

### **Case Example 3333: Elizabeth Inpatient Mental Health Interpretive Report**

Elizabeth is a 17-year-old white adolescent, 5 feet 7 inches tall, weighing 94 pounds when admitted to an inpatient eating disorders treatment program. Her physician referred her to the program after she failed to improve in outpatient treatment for anorexia over the previous year. The outpatient program included group and individual psychotherapy and weekly sessions with a nutrition specialist.

Elizabeth's parents are both successful attorneys with a prominent law firm in a large southeastern city who travel frequently for work. They employ a live-in nanny who has worked for the family for five years. Elizabeth is the youngest of three children. Her sister (age 20) is in college and her brother (age 24) is in law school.

During the intake interview, Elizabeth was very reluctant to discuss her problems and appeared to be irritable and antagonistic toward the interviewer's questions. She reported a number of physical symptoms and complained about having to participate in the evaluation. However, shortly after the intake interview, Elizabeth was cooperative in her responding to the MMPI-A, as the Validity Considerations section of the Minnesota Report indicates.

Elizabeth's scores on MMPI-A Clinical Scales profile present an unusual symptom pattern of elevations on Scales 1 and 9, suggesting, as the Minnesota Report narrative describes, an usually fast-paced personal tempo combined with significant somatic complaints. Her scores on the Harris-Lingoes Hypomania subscales for Scale 9, provided in the Additional Scales section of the Minnesota Report on p. 9, allow the psychologist to explore further the meaning of her Scale 9 elevation. Given the pattern of scores on Harris-Lingoes, it appears  $Ma_4$ , Ego Inflation, accounts for its elevation, as opposed to the others whose scores range from 44-54. Her MAC-R elevation is extremely high, indicating likely risk-taking behaviors, as well as the probability of an underlying alcohol or other drug problem. Other indicators of acting out symptoms in this mixed clinical picture, comes from her elevation on the Aggressiveness PSY-5 Scale, and endorsement of several of the Item Level Indicators on pp 12-14 in the Conduct Problems, School Problems, and Sexual Concerns categories. Also noteworthy is the lack of endorsement of any of the Eating Problems items, given her recent history of treatment, and current placement in an inpatient unit for eating disorders.

There are multiple indications on her Clinical and Content Scales profiles, as well as in the Additional Scales section that somatic complaints are prominent, and should be evaluated further. Other prominent internalizing symptoms include anxiety symptoms and her generally pessimistic approach to life and relationships, suggested by scores on the PSY-5 NEGE and Cynicism scales, and described in the narrative sections of her Minnesota Report. Given her mixed clinical picture on the MMPI-A and her uncooperative stance during the initial interview, the psychologist planned an extensive feedback session, using the Minnesota Report, to explore further her symptoms/behaviors she was willing to share in her MMPI-A responses, but not in the initial interview.