

Forensic use of the MMPI-A

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This chapter reviews information and issues vital to those who use the MMPI-A in forensic assessments as well as to those (e.g., attorneys) who encounter its use in forensic contexts. The focus is on the MMPI-A, but also includes information relevant to conducting forensic evaluations with adolescents in order to meet the highest standards of practice and to withstand close scrutiny in the adversarial forensic system.

The first section reviews the development of the MMPI-A for those who are new to the instrument. The second section discusses essential steps for those who are considering using the MMPI-A in a forensic assessment. The third section looks at the evolving research on the MMPI-A and highlights two case books that provide information and examples illustrating case interpretation. The fourth section examines the ways in which the MMPI-A can identify invalid or misleading responses.

Development of the MMPI-A

The original MMPI was widely used to assess adolescents (see [Pope, Butcher, & Seelen, 2006](#)). The earliest studies using the MMPI with adolescents sought to determine whether the instrument could reliably and validly identify subgroups of youth predisposed to delinquency. Early research by Capwell (1945a, 1945b) showed that the item pool on the MMPI provided useful clinical-personality information on delinquent girls. Monachesi (1948, 1950a, 1950b, 1953) extended Capwell's findings to boys, showing that delinquent boys and girls were significantly different from boys and girls characterized as "normal" on several MMPI scales, notably 4, 6, 7, 8, and 9 with Scale 4 being the most different. Much of the early adolescent MMPI research concentrated on identifying youth who were prone to juvenile delinquency (Hathaway and Monachesi, 1963).

The pioneering research on delinquent boys and girls led Hathaway and Monachesi (1963) to conduct a 15-year prospective study of the MMPI with normal and delinquent adolescents. A total of 15,300 ninth graders from Minnesota were administered the MMPI. Substantial demographic and biographic information on each of the participants was obtained from schools, law enforcement agencies, and social service organizations.

This extensive data base was then used to investigate whether delinquency and other acting-out behaviors could be predicted, as well as to describe differences in adult and adolescent personality as measured by the MMPI. Such studies on adult and adolescent differences helped in understanding how to use the MMPI with adolescents, and how to take account of the actuarial differences between groups (e.g., between adults and adolescents, between adolescents who were and were not delinquent).

In developing the MMPI-A, published in 1992 (Butcher, Williams, Graham, Archer, Tellegen, Ben-Porath, & Kaemmer, 1992), the MMPI Revision Committee was aware that the MMPI test item pool needed considerable modification in order to make the instrument more effective with adolescents. For example, the original MMPI items had been written from an adult perspective and had usually been administered without modification to adolescents. In addition, the MMPI scales had been developed using adult samples and a conceptualization of psychological disorders that was oriented toward adult psychopathology. Moreover, there were no adolescent subjects included in the norms for the MMPI and interpretation of the scales for adolescents was based, in part, on research with adults. It is interesting that despite these limitations, the MMPI came to be widely used with adolescents (Hathaway & Monachesi, 1963; Hathaway, Reynolds, & Monachesi, 1969).

To revise the MMPI for use with adolescents, a large representative national sample of adolescents was obtained using an experimental form for adolescents—a form made up of the original MMPI items, some new items contained on the MMPI-2, and a number of new items that address adolescent issues and behaviors such as attitudes about school and parents, peer group influence, and eating problems. These items were distributed throughout the booklet in order to make the instrument more visibly relevant to adolescents. Furthermore, items about youthful behaviors that were worded in the past tense on the MMPI and MMPI-2 were changed to the present tense for the MMPI-A.

The development of MMPI-A norms included obtaining a large, diverse, normative sample of young people from several regions of the United States including California, Minnesota, Ohio, North Carolina, New York, Pennsylvania, Virginia, and Washington State. These various testing locations were chosen to maximize the possibility of obtaining a balanced sample of participants according to geographic region, rural-urban residence, and ethnic background.

The experimental form of the MMPI (704-item Form TX) was administered to 815 girls and 805 boys in the normative sample and was also employed in an extensive clinical evaluation study (see Williams & Butcher, 1989a, 1989b; Williams et al., 1992). The MMPI-A normative sample was comprised of boys and girls, ages between 14 through 18. Upon completion of the norms, a final MMPI-A booklet was constructed of 478 items, many of which were on the original MMPI and were also included in the MMPI-2.

