Forensic Psychology Information Pack

A range of products from Pearson Assessment for professionals working in the area of forensic psychology

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Yours sincerely

Simone Lewendon
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P.S. Have you signed up to our bimonthly Health and Psychology e-newsletter? Visit www.pearsonclinical.co.uk/enewsletter to sign up today and receive you free copy.
Overview:

The Wechsler Abbreviated Scale of Intelligence - Second Edition (WASI–II), a revision of the WASI, provides a brief, reliable measure of cognitive ability for use in clinical, educational and research settings. This revision maintains the format and structure of the WASI while offering new content and improvements to provide greater clinical utility and efficiency.

Users & Applications:

Psychologists and researchers can use this quick and reliable measure when screening for learning difficulties or intellectual giftedness, or for other purposes:

- Screen to determine if in-depth intellectual assessment is needed
- Reassess after a comprehensive evaluation
- Estimate Full Scale IQ (FSIQ) scores in busy practice settings
- Assess cognitive functioning of individuals referred for psychiatric evaluations
- Provide FSIQ scores for vocational, rehabilitation, or research purposes

Content & Administration:

The WASI–II provides updated versions of the WASI Vocabulary, Similarities, Block Design and Matrix Reasoning subtests, flexible administration options (i.e., four- or two-subtest versions), and strengthened connections with the WISC®–IV and WAIS®–IV.

The WASI–II provides flexible administration options. The four-subtest form can be administered in just 30 minutes and the two-subtest form can be given in about 15 minutes.

Four-Subtest Form (Vocabulary, Similarities, Block Design, Matrix Reasoning) provides:
- FSIQ–4 score: Estimate of general cognitive ability
- VCI score: Measure of crystallised abilities
- PRI score: Measure of nonverbal fluid abilities and visuomotor/co-ordination skills

Two-Subtest Form (Vocabulary and Matrix Reasoning) provides:
- FSIQ–2 score: Estimate of general cognitive ability

Visit www.pearsonclinical.co.uk for further information.
Updated Subtests

The WASI-II subtests have been updated to provide a variety of improvements including shortened and streamlined instructions, better floors and ceilings, as well as item content that more closely mirrors that of the WISC–IV and the WAIS–IV.

Strengthened Connections with the WISC–IV and WAIS–IV:

The strengthened connections between the WASI–II and the comprehensive Wechsler intelligence scales result in a stronger empirical foundation for using the instruments together, and offer practical benefits that help you save time. The WASI–II subtests and items have been revised to more closely parallel their counterparts in the WISC–IV and WAIS–IV. Linking studies have been conducted with the WAIS–IV and the WISC–IV to establish equivalency and to improve comparability with the comprehensive Wechsler scales’ composite scores. Taken together, these improvements enhance the joint use of the WASI–II and the comprehensive scales.

The WASI–II can be used in conjunction with the comprehensive Wechsler scales as a screening instrument to determine if in-depth intellectual assessment is necessary, or as a reevaluation tool to follow up on comprehensive testing.

Features & Benefits:

The WASI–II offers significant enhancements and retains features you’ve come to rely on:

• Updated normative sample
• Four- and two-subtest versions allow you to control the administration time and depth of assessment
• Parallel items and subtests and strengthened links to the WISC–IV and the WAIS–IV maximise clinical utility and efficiency in cognitive assessment practice
• Simplified administration and scoring provide even more efficiency

Psychometric Information:

Updated norms: The standardisation of the WASI–II was conducted from January 2010 to May 2011 on a sample of approximately 2,300 individuals aged 6–90.


Ready for use in the United Kingdom: The link with the UK version of the WAIS-IV is straightforward. UK norms for the WAIS-IV are the same as in the US. Therefore, the relationship between the WASI-II and the WAIS-IV will be equivalent in the UK.

For the WISC-IV, some minor differences were found in the younger ages for the UK sample in 2004. Therefore, although some caution is advised for children below the age of 7, overall, the relationship between the WASI-II and WISC-IV will prove to be an invaluable in educational and clinical settings.

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Review:

Ruth Tully, Forensic Psychologist in Training under the supervision of Boyd Whitehead, Lead Consultant Clinical Forensic Psychologist, Nottingham Low Secure and Community Forensic Directorate

I was a regular user of the original WASI as a brief measure of cognitive ability. The revisions made to the WASI to produce the WASI-II have come at a good time now that clinicians have had time to become more familiar with the application of WAIS-IV which it closely parallels.

The original WASI offered an empirically sound brief alternative to the comprehensive WAIS-IV, however there was always the issue of practice effects to consider if, on analysis, a full WAIS would have been more appropriate for an individual client.

It is now possible to use the manual to substitute the parallel WAIS-IV tests with the WASI-II tests to avoid not only practice effects but also the time and cost demands of repeated administration, although this must be done with caution (see manual).

One of the most noticeable benefits of the WASI-II is the level of research that has gone into the development and assessment of the tool. Equivalency between the WASI-II and WAIS-IV/WISC-IV has been explored and the psychometric properties of the tool have been improved and updated. In line with the WAIS-IV there have also been improvements in the floors and ceilings of sub-tests.

In practice the simplified administration instructions are noticeable, along with simplified reversal rules.

A particular benefit of the WASI-II is the practical consideration that has gone into the new layout of the stimulus book.

The additional space to write on during administration of both the vocabulary and similarities subtests aids ease of legible recording of responses and this is one of my personal favourite improvements. Plus ‘vacation’ has been removed which is a bonus!

Find out more:

To find out more about the WASI-II watch a recording of a recent webinar on our YouTube channel at www.youtube.com/PsychCorpUK

Visit www.pearsonclinical.co.uk for further information.
Overview:
In recognition of emerging demographic and clinical trends, the *Wechsler Adult Intelligence Scale® – Fourth UK Edition (WAIS-IVUK)* is now available and provides you with the most advanced measure of cognitive ability and results you can trust. Our commitment to excellence led us to focus on four issues to guide the evolution of WAIS-IVUK:

- changing demographics
- emerging clinical needs
- new research
- increasing caseloads

Changing Demographics:
Since the publication of *WAIS-IIIUK* in 1999 much has changed both culturally and demographically. The population has aged, standards of living have improved, and society has become more diverse. These are just some of the considerations that influenced the normative data collection for the WAIS-IVUK. In response to the increase in cases involving older clients, WAIS-IVUK is designed to be more developmentally appropriate for older adults through the following:

- reduced administration time
- additional teaching items to ensure understanding of tasks
- reduced vocabulary level for additional instructions
- decreased emphasis on motor demands and time bonus points
- enlarged visual stimuli

Emerging Clinical Needs:
Meeting the needs of individuals with clinical issues is one of the most important services that psychologists provide. These needs change over time as research improves and new disorders and groups are defined.

The WAIS-IVUK has been developed with special emphasis on these unique groups and provides clinicians with valuable data and insight to better support these special populations. The new special group studies include: Gifted Intellectual Functioning, Borderline Intellectual Functioning, Asperger’s Disorder, Autistic Disorder, Major Depressive Disorder and Mild Cognitive Impairment.

The WAIS-IVUK has also been co-normed with the new Wechsler Memory Scale®-IV UK.

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New Research:
The field of Psychology is constantly evolving based on scientific research, new theories, and changes in culture and society. This evolution is represented in improvements to the WAIS-IVUK theoretical foundation and changes in the test structure itself.

Increasing Caseloads:
With increasing workloads and the limited time available for administering assessments, it was important to focus our efforts to provide you with the highest quality clinical information, in the most efficient time possible. Some of the changes that contribute to an overall reduction in administration time include:

- reduction of core battery from 13 subtests to 10
- simplified Record Form
- shortened discontinue rules contributing to an overall average reduction in administration time of nearly 15%

Test Structure:
The WAIS-IVUK structure has been modified to align with the widely popular WISC-IVUK and to reflect current theory regarding cognitive ability. The new structure is also more reflective of current cognitive ability theory and divides scores into four specific domains. The core battery consists of ten total subtests that yield the FSIQ and four Index Scores. There are also five supplemental subtests that may be substituted for core subtests or administered for additional information.

Updated structural foundations include:

New measure of fluid intelligence
- Developed new subtest to measure fluid reasoning:
  - Visual Puzzles
  - Contributes to Perceptual Reasoning Composite
  - More reliable measure than Object Assembly
  - Requires no motor skills
- Figure Weights
  - Contributes to Perceptual Reasoning Composite
  - Measure of quantitative and analogical reasoning
  - Requires no motor skills

Enhanced measures of working memory
- Revise arithmetic to emphasize WM
- Revise digit span to emphasize WM (added Digit Sequencing)
- Retain auditory WM measures on WAIS, visuo-spatial WM Measures on WMS

Improved measure of processing speed

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- Reduce fine motor demands
- Included an additional supplemental subtest: Cancellation
  - Contributes to Processing Speed Composite
  - Imbedded Stroop Effect
  - Provides scores for omission and commission errors

**VERBAL DOMAIN**

- Verbal Comprehension Scale
  - Core Subtest
  - Similarities
  - Vocabulary
  - Information
  - Supplemental Subtest
  - Comprehension

**PERCEPTUAL DOMAIN**

- Perceptual Reasoning Scale
  - Core Subtest
  - Block Design
  - Matrix Reasoning
  - Visual Puzzles NEW
  - Supplemental Subtest
  - Figure Weights (16-69 only) NEW
  - Picture Completion

**FSIQ (16:0-90:11)**

- Working Memory Scale
  - Core Subtest
  - Digit Span
  - Arithmetic
  - Supplemental Subtest
  - Letter-Number Sequencing (16-69 only)

- Processing Speed Scale
  - Core Subtest
  - Speech Search
  - Coding
  - Supplemental Subtest
  - Cancellation (16-69 only) NEW

**WORKING MEMORY DOMAIN**

**PROCESSING SPEED DOMAIN**

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**Endorsement:**
Dr. Carol A. Ireland, CPsychol, MBA, Forensic Psychologist, Chartered Scientist, University of Central Lancashire and CCATS (Coastal Child and Adolescent Therapy Services), UK

I have been involved with administering the WAIS for over fifteen years. I have been involved in regularly training individuals in this tool for many years. Over this time I have seen substantial developments in the tool, and in responses to changes in the literature.

I think this undoubtedly continues to be the strength of the WAIS; the willingness to consider developing changes and to waste no time in responding to these accordingly. The earlier WAIS (WAIS-III) was available to purchase in 1997, and so it would appear timely for the revisions presented through the WAIS-IV.

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The WAIS-IV is a crucial development from the WAIS-III. It offers a more streamlined version without losing any of its quality. Indeed, the quality of the tool is much enhanced by such developments. For example, it removes sub-tests that have more recently been considered unhelpful and which added little to the tool. From the WAIS-III, 12 sub-tests have been retained, four sub-tests have been removed, with three new sub-tests added.

Within the subtests which remain, there have been helpful and timely updates whilst there are some additions to the WAIS-IV, its revised strength is in the fine tuning of its subtests in line with changes to the literature. This not only ensures that the examinee’s time on the test is now more focused on what is key to understanding their general cognitive ability, but its norms for the consequent scores have been substantially updated. For example, the discontinue rules within the sub-tests have been helpfully reduced. I have always been impressed with the careful and considered approach of the publishers when developing this tool, and the WAIS-IV is no exception to this. Adequate time, careful training of researchers and ensuring testing is always undertaken under clear ethical guidelines, has continued to develop a robust and much valued tool. Whilst they may be quick to respond to changes in the literature, they are methodical in their approaches to any changes made. As a result, not only the norms of the tool have been carefully updated, but so have the reliabilities and validity, with floor and ceiling effects within the tool further improved.

It is clear that the WAIS-IV had a number of goals in its development, all of which are valid and timely. It has aimed, and succeeded, in enhancing the measure of fluid intelligence. Further, it has clearly responded to changes in research on working memory and processing speed, and has much enhanced these elements of the tool. Of great importance is its co-norming with the Wechsler Memory Scale IV, offering great utility and further application which will be invaluable to the clinician and researcher.

Further, the publishers have taken careful consideration of users views of the earlier tool. As such, they have worked hard and been successful in making the tool more user-friendly. This is demonstrated through a reduction in the testing time and therefore not using the valuable time of both the examiner and examinee unnecessarily.

The timing of subtests now has less emphasis, and so is more user-friendly and accurate for some of the clients who require extra time to consider the expectations of the subtest, without having an unnecessary time limit applied. The instructions for the tool have been successfully revised for greater clarity, as well as the development of a clear and helpful record form. For example, instructions for the subtests have been revised to take in to account any comprehension difficulties.

A challenge in the older tool was some more impaired individuals not understanding clearly some of the instructions, and which then potentially flawed some of the later results. These considerations have been taken in to account and very successfully removed. Even on a very practical level. The portability of the tool has been much improved.

The WAIS-IV continues to have the same applicability as to the earlier WAIS-III. This continues to be a real strength of the WAIS-IV, as you are able to maximise the use of the tool for a variety of purposes. Whilst you always have the option of the full scale IQ, you also have the richness of being able to compute the IQ for each of the index scores, such as working memory and processing speed.

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This is invaluable to those users who are interested in how best to engage with an individual following the assessment, such as through therapy or simply engaging with them in any one to one or group context. This is a real asset, particularly if the individual presents with any challenges in their cognitive abilities as measured by the WAIS-IV.

I think that the WAIS-IV is a timely and crucial development in continuing to examine general cognitive ability. It is a user-friendly, robust and well-developed tool. In my opinion it really is top of its class. It is a must for any psychologist who wishes to conduct an assessment of an individual’s cognitive abilities, or any researcher interested in this tool as part of their research. It is something which is highly recommended.

Scoring:

The WAIS-IVUK can be scored using the WAIS-IV / WMS-IV UK Scoring Software and Report Writer, simply enter raw scores, and the software does the following:

- Generates concise score reports and statistical reports with graphs and tables.
- Raw to scaled score conversions
- Strength and weakness discrepancies
- Interprets statistically significant discrepancies between scores.
- Includes comprehensive user manual.

View Sample Reports at www.pearsonclinical.co.uk/WAIS

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Overview:
Offering significant enhancements the new Wechsler Memory Scale® – Fourth UK Edition (WMS-IVUK) has evolved to give you the most comprehensive adult memory measure. WMS-IVUK helps clinicians evaluate memory capabilities as part of a standard adult psychological evaluation. This new edition of the test is brief, easier to administer, and places an increased focus on older adults in response to the increasing average age of clients.

Developments:

WMS-IVUK developments:
1. Improved assessment of visual memory with the addition of the NEW Design Memory subtest:
   • Containing four items of increasing difficulty, Design Memory evaluates immediate and delayed recall as well as delayed recognition. It does not include drawing and reduces the opportunity to guess the correct response. You can obtain scores for spatial, details, and correct content in the correct location as well as contrast scores for spatial versus detail, immediate versus delayed, and recognition versus delayed.

2. Enhanced working memory is now completely visual with the addition of the NEW Symbol Span and Spatial Addition subtests (WAIS-IVUK is completely auditory so there is no overlap):
   • Spatial Addition - Based on “N-Back Paradigm”, Spatial Addition requires minimal motor function as the client must:
     • remember location of dots on two separate pages
     • add or subtract locations
     • hold and manipulate visual spatial information
   • Symbol Span
     • A “Visual Analogue to Digit Span”, clients are asked to remember the design and the left to right sequence of the design. The clients are then asked to select the correct design from foils and choose them in the correct sequence.

3. Expanded clinical studies
4. Inclusion of a NEW cognitive screener which can be used to quickly evaluate significant cognitive impairment. You can assess: Temporal orientation; Mental control; Clock drawing; Memory; Inhibitory control; Verbal productivity.
5. Increased focus on older adults with a brief older adult battery to reduce fatigue, and reduce visual motor demands

Visit www.pearsonclinical.co.uk for further information.
Features and Benefits:

Expanded Clinical utility
- Improved floors across subtests
- Includes a general cognitive screening tool
- Enhanced assessment of visual memory
- Co-normed with the Wechsler Adult Intelligence Scale®-IV UK

Enhanced User Friendliness
- Includes a brief older adult battery
- Reduced subtest administration time
- Minimised visual motor demands
- Assesses working memory
- Modified story content and administration process

Improved Psychometric Properties
- Updated normative data for ages 16-90 years
- Improved floors
- Improved subtest and composite reliability
- Reduced item bias

Endorsement:
Professor Jane L Ireland, School of Psychology, University of Central Lancashire

The first difference that will undoubtedly be noted between the fourth edition of this test and its predecessor is its complete revision. It would be more aptly described as a revolution of this test than an evolution. The timing for such a significant change was perfect with regards to advances in the literature over recent years, and a growing application of such tests to a range of diverse populations, including forensic groups.

The only downside, however, is for the avid users of the WMS-III who will have to break from their well-developed administration skills and learn what is effectively a ‘new’ test. Previous knowledge of the WMS-III is simply not required: WMS-IV is more than a simple updating, it is an impressive revision. For example, a range of subtests have been removed from the WMS-III to create the WMS-IV, namely Faces, Family pictures, Word Lists, Letter-Number Sequencing, Digit Span, Spatial Span, Information and Orientation, and Mental Control.

This has proven very helpful for administration to forensic populations since what appears to have been removed are the subtests which can, advertently, cause considerable frustration to forensic clients with impulsivity or affect disorders – anyone who has tried to administer Letter-Number Sequencing to an offender with a low tolerance threshold will certainly appreciate the sentiment here.

