at or above a T score of 65 (Butcher, 1997b). In addition, among litigants who produce a somewhat defensive profile, this MMPI-2 profile peak score on the Hy scale is found with very high frequency (33.3%). Additionally, 22.2% are well-defined with a high-point score at or above a T of 65 (Butcher, 1997b).

His MMPI-2 profile peak score on the Hy scale occurs with relatively high frequency in head injury patients. Putnam et al. (1995) reported this high-point score for 5.8% of individuals with mild head injury and 5.1% with moderate to severe head injury.

PROFILE STABILITY

The relative elevation of the highest scales in his clinical profile reflects high definition. If he is retested at a later date, the peak scores are likely to retain their relative salience. His high-point score on Hy is likely to remain stable over time. Short-term test-retest studies have shown a correlation of 0.72 for this high-point score. Spiro, Butcher, Levenson, Aldwin, and Bosse (1993) reported a 0.65 stability index for a large study of normals in a five-year test-retest period.

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 have a low sex drive and may have problems in his marriage because of this. He seems to require an excessive amount of emotional support from his spouse. He is likely to use his physical complaints to gain attention for his perceived illness.

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

MENTAL HEALTH 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.

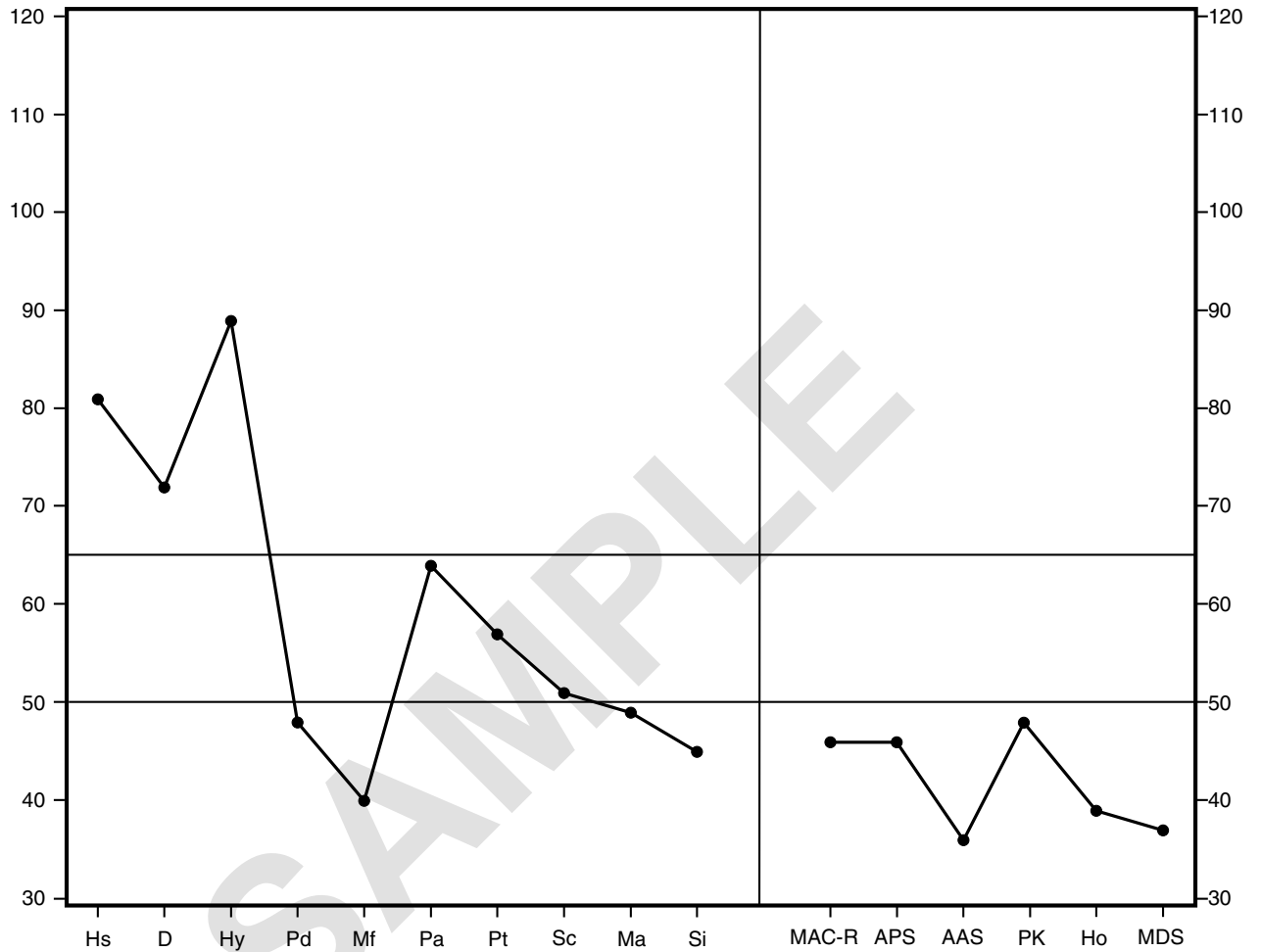
The client would probably be resistant to mental health treatment because he has little psychological insight and seeks medical explanations for his disorder. He is probably defensive and reluctant to engage in self-exploration. In addition, he seems to experience little anxiety about his situation and 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.