In the development of MMPI-A, continuity was maintained with the MMPI-2 for several scales including: The validity scales L and K, the standard scales (the eight clinical scales

and scales 5 and 0), the MacAndrew Alcoholism Scale (MAC-R), and supplementary scales A and R (Butcher et al., 1992).

A new set of adolescent specific content scales were developed in order to capitalize on the new adolescent-specific items. Internal consistency statistical analyses were used with adolescent samples and verified by rational procedures (that included using a developmental perspective) were used in developing the MMPI-A Content Scales. Three of the MMPI-A Content Scales were developed using primarily the new adolescent-specific items (School Problems, Low Aspirations, and Alienation). The Family Problems Scale (A-fam) was improved with the addition of adolescent-specific content. A new scale, Conduct Problems (A-con), was substituted for the MMPI-2 Antisocial Practices (ASP) Scale on the MMPI-A when inadequate empirical validity was found for ASP with adolescents (Williams et al., 1992).

To refine content-based interpretation of the MMPI-A further, Sherwood, Ben-Porath, and Williams (1997) developed a set of content component scales for the MMPI-A content scales. These scales further break down the content included in the MMPI-A content scales; for example, the Depression Content Scale contains four component scales: Dysphoria (5 items), Self-depreciation (5 items), Lack of drive (7 items), and Suicidal ideation (4 items). While these component scales are not long enough to provide psychometrically stable scores they, nevertheless, do provide the practitioner with a means of examining the content that might influence high elevations on the parent content scale.

The assessment of substance abuse problems has been the focus of several research studies with the MMPI-A. The MAC-R scale, originally developed for detecting adult substance abuse problems, has shown effectiveness in delineating adolescent substance abuse problems as well. In addition, two new scales have been developed with MMPI-A items to describe adolescent alcohol and drug use problems: the Alcohol-Drug Problem Proneness Scale (PRO) and the Alcohol-Drug Problem Acknowledgments Scale (ACK) (Weed, Butcher, & Williams, 1994). These scales have shown effectiveness in assessing adolescent substance abuse problems in cross-validation studies (Gallucci, 1997; Williams, Perry, Farbaksh, & Veblen-Mortensen, 1999).

As with the MMPI-2, the norms for the MMPI-A were based on the uniform T score transformation that were developed by Tellegen (1988). This transformation ensured that the percentile values were equivalent across the different MMPI scale scores (Butcher et al., 1992; Tellegen and Ben-Porath, 1992). Both the MMPI-2 and MMPI-A norms were developed using the same target distribution. This procedure assured the percentile equivalence across the two forms of the MMPI so that if an adolescent is tested with the MMPI-A at one point and is later tested with the MMPI-2, the T scores can be meaningfully compared.

Although the recommended cut-off for clinical interpretation (i.e., a T score of 65) is used for the MMPI-2, it is slightly different for adolescents (60 to 64 T score range) because these scores are considered to yield potentially useful personality descriptors.

The MMPI-A clinical scales have been shown to have high long-term stability (Stein, McClinton, & Graham, 1998).

The United States is an ethnically diverse country in which clients from different cultural and language backgrounds might require psychological evaluation. It is important that all assessment instruments administered to an individual be adequately matched to that person's cultural and language background. For example, the MMPI-A has been translated into Spanish and normed on a Spanish-speaking United States adolescent population. The Spanish language booklet (developed according to rigorous test adaptation procedures) is administered to the adolescent and the special T scores drawn from the Hispanic norms are used to plot the profile (Butcher, Cabiya, Lucio, Pena, Ruben, & Scott, 1998).

Some Essential Steps When Using the MMPI-A in Forensic Contexts

Properly used, the MMPI-A provides a variety of benefits in forensic assessment of adolescents (see [Table 1](#)). The following steps -- presented in the form of questions an examiner should ask him- or herself before conducting a forensic examination using the MMPI-A -- are useful in helping to ensure that the MMPI-A is properly used and that a forensic assessment is valid and meets the highest standards.

What is the MMPI-A expected to do in this assessment?

It can be tempting to reach for a widely-used assessment instrument simply because: (a) it is widely used, (b) we have a copy and know how to administer it, and (c) it is one of our favorites. But no instrument can do all things in all settings. It is important to know the degree to which an assessment instrument is well-matched to the assessment issue at hand. Even when certain instruments are known for their high reliability and validity, the reliability and validity have been established only for certain specific sets of criteria. Not only is it a significant responsibility to find out the MMPI-A's (and any other instrument under consideration) established reliability and validity for the assessment issue at hand before conducting the assessment, it is much more pleasant to learn this information ahead of time instead of during cross-examination.