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What comes with this revolution in revision, however, is an entirely updated administration manual that now provides an excellent core basis for both clinical and research interpretation and application. The manual includes invaluable detail on the rationale for the changes, and the importance of such a significant revision. In addition to the removal of tests, three of the original tests have also been modified, with four new tests developed, one of which includes a Brief Cognitive Status Exam. This latter test will be particularly helpful to practitioners who are after a quick ‘sketch’ of initial ability.

The WMS-IV has also sought to solve some of the previous difficulties across a range of areas such as the rather limited previous range of normative samples available, to enhance the practical interpretation of the scores, to increase the comparability with broader tests such as the WAIS-III, and to improve content, reliability and, importantly, clinical application.

Within forensic practice there is certainly a need to assess more routinely the full extent of memory difficulties that our clients present with. Too often such assessments are either not completed, are rudimentary in nature, or do not respond to the engagement style of such a client group. The value of obtaining a full assessment of immediate memory (auditory and visual), delayed (auditory, visual and auditory recognition), general and working memory is essential both for research and practice purposes, and is aptly provided via the WMS-IV.

With regards to the research, there is a need for research exploring memory in depth, with the majority of alternative tests tending to focus on working memory, immediate recall and inattention. For offenders, research application is broad, and we can use tests such as the WMS-IV to explore how memory correlates with substance disorders, information processing (e.g. hostile interpretations; and regulation disorders that result in anger loss and impulsivity etc), offence recall and denial, witness recall, suggestibility and compliance, executive functioning, cognitive interviewing, and a range of clinical disorders, to name but a view.

The potential research application of tests such as the WMS-IV are thus significant, and could assist with the development of theories into offence engagement and treatment responsivity. With regards to this area, specifically the area of practice, the value in assessing memory in detail has application to the whole remit of forensic practice, whether this involves completing treatment or assessments with victims, perpetrators and/or witnesses.

Tests such as the WMS-IV can provide practitioners with a detailed individual profile that can assist with an indication of how treatment, assessments or interviews can be best matched to an individual’s learning style. Treatment and interviews can sometimes suffer from a lack of information on memory profile which the practitioner can then utilise to ensure that they attend to the responsivity needs of their clients. The WMS-IV now provides one possible solution to this.

As noted earlier, although other memory tests do exist, none provide the depth of memory assessment in such an accessible form for use with forensic clients, as does the WMS-IV. This is an important point, particularly when you are dealing with offenders who present with attention and/or impulsivity difficulties, where being able to focus their attention for long periods of time can be challenging for even the most skilled practitioner.

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The WMS-IV has such a variety of tests that the management of these challenges are really assisted, with tests presented to clients in an engaging fashion, and importantly, in a way which does not automatically engender ‘failure’. The latter is a vital area to be aware of when dealing with clients who may routinely present with a self-depreciating style and/or a proneness to feeling ‘punished’.

Thus, I warmly recommend the WMS-IV to any practitioner or researcher who has a keen interest in understanding the complexities of memory, and in applying the most up-to-date assessments to benefit their clinical and research practice. It should provide an invaluable further tool in the repertoire of clinical and research assessments available.

**Scoring:**
- Scores are now derived for Older Adult Battery (65–90) and Adult Battery (16–69)
- Ability / Memory Discrepancy Scores (for use with WAIS–IV UK)
- Index Scores
  - Auditory Memory
  - Visual Memory
  - Visual Working Memory
  - Immediate Memory
  - Delayed Memory
- NEW – Contrast Scores
  - Scaled scores contrasting performance across scores
  - Provide information on clinical significance of changes in scores across subtests or indexes

The WMS-IVUK can be scored using the WAIS-IV / WMS-IV UK Scoring Software and Report Writer, simply enter raw scores, and the software does the following:
- Generates concise score reports and statistical reports with graphs and tables.
- Raw to scaled score conversions
- Strength and weakness discrepancies
- Interprets statistically significant discrepancies between scores.
- Includes comprehensive user manual.

View Sample Reports at www.pearsonclinical.co.uk/WMS
To aid your understanding and application of your new *Wechsler Adult Intelligence Scale - Fourth UK Edition (WAIS-IV UK)* and *Wechsler Memory Scale - Fourth UK Edition (WMS-IV UK)* we have prepared a free online training course for your use.

This online training package equips the psychologist with in-depth information on the new test. The tool enables you to learn at your own pace in the convenience of your home or office.

Training includes:

- Administration and scoring guidelines for all subtests in the new WAIS-IV UK
- Discussion of reversal and discontinue rules applicable to each subtest
- Video examples to illustrate the use of the test
- Games and quizzes to enhance learning

To access WAIS/WMS Online Training please contact Customer Services on 0845 630 8888 or visit www.pearsonclinical.co.uk/WAIS for more details.
Overview:
The Behavioural Assessment of Dysexecutive Syndrome (BADS) is a test battery aimed at predicting everyday problems arising from the dysexecutive syndrome. The term Dysexecutive Syndrome includes disorders of planning, organisation, problem solving, setting priorities, and attention; and is one of the major areas of cognitive deficit that can impede functional recovery and the ability to respond to rehabilitation programmes.

The BADS is an individually administered assessment that is standardised for use for ages 16 - 87 (a separate child version is available for 8 to 16 years).

BADS specifically assesses the skills and demands involved in everyday life. It is sensitive to the capacities affected by frontal lobe damage, emphasising those usually exercised in everyday situations. These being:

- Temporal judgement
- Cognitive flexibility and inhibition of response
- Practical problem solving
- Strategy formation
- Ability to plan
- Task scheduling

BADS is useful for Chartered Psychologists and other Therapists working in neuropsychological and psychiatric rehabilitation. It will assist in identifying whether or not a patient has executive deficits likely to interfere with everyday life; and will help determine whether a client has a general impairment of executive functioning or a specific kind of executive disorder.

The BADS might also prove to be useful in neuropsychological and psychiatric rehabilitation. Because the BADS provides a tool for picking up subtle difficulties in planning and organisation, particularly in those people who appear to be cognitively well preserved and functioning well in structured situations, it may prove to be particularly useful in assessing and preparing patients for moves from hospital care into more independent living situations.

Features:
BADS consists of 6 subtests and a Dysexecutive Questionnaire (DEX):

Subtest 1 - Rule Shift Cards Test - This is a simple measure of ability to shift from one rule to another and to

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keep track of the colour of the previous card and the current rule.

Subtest 2 - Action Program Test. This test was originally devised by Klosowska in 1976 and was designed to provide subjects with a novel, practical task that required the development of a plan of action in order to solve a problem. This test was adapted minimally for inclusion in the BADS, and requires five steps to its solution. All five steps involve simple skills that are in everyone’s repertoire; but one has to work backwards, working out what needs to be done before concentrating on how that end is to be achieved.

Subtest 3 - Key Search Test - Subjects are presented with an A4 piece of paper with a 100mm square in the middle and a small black dot 50mm below it. The subjects are told to imagine that the square is a large field in which they have lost their keys. They are asked to draw a line, starting at the black dot, to show where they would walk to search the field to make absolutely certain that they would find their keys. This enables us to examine the subject’s ability to plan an efficient and effective course of action.

Subtest 4 - Temporal Judgement Test. This test comprises of four questions concerning commonplace events which take from a few seconds to several years (e.g. how long does a dog live for). Subjects are assured that they are not expected to know the exact answer to the four questions, they are being asked to make a sensible guess.

Subtest 5 - Zoo Map Test - Subjects are required to show how they would visit a series of designated locations on a map of a zoo. However, when planning the route certain rules must be obeyed. There are two trials. While the aim of the task is identical in both trials, the instructions given vary. The first trial is a high demand version of the task in which the planning abilities of the subject are rigorously tested. The second (low demand) trial requires the subject to simply follow the instructions to produce an error free performance.

Subtest 6 - Modified Six Elements Test. This involves the subject being given instructions to do three tasks (dictation, arithmetic and picture naming), each of which is divided in to two parts (A and B), giving 6 tasks in total. The subject is required to attempt at least something from each of the 6 tasks within a ten minute period. In addition, there is one rule that must not be broken: they are not allowed to do the two parts of the same task consecutively. This test makes demands on a person’s ability to plan, organise and monitor behaviour. It also taps ‘prospective memory’ i.e. the ability to remember to carry out an intention at a future time.

The Dysexecutive Questionnaire - This is a 20 item questionnaire constructed in order to sample a range of problems commonly associated with the Dysexecutive Syndrome. The questions sample four broad areas of likely changes: emotional or personality changes, motivational changes, and cognitive changes. The Dysexecutive Questionnaire supplements information provided by performance on the full assessments, through the provision of additional qualitative information. It is therefore not used in the calculation of the profile score for the full assessment.

Performance Norms:
The control sample consists of a stratified sample of 216 neurologically healthy subjects comprising approximately equal numbers of subjects in each of 3 ability bands - ‘below average’, ‘average’ and ‘above average’ (determined by the National Adult Reading Test (NART) IQ equivalent scores of 89 and below, 90-109 and 110 and above respectively).

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The patient sample consists of 92 patients, who presented with a variety of neurological disorders. There was no significant difference between the normal controls and patients on performance on the NART.

**Reliability:**  
**Inter-rater reliability** across the six tests is high, ranging from 0.88 to 1.00. Absolute agreement was obtained on 8/18 items.

**Test-retest reliability** - 29 of the normal control subjects were re-tested on the battery 6 - 12 months after completing it for the first time. The same group of subjects also completed three frequently administered frontal lobe tests on both these occasions so that test-retest phenomena observed on the BADS could be contrasted with performance on these measures.

Results showed that there is a general tendency for those normal controls re-tested to perform slightly better on the six BADS tests on the second occasion they were tested. However none of these reached statistical significance. This alongside administration of other frontal lobe tests supports the idea that test-retest reliability may not be high on tests measuring executive functioning, as they are not novel when administered for a second time.

**Validity:**  
The overall BADS profile score successfully differentiates the performance of subjects with a brain injury from those who do not.

In addition the performance of the brain injured group is significantly poorer on all six of the individual tests of the BADS compared to the controls.

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Overview:

The Functional Living Scale – UK version (TFLSUK) is an ecologically valid, performance based measure of functional abilities with an emphasis on instrumental activities of daily living (IADL) skills. TFLSUK assesses an individual’s ability to perform a variety of tasks that support independent functioning in the community. Brief and easy to use, the measure is especially well-suited for use in assisted living and nursing home settings.

Users & Applications:

TFLSUK can be used in comprehensive assessments, to support placement decisions, aid treatment planning, evaluate treatment outcomes, and monitor disease progression.

It can be administered by a variety of professionals including:
• Neuropsychologists and clinical psychologists working with all age ranges, to determine appropriate level of care
• Therapists, to evaluate changes in level of care for individuals
• Researchers in pharmaceuticals companies, to help conduct Alzheimer/dementia drug efficacy trials.

The TFLSUK covers four functional domains:

• Time – Assesses the ability to use clocks and calendars
• Money and Calculation – Assesses the ability to count money and write cheques
• Communication – Assesses the ability to prepare a snack, use a phone and phone books
• Memory – Assesses the ability to remember simple information and to take medications
• Subscale cumulative percentages and an overall T-Score can be used to help determine the examinee’s ability to function independently.

Benefits:

• Assesses functional abilities quickly and easily
• Screens for dementia with a tool focused on skills likely to be affected by cognitive decline
• Monitors functional decline and disease progression
• Monitors treatment/drug efficacy
• Determines level of care required and adapt treatment plans
• Linked with key tools including the WAIS-IVUK and TOPFUK

Visit www.pearsonclinical.co.uk for further information.
The Functional Living Scale - UK Version (TFLS_UK)

The UK Project:

The anglicisation and validation of the TFLS was carried out in the UK primarily to provide clinicians with a tool that they can be confident to use with the local population. Data were collected on a representative sample of UK individuals. The validation sample consisted of 215 people (114 females, 101 males) ranging in age from 16 to 90 years with a mean age of 47.52 years (SD = 19.91).

The validation study examined the reliability of the scale, its relationship with other measures, and the comparability of the UK and US means and SDs for the TFLS total scores (T scores) and subscales. The validation study provides sufficient evidence that the UK data closely reflects that of the US, thereby allowing TFLS_UK to be used with confidence in the UK.

Links to Other Measures:

Links between the TFLS and other measures have also been examined. These include the Independent Living Scale (ILS), Adaptive Behaviour Assessment System - Second Edition (ABAS-II), Wechsler Memory Scale - Fourth Edition (WMS-IV), California Verbal Learning Test - Second Edition (CVLT-II), Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-IV), Advanced Clinical Solutions for WAIS-IV and WMS-IV Test of Pre-Morbid Functioning (AC TOPF) and the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS).

The TFLS standardisation sample was collected with the WAIS-IV and WMS-IV standardisation samples. The standardisation version of the TFLS was included within the WMS-IV standardisation protocol, enabling clinicians to directly compare performance between the instruments.

Overall, the studies on cognitive functioning and adaptive functioning demonstrate a complex relationship. Higher correlations are observed in more impaired individuals.

Special Group Studies:

A number of special group studies were conducted concurrently with the scale’s standardisation to examine the clinical utility of the TFLS_UK. The special groups were selected due to their known or presumed deficits in functional ability, as well as their high incidence in clinical referrals. The TFLS adds pertinent information to an evaluation because the performance of instrumental activities of daily living is important to patients and their families, and is an important predictor for an individual’s ability to live and function independently.

Group studies include:

- Alzheimer’s Disease - Mild Severity
- Mild or Moderate Intellectual Disability
- Major Depressive Disorder
- Traumatic Brain Injury (TBI)
- Schizophrenia
- Autistic Disorder
- Living Status Groups

Find out more about the TFLS_UK at www.pearsonclinical.co.uk/tfls

Visit www.pearsonclinical.co.uk for further information.
Research:


Review: Dr. Carol A. Ireland, CPsychol, MBA, Forensic Psychologist, Chartered Scientist, University of Central Lancashire and CCATS (Coastal Child and Adolescent Therapy Services)

This assessment is designed as a brief measure of performance based functional competence for individuals who may suffer from a variety of neurodevelopmental and neurodegenerative disorders. It assesses important aspects of their self-care and ability to function independently, focusing on paying bills, remembering instructions over a short time period, and performing basic money transactions. It was initially developed through research into Alzheimer’s, and where it was regarded to be a more adept assessment of cognitive decline in activities of daily living. Following this initial development, the focus of the instrument expanded to other groups, such as those with intellectual disability, traumatic brain injury and schizophrenia. It therefore, has a much wider remit, and where it can now be utilised with a wide population, from 16 to 90 years, and where an assessment of functional ability is felt to be helpful. It is a brief instrument, taking only 15 minutes to administer.

It does have helpful applicability with the relevant populations, such as assisting in questions of competence and levels of independent living. It is however more suited for community populations, including community forensic populations, as opposed to clients in a secure setting, and where their daily living as assessed by this tool may be more restricted. A strength of this assessment is its focus on the more complex skills required for independent living, and which are more cognitively demanding. It can therefore be considered a robust tool for assessing these more multifaceted components, with a general opinion that it is these components which can first be noted to disintegrate with neurodegenerative disorders, as opposed to the more basic aspects of daily care. As such, there is the potential to identify difficulties much earlier, and to then put in place supportive measures and interventions for the individual. It also moves away from a traditional over-reliance on the self-report of others when making a judgement on these skills, and focuses more directly on the observed ability in the client.

Outside of its clinical utility, a further advantage is its accessibility for the client by exploring their competence without potentially evoking a sense of prolonged failure. If a client presents as unsuccessful in some areas they can quickly move to another aspect of self-care and/or ability. It can further be an engaging assessment, and where the client is requested to demonstrate ability in a range of different ways.

Overall this is a helpful instrument to determine the aspects of complex daily living that an individual can readily undertake, and areas where further support may be needed. It is easily assessable for the examiner, with helpful instructions and reminders as you progress through the instrument. Yet, this is only achieved by the examiner fully familiarising themselves and practicing the administration prior to engaging with a client. A point of observation with this instrument however is the need for the examiner themselves to provide further materials. Whilst these are generally not problematic, there is a need to purchase items such as a timer, a stop watch and a zip-top bag. Whilst an examiner can source these, it would be more helpful if these were provided, even at an additional cost. Yet, this should not deter a potential purchaser, as the benefit of using this tool far outweighs such considerations. Dated: 17 July 2012

Visit www.pearsonclinical.co.uk for further information.
Cogmed Working Memory Training™ is built around three easy-to-use, age-specific applications. Coach Training Cogmed is an evidence-based program for helping children, adolescents, and adults sustainably improve attention by training their working memory. Cogmed acts as a “primer” for improved learning, allowing the student to build the cognitive platform needed to learn successfully.

For adults with poor working memory, training can help you stay focused, ignore distractions, plan next steps, remember instructions, and start and finish tasks. The objective is better performance and attentional stamina. For students training will allow them to absorb the curriculum-based instruction more effectively with the objective of improved academic performance in areas such as maths and reading comprehension.

What does Cogmed involve?
Cogmed consists of 25 sessions of up to 30-40 minutes each, five days a week for five weeks. Each session consists of a selection of various tasks that target the different aspects of working memory. The training is done online at home, in school, or at work.

The program is based on strong scientific research. Cogmed is a rigorous program designed to improve working memory through intensive and systematic training. Training is led by a Cogmed Coach – trained by Pearson as part of your subscription package – who works with the user/family to set a flexible training schedule, provide structure, motivation, and feedback on the progress. Cogmed delivers substantial and lasting benefits. this is due to its:

Very focused design – The program challenges the user’s working memory capacity. The computerised, cognitive exercises are designed by neuroscientists to target this key cognitive function that has been proven to be fundamental to executive function and attention.