PERSONAL INJURY (NEUROLOGICAL) CONSIDERATIONS

The validity profile suggests that there are questionable aspects of his performance that must be addressed before credibility can be assured. Some problems are evident in his MMPI-2 profile. His profile pattern indicates an interest in portraying himself as being physically disabled. He reported extensive vague physical problems that are unlikely to be the result of a specific physical disorder. This is most likely the result of a long-term, chronic pattern of somatization that stems from basic ingrained personality problems. He reports being unable to function effectively because of his physical symptoms, which appear to intensify when he faces life conflicts. Individuals with this clinical pattern tend to be uninsightful when it comes to understanding the causes of their symptoms, in part because they prefer to rely on medical explanations for their symptoms. Individuals with this pattern often obtain substantial secondary gain from their symptoms.

In addition to the problems indicated by his MMPI-2 clinical scale scores, he endorsed some items on the content scales that could reflect difficulties for him. His proneness to experience problems with his health might make it difficult for him to think clearly or function effectively.

MMPI-2 CLINICAL AND SUPPLEMENTARY SCALES PROFILE



| | | | | | | | | | | | | | | | | |
|-----------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Raw Score: | 16 | 29 | 37 | 14 | 21 | 14 | 10 | 7 | 16 | 20 | 19 | 22 | 0 | 7 | 9 | 0 |
| K Correction: | 10 | | | 8 | | | 20 | 20 | 4 | | | | | | | |
| T Score (plotted): | 81 | 72 | 89 | 48 | 40 | 64 | 57 | 51 | 49 | 45 | 46 | 46 | 36 | 48 | 39 | 37 |
| Non-Gendered T Score: | 79 | 70 | 86 | 48 | | 64 | 56 | 51 | 50 | 44 | 48 | 47 | 38 | 48 | 39 | 36 |
| Response %: | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Welsh Code: 31"2'+6-78/9405: L'+K-/F:

Profile Elevation: 63.9

ADDITIONAL SCALES

| | Raw Score | T Score | Non-Gendered T Score | Resp % |
|--|-----------|---------|-------------------------|--------|
| Personality Psychopathology Five (PSY-5) Scales | | | | |
| Aggressiveness (AGGR) | 7 | 45 | 47 | 100 |
| Psychoticism (PSYC) | 3 | 49 | 49 | 100 |
| Disconstraint (DISC) | 8 | 37 | 41 | 100 |
| Negative Emotionality/Neuroticism (NEGE) | 9 | 49 | 48 | 100 |
| Introversion/Low Positive Emotionality (INTR) | 12 | 52 | 52 | 100 |
| Supplementary Scales | | | | |
| Anxiety (A) | 6 | 44 | 44 | 100 |
| Repression (R) | 20 | 61 | 60 | 100 |
| Ego Strength (Es) | 31 | 36 | 40 | 100 |
| Dominance (Do) | 20 | 61 | 62 | 100 |
| Social Responsibility (Re) | 26 | 65 | 65 | 100 |
| Harris-Lingoes Subscales | | | | |
| Depression Subscales | | | | |
| Subjective Depression (D ₁) | 14 | 69 | 67 | 100 |
| Psychomotor Retardation (D ₂) | 8 | 65 | 64 | 100 |
| Physical Malfunctioning (D ₃) | 5 | 67 | 65 | 100 |
| Mental Dullness (D ₄) | 5 | 62 | 62 | 100 |
| Brooding (D ₅) | 3 | 57 | 55 | 100 |
| Hysteria Subscales | | | | |
| Denial of Social Anxiety (Hy ₁) | 6 | 61 | 62 | 100 |
| Need for Affection (Hy ₂) | 8 | 55 | 55 | 100 |
| Lassitude-Malaise (Hy ₃) | 8 | 75 | 73 | 100 |
| Somatic Complaints (Hy ₄) | 10 | 86 | 80 | 100 |
| Inhibition of Aggression (Hy ₅) | 4 | 55 | 55 | 100 |
| Psychopathic Deviate Subscales | | | | |
| Familial Discord (Pd ₁) | 1 | 45 | 44 | 100 |
| Authority Problems (Pd ₂) | 2 | 40 | 43 | 100 |
| Social Imperturbability (Pd ₃) | 5 | 57 | 58 | 100 |
| Social Alienation (Pd ₄) | 4 | 50 | 50 | 100 |
| Self-Alienation (Pd ₅) | 3 | 48 | 48 | 100 |
| Paranoia Subscales | | | | |
| Persecutory Ideas (Pa ₁) | 5 | 70 | 70 | 100 |
| Poignancy (Pa ₂) | 3 | 55 | 54 | 100 |
| Naivete (Pa ₃) | 5 | 51 | 50 | 100 |