Is the examiner qualified to conduct this assessment?

Just as no instrument can do all things in all settings, neither can an examiner. Someone who is a leading expert in the forensic assessment of children or adults may not be qualified to perform a forensic assessment of adolescents aged 14-18. The examiner needs adequate education, training, and supervised experience not only in forensic assessment and the relevant instruments (e.g., the MMPI-A) but also in the developmental issues and other areas of competence relevant to assessing adolescents.

How old is the person to be assessed?

The MMPI-A was normed -- and the reliability and validity studies focused -- on people ages 14-18. However "interesting" it might be to administer the inventory to a 7 year old child, a 57 year old adult, or others outside the MMPI-A's age range, there is no scientific basis for interpreting the results.

Is English an appropriate language?

Even the most comprehensive forensic assessments can be undermined by assessment instruments that are poor matches for the language of the person being assessed. At present there are well tested translations of the MMPI-A in several languages: Arabic, Chinese, Dutch, French, Greek, Italian, Hebrew, Korean, Norwegian, Russian, Spanish (U.S.), Spanish (Mexico), and Thai. For a listing of available translations and translators see Butcher (in press).

Is vision an issue?

Some adolescents are blind or have other severe visual disabilities that prevent them from reading the standard MMPI-A test booklet and using the standard MMPI-A response sheet. The MMPI-A can be administered orally. It is better to administer the test in a standardized manner by using a tape recorded version of the test that is available through the test distributor, Pearson Assessments, rather than reading the items in person.

Have relevant issues of informed consent and/or assent been adequately addressed?

Issues of informed consent and/or assent for the assessment of minors can be enormously complex, and these issues can become even more difficult in forensic contexts. It is crucial that the examiner identify everyone (the adolescent? a custodial parent or guardian? a non-custodial parent? a court or other state or federal agency?) who has a right to participate in the process of authorizing or refusing the assessment, and to clarify whether an assessment has been duly authorized and consented or assented to by all who have a right to involvement in the decision before undertaking the assessment.

Have relevant issues of privacy, confidentiality, privilege, discretionary or mandated reporting, who will receive the results (and in what form), who will have access to raw data, and how feedback will be provided to the person assessed been adequately clarified and addressed?

Within the complex context of a forensic assessment of a minor, it is easy to overlook the issues of what feedback is to be given to the person assessed, and how and when it is to be provided. A discussion of 10 fundamental aspects of the feedback process -- (a) feedback as process; (b) clarification of tasks and roles; (c) responding effectively to a crisis; (d) informed consent and informed refusal; (e) framing the feedback; (f) acknowledging fallibility; (g) the misuse of feedback; (h) records, documentation, and follow-up; (i) looking toward the future; and (j) assessing and understanding important reactions. -- is available at <http://kspope.com/assess/feedabs1.php>.

Beyond the anticipated feedback to the person being assessed, the court, and/or other individuals, there is also the possibility of unanticipated requests for information. The following scenario is adapted from Pope & Vasquez (1998; see also 2005).

An attorney who is a great source of referrals for you retains you to conduct a forensic assessment on a 17-year-old boy who has been suffering anxiety and depression and is considering filing a worker's compensation claim for his condition. He quit high school to get married about a year ago and has a 1-year-old baby. However, several months ago he moved out of the apartment he'd shared with his wife and child and had gone back to live with his parents. He works full time as an auto mechanic.

You complete the assessment and immediately begin to receive, over the course of the following year, formal requests for information from:

- The boy's physician, an internist
- The boy's parents, who are concerned about his depression
- The boy's employer, in connection with the worker's compensation claim filed by the boy
- The attorney for the insurance company that is contesting the worker's compensation claim
- The attorney for the boy's wife, who is suing for divorce and for custody of the baby
- The boy's attorney, the source of the original referral, who is considering filing a licensing and an ethics complaint against you because he does not like the assessment results and believes they are due to a faulty assessment

Each of these people asks you to send them the full formal assessment report, the raw test data, and copies of each of the tests you administered (for example, instructions and all items for the MMPI-A).