Finely tuned difficulty level – The difficulty level of the training is adjusted in real time by the software based on the user’s performance.

Highly personal support - Cogmed is carefully designed, rigorous, and focused on a key cognitive function. But to have strong real life effects, it has to be used in the right way. This is why Cogmed training is always supported by a Cogmed-trained coach.

Improved working memory “generalises” to behaviour - When you improve your working memory capacity, the change generalises to your behaviour. In other words, the change is translated to other things than just working memory. You will be better able to pay attention, resist distractions, self-manage, and learn.

The complete package includes
Cogmed Working Memory Training™ is built around three easy-to-use, age-specific applications. Coach Training

Cogmed JM
Preschool
Younger children use their working memory for a number of things, such as focusing on and following instructions, and remaining seated to complete independent activities. Cogmed JM features an interface especially designed for younger children, and requires participation for around 10-15 minutes every five weeks.

Cogmed RM
School Age
Working memory is crucial for children and adolescents in school, and socially. Reading, solving maths problems, planning, and following a conversation all rely on working memory. The program consists of approximately 25 sessions, over a 5 week period, and features a reward game at the end of each session.

Cogmed QM
Adult
Working memory in adult and professional life is critical for challenges such as planning, focusing, resisting distraction, and meeting deadlines. This program has an interface specifically designed for the older age-range, and like the other programs feature exercises that automatically adjust in difficulty to expand working memory capacity.

The Cogmed Training Web is a tool that allows coaches to monitor training data in detail. The Training Web also provides support material necessary for motivating and guiding individuals through the training.

Cogmed Coach Training provides you with the skills and resources needed to support clients and students. To ensure maximum success with Cogmed the annual licence includes Cogmed Coach Training for named coaches up to the amount covered by your subscription. The named coaches can attend training at any time within the subscription year at various venues around the country.
Research

Studies consistently show that problems with attention and learning are often caused by poor working memory. That holds true for those with ADHD, a specific learning disability, traumatic brain injury, or milder forms of learning problems. It is also often true for general concentration problems and poor academic performance.

Research also shows that deficits in working memory are related to poor academic or professional performance. Conversely, strong working memory capacity is closely correlated with fluid intelligence.

Research shows increases in task-related prefrontal and parietal brain activity (blue) following training.

Olesen et al. (2004)

A substantial body of research shows Cogmed to be effective in improving working memory - leading to improved attention. It began with Klingberg’s 2005 study on school age children showing strong results in a placebo-controlled, multi-center trial on children with ADHD.

Since then, leading research teams around the world have added to the Cogmed Research case. Revealing that individuals of all ages have improved working memory capacity using the Cogmed program.

Studies have also demonstrated transfer effects to executive functions such as attention, inhibition and reasoning; behavioral assessment; neuronal activity; and learning.

The increased interest in and use of Cogmed in school, clinical and research settings worldwide is a testament to the growing acceptance of WM training in the scientific community as well as a step forward in the field of evidence-based cognitive training.

Visit www.cogmed.com/research for comprehensive research, the latest research references, articles, and ongoing studies.

Benefits of Cogmed

Working memory is a cognitive function critical for focusing, resisting distractions, and for complex thinking. Improved working memory capacity generalizes to improved attention, impulse control and learning capacity.

8 out of 10 users who complete training show measurable effects; working memory capacity is increased, leading to better ability to focus, follow instructions, and stay on task.

Benefits and Features

• Annual subscriptions – choose from a small (20 user IDs) medium (40 user IDs) or large (60 user ID’s) model. Subscription includes coach training and access for the number of staff covered by your subscription.
• Train at home - Cogmed is accessible online, allowing completion both at home and at work/school.
• Access to all three training programs
• Variable Protocols - choose the number of minutes per training session (Training Session Length) and the number of days of training per week (Training Session Frequency) for each end user.
• New features – mandatory breaks, a Cogmed Progress Indicator (CPI), automatic notifications and full sequence testing to avoid disruptions.

Sign up for a free webinar

Learn more from experienced professionals about how Cogmed works. For dates visit www.cogmed.uk.com

About Cogmed

Cogmed was founded in 2001 by neuroscientists at the Karolinska Institute in Stockholm, Sweden. Cogmed training has been in successful use in the United States and Canada since 2006. The Cogmed system is now applied in more than 20 countries and 10 languages.

In 2010, Cogmed joined the Clinical Assessment Group of Pearson. Pearson is the world’s leading education company, providing educational materials, technologies, assessments, and related services to teachers and students of all ages.

Learn more at www.cogmed.uk.com
A tool to help support forensic or neuropsychological evaluations

Overview:

Designed to help meet the need for a well-validated, psychometrically sound test that can provide empirical support in courtrooms and other legal institutions, the VIP test provides a broad spectrum of information about an individual’s performance on an assessment battery.

As a measure of response styles, test results help assess whether the results of cognitive, neuropsychological or other types of testing should be considered representative of an individual’s overall capacities.

Uses of the VIP:

The VIP test is intended to provide support for conclusions that may impact the awarding of large sums of money or the determination of competence or culpability. As a result, the test is potentially useful to neuropsychologists, forensic and clinical psychologists in a variety of situations, including:

• Civil and criminal trials
• Competency-to-stand-trial evaluations
• Medical insurance examinations
• Social Security disability reviews
• Workers compensation examinations
• Rehabilitative treatment assessments

Administration:

The VIP test contains verbal and nonverbal subtests, each of which can be administered independently. As a self-administered forced-choice validity indicator, the VIP test provides more information than a yes/no decision regarding malingering. The test helps assess the relationship between the individual’s intention and the effort in completing the test. Based on this information, the report categorizes the individual’s style as Compliant, Inconsistent, Irrelevant or Suppressed.

A graph of results helps make it easy to explain the results in hearing or court proceedings. When used as part of a battery of tests, it complements most personality assessments. When used as a screening tool, the VIP test can help indicate who may not benefit from further, more extensive neuropsychological testing.
VIP Measures:

Validity Indicators - The VIP test uses six primary validity indicators to classify an individual’s performance as either valid or invalid.

Response Styles - The test also categorises the individual’s response style as:

- **Compliant** - Suggests an individual’s intent to perform well, along with the probability that his or her performance is an accurate representation of ability
- **Inconsistent** - Suggests that the respondent is motivated to perform well but the effort is inconsistent or minimal
- **Irrelevant** - Suggests that the individual intended to perform poorly and that he or she was most likely responding without regard to item content
- **Suppressed** - Suggests high effort to perform poorly and that the individual tried to feign cognitive defects.

Technical information:

Scoring rules for the VIP test were developed using a sample of more than 1,000 clinical and non-clinical subjects. Results were then cross-validated using an independent sample of 312 cases comprised of 5 criterion groups:

- Traumatic brain injured patients
- Suspected malingerers
- Normal subjects
- A “faking bad” group
- A group of random responders

Scoring:

The VIP is now available on Q-global (see product bulletin sheet included) our new web-based platform for test administration, scoring and reporting. The results can be outputted into an Interpretive Report and or a Profile report:

Interpretive Report - Respondent’s answers are not only compared to a normative group but against the individual’s own demonstrated abilities. The report contains two key sections:

- Classification of Test Performance - Summarises the respondent’s approach to the assessment and includes a narrative explanation of the validity determination.
- Expected and Actual Performance Curve - Graphs the test taker’s performance on test items by ascending order of item difficulty. The visual representation gives the evaluator an immediate overview of the respondent’s response style. A more detailed interpretation is included in the measurements and narrative that follow the graph.

Profile Report - The report provides a graphical representation of the test taker’s performance on test items.

“[A] well conceived, sophisticated, and invisible instrument...It is well designed, easy to administer, and generally cost effective” Michael Gamache, awarded a doctoral degree in clinical psychology, University of Missouri, Columbia.

Visit www.pearsonclinical.co.uk for further information.
Measure the accuracy of an individual’s responses to tests

Overview:

The PDS is a self-report instrument that identifies individuals who, when responding to assessments and rating scales, distort their responses. It is designed to be administered concurrently with other instruments to indicate the validity of the results of the other instruments. It contains 40 items that use contemporary, gender-neutral language.

Key areas / scales measured are:

• Impression management (IM) - how likely an individual is to give inflated self-descriptions because of certain contextual factors
• Self-Deceptive Enhancement (SDE) - how likely an individual is to provide honest, yet self-inflated responses.

Administration:

As a self-report instrument the PDS kit comes complete with a users manual and 25 quickscore forms. Individuals are asked to rate their response to 40 items on a five-point scale of 'Not true' to 'Very true'. The test can be used in clinical and non-clinical environments.

Scoring:

The PDS is quick and easy to score. The manual provides the necessary tables for converting raw scores to T-Scores for profiling, and assigns only points to only the most extreme scores, eliminating any typical responses. There are samples for the general population and prison settings (based on US norms) allowing you to compare profiles. The manual also provides case histories.

Also Available:

Coping Inventory for Stressful Situations (CISS): effectively measure three major types of coping styles: Task-Orientated, Emotion-Orientated and Avoidance Coping.

Hare Psychopathy Checklist-Revised: (PCL-R) 2nd Edition: a 20 item scale for the assessment of psychopathy in research, clinical and forensic settings.

Visit www.pearsonclinical.co.uk for further information.
Overview:

The Spousal Assault Risk Assessment Guide (SARA) helps criminal justice professionals predict the likelihood of domestic violence. The tool is a quality-control checklist that determines the extent to which a professional has assessed risk factors of crucial predictive importance according to clinical and empirical literature.

With 20 items, the SARA assessment screens for risk factors in individuals suspected of or being treated for spousal or family-related assault.

The SARA can help determine the degree to which an individual poses a threat to his spouse, children, family members, or other people involved.

The instrument can be used by members of various boards or tribunals (e.g., parole and review boards, professional ethics committees, etc.), lawyers, victims’ rights advocates, and prisoners’ rights advocates.

Scales & Forms:

SARA Checklist of Information Sources
- The SARA Checklist of Information Sources is a checklist designed to ensure that all possible information resources have been tapped.

SARA QuikScore™ Form
- The clinician-completed QuikScore™ form is a self-scoring form designed to screen for risk factors of spousal or family-related assault.

Scales:
- Spousal Assault History
- Criminal History
- Alleged/Most Recent Offense
- Psychosocial Adjustment

Related products:
- Hare Psychopathy Checklist: Screening Version (PCL:SV)

Visit www.pearsonclinical.co.uk for further information.
Overview:

*Hare PCL-R* is a 20 item scale for the assessment of psychopathy in research, clinical and forensic settings. It uses a semi-structured interview, file and collateral information to measure inferred personality traits and behaviours related to a widely understood traditional concept of psychopathy. It yields dimensional scores but also can be used to classify or diagnose individuals for research and clinical purposes.

Changes from the 1st edition:

The major difference is the large amount of data that is now available for establishing comparison tables and descriptive statistics for selected groups and for addressing issues of reliability, validity and generalisability.

Administration:

Included in the *PCL-R* kit is a technical manual, rating booklet, quick score forms and interview guide. The rating booklet contains the *PCL-R* items described in detail with suggestions of the sources of information needed to score each item. The quick score form is a self-scoring form used to record the ratings of the individual on each of the 20 *PCL-R* items. The interview guide includes interview questions that are recommended to elicit information for the *PCL-R*.

Hare PCL-R items:

1. Glibness/superficial charm
2. Grandiose sense of self worth
3. Need for stimulation/proneness to boredom
4. Pathological lying
5. Conning/manipulative
6. Lack of remorse or guilt
7. Shallow affect
8. Callous/Lack of empathy
9. Parasitic lifestyle
10. Poor behavioural controls
11. Promiscuous sexual behaviour

Visit [www.pearsonclinical.co.uk](http://www.pearsonclinical.co.uk) for further information.
12. Early behavioural problems
13. Lack of realistic, long-term goals
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility for own actions
17. Many short-term marital relationships
18. Juvenile delinquency
19. Revocation of conditional release
20. Criminal versatility

Scoring:

Each item is rated using a 3-point ordinal scale (0, 1 or 2). No more than two of the 20 items should be omitted. If too many items are omitted the individual should be re-interviewed. The total score can range from 0-40. Factor scores range from 0-14 for factor 1 (Interpersonal/affective), 0-20 for factor 2 (Social deviance), and facet scores from 0-8 for facets 1 (Interpersonal) & 2 (Affective), and 0-10 for facets 3 (Lifestyle) & 4 (Antisocial).

T-scores available in the Quickscore form for total score, Factor scores and Facet scores. Percentile ranks for total, factor and facet scores are available in the manual.

Technical information:

Included in the manual are descriptive and validation data for use of the PCL-R with male and female offenders, substance-abusers, sex offenders, African-american offenders, forensic psychiatric patients, as well as with offenders in several other countries.

Also available:

Hare PCL screening version: For use with non criminal populations and as a screen for psychopathy in forensic populations. 12 items rather than 20.

Hare PCL youth version: Designed for use with young offenders aged 12-18. Both of these are strongly related to the PCL-R conceptually and empirically.
Assess personality disorders and clinical syndromes

Overview:

The *Millon™ Clinical Multiaxial Inventory-III (MCMI-III™)* provides a measure of adult psychopathology that is rooted in Dr Theodore Millon’s groundbreaking theory of personality and pathology. It is suitable for the diagnostic screening or clinical assessment of adults (aged 18 years and older), who:

• show evidence of problematic emotional and interpersonal symptoms, and/or
• are undergoing professional psychotherapy or psychodiagnostic evaluation.

A self-report inventory, the *MCMI-III* consists of 175 true or false statements that people use to describe themselves. The interpretation of these statements aims to help clinicians assess the interaction of Axis I (the acute clinical disorders that patients display e.g. Anxiety, Somatoform, PTSD) and Axis II (the enduring personality characteristics e.g. Schizoid, Dependent, Histrionic) disorders.

These Axes have been based on the most recent classification system as published in the *Diagnostic and Statistical Manual of Mental Disorders - DSM-IV®,* (American Psychiatric Association, 1994), making it one of few diagnostic instruments available, that closely reflects current nosology.

New developments:

The *MCMI-III* now includes three new facet scales for each *MCMI-III* personality scale. These three scales are; Severe Personality Pathology – Schizotypal, Borderline, and Paranoid; and for Severe Clinical Syndromes – Thought Disorder, Major Depression and Delusional Disorder.

By looking at the Clinical Personality Patterns and Severe Personality Pathology scales and pinpointing which specific personality processes (e.g. self-image, interpersonal relations) underlie any elevations; clinicians are able to form an integrated view of a patient’s long-standing coping styles and psychological stressors. This has the benefit of helping clinicians to form theoretically substantiated and clinically sound case conceptualizations along with personalised treatment plans and therapeutic directions.

Visit www.pearsonclinical.co.uk for further information.
Uses of MCMI-III:

The *MCMI-III* test can be used in a variety of different settings or scenarios, including: Forensic settings, Neuropsychological evaluations, Substance abuse, Post-Traumatic Stress Disorder, Correctional Settings, and Treatment Planning and Psychotherapy.

Normative data and transformation scores for the *MCMI-III* are based on clinical samples and are applicable only to individuals who evidence problematic emotional and interpersonal symptoms or who are undergoing professional psychotherapy or psychodiagnostic evaluation.

Administration:

Included in the *MCMI-III* kit is a manual, user’s guide, 10 test booklets, 50 answer sheets, 50 worksheets, 50 profile forms and answer keys. The test can be administered in pencil and paper format and scored by a computer or by hand; administered and scored by computer; or alternatively audio recordings are also available for clients with normal comprehension who have visual handicaps or limited reading skills.

MCMI-III Scales:

Clinical Personality Patterns
- 1 Schizoid
- 2A Avoidant
- 2B Depressive
- 3 Dependent
- 4 Histrionic
- 5 Narcissistic
- 6A Antisocial
- 6B Sadistic
- 7 Compulsive
- 8A Negativistic
- 8B Masochistic

Severe Personality Pathology
- S Schizotypal
- C Borderline
- P Paranoid

Clinical Syndromes
- A Anxiety
- H Somatoform
- N Bipolar: Manic
- D Dysthymia
- B Alcohol Dependence
- T Drug Dependence

Visit www.pearsonclinical.co.uk for further information.
Millon™ Clinical Multiaxial Inventory-III (MCMI-III™)

- R Post-Traumatic Stress Disorder
- Severe Clinical Syndromes
- SS Thought Disorder
- CC Major Depression
- PP Delusional Disorder

Modifying Indices
- X Disclosure
- Y Desirability
- Z Debasement
- V Validity

Scoring:

The MCMI-III can be hand-scored or computer scored via Q-global (see product bulletin sheet included) our new web-based platform for test administration, scoring and reporting. Users who choose to use Q-global will have three report options; an interpretive Report, a Profile Report and a Corrections Report.

The Interpretive Report includes a Treatment Guide that provides short-term, focused treatment options and a Capsule Summary that gives a concise overview of diagnostic and therapeutic findings indicated by test results. The report also provides an integrated interpretation of the scales.

The Profile Report, a useful screening device for identifying patients who may require more intensive evaluation, provides a graphic representation of individual scale cutting lines.

The Corrections Report is similar to the Interpretive Report, but also includes a section that summarises behavioural and characterological features that are relevant to individuals in prison settings.

Sample copies of these reports can be downloaded from our website and are included in this pack.

