



Child Custody Interpretive Report

MMPI-2™

The Minnesota Report™: Reports for Forensic Settings

James N. Butcher, PhD

Name:	Gerald F
ID Number:	2539
Age:	40
Gender:	Male
Marital Status:	Separated
Years of Education:	19
Date Assessed:	02/28/2008

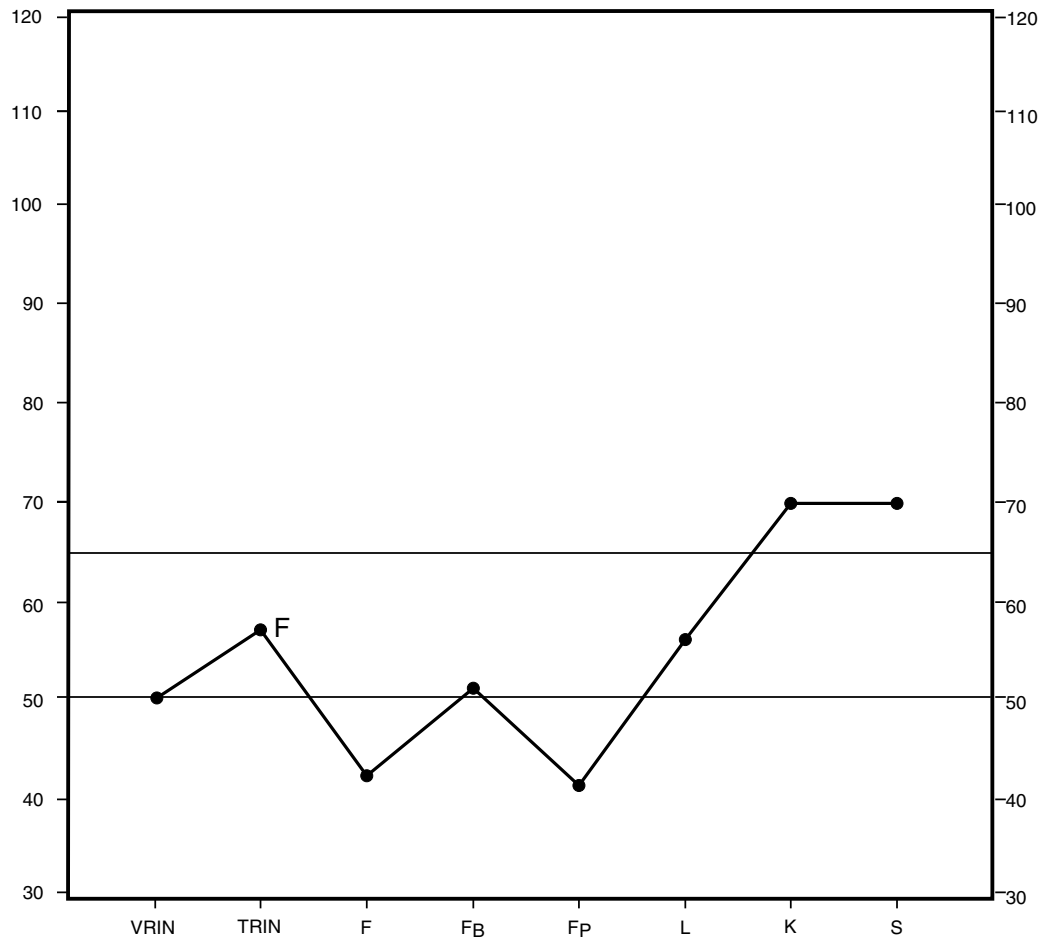


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TRADE SECRET INFORMATION

Not for release under HIPAA or other data disclosure laws that exempt trade secrets from disclosure.