Among the questions you face are: Do you have a legal or ethical obligation to provide any of these people all the materials they requested? partial information? a summary? nothing at all? Do any of the requests require the boy's written informed consent and/or his parents' consent?

There is, unfortunately, no one-size-fits-all answer to the questions in this scenario that holds across every jurisdiction. These issues tend to be influenced by constantly-evolving state (or provincial) legislation and case law in the context of federal regulations. It is the responsibility of the examiner to ensure that he or she understands the relevant requirements for the specifics of the situation and the jurisdiction.

Is there an appropriate environment for a forensic assessment?

A room rattled by the sounds of loud construction next door and in which there are frequent intrusions and interruptions is an example of a room that is not appropriate for forensic assessment. Beyond an environment that offers reasonable quiet, privacy, and freedom from distractions is the issue of monitoring. Unless a forensic assessment using

the MMPI-A and similar instruments is adequately monitored there is no way for the examiner to know with certainty whether the examinee received "help" in filling out the form or even if he or she filled in the form. The MMPI-A and similar instruments should not be sent home, back to the ward, or to other unmonitored places with the examinee.

MMPI-A Research and Clinical Case Books

Since its publication in 1992, the MMPI-A has been the subject of considerable research and a broadening of clinical use. The MMPI-A has been used extensively in the study of delinquents (Archer, Bollnskey, Morton, & Farris, 2003; Archer, Bolinskey, Morton, & Farris, 2002; Arita & Baer, 1998; Bannen, 2000; Baron, 2003; Losado-Paisley, 1998; Cashel, Ovaert, & Holliman, 2000; Cashel, Rogers, Sewell, & Holliman, 1998; Glaser, Calhoun, & Petrocelli, 2002; Gomez, Johnson, Davis, & Velasquez, 2000; Green, 2000; Gumbiner, Arriaga, & Stevens, 1999; Hammel, 2001; Hunter, 2000; Moore, Thompson-Pope, & Whited, 1996; Morton, Farris, & Brenowitz, 2002; Morton, & Farris, 2002; Pena, Megargee, & Brody, 1996; Riethmiller, 2003; Stein & Graham, 1999; Toyer & Weed, 1998; Vande Streek, 2000).

Several clinical populations have also been studied: people suffering from anxiety disorders (James, Reynolds, & Dunbar, 1994); ADHD (Toyer, 1999); depression (Figuered, 2002) people with eating disorders (Cumella, Wall, & Kerr-Almeida, 1999; Lilienfeld, 1994); psychiatric inpatients (Archer, & Krishnamurthy, 1997; Arita & Baer, 1998; Deluca, 2003; Hilts, & Moore, 2003; Janus, Tolbert, Calestro, & Toepfer, 1996; Janus, de Groot, & Toepfer, 1998; McGrath, Pogge, & Stokes, 2002; Micucci, 2002; Pogge, Stokes, McGrath, Bilginer, & DeLuca, 2002; Powis, 1999); outpatients (Garyfallos, Adamopoulou, Karastergiou, Voikli, Sotiropoulou, Donias, iouzepas, & Paraschos, 1999); suicidal adolescents (Batigun & Sahin, 2003; Kopper, Osman, Osman & Hoffman, 1998); and substance abusing adolescents (Dimino, 2003; Gallucci, 1997; Ingersoll, 2003; Palmer, 1999; Weed, Butcher, & Williams, 1994; Williams, Perry, Farbakhsh, & Veblen-Mortensen, 1999; Price, 1999; Stein & Graham, 2001); sexually abused adolescents (Forbey, Ben-Porath, & Davis, 2000; Holifield, Nelson, & Hart, 2002); and stress Scott, Knoth, Beltran-Quiones, & Gomez, 2003). Weis, Crockett, & Vieth (2004) used the MMPI-A with effectiveness to assess adolescents being evaluated for acceptance in a "boot camp" rehabilitation program. (Additional MMPI-A research information is available at <http://www1.umn.edu/mmpi>.)

The use of "critical items" to detect the presence of specific psychological problems has also been explored with the MMPI-A. Although the use of "critical items" is somewhat controversial in forensic settings, the practitioner should be aware that a "critical item" set has been developed by Forbey and Ben-Porath (1998) for use in clinical evaluations. The authors studied a sample of 419 adolescent patients from diverse clinical settings to develop their item lists. They compared the clinical samples with the adolescent normal sample to develop items that focus upon specific problem areas such as aggression, conduct problems, depressed suicidal ideation, and so forth. These items have been found to be informative in providing clues to specific problem areas in clinical evaluations, but

it should be kept in mind that their use in forensic evaluations has not been sufficiently explored.