Visit www.pearsonclinical.co.uk for further information.
Technical Information:

The updated norms are based on a US nationally representative sample that included 752 males and females with a wide variety of diagnoses, including patients seen in clinics, mental health centres, forensic settings, and hospitals. The new Corrections Report builds on the clinical norms and has norms based on US 1,676 male and female inmates. The normative data and transformation scores of the MCMI-III are based entirely on clinical samples.

Review:

Dr Ruth Tully, Forensic Psychologist in NHS and Private Practice

As a frequent user of MCMI-III, and as someone who trains other professionals to use the tool competently and ethically, I was delighted to hear that the MCMI-III is now available on the modern platform of Q-global.

I use the MCMI-III in various contexts including prisons, psychiatric settings and the community. I was therefore pleased that the correctional norms are available to use within Q-global alongside the psychiatric norms.

I have found the MCMI-III profile generator very useful in my clinical practice. From the outset the platform itself is easy to use and when inputting the MCMI-III raw answers the platform has a built in ‘second check’, which is especially helpful. In my experience of using MCMI-III on Q-global I have found that the profile generator saves me a lot of time (and consequently money – time is money after all!) when compared to hand scoring, second scoring and converting raw scores to BR scores.

The report generator is also easy to use and the resulting reports are thorough. The language at times is somewhat Americanised, however is easy to understand and change. The reports are (logically) heavily based on Millon’s theories of personality. For the purposes that I use MCMI-III assessments for, I use some of the generated interpretative report within my larger psychological assessment report. I find that the generated report helps me to reflect on the findings of the assessment and aids my independent report writing as a result. I am a forensic psychologist and my reports are usually to aid psychological treatment and risk reduction/management, and the generated report does help to inform this but of course such reports need independent thinking and writing.

Overall, the Q-global platform is easy to use with MCMI-III. In my opinion the MCMI-III profile generator is the best feature and is extremely useful for my clinical practice as it saves time and helps to reduce human error in scoring. This has become my usual way of scoring MCMI-III assessments. The interpretative reports are insightful as they can aid reflection and can therefore help inform the reports of psychologists in clinical practice.

Dated: 7 January 2014

Visit www.pearsonclinical.co.uk for further information.
Also available:

Millon Pre-Adolescent Clinical Inventory (M-PACI)
The M-PACI assessment provides an integrated view that synthesises the child’s emerging personality styles and clinical syndromes, helping clinicians detect early signs of Axis I and Axis II disorders.

Millon™ Adolescent Clinical Inventory (MACI)
The MACI assessment was specifically created to address the unique concerns, pressures and situations facing teens. Brief and easy to administer, the MACI test can assist practitioners in constructing treatment plans customised to individual needs and help them guide troubled youth towards healthier, more authentic lives.

Millon Index of Personality Styles Revised (MIPS Revised)
This widely useful test offers a convenient tool to help professionals assist ostensibly normally functioning adults who may be experiencing difficulties in work, family or social relationships. It may also be helpful in career counselling or employment settings.

Millon™ Behavioral Medicine Diagnostic (MBMD)
The MBMD assessment helps provide a broader understanding of the personal reality that each patient faces. By helping identify psychosocial assets and liabilities that may affect an individual’s response to treatment, the MBMD test enables clinicians to develop tailored treatment recommendations.

The MBMD’s recently added bariatric norms can help determine a candidate’s psychological suitability for surgery, assist patients in making significant lifestyle changes and prepare medical staff to respond to patients’ likely reactions following surgery.
The Minnesota Multiphasic Personality Inventory Range

The most widely used and researched tests of adult psychopathology

MMPI product range - quick facts

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<th>MMPI-A</th>
<th>MMPI-2</th>
<th>MMPI-2-RF</th>
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<td>18 years and older</td>
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Minnesota Multiphasic Personality Inventory-Adolescent™ (MMPI-A)

An empirically based measure of adolescent psychopathology, the MMPI-A test contains adolescent-specific scales, and other unique features designed to make the instrument especially appropriate for today’s youth. Offering reports tailored to particular settings, the MMPI-A test helps provide relevant information to aid in problem identification, diagnosis, and treatment planning for youth (ages 14–18).

**How to Use This Test**
Educational, clinical and counselling psychologists can use this self-report inventory to help:
- Support diagnosis and treatment planning in a variety of settings.
- Identify the root causes of potential problems early on.
- Provide easy-to-understand information to share with parents, teachers, and others in the adolescent’s support network.
- Guide professionals in making appropriate referrals.

**Key Features**
- Item content and language are relevant for adolescents.
- At the psychologist’s discretion, the clinical scales and three of the validity scales can be scored from the first 350 items, a significant savings in administration time.
- Norms are adolescent-specific.
- Scales help address problems clinicians are more likely to see with adolescents, including family issues, eating disorders, and chemical dependency.

Visit www.pearsonclinical.co.uk for further information.
Reports available via Q-global™

Basic Service Report
• This report provides a one-page profile of raw and T scores for three Validity Scales (L, F1, K) and the 10 Clinical Scales. This report is provided to facilitate an abbreviated administration of the MMPI-A test using the first 350 items.

Adolescent Interpretive System Report
This comprehensive report helps provide an objective psychological picture of the adolescent through scale scores, special indices, and narrative statements. Based on extensive experience in MMPI and MMPI-2 research and clinical practice, authors James N Butcher, PhD, and Carolyn L Williams, PhD, provide information on the following:
• Symptomatic Behaviour
• Interpersonal Relationships
• Behavioural Stability
• Diagnostic and Treatment Considerations
• A list of omitted items and suggested items for follow-up

Specialised reports are available for the following settings:
Correctional, General medical, Inpatient mental health, Outpatient mental health, School settings and Alcohol and drug treatment

Extended Score Report
• This report provides raw and T scores for all standard MMPI-A scales. Recently updated for 2006, the report now includes PSY-5 Scales, Content Component Subscales, and critical items.

Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

Relevant to a range of contemporary applications, the MMPI-2 instrument remains the most widely used and widely researched test of adult psychopathology.

Used by clinicians to assist with the diagnosis of mental disorders and the selection of appropriate treatment methods, the MMPI-2 test continues to help meet the assessment needs of mental health professionals in an ever-changing environment.

The MMPI-2 test’s contemporary normative sample and extensive research base help make it the gold standard in assessment for a wide variety of settings.

The test can be used to help:
• Assess major symptoms of social and personal maladjustment.
• Identify suitable candidates for high-risk public safety positions.
• Give a strong empirical foundation for a clinician’s expert testimony.
• Assess medical patients and design effective treatment strategies, including chronic pain management.

Visit www.pearsonclinical.co.uk for further information.
• Evaluate participants in substance abuse programs and select appropriate treatment approaches.
• Support college and career counselling recommendations.
• Provide valuable insight for marriage and family counselling.

Key Features
• Descriptive and diagnostic information relevant to today’s clients. Tailored reports present interpretive information for specific settings to help meet a wide range of needs.
• Nationally representative normative sample. Normative sample consists of 1,138 males and 1,462 females between the ages of 18 and 80 from several regions and diverse communities within the U.S.
• Flexible administration and scoring. The test can be administered in several formats: traditional paper-and-pencil, CD recording, and computer.

Reports available via Q-global™
• Reports for Forensic Settings
• Adult Clinical System Interpretive Report
• Criminal Justice and Correctional Report
• Extended Score Report
• Personnel Adjustment Rating Report
• Personnel Interpretive Report

Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF)
The MMPI-2-RF provides a valuable alternative to the MMPI-2 test

Composed of 338 items, with the RC (Restructured Clinical) Scales at its core, the MMPI-2-RF builds on the strengths of the MMPI®-2 test to create a new standard.

A comprehensive technical manual for the MMPI-2-RF reports empirical correlates of the scales in a range of settings, including mental health inpatient and outpatient clinics, substance abuse treatment centers, criminal court proceedings, personal injury and disability evaluations, and public safety employment evaluations.

How to use this test
The MMPI-2-RF aids clinicians in the assessment of mental disorders, identification of specific problem areas, and treatment planning in a variety of settings. The test can be used to help:
• Assess major symptoms of psychopathology, personality characteristics, and behavioural proclivities.
• Evaluate participants in substance abuse programs and select appropriate treatment approaches.
• Assess medical patients and design effective treatment strategies, including chronic pain management.
• Provide valuable insight for marriage and family counselling.
• Support classification, treatment, and management decisions in criminal justice and correctional settings.
• Identify high-risk candidates in public safety screening and selection settings.
• Give strong empirical foundation for expert testimony in forensic evaluations.

Key Features
• Nationally representative normative sample. Drawn from the MMPI-2 normative sample, the MMPI-2-
RF normative sample consists of 2,276 men and women between the ages of 18 and 80 from several regions and diverse communities in the US.

- Availability of comparison samples. Descriptive data from a broad range of settings make it possible for test users to compare individual test results with relevant reference groups in settings such as mental health, medical, forensic, criminal justice, and public safety.
- Only 35–50 minutes to administer.
- Software and report features:
  - Audio on-screen administration of the MMPI-2-RF
  - Easily convert MMPI-2 records to MMPI-2-RF records for comparison
  - Add annotation, end notes, and hover text to your MMPI-2-RF Interpretive Report.

Reports available via Q-global™

The MMPI-2-RF® Score and Interpretive Reports provide raw and T scores for all 51 empirically validated scales of the MMPI-2-RF. These reports also enable users to include comparative means and standard deviations for groups from 20 different settings to create their own customized comparison groups

Interpretive Report Clinical Settings
This report includes full scoring information and an integrated interpretation of scores organized in the following sections:
- Synopsis – Summary of the major conclusions
- Protocol Validity – Comprehensive information about potential threats to test validity
- Substantive Scale Interpretation – Description of clinical symptoms, personality characteristics, and behavioral tendencies
- Diagnostic Considerations – Diagnostic possibilities indicated by test results
- Treatment Considerations – Recommendations pertaining to treatment planning
- Item-Level Information – List of unscorable responses, critical responses, and user-designated item-level information
- Endnotes – Identification of scores that triggered each statement
- Research Reference List – Sources of statements based on empirical correlates

Score Report
This report provides a comprehensive representation of scales organized in the following sections:
- Validity Indicators
- Higher-Order scales
- Somatic/Cognitive and Externalizing scales
- Externalizing, Interpersonal, and Interest scales
- PSY-5 scales

Visit www.pearsonclinical.co.uk for further information.
Overview:
Tells you how individuals experience anger and what kind of situations provoke it.

Features:
Initially developed in conjunction with the MacArthur Foundation Network on Mental Health and Law, the NAS-PI helps clinicians and researchers evaluate the role of anger in various psychological and physical conditions.

Brief and easy-to-administer, this self-report questionnaire is an excellent way to assess anger in clinical, community, and correctional settings.

The NAS-PI is composed of two parts:

1. The Novaco Anger Scale (60 items), which tells you how an individual experiences anger;
2. The Provocation Inventory (25 items), which identifies the kind of situations that induce anger in particular individuals.

The entire questionnaire can be completed in just 25 minutes by anyone with a reading age of 8 or above. (It can also be administered to clients who are mentally disordered or developmentally delayed, though items may have to be read to these individuals.)

The NAS-PI produces the following scores:

Novaco Anger Scale: Total
General inclination toward anger reactions, based on Cognitive, Arousal and Behaviour subscales.

Cognitive: Anger justification, rumination, hostile attitude and suspicion.

Arousal: Anger intensity, duration, somatic tension and irritability.

Behaviour: Impulsive reaction, verbal aggression, physical confrontation and indirect expression.

Anger Regulation: Ability to regulate anger-engendering thoughts, effect self-calming, and engage in constructive behaviour when provoked.

Provocation Inventory: Total
A reflection of five content areas: disrespectful treatment, unfairness, frustration, annoying traits of others, and irritations.

In addition, a validity index helps identify inconsistent responding, whether intentional or inadvertent.

Technical Information:
Visit www.pearsonclinical.co.uk for further information.
The NAS-PI can be administered as a whole, or the two parts can be used independently. Normative data are based on an age-stratified sample of 1,546 individuals, from 9 to 84 years of age. Separate norms are provided for pre-adolescents and adolescents (9 to 18) and adults (19 and older).

The test has shown good test-retest reliability in nonclinical, clinical, and correctional samples. Studies reported in the Manual demonstrate that the NAS-PI can distinguish between assaultive and non-assaultive forensic inpatients and predict assaultive behavior in institutions as well as violent behaviour in the community following hospital discharge.

Why choose NAS-PI?

- Brief and easy to administer in approximately 25 minutes
- Is an excellent way to assess anger reactivity, anger suppression and change in anger disposition

Related assessment:

Screen child and adults for aggressive tendencies with this routine self-report inventory. The Aggression Questionnaire (AQ) measures an individual’s aggressive responses and his or her ability to channel those responses in a safe, constructive manner.

The self-report consisting of 34 items on which individuals rate themselves on a 5-point scale ranging from “Not at all like me” to “Completely like me.”

- Physical Aggression
- Hostility
- Verbal Aggression
- Indirect Aggression

Anger Standardisation is based on a US sample of 2,138 individuals, ages 9 years to 88 years. In addition, norms for the Verbal Aggression and Physical Aggression scales are separated by sex. Scores can be used in treatment planning and outcome measurement. The AQ is ideal for use in correctional settings, schools, military installations and geriatric or convalescent hospitals for both screening and program evaluation.

Visit www.pearsonclinical.co.uk for further information.
Overview:
The third edition of Conners™ has been designed as an in-depth, focused assessment of ADHD (Attention Deficit Hyperactivity Disorder). Conners 3™ aims to assess and screen for problems and disorders most commonly co-morbid or associated with ADHD.

With streamlined content, the third edition is a refined revision of Conners-Revised with new normative data and updated psychometric properties. The respondent-friendly translations of DSM-IV concepts allows for detailed assessment and can be used in a variety of ways:

- As an initial evaluation when the referral question – includes features of ADHD.
- As part of a re-evaluation to help determine progress in treatment, and to see if new issues have emerged
- As part of a screening evaluation to determine if further consideration should be given to the possibility of ADHD, ODD, or CD.
- When the Conners CBRS™ indicates that more thorough assessment of ADHD and associated issues must be pursued.
- For frequent administration in monitoring response to intervention. In contrast to other rating scales Conners 3™ can be administered frequently due to high test retest reliability.

The Conners 3™ has DSM-IV-based symptoms of ADHD, and has added Opposition Defiant Disorder and Conduct Disorder. It also contains symptom-level information from the DSM-IV-TR. *

* Following the publication of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition™ (DSM-V™) last year, the publishers of this title have issued an update to the Conners 3™. In line with the release of the DSM-V™, revisions have been made to the symptom criteria for ADHD, Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD) and updates carried out to the Conners 3™ manual (detailed in supplement), full-length hand-scored forms and scoring software. See our website for further details.

Features:
The Conners 3™ has a modified age range (6-18 years), increased similarities across forms and has been written with teachers, parents, and students in mind.

For each item the respondent indicates how often they feel that the statement applies to the child described; 0 = Not true at all (Never, Seldom); 1 = Just a little true (Occasionally); 2 = Pretty much true (Often, Quite a bit); 3 = Very much true (Very often, Very frequently); ? = Omitted item.
Key areas measured are:

- Hyperactivity
- Impulsivity
- Executive Functioning
- Learning Problems
- Aggression
- Peer Relations
- Family Relations
- Inattention

Other important features of the Conners 3™ include:

- 8 Screener Items for Anxiety and Depression
- 6 Severe Conduct Critical Items - These groups of items alert the assessor to behaviors that are of significant concern at any age and warrant immediate investigation and/or intervention. e.g. fire-setting
- 3 Validity Scales - Negative Impression; Positive Impression; Inconsistency Index.

Scoring and Forms:

Following the updates with regards to DSM-V you now have the choice of two scoring options for the Conners 3™:

- DSM-IV-TR™: DSM Symptom Scales are scored based on diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR).
- DSM-5™: DSM Symptom Scales are scored based on diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5).

There are several forms available for the Parent, Teacher and Child (Self-report), and updated DSM-V™ hand-scored forms for the Conners 3 Full-length Parent, Teacher, and Self-Report QuikScore™ Forms are now available. The long form is recommended for use when comprehensive information and symptoms are required.

Short forms are useful when administration of the full-length versions is not possible or practical. It is made up of a subset of items from the full-length form, representing concepts from all empirical scales, the inattention scale, and the validity scales. Both of these forms have scales that closely parallel each other.

In addition, there is a 10-item ADHD index form available. This is a separate, brief, ADHD-focused measure with items selected as the best to differentiate between people with ADHD from individuals with no clinical diagnosis. Not only is it a useful as a quick check to see if further ADHD evaluation is warranted but it can also be useful for repeated measures.

As part of the full-length form, or available as a separate form is the Conners Global Index. This is a fast and effective measure of general psychopathology. Including the 10 best predictive items from the parent and teacher rating scales. It allows professionals to carefully measure the general psychopathology of their clients and determine the next steps to take in further examination. The Conners 3GI has proven to be a fast and effective measure and is specifically used in monitoring treatment and intervention.