MMPI-2 VALIDITY PATTERN



Raw Score:	5	8	2	2	0	5	25	42
T Score (plotted):	50	57F	42	51	41	56	70	70
Non-Gendered T Score:	50	57F	43	50	42	57	71	70
Response %:	100	100	100	100	100	100	100	100

Cannot Say (Raw): 0
 Percent True: 29
 Percent False: 71

	Raw Score	T Score	Resp. %
S1 - Beliefs in Human Goodness	13	65	100
S2 - Serenity	11	68	100
S3 - Contentment with Life	6	60	100
S4 - Patience/Denial of Irritability	8	68	100
S5 - Denial of Moral Flaws	3	51	100

PROFILE VALIDITY

This profile has low clinical utility because the client attempted to place himself in an overly positive light by minimizing his faults and denying psychological problems. This defensive stance is characteristic of individuals who are trying to maintain the appearance of adequacy and self-control. This client tends to deny problems and is not very introspective or insightful about his own behavior.

The clinical profile is likely to be an underestimate of the individual's psychological problems. He is likely to have little awareness of his difficulties. He is probably rigid and inflexible in his approach to problems and may not be open to psychological self-evaluation. He is likely to project an excessively positive self-image and to be somewhat arrogant and intolerant of others' failings. He is unlikely to seek psychological treatment or to cooperate fully with treatment if it is recommended to him.

SYMPTOMATIC PATTERNS

The clinical scale prototype used in the development of this narrative includes a prominent elevation on Scale *Pd*. The client is immature, impulsive, and hedonistic, and he frequently rebels against authority. He appears to be hostile, quite aggressive, and often frustrated. He seems to be unable to learn from punishing experiences and repeatedly gets himself into the same type of trouble. Many individuals with this profile develop severe addictive problems and frequently have legal, family, and work difficulties.

PROFILE FREQUENCY

Profile interpretation can be greatly facilitated by examining the relative frequency of clinical scale patterns in various settings. The client's high-point clinical scale score (*Pd*) occurs in 9.1% of the MMPI-2 normative sample of men. However, only 3.3% of the normative men have *Pd* as the peak score equal to or greater than a T score of 65, and only 1.9% have well-defined *Pd* spikes.

The relative frequency of this profile in various outpatient settings is useful information for clinical interpretation. In the Pearson Assessments male outpatient sample, *Pd* is the most frequent high-point clinical scale score, occurring in 17.8% of the sample. Additionally, 10.9% of the male outpatients have *Pd* spike at or above a T score of 65, and 7% have well-defined *Pd* spikes.

In the community mental health center population researched by Graham, Ben-Porath, and McNulty (1997), male outpatients produced a *Pd* high-point score with a frequency of 23.9% (the highest single-point code frequency in this sample). The investigators found that 11.7% of male outpatients had well-defined high-point *Pd* spikes at or above a T score of 65.

The relative frequency of this high-point profile peak in custody evaluations can provide the practitioner with useful context information. In the large sample of custody cases (Butcher, 1997a), this high-point clinical scale score (*Pd*) occurs in 18.3% of the men. In addition, 2.9% of the sample have the *Pd* scale as a well-defined spike at or above a T score of 65. The *Pd* score is the most frequent high-point score among men in custody evaluations, although it is typically at or below a T score of 64.

He scored relatively high on AAS, suggesting the possibility of a drug- or alcohol-abuse problem. The base rate data for his profile type among residents in alcohol and drug programs should be evaluated. This MMPI-2 profile configuration contains the most frequent high point (Pd) among alcohol- and drug-abusing populations. More than 24% of the men in substance-abuse treatment programs have this pattern (McKenna & Butcher, 1987). In addition, 12.3% of veterans in inpatient substance abuse treatment have this high-point spike as a well-defined high-point score (Ben-Porath, McNulty, Waats, & McCormick, 1997). However, 27.1% of the men in this sample produced high-point Pd scores, although they were not necessarily well defined or in the elevated range.

PROFILE STABILITY

The relative elevation of the highest scales in his clinical profile shows very high profile definition. His peak scores are likely to be very prominent in his profile pattern if he is retested at a later date. His high-point score on Pd is likely to remain stable over time. Short-term test-retest studies have shown a correlation of 0.81 for this high-point score. Spiro, Butcher, Levenson, Aldwin, and Bosse (1993) reported a moderate test-retest stability index of 0.62 in a large study of normals over a five-year test-retest period.