Two clinical case books have been published on the use of the MMPI-A. The first, by Ben-Porath & Davis (1996), provides extensive case material on adolescents from a juvenile detention program. This case book is an extremely valuable resource for teaching MMPI-A interpretation because it presents 16 detailed cases from a broad range of clinical settings and problem areas along with a rich amount of biographical information. The second, by Butcher et al. (2000) presents a group of fourteen cases from 14 other countries using translations of the MMPI-A. Psychologists in China, England, Greece, Holland, France, South Korea, Italy, Mexico, Norway, Peru, Russia, South Africa, Spain, and Thailand were asked to conduct a psychological evaluation of an adolescent and provide a detailed case history and the MMPI-A answer sheet to James Butcher in Minnesota to process the protocol on the computer-based interpretation system, the Minnesota Report. The case histories and the computer-based report are presented in the book illustrating the considerable extent to which the computer-based MMPI-A interpretations developed for the United States fit cases of adolescents from other cultures taking the test in other languages.

Invalid and Misleading Profiles

Forensic practitioners who evaluate adolescents in preparation for a court appearance face the question: how credible is the information obtained from the adolescent? Although the issue of response credibility in self-report-based personality assessment is an important one in the clinical assessment, it is more important in forensic evaluations because of the increased motivation on the part of the adolescent to impress the examiner in a particular way, for example to exaggerate or deny their problems.

It is important for the practitioner to carefully evaluate the adolescent's response attitudes in forensic testing (McCann, 1998). Yet, many psychological tests used with adolescents lack a means of detecting deviant response attitudes such as exaggerated or defensive responding that are so prominent in forensic evaluations. There is no way for the psychologist to know whether the client has accurately presented a true picture of his or her psychological make-up unless validity scales are incorporated in the evaluation.

The MMPI-A contains several methods to assess invalidating response patterns and these measures must be carefully addressed before clinical scale interpretation can be relied upon. The first scales to assess are those that provide non-content oriented response information. For example, it is crucial to address general "patterns" of deviant responding such as whether the person has omitted items in the inventory, answered randomly, or responded in an "all true" or "all false." Next, it is important to determine if he or she has responded in an inconsistent manner. Two consistency scales have been developed for this purpose, the Variable Response Inconsistency Scale (VRIN) and the True Response Consistency Scale (TRIN). Subsequent research has demonstrated the effectiveness of these scales in assessing inconsistency. Baer, Kroll, Rinaldo, and Ballinger (1999), e.g., found VRIN to be a good predictor of random responding.

Three Infrequency scales are also used on the MMPI-A to evaluate the tendency on the part of some adolescents to exaggerate problems or to respond in a “fake-bad” direction on the test: The F scale and its component scales F1 and F2. For example, random responding has been shown to be detectable on the MMPI-A validity indicators, particularly scale F (Baer, Ballenger, Berry, & Wetter, 1997).

The F scale was originally developed for the MMPI by Hathaway and McKinley in order to assess this tendency. However, the F scale on the original MMPI never worked well with adolescents because almost all subjects (even normal adolescents) tended to show high elevations on the scale. This resulted from the fact that adult responses were used to develop the scale and not adolescents who tend to have a somewhat different response frequency to the items. The difference between adolescents and adults required an extensive revision when the MMPI-A was developed to ensure that it performed as an infrequency measure for adolescents.

Three infrequency scales were developed for the MMPI-A based on adolescent response frequencies. These scales all assess the tendency for some adolescents to answer in an extreme way on the test. The F scale contains a total of 66 items; F1 is comprised of 33 items that occur toward the front of the booklet, and F2 is comprised of 33 of the later appearing items. The conjoint use of these scales gives the practitioner a picture of whether the adolescent has responded differently to items in the back of the booklet versus those in the front of the booklet. Empirical research has shown that the MMPI-A is highly effective at discriminating adolescents who are faking-bad on the test (Stein, Graham, & Williams, 1995). The relationship between the F scale and the K scale has also been found to be useful in assessing faking in adolescents. For example, Rogers, Hinds, and Sewell (1996) found that F-K appeared to be promising as a predictor of feigning psychopathology.