| | Raw Score | T Score | Non-Gendered T Score | Resp % |
|---|-----------|---------|-------------------------|--------|
| Schizophrenia Subscales | | | | |
| Social Alienation (Sc ₁) | 1 | 43 | 42 | 100 |
| Emotional Alienation (Sc ₂) | 2 | 59 | 59 | 100 |
| Lack of Ego Mastery, Cognitive (Sc ₃) | 0 | 42 | 42 | 100 |
| Lack of Ego Mastery, Conative (Sc ₄) | 3 | 55 | 55 | 100 |
| Lack of Ego Mastery, Defective Inhibition (Sc ₅) | 1 | 47 | 47 | 100 |
| Bizarre Sensory Experiences (Sc ₆) | 2 | 51 | 50 | 100 |
| Hypomania Subscales | | | | |
| Amorality (Ma ₁) | 1 | 42 | 44 | 100 |
| Psychomotor Acceleration (Ma ₂) | 5 | 49 | 49 | 100 |
| Imperturbability (Ma ₃) | 4 | 53 | 54 | 100 |
| Ego Inflation (Ma ₄) | 2 | 43 | 43 | 100 |
| Social Introversion Subscales (Ben-Porath, Hostetler, Butcher, & Graham) | | | | |
| Shyness/Self-Consciousness (Si ₁) | 2 | 42 | 41 | 100 |
| Social Avoidance (Si ₂) | 1 | 41 | 42 | 100 |
| Alienation--Self and Others (Si ₃) | 2 | 41 | 41 | 100 |
| Content Component Scales (Ben-Porath & Sherwood) | | | | |
| Fears Subscales | | | | |
| Generalized Fearfulness (FRS ₁) | 0 | 44 | 43 | 100 |
| Multiple Fears (FRS ₂) | 4 | 54 | 50 | 100 |
| Depression Subscales | | | | |
| Lack of Drive (DEP ₁) | 4 | 62 | 61 | 100 |
| Dysphoria (DEP ₂) | 2 | 58 | 55 | 100 |
| Self-Depreciation (DEP ₃) | 0 | 41 | 41 | 100 |
| Suicidal Ideation (DEP ₄) | 0 | 45 | 46 | 100 |
| Health Concerns Subscales | | | | |
| Gastrointestinal Symptoms (HEA ₁) | 1 | 57 | 55 | 100 |
| Neurological Symptoms (HEA ₂) | 5 | 74 | 70 | 100 |
| General Health Concerns (HEA ₃) | 4 | 72 | 72 | 100 |
| Bizarre Mentation Subscales | | | | |
| Psychotic Symptomatology (BIZ ₁) | 1 | 54 | 54 | 100 |
| Schizotypal Characteristics (BIZ ₂) | 0 | 41 | 41 | 100 |
| Anger Subscales | | | | |
| Explosive Behavior (ANG ₁) | 0 | 39 | 39 | 100 |
| Irritability (ANG ₂) | 1 | 41 | 40 | 100 |
| Cynicism Subscales | | | | |
| Misanthropic Beliefs (CYN ₁) | 5 | 47 | 48 | 100 |
| Interpersonal Suspiciousness (CYN ₂) | 2 | 43 | 45 | 100 |

| | Raw Score | T Score | Non-Gendered T Score | Resp % |
|--|-----------|---------|-------------------------|--------|
| Antisocial Practices Subscales | | | | |
| Antisocial Attitudes (ASP ₁) | 5 | 46 | 48 | 100 |
| Antisocial Behavior (ASP ₂) | 0 | 38 | 41 | 100 |
| Type A Subscales | | | | |
| Impatience (TPA ₁) | 0 | 34 | 34 | 100 |
| Competitive Drive (TPA ₂) | 0 | 33 | 34 | 100 |
| Low Self-Esteem Subscales | | | | |
| Self-Doubt (LSE ₁) | 0 | 39 | 40 | 100 |
| Submissiveness (LSE ₂) | 0 | 41 | 40 | 100 |
| Social Discomfort Subscales | | | | |
| Introversion (SOD ₁) | 1 | 39 | 40 | 100 |
| Shyness (SOD ₂) | 2 | 47 | 46 | 100 |
| Family Problems Subscales | | | | |
| Family Discord (FAM ₁) | 0 | 35 | 35 | 100 |
| Familial Alienation (FAM ₂) | 0 | 40 | 41 | 100 |
| Negative Treatment Indicators Subscales | | | | |
| Low Motivation (TRT ₁) | 0 | 42 | 42 | 100 |
| Inability to Disclose (TRT ₂) | 0 | 37 | 38 | 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.

Gass Head Injury Items

The Gass Correction for Head Injury has been found to be useful in accounting for some scale elevations in neuropsychological cases. The client endorsed 1 of the 14 Gass Correction items in the scored direction. The practitioner might consider the effect of reducing the designated scale raw scores in this case if there is a history of head injury that might account for the scale elevations. The items and their scale membership are listed below. (See Appendix A of the User's Guide or Gass, 1991.)

179. Item Content Omitted. (False) Scales 1, 3, and 8



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 with diverse groups of people. 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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