Technical Information:
Normative Sample- US (2001 census)

- 1200 Parent and Teacher rated (6-18yrs)
- 1000 youth self-reports (8-18yrs)

Visit www.pearsonclinical.co.uk for further information.
• Stratifies by age and gender
• Representative of all ethnicities/races/SES groups/geographic regions

Internal Consistency

<table>
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<th></th>
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<th>Teacher</th>
<th>Self</th>
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<tr>
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</tbody>
</table>

Test-Retest Reliability
• .65-.94 (2-4 Weeks)

Gender Effects
• Girls with ADHD are often not diagnosed because they don’t typically exhibit the same symptoms as their male counterparts. The Conners 3™ can be useful in discerning between gender specific differences.
• T-scores are calculated based on youth’s age and gender to adjust for these differences

Why choose Conners 3™:
• Multi-informant approach to assessment
• Links to DSM-IV
• Respondent-friendly translations of DSM-IV concepts
  • DSM-IV symptoms of ODD and CD
  • Assessment of Executive Functioning (P&T)
  • New validity scales (PI, NI, IncX)
  • Screener items for Anxiety and Depression
  • Severe conduct critical items
  • Impairment items
  • ADHD index available as separate 10-item index
• Easy Scoring options
• Scoring software generates in-depth detailed reports useful for parents and all health professionals

Links to other measures:
During development of Conners 3™, the need for a comprehensive rating scale based on empirical research, that could be used by assessors for a wide range of clinical issues affecting children was identified. Hence the Conners Behavioural Rating Scales™ was developed and can be used in conjunction with Conners 3™ enabling a thorough assessment of children displaying clinical problems to take place.

Visit www.pearsonclinical.co.uk for further information.
Overview:

BASC-2 is a multimethod, multidimensional system used to evaluate behaviour and self-perceptions of children and adults aged 2–25 years. It is sensitive to both obvious and subtle behavioural and emotional disorders as expressed in school and clinical settings, and to academic and familial demands on child and adolescent development. It provides a sophisticated approach to the evaluation of behavioural and emotional disorders among children and adolescents.

It has five components which can be used individually or in any combination:

- Two rating scales (teacher - TRS and parent - PRS). These gather descriptions of a child’s observable behaviour, each divided into age-appropriate forms.
- A self-report scale (self-report of personality - SRP). This allows the child to describe their emotions and self-perceptions.
- A structured developmental history (SDH)
- A form to record and classify directly observed classroom behaviour (Student Observation System - SOS)
- BASC-2 measures numerous aspects of behaviour and personality including positive (adaptive) and negative (clinical) dimensions.

BASC-2 was designed to facilitate the evaluation of a variety of emotional and behavioural disorders of children and to aid in design of treatment plans.

Features:

- Assesses a wide range of distinctive dimensions. As well as evaluating personality, behavioural problems and emotional disturbance, it can identify positive attributes that are useful in the treatment process.
- The range of dimensions assessed can help to make a diagnosis of a specific category of disorder such as those in the DSM-IV-TR (American Psychiatric Association, 2000) and general categories of problems such as those addressed by the Individuals with Disabilities Education Act (IDEA, 1997).
- It allows information from multiple sources to be compared to help achieve reliable and accurate diagnoses.
- Each component is designed for a specific setting or type of respondent because some behaviours are more important or measurable in some settings rather than others.
- The scales are highly interpretable because they are built around clearly specified constructs with matching item content developed through a balance of theory and empirical data.
- Scales also have high internal consistency and test-retest reliability.
- Forms can be either hand-scored or computer-scored.
- Norms are based on large representative samples and differentiated according to gender, age and clinical status of the child. (N.B US Census data 2001). Clinicians can choose from gender-based norms or combined-gender norms when deriving standard scores for the various sub-scales on composites.
- It offers validity checks to help detect careless or untruthful responding, misunderstanding or other threats to validity.
- Scales are consistent across gender and age as well as between teacher and parent forms. This enables consistent interpretation of scales and meaningful across-source and across-time score comparisons.

Visit www.pearsonclinical.co.uk for further information.
BASC-2 is now available on Q-global™ (see product bulletin sheet included) our new web-based platform for test administration, scoring and reporting.

Reports available include the Interpretive Summary Report, Clinical Report and Score Summary Report. Find out more at www.pearsonclinical.co.uk/Qglobal

Technical Information:
US Norms, Sample Size: 3 400 – 4 500 for each scale
There is a choice of norm groups:
• General, combined gender
• General, separate gender
• Clinical
The norms have been sampled across race, ethnicity, parent education, geographical region and clinical/special education status.

Why choose BASC-2:
• Can aid clinical diagnosis of disorders that are first apparent in childhood or adolescents.
• Can be used in a variety of clinical or educational settings.
• BASC-2 is sensitive to numerous presenting problems in the classroom: academic difficulties are frequently linked to behaviour problems. It is also useful for assessing severe emotional disturbance.
• BASC-2 may be particularly useful for designing individual educational plans.
• Repeated use of the BASC-2 can help to identify a child’s progress in specific programmes.
• Uses a multidimensional approach for conducting a comprehensive assessment
• Strong base of theory and research gives you a thorough set of highly interpretable scales
• Enhanced computer scoring and interpretation provide efficient, extensive reports
• Differentiates between hyperactivity and attention problems with one efficient instrument

Links to other measures:
• BASC-2 BESS (Behavioral and Emotional Screening System)
• BASC-2 Intervention Guide and Progress Monitor
• Q-global™

Visit www.pearsonclinical.co.uk for further information.
A brief assessment of quality of life/life satisfaction

Age Range: 18 years and older
Administration: Individual - Approximately 15 minutes (32 items with 3-point rating scale for importance, and 6-point rating scale for satisfaction)

The QOLI test is a measure of positive psychology and mental health. Brief but comprehensive, the QOLI assessment yields an overall score and a profile of problems and strengths in 16 areas of life such as love, work and play. The assessment can help qualified professionals in a variety of settings:

- **Clinical** - well-suited for planning, evaluating & tracking medical & psychological treatment & patient progress.
- **Substance abuse/chemical dependency programs** - results can help build motivation for treatment & yield a blueprint for a balanced drug-free lifestyle.
- **Positive psychology, personal growth counselling & employee assistance programs** - QOLI measures assets, strengths & problems in a non-pathological way.
- **Gerontology settings** - to help measure "successful ageing" as defined by leaders in the field.
- **Career counselling** - to help predict future job satisfaction & productivity.
- **Research and quality assurance programs** - test results can be used to help measure treatment outcomes for a wide array of physical and psychological disorders.

**Key Features**

- The QOLI contains only 32 items & takes just 15 minutes to administer.
- Can be used to help screen for mental health & physical problems & to help quickly measure a patient’s progress.
- Helping to identify “real life” issues, it will aid clinicians in developing relevant treatment plans & predicting future health problems.
- By providing a positive mental health picture, the QOLI can help increase the likelihood that treatment will be successful.
- Two Scoring options: Q-Local™ Software - Enables you to score assessments, report results, and store and export data on your computer. Hand Scoring - Administer assessments on answer sheets and score them quickly yourself with an answer key.

Find out more about the reporting options available for the QOLI, download a sample profile report, author details and read the QOLI’s frequently asked questions at www.pearsonclinical.co.uk

Visit www.pearsonclinical.co.uk for further information.
Introducing Q-global™—Pearson’s new web-based platform for test administration, scoring, and reporting. It houses the industry’s gold standard in assessment tools and is accessible from any computer connected to the Internet. Secure and affordable, this helps you quickly and automatically organize examinee information, generate scores, and produce accurate, comprehensive reports.

The following assessments are available on the Q-global platform.

- Basic Achievement Skills Inventory (BASI)
- Battery for Health Improvement 2 (BHI2) and Brief Battery for Health Improvement 2 (BBHI2)
- Becks Family of Assessments
- Behavior Assessment System for Children (BASC-2)
- Brief Symptom Inventory (BSI) and Brief Symptom Inventory 18 (BSI 18)
- Bruininks Motor Ability Test (BMAT)
- Bruininks-Oseretsky Test of Motor Proficiency, Second Edition (BOT-2)
- Delis Rating of Executive Functions (D-REF)
- Millon Family of Assessments
- Minnesota Multiphasic Personality Inventory Family
- Pain Patient Profile 3 (P-3)
- Parenting Relationship Questionnaire (PRQ)
- Symptom Checklist 90 - Revised (SCL-90-R)
- Validity Indicator Profile (VIP)
- Woodcock Reading Mastery Tests, Third Edition (WRMT-III)
- WPPSI-IV UK Writer

Find out more at www.pearsonclinical.co.uk/qglobal
Overview:

As the worldwide leader in the field of assessment, Pearson has always strived towards up-to-the-minute innovation. Now we’re thrilled to introduce an exciting leap forwards with: Q-interactive™, offering the world’s most advanced assessment tools with the convenience of today’s technology.

Intuitive and comprehensive, Q-interactive™ uses two tablets that “talk” to each other via Bluetooth connection to facilitate administration. Benefiting from unprecedented flexibility, portability, convenience and efficiency; Q-interactive™ enables you to create unique, client-centric batteries at both the instrument and subtest levels.

Simply put, Q-interactive is your administration manual, stimulus book, record forms, note pad, stop-watch, age calculator & scoring assistant.

Flexible assessments at your fingertips:

One of the most exciting features of Q-interactive is its flexibility. As a clinician you can log into Q-interactive and access a library of assessments, choose which subtests you want to administer and the order you want to administer them in. Currently the subtests available can be used to assess domains such as ability, achievement, memory, executive function and language.

The Q-interactive library is home to the following assessments:

- WAIS–IVUK - Wechsler Adult Intelligence Scale - Fourth UK Edition
- WISC–IVUK - Wechsler Intelligence Scale for Children - Fourth UK Edition
- CVLT–C - The California Verbal Learning Test - Children’s Version
- D–KEFS - Delis-Kaplan Executive Function System - Selected tests to complement your Q-interactive battery
- NEPSY-II - NEPSY - Second Edition
- CMS - Children’s Memory Scale.

With many of these tests already familiar to you the content and administration procedures will be recognisable. Once you become familiar with Q-interactive and it’s features you will quickly be able to benefit from its ease of usability; giving you more time to focus on your clients and interpret their results.

Several of these assessments and subtests at this time require manipulative items or paper response booklets and scoring templates. In the future subtests exclusively developed for Q-interactive™ will also be available.

Visit www.pearsonclinical.co.uk for further information.
Bringing efficiency and adaptability to the forefront of assessment

Clinicians using Q-interactive are already benefiting from a variety of benefits, from saving them time, to freeing them up to focus on the intricacies and nuances of clients' needs.

Efficiency
With Q-interactive all of your assessment tools are consolidated in one place. This frees you from having to juggle the various administration materials required for traditional paper-pencil tests. Key features enable you to:
• Upon completion of a subtest, immediately review results
• Add additional subtests to your assessment on the fly during the testing session, even if it is from a different assessment.
• Create and save custom batteries from all available instruments on Q-interactive.
• Keep all your scores in one database accessible from any web based computer.
• Built-in timer/stopwatch on screen.
• Make notes to view later on the iPad and record handwritten responses.

Data from a four-month customer review period carried out pre-launch revealed that clinicians using Q-interactive experienced a 30% time saving and a 35% cost saving when compared with using paper and pencil assessments.

Customisation
Q-interactive allows you to select and tailor assessment batteries to fit the specific needs of your clients. Simply tap on your digital device to choose from a list of the appropriate subtests. You can then save your chosen assessment battery to your list of favourites, making it easier for you to find that assessment and start testing without delay.

Unprecedented flexibility, portability, convenience and efficiency for you.

Familiarity
Every new assessment takes time to learn, but with Q-interactive even though the tests are presented in a new digital environment, the content and administration procedures of many of the assessments will be recognisable.

“Like anything, one must familiarise oneself with the software interface before actually administering the tests with clients, but this isn’t an onerous task and simply enables you to feel more confident using it.”
Emma Turner CPsychol, HCPC Registered Occupational Psychologist

Adaptability
One of the most exciting features of Q-interactive is that the system lets you adjust your batteries as you see fit, as you’re administering them. Clinicians can quickly modify an assessment battery as needed in real time by choosing different assessments and/or subtests than originally planned, mid-administration. Q-interactive offers:
• Real time scoring of subtests.
• Calculate scaled scores, composites and comparisons.
• Verbal responses are recorded and automatically saved alongside the item for reference at a later date.
• When a reversal or discontinue rule is triggered, the clinician is made aware from a drop down notification.

Visit www.pearsonclinical.co.uk for further information.
Portability
Access to eight different assessments in one place and as more become available these will automatically be available to you for no additional charge.

Q-interactive lets you take your entire practice digital.

Q-interactive works across two iPads. You’ll use one to administer instructions, record responses, score, take notes and control stimuli, Your client will use the other to respond. Two applications let you manage the entire process: Central and Assess.

Central is your home base for choosing subtests and sharing data. It’s where you’ll:
• Create and manage client profiles
• Select, customize, and save assessment batteries
• Search and browse available subtests
• Review scores and item-level data
• Print and export scores and notes
• Archive client batteries back to our secure server.

Assess is the application you’ll use to administer your assessment batteries. Key features include:
• An integrated timer
• Response capture via: handwriting, audio recording, and various design interfaces created specifically for each subtest type
• A notepad to facilitate easy note-taking and recording of observations
• “To-do” list that aggregates items with unresolved recording and/or scoring needs
• Quick-use manual content
• On-the-fly battery adaptation
• Real-time scoring
• Prompts and rule assistance.

Research
Q-interactive has a solid foundation of research supporting its use. Prior to inclusion in the Q-interactive assessment library, each new type of subtest undergoes an equivalency study to evaluate whether scores generated via testing with Q-interactive are interchangeable with those generated via testing with our standard paper-and-pencil versions.

Currently, raw scores obtained using Q-interactive are interpreted using paper-pencil norms, and the equivalency studies provide support for the validity of this practice.

Find out more about Q-interactive at www.HelloQ.co.uk/home

Visit www.pearsonclinical.co.uk for further information.
At least 60% of young people in the youth justice system have speech, language and communication needs, a fact highlighted during the 2011 *Hello*, national year of communication campaign, sponsored by Pearson Assessment.

As a result, many of these young people cannot comprehend basic legal terminology to assist them through the legal process\(^1\). Many also lack the communication skills necessary to benefit from rehabilitation programmes\(^2\).

In line with The Children’s Communication Coalition (CCC) for England’s key objective to:

*Ensure appropriate screening, specialist assessment and intervention are available to children and young people who are already in the criminal justice pathway.*

Our new minisite is designed to provide a range of assessments which are available from Pearson Assessment.

You can find separate pages covering areas including Language, Communication, Literacy, Achievement and General Ability, Cognition and Memory, Behaviour, Mental Health, and Life Skills and Well Being all of which may be suitable in helping you support young offenders with speech, language and communication needs.

You can also find information on The Communication Trust’s new Youth Justice programme as well as links to relevant websites, groups and newsletters.

For more details, please visit www.pearsonclinical.co.uk/forensicSLCN

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1 RCSLT, press release, 18 November, 2009
2 Hartley, K., 2012. Developing a SLT justice service from scratch; an account and learning from our journey so far. RCSLT Scientific Conference, September, 11, 2012, Manchester
MCMI-III™
Millon™ Clinical Multiaxial Inventory-III
Profile Report with Grossman Facet Scales
Theodore Millon, PhD, DSc

Name: Sample Profile Report
ID Number: 12345
Age: 36
Gender: Female
Setting: Outpatient Never Hospitalized
Race: Hispanic
Marital Status: First Marriage
Date Assessed: 04/02/2009
INTERPRETIVE CONSIDERATIONS

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for nonclinical purposes may have inaccurate reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to patients or their relatives.

The client is a 36-year-old married Hispanic female with 13 years of education. She is currently being seen as an outpatient, and she reports that she has recently experienced problems that involve illness or fatigue and low self-confidence. These self-reported difficulties, which have occurred in the last one to four weeks, may take the form of an Axis I disorder.

The BR scores reported for this individual have been modified to account for the psychic tension indicated by the elevation on Scale A (Anxiety).
## MILLON CLINICAL MULTIAXIAL INVENTORY - III

### CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

Invalidity (Scale V) = 0  Inconsistency (Scale W) = 5


Syndrome Code: A ** - * // - ** CC * //

Demographic Code: 12345/ON/F/36/H/F/13/IL/SC/30030/2/-----/

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FACET SCORES FOR HIGHEST PERSONALITY SCALES BR 65 OR HIGHER

HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 3  Dependent

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FACET SCALES:
- Immature Representations
- Interpersonally Submissive
- Inept Self-Image

SECOND-HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 2A Avoidant

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FACET SCALES:
- Interpersonally Aversive
- Alienated Self-Image
- Vexatious Representations

THIRD-HIGHEST PERSONALITY SCALE BR 65 OR HIGHER: SCALE 7  Compulsive

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FACET SCALES:
- Cognitively Constricted
- Interpersonally Respectful
- Reliable Self-Image
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For each of the Clinical Personality Patterns and Severe Personality Pathology scales (the scale names shown in **bold**), scores on the three facet scales are shown beneath the scale name.
NOTEWORTHY RESPONSES

The client answered the following statements in the direction noted in parentheses. These items suggest specific problem areas that the clinician may wish to investigate.

Health Preoccupation
1. Omitted Item (True)
4. Omitted Item (True)
74. Omitted Item (True)
75. Omitted Item (True)
107. Omitted Item (True)

Interpersonal Alienation
27. Omitted Item (True)
99. Omitted Item (True)

Emotional Dyscontrol
34. Omitted Item (True)
124. Omitted Item (True)

Self-Destructive Potential
24. Omitted Item (True)

Childhood Abuse
No items endorsed.

Eating Disorder
No items endorsed.