The MMPI-A has also been found to detect underreporting of symptoms in adolescent populations (Baer, Ballenger, & Kroll, 1998). Two scales on MMPI-A address the tendency on the part of some individuals to present an overly favorable or defensive response pattern on the test. The K scale, developed for adults, has also been found to be sensitive to test defensiveness in adolescents and the L scale addresses extreme virtue claiming in adolescent samples as well (see the discussion on validity scales on the MMPI-2 in Butcher & Williams, (2000; Pope, et al., 2000). Empirical evaluations of the effectiveness of the MMPI-A in detecting fake good response patterns have been published. Stein and Graham (1999) reported that it was possible to differentiate adolescents who were instructed to “fake good” from adolescents who took the test under standard instructions and correctional youth who were asked to fake the test as well as correctional youth who took the test under standard instructions.

Summary

The original MMPI was used extensively to evaluate adolescents in a wide variety of settings. The earliest studies using the MMPI with adolescents sought to determine whether the instrument could reliably and validly identify subgroups of youth

predisposed to delinquency. The early successes of the MMPI resulted in wide use with adolescents.

The revised instrument for adolescents, the MMPI-A, was developed using a large, representative, national sample of adolescents. The MMPI-A is made up of many of the original MMPI items, some new items developed for MMPI-2, and a number of new items that address adolescent issues and behaviors such as attitudes about school and parents, peer group influence, and eating problems. The development of the MMPI-A norms included obtaining a large, diverse, normative sample of young people from several regions of the United States. The MMPI-A normative sample was comprised of boys and girls, ages between 14 through 18.

A new set of adolescent specific content scales were developed in order to capitalize on the new adolescent-specific items. Internal consistency statistical analyses were used with adolescent samples and verified by rational procedures (that included using a developmental perspective) were used in developing the MMPI-A Content Scales. Two new scales were developed with MMPI-A items to describe adolescent alcohol and drug use problems: the Alcohol-Drug Problem Proneness Scale (PRO) and the Alcohol-Drug Problem Acknowledgments Scale (ACK).

Several well- tested translations of the MMPI-A are available: Arabic, Chinese, Dutch, French, Greek, Italian, Hebrew, Korean, Norwegian, Russian, Spanish (U.S.), Spanish (Mexico), and Thai. A standardized recoded version of the instrument is available from Pearson Assessments (formerly NCS) for use with people who have severe visual difficulties that interfere with their ability to read the test items. Since its publication in 1992, the MMPI-A has been the subject of considerable research and a broadening of clinical use. The MMPI-A has been used extensively in the study of delinquents and a number of clinical populations.

This article also discussed specific steps a forensic examiner can take to help ensure that a forensic evaluation using the MMPI-A is valid and meets the highest professional standards.

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Table 1

Advantages of Using the MMPI-A in Forensic Assessment

Some advantages of using the MMPI-A in forensic assessment include:

Practitioners and researchers choose the MMPI over other personality measures because of its ability to assess a broad range of psychological problems using limited professional time.

Its objective format makes it easy to administer in either individual or group settings such as schools. Students are accustomed also to the true-false responding and are willing to disclose psychological problems by responding to MMPI-A items.

The MMPI-A is only 478 items long (in contrast to the 567-item MMPI-2 booklet) and readily completed by most adolescents in one hour.

The MMPI-A is relatively easy to administer by computer. The computer-administered version of the test is preferred by adolescents.

The scales for MMPI-A are easy to score-- either manually or by computer. Using a computer allows many different scales, including content scales, subscales, and special scales, to be scored quickly and accurately.

A clear advantage of the MMPI-A is that there is a parallel instrument (MMPI-2) that can be used with other family members such as parents. This reduces the frequently occurring tendency in treatment settings to single out the referred adolescent as the only family member with problems. Adolescent clients are more willing to complete the MMPI-A knowing that their parents and/or siblings will be completing a similar instrument.

The item level problems assessed by the MMPI-A allow for the appropriate assessment of young people, that is, the MMPI-A has content validity for adolescent problems such as specific themes, including peer group influences, family relations, and school issues.

The MMPI-A contains a number of validity scales that address response distorting or invalidating conditions such as exaggerated responding, inconsistency, and faking good.

The MMPI-A includes a number of well-researched clinical measures, content-based measures, and substance abuse measures to address a broad range of adolescent problem areas.