INTERPERSONAL RELATIONS

He may appear charming and tends to make a good first impression, but he is superficial, selfish, hedonistic, and untrustworthy in interpersonal relations, apparently only interested in people for how they can be useful to him. He seems to be interested only in his own pleasure, and he is not sensitive to the needs of others. He seems unable to experience guilt about causing others trouble.

Because he is unable to form stable, warm relationships, his current relationships are likely to be quite strained. In addition, he is likely to be openly hostile and resentful. His acting-out behavior is likely to put great strain on his relationships. Rocky relationships are the norm among individuals with this profile. Marital breakup is relatively common.

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. His personal relationships are likely to be somewhat superficial. He appears to be rather spontaneous and expressive and may seek attention from others, especially to gain social recognition.

MENTAL HEALTH CONSIDERATIONS

This MMPI-2 pattern suggests a severe personality disorder. Alcohol or drug abuse may be a problem. The alcohol or drug problems he acknowledged in his responses should be taken into consideration in any diagnostic evaluation.

His treatment prognosis is poor. Although he may enter treatment through court referral or at the insistence of a family member, he is not motivated to change. He tends to feel that others are to blame for his difficulties, and he is likely to terminate therapy when the pressure eases. He may also abuse medication.

When individuals like this are seen in therapy on an outpatient basis, they are usually antagonistic and tend to disrupt the process by acting out. Treatment in a controlled setting that prevents acting out has reportedly had some success. These individuals tend to react negatively to punishment, but they may respond more favorably to positive rewards for appropriate behavior.

His acknowledged problems with alcohol or drug use should be addressed in therapy.