End of Report

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

MCMI-III™
Millon™ Clinical Multiaxial Inventory-III
Interpretive Report with Grossman Facet Scales

*Theodore Millon, PhD, DSc*

Name: Sample Interpretive Report
ID Number: 98765
Age: 22
Gender: Female
Setting: Outpatient Never Hospitalized
Race: White
Marital Status: Never Married
Date Assessed: 04/03/2009
CAPSULE SUMMARY

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for nonclinical purposes may have inaccurate reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to patients or their relatives.

Interpretive Considerations
The client is a 22-year-old single white female with 11 years of education. She is currently being seen as an outpatient, and she reports that she has recently experienced problems that involve her job or school and use of alcohol. These self-reported difficulties, which have occurred for an undetermined period of time, may take the form of an Axis I disorder.

Unless this patient is a well-functioning adult with only minor life stressors, her responses suggest a need for social approval or naivete about psychological matters. This interpretive report should be read with these characteristics in mind.

Profile Severity
On the basis of the test data, it may be reasonable to assume that the patient is experiencing a moderately severe mental disorder; further professional study may be advisable to assess the need for ongoing clinical care. The text of the following interpretive report may need to be modulated only slightly upward or downward given this probable level of severity.

Possible Diagnoses
She appears to fit the following Axis II classifications best: Antisocial Personality Disorder, with Histrionic Personality Features, and Paranoid Personality Features.

Axis I clinical syndromes are suggested by the client's MCMI-III profile in the areas of Alcohol Abuse and Psychoactive Substance Abuse NOS.

Therapeutic Considerations
Superficially gregarious and friendly, this patient can readily become ill-humored and touchy if subjected to persistent social discomfort and external demands. She is disinclined to persevere in routine tasks such as long-term therapeutic compliance, but there may be considerable gain by using short-term treatment regimens that focus on specific goals and time-limited techniques.
## MILLON CLINICAL MULTIAXIAL INVENTORY - III

### CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

**INTEGRITY (SCALE V) = 0**  **INCONSISTENCY (SCALE W) = 4**

**PERSONALITY CODE:** 6A **- - * 4 5 6B 8A 8B 3 + 7 2A " 1 2B ' // - ** - //

**SYNDROME CODE:** B **T * // - ** - * //

**DEMOGRAPHIC CODE:** 98765/ON/F/22/W/N/11/JO/AL/------/10/------/

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For each of the Clinical Personality Patterns and Severe Personality Pathology scales (the scale names shown in **bold**), scores on the three facet scales are shown beneath the scale name.
RESPONSE TENDENCIES

Unless this patient is a demonstrably well-functioning adult who is currently facing minor life stressors, her responses suggest (1) a well-established need for social approval and commendation, evident in tendencies to present herself in a favorable light, or (2) a general naivete about psychological matters, including a possible deficit in self-knowledge. The interpretation of this profile should be made with these characteristics in mind.

No adjustments were made to the BR scores of this individual to account for any undesirable response tendencies.

AXIS II: PERSONALITY PATTERNS

The following paragraphs refer to those enduring and pervasive personality traits that underlie this woman's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up Axis I clinical syndromes, this section concentrates on her more habitual and maladaptive methods of relating, behaving, thinking, and feeling.

The MCMI-III profile of this woman suggests a veneer of friendliness and sociability overlying a deeper contempt for conventional morals. Although she is able to make a good impression on casual acquaintances, there is a characteristic unreliability, impulsiveness, restlessness, and moodiness that may be seen frequently by family members and close associates. There is the possibility that she is untrustworthy and unreliable, persistently seeking attention and excitement and often engaging in seductive and self-dramatizing behavior. Her relationships may be shallow and fleeting, and she may fail to meet routine responsibilities. Interactions may be disrupted by caustic comments and hostile outbursts. Not infrequently, she may act impetuously with insufficient deliberation and poor judgment. She also tends to exhibit short-lived enthusiasm followed by disillusionment and resentment at having been misled. The referring clinician may wish to corroborate these hypotheses as well as those in subsequent paragraphs.

This woman is unlikely to admit responsibility for personal or family difficulties, possessing what may be an easily circumvented conscience. Moreover, she may be quite facile in denying the presence of psychological tension or conflicts. Interpersonal problems are likely to be rationalized, especially those that she engenders, and blame may readily be projected onto others. Although she is prone to be self-indulgent and insistent on gaining the center of attention, she may reciprocate this attention with only minimal loyalty and affection.

When her actions are criticized or she is subjected to minor pressures or faced with potential embarrassment, she may be inclined to abandon her responsibilities, possibly with minimal guilt or remorse. Unfettered by the restrictions of social conventions or the restraints of personal loyalties, she may be quick to free herself from unwanted obligations. Her superficial affability may easily collapse, and she may be readily inclined to jettison anyone who might undermine her autonomy. Although infrequent, her temper outbursts may turn into uncontrollable rages. More typically, she is impetuous and imprudent, driven by a need for excitement and an inability to delay gratification, with minimal regard for consequences. Stimulus-seeking, she may restlessly chase one capricious whim after another, and she may have traveled an erratic course of irresponsibility, perhaps even delighting in defying social
conventions. She appears to have a poor prognosis for staying out of trouble.

GROSSMAN PERSONALITY FACET SCALES

The Grossman facet scales are designed to aid in the interpretation of elevations on the Clinical Personality Patterns and Severe Personality Pathology scales by helping to pinpoint the specific personality processes (e.g., self-image, interpersonal relations) that underlie overall scale elevations. A careful analysis of this patient's facet scale scores suggests that the following characteristics are among her most prominent personality features.

Most notable is her view of herself as a socially stimulating and charming person, one who seeks to pursue a busy and pleasure-oriented lifestyle and is invariably perceived by others as appealing and attractive. She probably lacks insight, however, failing to recognize, or to admit recognizing, her deeper insecurities and her desperate need to garner attention and to be well liked. Signs of inner turmoil, weakness, depression, or hostility are almost invariably denied, suppressed so as not to be part of her sense of self.

Also salient are her failure to constrain or postpone the expression of offensive thoughts or malevolent actions, a deficit in guilt feelings, and a consequent disinclination to refashion repugnant impulses in sublimated form. Given her perception of the environment, she does not feel the need to rationalize her outbursts, which she believes are fully justified as a response to the supposed malevolence of others. She experiences herself as the victim, an indignant bystander subjected to persecution and hostility. Through this intrapsychic maneuver, she not only disowns her malicious impulses but attributes the evil to others. As a persecuted victim, she feels free to counterattack and gain restitution and vindication.

Also worthy of attention are her suspiciousness regarding the motives of others and her tendency to misconstrue innocuous events as signifying proof of duplicity or conspiratorial intent. Her learned feelings and attitudes have produced deep mistrust and pervasive suspiciousness of others. She is notoriously oversensitive and disposed to detect signs of trickery and deception everywhere. She is preoccupied with these thoughts, actively picking up minute cues, then magnifying and distorting them so as to confirm her worst expectations. To further complicate matters, events that fail to confirm her suspicions are evidence in her mind of just how deceitful and clever others can be.

Early treatment efforts are likely to produce optimal results if they are oriented toward modifying the personality features just described.

AXIS I: CLINICAL SYNDROMES

The features and dynamics of the following Axis I clinical syndromes appear worthy of description and analysis. They may arise in response to external precipitants but are likely to reflect and accentuate several of the more enduring and pervasive aspects of this woman's basic personality makeup.

The evidence is strong that this woman exhibits an alcoholic disorder, probably contained within the context of a pervasive substance-abuse syndrome. Her excessive drinking may also be seen, as well as understood, within the context of a broad-based, somewhat self-indulgent, and excitement-seeking
lifestyle. Hedonistic and manipulative, she may use alcohol to maintain the camaraderie of youthful socializing. In addition to accommodating her immature, pleasure-oriented, and exploitive traits, alcoholism permits her to express a number of narcissistic attitudes, antiauthority resentments, an unwillingness to tolerate the limits of conventional society, and rejection of traditional family constraints.

An addictive disposition, probably involving active use of illicit or street agents, seems highly probable in this woman, who is hedonistic and exploitive. That drug use fits her recreational pattern of adolescent-like stimulus seeking and narcissistic indulgence is likely. Also consonant with her personality is the use of drugs as a symbol of disdain for conventional social values as well as an image of flouting authority that includes the posturing of independence from her family.

**NOTEWORTHY RESPONSES**

The client answered the following statements in the direction noted in parentheses. These items suggest specific problem areas that the clinician may wish to investigate.

**Health Preoccupation**
No items endorsed.

**Interpersonal Alienation**
48. Omitted Item (True)
63. Omitted Item (True)

**Emotional Dyscontrol**
14. Omitted Item (True)

**Self-Destructive Potential**
24. Omitted Item (True)

**Childhood Abuse**
No items endorsed.

**Eating Disorder**
No items endorsed.

**POSSIBLE DSM-IV® MULTIAXIAL DIAGNOSES**

The following diagnostic assignments should be considered judgments of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-III differ somewhat from those in the *DSM-IV*, but there are sufficient parallels in the MCMI-III items to recommend consideration of the following assignments. It should be noted that several *DSM-IV* Axis I syndromes are not assessed in the MCMI-III. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMI-III.
Axis I: Clinical Syndrome
The major complaints and behaviors of the patient parallel the following Axis I diagnoses, listed in order of their clinical significance and salience.

305.00 Alcohol Abuse
305.90 Psychoactive Substance Abuse NOS

Axis II: Personality Disorders
Deeply ingrained and pervasive patterns of maladaptive functioning underlie Axis I clinical syndromal pictures. The following personality prototypes correspond to the most probable DSM-IV diagnoses (Disorders, Traits, Features) that characterize this patient.

Personality configuration composed of the following:

301.70 Antisocial Personality Disorder
   with Histrionic Personality Features
   and Paranoid Personality Features

Course: The major personality features described previously reflect long-term or chronic traits that are likely to have persisted for several years prior to the present assessment. The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

Axis IV: Psychosocial and Environmental Problems
In completing the MCMI-III, this individual identified the following problems that may be complicating or exacerbating her present emotional state. They are listed in order of importance as indicated by the client. This information should be viewed as a guide for further investigation by the clinician.

   Job or School Problems; Use of Alcohol

TREATMENT GUIDE

If additional clinical data are supportive of the MCMI-III's hypotheses, it is likely that this patient's difficulties can be managed with either brief or extended therapeutic methods. The following guide to treatment planning is oriented toward issues and techniques of a short-term character, focusing on matters that might call for immediate attention, followed by time-limited procedures designed to reduce the likelihood of repeated relapses.

Worthy of note is the possibility of a troublesome alcohol and/or substance-abuse disorder. If verified, appropriate short-term behavioral management or group therapy programs should be rapidly implemented.

Once this patient's more pressing or acute difficulties are adequately stabilized, attention should be directed toward goals that would aid in preventing a recurrence of problems, focusing on circumscribed issues and employing delimited methods such as those discussed in the following paragraphs.
Essential to the success of a short-term approach with this woman is the therapist’s readiness to see things from the patient’s point of view and to convey a sense of trust and to create a feeling of alliance. To achieve reasonable short-term goals, this building of rapport must not be interpreted as a sign of the therapist’s capitulation to the patient’s bluff and arrogance. Brief treatment with her will require a balance of professional firmness and authority, mixed with tolerance for the patient’s less attractive traits. By building an image of a fair-minded and strong authority figure, the therapist may successfully employ cognitive methods that will encourage the patient to change her expectations. Through reasoned and convincing comments, the therapist may provide a model for the patient to learn the mix of power, logic and fairness.

Less confrontive cognitive approaches may provide the patient with opportunities to vent her anger, even in short-term therapy. Once drained of these hostile feelings, she may be led to examine her habitual behavior and cognitive attitudes and be guided into less destructive perceptions and outlets than before. Interpersonal methods, such as those of Benjamin and Kiesler, may provide a means to explore more socially acceptable behaviors. As far as group methods are concerned, until the patient has incorporated changed cognitions and actions, she may intrude and disrupt therapeutic functions. On the other hand, she may become a useful catalyst for short-term group interaction and gain some useful insights and a few constructive skills.

A useful short-term goal for this woman is to enable her to tolerate the experience of guilt or to accept blame for the turmoil she may cause. Cognitive methods using a measure of confrontation may help undermine her tendency to always trace problems to another person’s stupidity, laziness, or hostility. When she does accept responsibility for some of her difficulties it is important that the therapist be prepared to deal with the patient’s inclination to resent the therapist for supposedly tricking her into admitting it. Similarly, the therapist should be ready to be challenged and avoid efforts to outwit her. The patient may try to set up situations to test the therapist's skills, to catch inconsistencies, to arouse ire and, if possible, to belittle and humiliate the therapist. Restraining impulses to express condemning attitudes can be a major task for the therapist, but one that can be used for positive gains, especially if tied into the application of combined cognitive (e.g., Beck, Ellis) and interpersonal interventions.

It should be noted that the precipitant for this woman's treatment is probably situational rather than internal. Hence, she is unlikely to have sought therapy voluntarily, and she may be convinced that if she were just left alone, she could work matters out on her own. Such beliefs will have to be confronted, albeit carefully. Similarly, if treatment is self-motivated, it probably was inspired by a series of legal entanglements, family problems, social humiliations, or achievement failures. Whatever its source, a firm cognitive and behavior-change approach would seem required. For this domineering and often intimidating woman, complaints are likely to be expressed in the form of irritability and restlessness. To succeed in her initial disinclination to be frank with authority figures, she may wander from one superficial topic to another. This inclination should be monitored and prevented. Moreover, contact with family members may be advisable because they may report matters quite differently than the patient. To ensure that she takes discussions seriously, she may have to be confronted directly with evidence of her contribution to her troubles. Treatment is best geared to short-term goals, reestablishing her psychic balance, and strengthening her previously adequate coping behavior with cognitive methods, unless her actions are frankly antisocial. In general, short-term approaches with this patient are best directed toward building controls rather than insights, toward the here and now rather than the past, and toward teaching her ways to sustain relationships cooperatively rather than with dominance and intimidation.
End of Report

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

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Name:  Sample Corrections Interpretive Report
ID Number:  12345
Age:  37
Gender:  Male
Setting:  Correctional Inmate
Race:  White
Marital Status:  First Marriage
Date Assessed:  04/03/2009
CLINICAL SUMMARY

MCMI-III reports were normed on offenders who were in the early phases of psychological screening or assessment to predict how well they would adjust to prison. Respondents who do not fit this normative correctional population or who took the MCMI-III test for other clinical purposes may receive inaccurate reports.

Note that the MCMI-III report cannot, by itself, be considered definitive. It should be evaluated in conjunction with additional clinical and biographical information. This correctional report should be evaluated by a mental health clinician who is trained in the use of psychological tests. The report should not be shown to offenders or their relatives.

Interpretive Considerations
The offender is a 37-year-old married white male with 12 years of education. He is currently being seen as a correctional offender, and he reports that he has recently experienced problems that involve antisocial behavior and marriage or family. These self-reported difficulties, which have occurred in the last three to 12 months, may take the form of an Axis I disorder.

Profile Severity
On the basis of MCMI-III test data, it may be inferred that the offender is experiencing a severe mental disorder; further professional observation and inpatient care may be appropriate. The text of the following interpretive report may need to be modulated upward given this probable level of severity. Empirical research indicates that this offender is likely to require mental health services.

Possible DSM-IV® Diagnoses
He appears to fit the following Axis II classifications best: Schizoid Personality Disorder, with Dependent Personality Traits, Avoidant Personality Traits, and Depressive Personality Features.

Axis I clinical syndromes are suggested by the client's MCMI-III profile in the areas of Major Depression (recurrent, severe, without psychotic features) and Generalized Anxiety Disorder.

If Treatment Services are Recommended
This offender may have developed a pattern of relating to others in a retiring, listless, and dejected manner. A poor reporter of his personal history and increasingly withdrawn from his problems, he may be difficult to engage in therapeutic intervention. Enlisting the aid of family members and focusing on short-term cognitive techniques may be useful in maximizing compliance and achieving a measure of progress.
## MILLON CLINICAL MULTIAXIAL INVENTORY - III

**CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY**

### VALIDITY (SCALE V) SCORE = 0

**PERSONALITY CODE:** 1 ** 3 2A * 2B + 7 5 8B 4 " 8A 6B 6A ' ' / - ** - * /  
**SYNDROME CODE:** - ** A D * / - ** CC * /  
**DEMOGRAPHIC CODE:** 12345/CI/M/37/W/F12/AN/MA/------/4/------/

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### DIAGNOSTIC SCALES

- **DISCLOSURE**
- **DESPERABILITY**
- **DEBASEMENT**
- **SCHIZOID**
- **AVOIDANT**
- **DEPRESIVE**
- **DEPENDENT**
- **HISTRIONIC**
- **NARCISSISTIC**
- **ANTISOCIAL**
- **SADISTIC**
- **COMPULSIVE**
- **NEGATIVISTIC**
- **MASOCHISTIC**
- **SCHIZOTYPAL**
- **BORDERLINE**
- **PARANOID**
- **ANXIETY**
- **SOMATOFORM**
- **BIPOLAR: MANIC**
- **DYSTHYMIA**
- **ALCOHOL DEPENDENCE**
- **DRUG DEPENDENCE**
- **POST-TRAUMATIC STRESS**
- **THOUGHT DISORDER**
- **MAJOR DEPRESSION**
- **DELUSIONAL DISORDER**

**Note.** Base rate transformations for the Clinical Personality Patterns scales are based on a sample of male correctional offenders.
CORRECTIONAL SUMMARY

The following classifications are based on prediction models developed as part of a research study involving over 10,000 offenders who completed the MCMI-III test at intake. The *MCMI-III Corrections Report User's Guide* summarizes this research and the validity evidence supporting these classifications. These research-based classifications are intended to assist with key programming and placement decisions made at intake.

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The statements below are relevant to offenders who have been adjudicated and recently confined to prison. These judgments are based primarily on clinical and theoretical hypotheses that derive from scores and profiles obtained on the MCMI-III test.

**Reaction to Authority**
This offender is apt to be socially isolated, anxious, and dependent. He is not inclined to be troublesome, and is rather quiet, submissive, generally ineffectual, and withdrawn.

**Escape Risk**
Even if opportunities arise, this offender is not likely to engage in escape behavior.

**Disposition to Malinger**
This offender's characteristic withdrawal and worrisomeness may resemble malingering but actually represent a pattern of ineffectuality that is not consciously intended.

**Response to Crowding/Isolation**
Placement of this offender in a "safe" living unit would be wise, in part to reduce discomfiting social pressures and in part to decrease the likelihood of his being preyed upon and humiliated.

**Amenability to Treatment/Rehabilitation**
It may be necessary to prevent this prisoner from withdrawing into self-imposed isolation. Educational rehabilitation may be advisable to compensate for a limited school or work background. The program should be sufficient to ensure at least a modicum of marketable post-release skills. His receptivity to such efforts, however, may prove to be slow and arduous.

**Suicidal Tendencies**
As indicated above, the research-based, multi-scale MCMI-III prediction model classifies this offender as having a high probable need for mental health intervention. In addition, his item responses indicate that he has recently thought about committing suicide.
RESPONSE TENDENCIES

The BR scores reported for this individual have been modified to account for the psychic tension and dejection indicated by the elevations on Scale A (Anxiety) and Scale D (Dysthymia).

AXIS II: PERSONALITY PATTERNS

The following paragraphs refer to those enduring and pervasive personality traits that underlie this man's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up Axis I clinical syndromes, this section concentrates on his more habitual and maladaptive methods of relating, behaving, thinking, and feeling.

MCMI-III profiles such as this man's signify tendencies to be introversion, emotionally impoverished, and expressively either impassive or depressed. Preferring to remain in the background, he may lack social initiative and display little stimulus-seeking behavior. Notable also are cognitive deficits and unclear thinking about interpersonal matters. Anger and discontent rarely surface. More typically, he will appear sad or disengaged emotionally. Reluctant to accept help from others, he is likely to sacrifice his own interests, try not to be a burden to others, and act in a compliant and placating manner. His easy fatigability and slow personal tempo may be compounded by a general weakness in expressiveness and spontaneity. Although he is prone to assume a peripheral role in social and family relationships, he may also have a need to gain some measure of support from significant others. These conflicting attitudes stem in part from his feelings of low self-esteem and his deficiencies in autonomous and competent behavior. Quick to self-blame, he is inclined to belittle himself and to possess a self-image of being a weak and ineffectual person.

Daily life for this offender may be experienced as uneventful, with extended periods of passive solitude interspersed with feelings of sadness and emptiness. He is likely to have endorsed items such as "Few things in life give me pleasure." He tries to be indifferent to his social surroundings, is minimally introspective, and is sufficiently withdrawn as to miss the subtleties of emotional life, and he exhibits few affectionate or erotic needs. His thought processes tend to be unfocused and tangential, particularly in regard to interpersonal matters. As a result, his social communications are often strained and self-conscious. His hesitation to express affection may stem from an inability to experience enthusiasm or pleasure. Moreover, for extended periods, he may exhibit a pervasive dysthymic mood that is punctuated occasionally by unanchored and ill-defined anxiety.

This man prefers to follow a simple, repetitive, and dependent life pattern. He actively avoids self-assertion, appears spiritless and cheerless, abdicates autonomous responsibilities, and may be indifferent to conventional social aspirations. Disengaged from and uninterested in most of the rewards of human affairs, he often appears apathetic, if not depressed and morose. Although lacking in drive, he is also fearful of rebuff. Therefore, he restricts his social and emotional involvements, which consequently perpetuates his pattern of social isolation and sadness.
AXIS I: CLINICAL SYNDROMES

The features and dynamics of the following Axis I clinical syndromes appear worthy of description and analysis. They may arise in response to external precipitants but are likely to reflect and accentuate several of the more enduring and pervasive aspects of this man’s basic personality makeup.

Preoccupation with matters of personal adequacy and chronic feelings of worthlessness and guilt appear to predominate in the major depression evident in the clinical picture of this socially awkward and introverted man. Timid, shy, and apprehensive, he is especially sensitive to public humiliation and rejection. Worthy of note is his tolerance of daily unhappiness and emptiness, a willingness to accept his feelings of worthlessness and guilt. Plagued with self-doubts and thoughts of death, he may be notably saddened by the view that he is both socially unattractive and physically inferior. Fearful of expressing his discontent to others who might thereby reject or humiliate him, he deals with his frustration by turning it inward, becoming introapeutically depressed. This offender's score on MCMI-III Scale CC (Major Depression) is 78. Empirical research has shown that offenders scoring 75 or higher on Scale CC at intake are very much more likely to require prison-provided mental health services compared to offenders scoring below 75. This research is described in the MCMI-III Corrections Report User’s Guide.

This man may be experiencing an anxiety disorder, noted by symptoms such as fatigue, insomnia, muscular tension, distracted thinking, and a general dysphoric mood. Basically shy and socially uncomfortable, he may be plagued by self-doubt. Especially hypersensitive to public humiliation or reproval, he may lack sufficient self-esteem to respond to such events by expressing the anger and resentment he might feel. His anxiety not only may be one of his general states—an omnipresent level of discomfort, especially with others—but also may be intensified by fear that his restrained anger may spew forth against persons he dares not provoke. This offender's score on MCMI-III Scale A (Anxiety) is 82. Empirical research has shown that offenders scoring 75 or higher on Scale A at intake are more likely to require prison-provided mental health services compared to offenders scoring below 75. This research is described in the MCMI-III Corrections Report User’s Guide.

NOTEWORTHY RESPONSES

He answered the following statements in the direction noted in parentheses. These items suggest specific problem areas that the clinician may wish to investigate.

Health Preoccupation
1. Omitted Item (True)
4. Omitted Item (True)
55. Omitted Item (True)
74. Omitted Item (True)
130. Omitted Item (True)
149. Omitted Item (True)

Special Note:
The content of the test items is included in the actual reports. To protect the integrity of the test, the item content does not appear in this sample report.
It should be noted that several DSM-IV Axis I syndromes are not assessed in the MCMI-III test. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMI-III test.

Axis I: Clinical Syndromes
The major complaints and behaviors of the offender parallel the following Axis I diagnoses, listed in order of their clinical significance and salience.

- 296.33 Major Depression (recurrent, severe, without psychotic features)
- 300.02 Generalized Anxiety Disorder

Axis II: Personality Disorders
Deeply ingrained and pervasive patterns of maladaptive functioning underlie Axis I clinical syndromal pictures. The following personality prototypes correspond to the most probable DSM-IV diagnoses (Disorders, Traits, Features) that characterize this offender.
Personality configuration composed of the following:

301.20 Schizoid Personality Disorder  
   with Dependent Personality Traits  
   Avoidant Personality Traits  
   and Depressive Personality Features

Course: The major personality features described previously reflect long-term or chronic traits that are likely to have persisted for several years prior to the present assessment.

The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

Axis IV: Psychosocial and Environmental Problems
In completing the MCMI-III test, this individual identified the following problems that may be complicating or exacerbating his present emotional state. They are listed in order of importance as indicated by the individual. This information should be viewed as a guide for further investigation by the clinician.

   Antisocial Behavior; Marriage or Family Problems

TREATMENT GUIDE

If additional clinical data are supportive of the MCMI-III's hypotheses, it is likely that this offender's difficulties can be managed with either brief or extended therapeutic methods. The following guide to treatment planning is oriented toward issues and techniques of a short-term character, focusing on matters that might call for immediate attention, followed by time-limited procedures designed to reduce the likelihood of repeated relapses.

As a first step, it would appear advisable to implement methods to ameliorate this offender's current state of clinical anxiety, depressive hopelessness, somatic or stress difficulties, as well as pathological personality functioning by the rapid implementation of supportive psychotherapeutic measures. With appropriate consultation, targeted psychopharmacologic medications may also be useful at this initial stage.

Once this offender's more pressing or acute difficulties are adequately stabilized, attention should be directed toward goals that would aid in preventing a recurrence of problems, focusing on circumscribed issues and employing delimited methods such as those discussed in the following paragraphs.

A major thrust of brief therapy for this offender should be to enhance his social interest and competence. Although he should not be pushed beyond tolerable limits, careful and well-reasoned cognitive methods (e.g., Beck, Meichenbaum) may foster the development of more accurate and focused styles of thinking. In addition to working toward the extinction of false beliefs about himself and the attitudes of others toward him, the therapist should be alert to spheres of life in which the offender possesses positive emotional inclinations and should encourage the offender, through interpersonal methods and behavior skill development techniques, to undertake activities consonant with these
tendencies.

Although the success of short-term methods may justify an optimistic outlook, the offender's initial receptivity may create the misleading perception that further advances and progress will be rapid. Care should be taken to prevent early treatment success from precipitating a resurfacing of his established ambivalence between wanting social acceptance and fearing that he is placing himself in a vulnerable position. Enabling him to forgo his long-standing expectations of disappointment may require "booster" sessions following initial, short-term success. Support should be provided to ease his fears, particularly his feeling that his efforts may not be sustainable and will inevitably result in social disapproval again.

With appropriate consultation, psychopharmacologic treatment may be considered. Trial periods with a number of agents may be explored to determine whether any effectively increase his energy and affectivity. Such agents should be used with caution, however, because they may activate feelings that the offender is ill-equipped to handle. As noted, attempts to cognitively reorient his problematic attitudes may be useful in motivating interpersonal sensitivity and confidence. Likewise, short-term techniques of behavioral modification may be valuable in strengthening the offender's social skills. Group and family methods may be useful in encouraging and facilitating his acquisition of constructive social attitudes. In these benign settings, he may begin to alter his social image and develop both the motivation and the skills for a more effective interpersonal style. Preceding or combining short-term programs with individual treatment sessions may aid in forestalling untoward recurrences of the discomfort currently experienced by the offender.

Focused treatment efforts for this introverted and passive man are best directed toward countering his withdrawal tendencies. Minimally introspective and evincing diminished affect and energy, he must be prevented, through circumscribed therapies, from becoming increasingly isolated from others, be they disconcerting or benign. Energy should be invested to enlarge his social world owing to his tendencies to pursue with diligence only those activities required by his job or by his family obligations. By shrinking his interpersonal milieu, he precludes exposure to new experience. Of course, this is his preference, but such behavior only fosters his isolated and withdrawn existence. To prevent such backsliding and a relapse, the therapist should ensure the continuation of all constructive social activities as well as potential new ones. Otherwise, he may become increasingly lost in asocial and fantasy preoccupations. Excessive social pressure, however, should be avoided because the offender's tolerance and competencies in this area are likely to be limited. Initial brief and focused treatment techniques will aid him in developing more skills in this area.

End of Report

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

1: 1  2: 1  3: 2  4: 1  5: 2  6: 2  7: 2  8: 2  9: 2  10: 1
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141: 2  142: 1  143: 2  144: 2  145: 2  146: 2  147: 1  148: 1  149: 1  150: 2
171: 1  172: 1  173: 2  174: 2  175: 1
This report is based on correctional norms.

Corrections Interpretive Report - Revised

MCMI-III™
Millon™ Clinical Multiaxial Inventory-III
Theodore Millon, PhD, DSc

Name:  Sample One
ID Number:  1
Age:  35
Gender:  Male
Setting:  Correctional Inmate
Race:  White
Marital Status:  First Marriage
Date Assessed:  07/03/2009

Includes empirically based statements in key areas critical to offender management and classification.
CLINICAL SUMMARY

MCMI-III reports were normed on offenders who were in the early phases of psychological screening or assessment to predict how well they would adjust to prison. Respondents who do not fit this normative correctional population or who took the MCMI-III test for other clinical purposes may receive inaccurate reports.

Note that the MCMI-III report cannot, by itself, be considered definitive. It should be evaluated in conjunction with additional clinical and biographical information. This correctional report should be evaluated by a mental health clinician who is trained in the use of psychological tests. The report should not be shown to offenders or their relatives.

Interpretive Considerations
The offender is a 35-year-old married white male with 12 years of education. He is currently being seen as a correctional offender, and he reports that he has recently experienced problems that involve antisocial behavior and marriage or family. These self-reported difficulties, which have occurred in the last three to 12 months, may take the form of an Axis I disorder.

Profile Severity
On the basis of MCMI-III test data, it may be inferred that the offender is experiencing a severe mental disorder; further professional observation and inpatient care may be appropriate. The text of the following interpretive report may need to be modulated upward given this probable level of severity. Empirical research indicates that this offender is likely to require mental health services.

Possible DSM-IV® Diagnoses
He appears to fit the following Axis II classifications best: Schizoid Personality Disorder, with Dependent Personality Traits, Avoidant Personality Traits, and Depressive Personality Features.

Axis I clinical syndromes are suggested by the client's MCMI-III profile in the areas of Major Depression (recurrent, severe, without psychotic features) and Generalized Anxiety Disorder.

If Treatment Services are Recommended
This offender may have developed a pattern of relating to others in a retiring, listless, and dejected manner. A poor reporter of his personal history and increasingly withdrawn from his problems, he may be difficult to engage in therapeutic intervention. Enlisting the aid of family members and focusing on short-term cognitive techniques may be useful in maximizing compliance and achieving a measure of progress.

This section summarizes the offender's demographics, reported complaints, duration of disorder, severity of difficulties, possible DSM-IV diagnoses, and likely course of treatment.
MILLON CLINICAL MULTIAXIAL INVENTORY - III

These indices indicate report validity.

VALIDITY (SCALE V) SCORE = 0
PERSONALITY CODE: 1 ** 3A * 2B + 75 8B 4 " 8A 6B 6A ' / - ** - * //
SYNDROME CODE: - ** A_D * / - ** CC * //
DEMOGRAPHIC CODE: 1/Ci/M/35/W/F/12/AN/MA/-/-/-/-/4/------/

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Note: Base rate transformations for the Clinical Personality Patterns scales are based on a sample of male correctional offenders.
CORRECTIONAL SUMMARY

The following classifications are based on prediction models developed as part of a research study involving over 10,000 offenders who completed the MCMI-III test at intake. The MCMI-III Corrections Report User's Guide summarizes this research and the validity evidence supporting these classifications. These research-based classifications are intended to assist with key programming and placement decisions made at intake.

<table>
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<th>This inmate's probable need for:</th>
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<td>Mental Health Intervention</td>
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<td>Substance Abuse Treatment</td>
<td>Low</td>
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<td>Anger Management Services</td>
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These classifications help to quickly identify an offender's probable need for these services.

The statements below are relevant to offenders who have been adjudicated and recently confined to prison. These judgments are based primarily on clinical and theoretical hypotheses that derive from scores and profiles obtained on the MCMI-III test.

**Reaction to Authority**
This offender is apt to be socially isolated, anxious, and dependent. He is not inclined to be troublesome, and is rather quiet, submissive, generally ineffectual, and withdrawn.

**Escape Risk**
Even if opportunities arise, this offender is not likely to engage in escape behavior.

**Disposition to Malingering**
This offender's characteristic withdrawal and worrisomeness may resemble malingering but actually represent a pattern of ineffectuality that is not consciously intended.

**Response to Crowding/Isolation**
Placement of this offender in a "safe" living unit would be wise, in part to reduce discomfiting social pressures and in part to decrease the likelihood of his being preyed upon and humiliated.

**Amenability to Treatment/Rehabilitation**
It may be necessary to prevent this prisoner from withdrawing into self-imposed isolation. Educational rehabilitation may be advisable to compensate for a limited school or work background. The program should be sufficient to ensure at least a modicum of marketable post-release skills. His receptivity to such efforts, however, may prove to be slow and arduous.

**Suicidal Tendencies**
As indicated above, the research-based, multi-scale MCMI-III prediction model classifies this offender as having a high probable need for mental health intervention. In addition, his item responses indicate that he has recently thought about committing suicide.
RESPONSE TENDENCIES

The BR scores reported for this individual have been modified to account for the psychic tension and dejection indicated by the elevations on Scale A (Anxiety) and Scale D (Dysthymia).

AXIS II: PERSONALITY PATTERNS

The following paragraphs refer to those enduring and pervasive personality traits that underlie this man's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up Axis I clinical syndromes, this section concentrates on his more habitual and maladaptive methods of relating, behaving, thinking, and feeling.

MCMI-III profiles such as this man's signify tendencies to be introverted, emotionally impoverished, and expressively either impassive or depressed. Preferring to remain in the background, he may lack social initiative and display little stimulus-seeking behavior. Notable also are cognitive deficits and unclear thinking about interpersonal matters. Anger and discontent rarely surface. More typically, he will appear sad or disengaged emotionally. Reluctant to accept help from others, he is likely to sacrifice his own interests, try not to be a burden to others, and act in a compliant and placating manner. His easy fatigability and slow personal tempo may be compounded by a general weakness in expressiveness and spontaneity. Although he is prone to assume a peripheral role in social and family relationships, he may also have a need to gain some measure of support from significant others. These conflicting attitudes stem in part from his feelings of low self-esteem and his deficiencies in autonomous and competent behavior. Quick to self-blame, he is inclined to belittle himself and to possess a self-image of being a weak and ineffectual person.