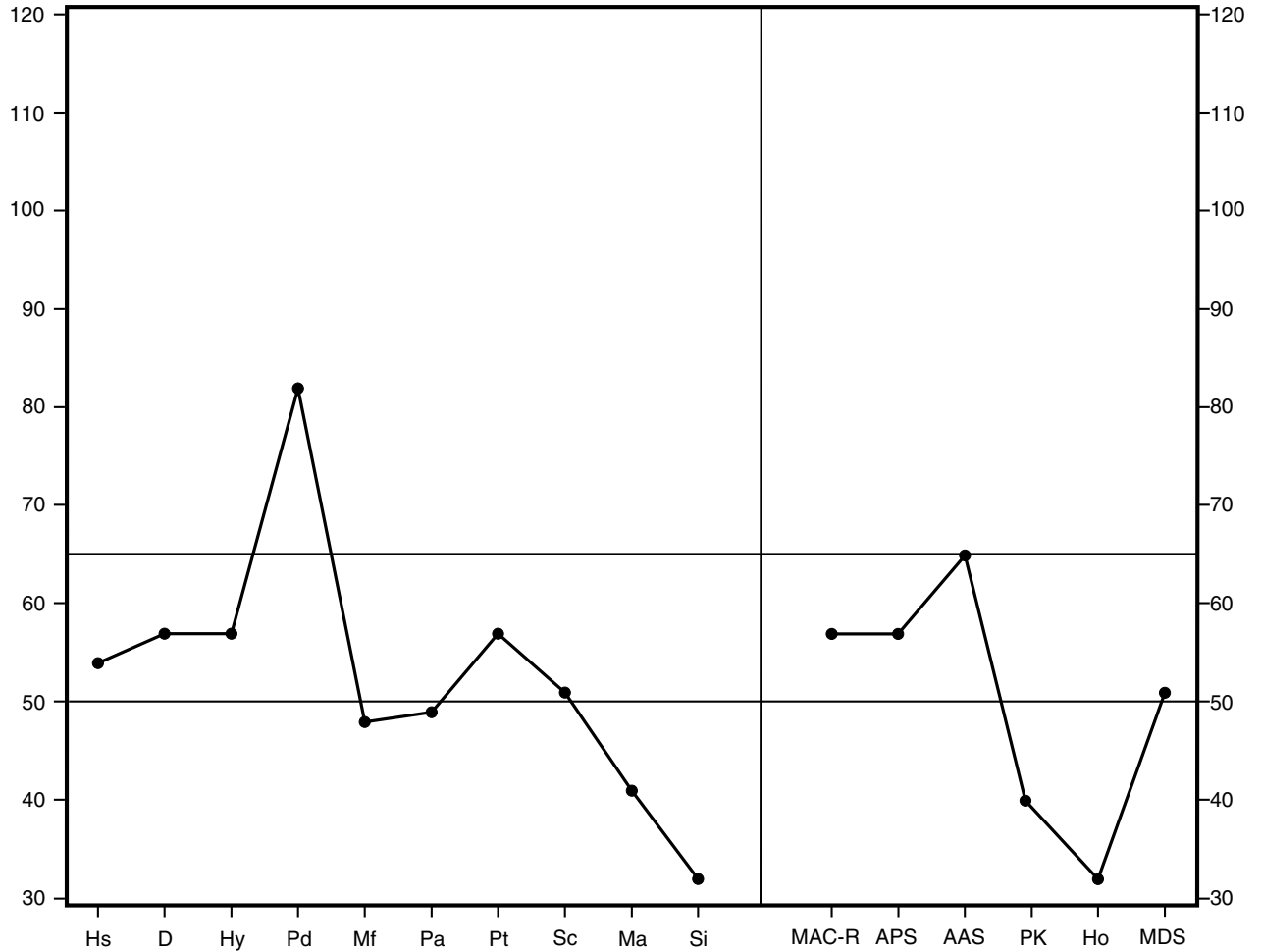
CHILD CUSTODY CONSIDERATIONS

His responses to the validity items of the MMPI-2 suggest that he attempted to present a very positive picture of his psychological adjustment. This is not unusual for people who are involved in family custody disputes and who try to avoid disclosing any personal problems they might be experiencing. In spite of his effort to put on a good face and show his better side, some problems are evident in his MMPI-2 profile.

He presented some clear personality problems that are probably pertinent to an assessment of his day-to-day functioning as a parent. His high elevation on the *Pd* scale is often associated with a tendency to engage in irresponsible, immature, and possibly antisocial behavior. Individuals with this pattern tend to have rebellious attitudes toward authority figures, have stormy family relationships, and tend to blame others for their problems. They often have a spotty history of employment or school performance. They tend to have turbulent relationships and marital problems. Their impulsivity, low frustration tolerance, and need for immediate self-gratification probably influence their functioning as parents. They tend to be somewhat self-centered and may engage a great deal in self-gratification in a pleasure-oriented lifestyle. It should be kept in mind that individuals with this extreme personality-disordered pattern are unlikely to change or to benefit from experience.

In addition to the problems he exhibited on the MMPI-2 clinical scales, he endorsed some items on the content scales that could indicate problems for him. The possibility that he has a substance abuse or use problem should be evaluated further to determine if this is a possible source of family conflict.

MMPI-2 CLINICAL AND SUPPLEMENTARY SCALES PROFILE



Raw Score:	1	21	24	26	25	10	5	2	11	9	24	26	6	2	3	3
K Correction:	13			10			25	25	5							
T Score (plotted):	54	57	57	82	48	49	57	51	41	32	57	57	65	40	32	51
Non-Gendered T Score:	53	54	55	83		49	56	51	42	32	60	57	68	40	32	51
Response %:	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Welsh Code: 4⁺+23718/659:0# K'+-L/F:

Profile Elevation: 56.0

ADDITIONAL SCALES

	Raw Score	T Score	Non-Gendered	
			T Score	Resp %
Personality Psychopathology Five (PSY-5) Scales				
Aggressiveness (AGGR)	6	43	44	100
Psychoticism (PSYC)	1	40	41	100
Disconstraint (DISC)	21	71	74	100
Negative Emotionality/Neuroticism (NEGE)	5	43	41	100
Introversion/Low Positive Emotionality (INTR)	10	48	48	100
Supplementary Scales				
Anxiety (A)	2	39	38	100
Repression (R)	19	58	58	100
Ego Strength (Es)	42	60	62	100
Dominance (Do)	20	61	62	100
Social Responsibility (Re)	20	50	48	100
Harris-Lingoes Subscales				
Depression Subscales				
Subjective Depression (D ₁)	5	45	44	100
Psychomotor Retardation (D ₂)	6	54	53	100
Physical Malfunctioning (D ₃)	4	59	57	100
Mental Dullness (D ₄)	1	43	43	100
Brooding (D ₅)	1	45	44	100
Hysteria Subscales				
Denial of Social Anxiety (Hy ₁)	6	61	62	100
Need for Affection (Hy ₂)	11	67	67	100
Lassitude-Malaise (Hy ₃)	2	48	47	100
Somatic Complaints (Hy ₄)	0	38	38	100
Inhibition of Aggression (Hy ₅)	3	48	47	100
Psychopathic Deviate Subscales				
Familial Discord (Pd ₁)	3	58	57	100
Authority Problems (Pd ₂)	7	73	77	100
Social Imperturbability (Pd ₃)	6	63	63	100
Social Alienation (Pd ₄)	4	50	50	100
Self-Alienation (Pd ₅)	3	48	48	100
Paranoia Subscales				
Persecutory Ideas (Pa ₁)	0	40	39	100
Poignancy (Pa ₂)	2	48	47	100
Naivete (Pa ₃)	7	60	60	100

	Raw Score	T Score	Non-Gendered T Score	Resp %
Schizophrenia Subscales				
Social Alienation (Sc ₁)	0	39	38	100
Emotional Alienation (Sc ₂)	0	40	40	100
Lack of Ego Mastery, Cognitive (Sc ₃)	0	42	42	100
Lack of Ego Mastery, Conative (Sc ₄)	0	39	39	100
Lack of Ego Mastery, Defective Inhibition (Sc ₅)	0	40	40	100
Bizarre Sensory Experiences (Sc ₆)	0	41	41	100
Hypomania Subscales				
Amorality (Ma ₁)	2	50	52	100
Psychomotor Acceleration (Ma ₂)	3	39	39	100
Imperturbability (Ma ₃)	5	59	61	100
Ego Inflation (Ma ₄)	0	30	31	100
Social Introversion Subscales (Ben-Porath, Hostetler, Butcher, & Graham)				
Shyness/Self-Consciousness (Si ₁)	0	36	36	100
Social Avoidance (Si ₂)	1	41	42	100
Alienation--Self and Others (Si ₃)	1	38	38	100
Content Component Scales (Ben-Porath & Sherwood)				
Fears Subscales				
Generalized Fearfulness (FRS ₁)	0	44	43	100
Multiple Fears (FRS ₂)	2	45	42	100
Depression Subscales				
Lack of Drive (DEP ₁)	0	40	40	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)	0	44	44	100
Neurological Symptoms (HEA ₂)	0	40	40	100
General Health Concerns (HEA ₃)	1	48	49	100
Bizarre Mentation Subscales				
Psychotic Symptomatology (BIZ ₁)	0	44	44	100
Schizotypal Characteristics (BIZ ₂)	0	41	41	100
Anger Subscales				
Explosive Behavior (ANG ₁)	1	45	46	100
Irritability (ANG ₂)	1	41	40	100
Cynicism Subscales				
Misanthropic Beliefs (CYN ₁)	1	36	37	100
Interpersonal Suspiciousness (CYN ₂)	0	34	35	100

	Raw Score	T Score	Non-Gendered T Score	Resp %
Antisocial Practices Subscales				
Antisocial Attitudes (ASP ₁)	1	35	36	100
Antisocial Behavior (ASP ₂)	4	67	72	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)	1	44	44	100
Submissiveness (LSE ₂)	0	41	40	100
Social Discomfort Subscales				
Introversion (SOD ₁)	1	39	40	100
Shyness (SOD ₂)	0	36	36	100
Family Problems Subscales				
Family Discord (FAM ₁)	1	40	39	100
Familial Alienation (FAM ₂)	1	49	50	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.

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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ITEM RESPONSES

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