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NOTEWORTHY RESPONSES

He answered the following statements in the direction noted in parentheses. These items suggest specific problem areas that the clinician may wish to investigate.

**Health Preoccupation**

1. Lately, my strength seems to be draining out of me, even in the morning. (True)
4. I feel weak and tired much of the time. (True)
55. In recent weeks I feel worn out for no special reason. (True)
74. I can't seem to sleep, and wake up just as tired as when I went to bed. (True)
130. I don't have the energy to concentrate on my everyday responsibilities anymore. (True)
149. I feel shaky and have difficulty falling asleep because painful memories of a past event keep running through my mind. (True)
Interpersonal Alienation
10. What few feelings I seem to have I rarely show to the outside world. (True)
27. When I have a choice, I prefer to do things alone. (True)
92. I'm alone most of the time and I prefer it that way. (True)
105. I have little desire for close friendships. (True)
167. I take great care to keep my life a private matter so no one can take advantage of me. (True)

Emotional Dyscontrol
34. Lately, I have gone all to pieces. (True)

Self-Destructive Potential
44. I feel terribly depressed and sad much of the time now. (True)
142. I frequently feel there's nothing inside me, like I'm empty and hollow. (True)
171. I have given serious thought recently to doing away with myself. (True)

Childhood Abuse
No items endorsed.

Eating Disorder
No items endorsed.

This section is organized in multiaxial diagnostic format, including detailed subsections on Axes I, II, and IV.

POSSIBLE DSM-IV® MULTIAXIAL DIAGNOSES

The following diagnostic assignments should be considered judgments of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-III test differ somewhat from those in the DSM-IV, but there are sufficient parallels in the MCMI-III items to recommend consideration of the following assignments. It should be noted that several DSM-IV Axis I syndromes are not assessed in the MCMI-III test. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self-report inventories such as the MCMI-III test.

Axis I: Clinical Syndromes
The major complaints and behaviors of the offender parallel the following Axis I diagnoses, listed in order of their clinical significance and salience.

296.33 Major Depression (recurrent, severe, without psychotic features)
300.02 Generalized Anxiety Disorder

Axis II: Personality Disorders
Deeply ingrained and pervasive patterns of maladaptive functioning underlie Axis I clinical syndromal pictures. The following personality prototypes correspond to the most probable DSM-IV diagnoses (Disorders, Traits, Features) that characterize this offender.
Course: The major personality features described previously reflect long-term or chronic traits that are likely to have persisted for several years prior to the present assessment.

The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

**Axis IV: Psychosocial and Environmental Problems**

In completing the MCMI-III test, this individual identified the following problems that may be complicating or exacerbating his present emotional state. They are listed in order of importance as indicated by the individual. This information should be viewed as a guide for further investigation by the clinician.

- Antisocial Behavior; Marriage or Family Problems

**TREATMENT GUIDE**

This section presents the major considerations and recommendations regarding treatment planning.

If additional clinical data are supportive of the MCMI-III's hypotheses, it is likely that this offender's difficulties can be managed with either brief or extended therapeutic methods. The following guide to treatment planning is oriented toward issues and techniques of a short-term character, focusing on matters that might call for immediate attention, followed by time-limited procedures designed to reduce the likelihood of repeated relapses.

As a first step, it would appear advisable to implement methods to ameliorate this offender's current state of clinical anxiety, depressive hopelessness, somatic or stress difficulties, as well as pathological personality functioning by the rapid implementation of supportive psychotherapeutic measures. With appropriate consultation, targeted psychopharmacologic medications may also be useful at this initial stage.

Once this offender's more pressing or acute difficulties are adequately stabilized, attention should be directed toward goals that would aid in preventing a recurrence of problems, focusing on circumscribed issues and employing delimited methods such as those discussed in the following paragraphs.

A major thrust of brief therapy for this offender should be to enhance his social interest and competence. Although he should not be pushed beyond tolerable limits, careful and well-reasoned cognitive methods (e.g., Beck, Meichenbaum) may foster the development of more accurate and focused styles of thinking. In addition to working toward the extinction of false beliefs about himself and the attitudes of others toward him, the therapist should be alert to spheres of life in which the offender possesses positive emotional inclinations and should encourage the offender, through interpersonal methods and behavior skill development techniques, to undertake activities consonant with these

Personality configuration composed of the following:

- 301.20 Schizoid Personality Disorder
  - with Dependent Personality Traits
  - Avoidant Personality Traits
  - and Depressive Personality Features

Course: The major personality features described previously reflect long-term or chronic traits that are likely to have persisted for several years prior to the present assessment.

The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

**Axis IV: Psychosocial and Environmental Problems**

In completing the MCMI-III test, this individual identified the following problems that may be complicating or exacerbating his present emotional state. They are listed in order of importance as indicated by the individual. This information should be viewed as a guide for further investigation by the clinician.

- Antisocial Behavior; Marriage or Family Problems
tendencies.

Although the success of short-term methods may justify an optimistic outlook, the offender's initial receptivity may create the misleading perception that further advances and progress will be rapid. Care should be taken to prevent early treatment success from precipitating a resurfacing of his established ambivalence between wanting social acceptance and fearing that he is placing himself in a vulnerable position. Enabling him to forgo his long-standing expectations of disappointment may require "booster" sessions following initial, short-term success. Support should be provided to ease his fears, particularly his feeling that his efforts may not be sustainable and will inevitably result in social disapproval again.

With appropriate consultation, psychopharmacologic treatment may be considered. Trial periods with a number of agents may be explored to determine whether any effectively increase his energy and affectivity. Such agents should be used with caution, however, because they may activate feelings that the offender is ill-equipped to handle. As noted, attempts to cognitively reorient his problematic attitudes may be useful in motivating interpersonal sensitivity and confidence. Likewise, short-term techniques of behavioral modification may be valuable in strengthening the offender's social skills. Group and family methods may be useful in encouraging and facilitating his acquisition of constructive social attitudes. In these benign settings, he may begin to alter his social image and develop both the motivation and the skills for a more effective interpersonal style. Preceding or combining short-term programs with individual treatment sessions may aid in forestalling untoward recurrences of the discomfort currently experienced by the offender.

Focused treatment efforts for this introverted and passive man are best directed toward countering his withdrawal tendencies. Minimally introspective and evincing diminished affect and energy, he must be prevented, through circumscribed therapies, from becoming increasingly isolated from others, be they discomforting or benign. Energy should be invested to enlarge his social world owing to his tendencies to pursue with diligence only those activities required by his job or by his family obligations. By shrinking his interpersonal milieu, he precludes exposure to new experience. Of course, this is his preference, but such behavior only fosters his isolated and withdrawn existence. To prevent such backsliding and a relapse, the therapist should ensure the continuation of all constructive social activities as well as potential new ones. Otherwise, he may become increasingly lost in asocial and fantasy preoccupations. Excessive social pressure, however, should be avoided because the offender's tolerance and competencies in this area are likely to be limited. Initial brief and focused treatment techniques will aid him in developing more skills in this area.

End of Report

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

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171: 1  172: 1  173: 2  174: 2  175: 1
Interpretive Report: Clinical Settings

MMPI-2-RF™
Minnesota Multiphasic Personality Inventory-2-Restructured Form™
Yossef S. Ben-Porath, PhD, & Auke Tellegen, PhD

ID Number: 9
Age: 34
Gender: Female
Marital Status: Never Married
Years of Education: 12
Date Assessed: 08/02/2008
MMPI-2-RF Validity Scales

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Percent True (of items answered): 45%

Comparison Group Data: Forensic, Pre-trial Criminal (Women), N = 223

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The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.
MMPI-2-RF Higher-Order (H-O) and Restructured Clinical (RC) Scales

Higher-Order

Restructured Clinical

Raw Score: 5 0 17 4 8 4 11 15 1 3 2 20
T Score: 43 39 78 51 63 50 65 79 56 44 52 69
Response %: 100 100 100 100 100 100 100 100 100 100 100 100

Comparison Group Data: Forensic, Pre-trial Criminal (Women), N = 223
Mean Score (−1 SD): 61 56 54 61 63 58 52 59 59 56 56 48
Standard Dev (±1 SD): 14 15 11 14 15 14 11 12 16 13 14 10

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.
MMPI-2-RF Somatic/Cognitive and Internalizing Scales

Raw Score:  6  1  2  1  2  0  3  0  3  1  0  4  0  2
T Score:    75  64  59  53  54  45  69  42  51  43  44  59  43  46
Response %: 100  100  100  100  100  100  100  100  100  100  100  100  100

Comparison Group Data:  Forensic, Pre-trial Criminal (Women), N = 223
Mean Score (---):  63  62  61  61  59  57  53  59  57  58  62  53  55  55
Standard Dev (±1 SD):  13  18  14  15  16  19  13  13  13  12  17  12  13  10

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.
MMPI-2-RF Externalizing, Interpersonal, and Interest Scales

Raw Score:  5  5  5  4  3  0  1  2  2  0  4
T Score:  77  77  67  53  53  34  43  47  68  33  56
Response %:  100  100  100  100  100  100  100  100  100  100  100

Comparison Group Data: Forensic, Pre-trial Criminal (Women), N = 223
Mean Score (---):  55  57  50  52  55  52  54  52  49  44
Standard Dev (±1SD):  12  13  11  13  14  11  12  11  12  11  7

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.
MMPI-2-RF PSY-5 Scales

Raw Score: 17 0 14 5 3
T Score: 83 38 72 47 42
Response %: 100 100 100 100 100

Comparison Group Data: Forensic, Pre-trial Criminal (Women), N = 223
Mean Score (±1 SD): 47 54 51 59 54
Standard Dev (±1 SD): 9 15 10 13 13

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.
SYNOPSIS

Scores on the MMPI-2-RF validity scales raise concerns about the possible impact of inconsistent responding, over-reporting, and under-reporting on the validity of this protocol. With that caution noted, scores on the substantive scales indicate somatic complaints and emotional, behavioral, and interpersonal dysfunction. Somatic complaints relate to malaise. Emotional-internalizing findings relate to helplessness and hopelessness. Behavioral-externalizing problems include antisocial behavior, juvenile conduct problems, substance abuse, and aggression. Interpersonal difficulties include over-assertiveness, a dislike of people and being around them, and cynicism.

PROTOCOL VALIDITY

Content Non-Responsiveness

Unscorable Responses
The test-taker produced scorable responses to all the MMPI-2-RF items.

Inconsistent Responding
There is some evidence of inconsistency because of fixed True responding to the MMPI-2-RF items. This level of inconsistency does not invalidate the test protocol. However, scores on the MMPI-2-RF scales should be interpreted with some caution.

Over-Reporting
The test-taker generated a larger than average number of infrequent responses to the MMPI-2-RF items. This level of infrequent responding may occur in individuals with genuine psychological difficulties who report credible symptoms. However, for individuals with no history or current corroborating evidence of dysfunction it likely indicates over-reporting.

Under-Reporting
There is also evidence of possible under-reporting in this protocol. The test-taker presented herself in a positive light by denying some minor faults and shortcomings that most people acknowledge. This level of virtuous self-presentation may reflect a background stressing traditional values. Any absence of elevation on the substantive scales should be interpreted with caution. Elevated scores on the substantive scales may underestimate the problems assessed by those scales.
SUBSTANTIVE SCALE INTERPRETATION

Clinical symptoms, personality characteristics, and behavioral tendencies of the test-taker are described in this section and organized according to an empirically guided framework. Statements containing the word "reports" are based on the item content of MMPI-2-RF scales, whereas statements that include the word "likely" are based on empirical correlates of scale scores. Specific sources for each statement can be viewed with the annotation features of this report.

The following interpretation needs to be considered in light of cautions noted about the possible impact of inconsistent responding, over-reporting, and under-reporting on the validity of this protocol.

Somatic/Cognitive Dysfunction
The test-taker reports experiencing poor health and feeling weak or tired. She is indeed likely to be preoccupied with poor health and to complain of sleep disturbance, fatigue, low energy, and sexual dysfunction.

Emotional Dysfunction
The test-taker reports feeling hopeless and pessimistic. She is likely to feel overwhelmed and that life is a strain, to believe she cannot be helped and gets a raw deal from life, and to lack motivation for change.

Thought Dysfunction
There are no indications of disordered thinking in this protocol. However, because of indications of under-reporting described earlier, such problems cannot be ruled out.

Behavioral Dysfunction
The test-taker's responses indicate significant, generalized, externalizing, acting-out behavior, which is likely to have gotten her into difficulties. More specifically, she reports a significant history of antisocial behavior and is likely to have been involved with the criminal justice system and to have difficulties with individuals in positions of authority. She is also likely to act out when bored and to have antisocial characteristics. She also reports a history of problematic behavior at school. She is likely to have a history of juvenile delinquency and criminal and antisocial behavior and to experience conflictual interpersonal relationships. In addition, she reports significant past and current substance abuse, and is indeed likely to have a history of problematic use of alcohol or drugs and to have had legal problems as a result of substance abuse.

She is likely to be restless and become bored and to be over-activated as manifested in poor impulse control, aggression, mood instability, euphoria, and sensation-seeking, risk-taking, or other forms of under-controlled behavior. She reports engaging in physically aggressive, violent behavior and losing control, and is indeed likely to have a history of violent behavior toward others.

Interpersonal Functioning Scales
The test-taker describes herself as having strong opinions, as standing up for herself, as assertive and direct, and able to lead others. She is likely to believe she has leadership capabilities, but to be viewed by others as domineering, self-centered, and possibly grandiose. She also reports having cynical beliefs,
distrust of others, and believing others look out only for their own interests. She is likely to be hostile toward others and feel alienated from them, and to have negative interpersonal experiences as a result of her cynical beliefs. In addition, she reports disliking people and being around them, and is likely to be asocial and socially introverted, but her asocial behavior is not associated with social anxiety.

**Interest Scales**
The test-taker reports an average number of interests in activities or occupations of a mechanical or physical nature (e.g., fixing and building things, the outdoors, sports). She indicates little or no interest in activities or occupations of an aesthetic or literary nature (e.g., writing, music, the theater).

**DIAGNOSTIC CONSIDERATIONS**

*This section provides recommendations for psychodiagnostic assessment based on the test-taker's MMPI-2-RF results. It is recommended that she be evaluated for the following:*

**Emotional-Internalizing Disorders**
- Somatoform disorder, if physical origin for malaise has been ruled out

**Behavioral-Externalizing Disorders**
- Antisocial personality disorder, substance use disorders, and other externalizing disorders
- Disorders associated with interpersonally aggressive behavior such as intermittent explosive disorder

**Interpersonal Disorders**
- Personality disorders involving mistrust of and hostility toward others

**TREATMENT CONSIDERATIONS**

*This section provides inferential treatment-related recommendations based on the test-taker's MMPI-2-RF scores.*

**Areas for Further Evaluation**
- Origin of malaise complaints.

**Psychotherapy Process Issues**
- Malaise may impede her willingness or ability to engage in treatment.
- Unlikely to be internally motivated for treatment.
- Acting-out tendencies can result in treatment non-compliance and interfere with the development of a therapeutic relationship.
- Cynicism may interfere with forming a therapeutic relationship.
- Her aversive response to close relationships may make it difficult to form a therapeutic alliance and achieve progress in treatment.
Possible Targets for Treatment

- Loss of hope and feelings of despair as early targets for intervention
- Inadequate self-control
- Reduction or cessation of substance abuse
- Reduction in interpersonally aggressive behavior
- Lack of interpersonal trust

ITEM-LEVEL INFORMATION

Unscorable Responses

The test-taker produced scorable responses to all the MMPI-2-RF items.

Critical Responses

Seven MMPI-2-RF scales—Suicidal/Death Ideation (SUI), Helplessness/Hopelessness (HLP), Anxiety (AXY), Ideas of Persecution (RC6), Aberrant Experiences (RC8), Substance Abuse (SUB), and Aggression (AGG)—have been designated by the test authors as having critical item content that may require immediate attention and follow-up. Items answered by the individual in the keyed direction (True or False) on a critical scale are listed below if her T score on that scale is 65 or higher. The percentage of the MMPI-2-RF normative sample (NS) and of the Forensic, Pre-trial Criminal (Women) comparison group (CG) that answered each item in the keyed direction are provided in parentheses following the item content.

Helplessness/Hopelessness (HLP, T Score = 69)

135. Omitted Item. (True; NS 24.2%, CG 30.9%)
282. Omitted Item. (False; NS 17.3%, CG 30.0%)
336. Omitted Item. (True; NS 38.0%, CG 29.1%)

Substance Abuse (SUB, T Score = 77)

49. Omitted Item. (True; NS 29.6%, CG 35.9%)
141. Omitted Item. (True; NS 34.2%, CG 40.4%)
237. Omitted Item. (False; NS 27.4%, CG 57.0%)
266. Omitted Item. (True; NS 5.0%, CG 55.6%)
297. Omitted Item. (True; NS 14.4%, CG 18.4%)

Aggression (AGG, T Score = 67)

26. Omitted Item. (True; NS 19.9%, CG 12.1%)
84. Omitted Item. (True; NS 12.1%, CG 8.5%)
316. Omitted Item. (True; NS 45.1%, CG 39.5%)
329. Omitted Item. (True; NS 12.7%, CG 16.1%)

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.
337. Omitted Item. (True; NS 50.2%, CG 52.0%)

End of Report

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