MMPI-2 profiles of clients with substance dependencies accessing a therapeutic community treatment facility

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Abstract

The aim of the study was to describe the psychological profile, as measured by the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), of 921 substance dependent clients assessed after five weeks admission to a Therapeutic Community (TC). Overall, the profile of the sample showed prominent peaks reflecting character disorder (high psychopathic deviate [Pd]) and disturbed thinking and affect (high schizophrenia [Sc]). The validity scales suggested that the sample was admitting to personal and emotional difficulties and requesting assistance with these problems. The psychotic triad was somewhat more elevated than the neurotic triad indicating distress about behaviours or symptoms related to psychotic disorders. Psychopathology was greater for women, who reported significantly higher scores on confusion, hypochondriasis, character disorder, and hysteria than men, although the shape of male and female MMPI-2 profiles was similar. Those aged up to 35 years scored significantly higher on five clinical scales (depression, character disorder, paranoia, Pd and Sc) than an older (35 and over) group; they also significantly differed on all the validity scales from their older counterparts. Clients who completed the MMPI-2 at five weeks but stayed less than four months at the TC were more likely to be younger, female and admit to psychopathology (lower defensiveness scores, higher mania) than those who went on to complete the first phase of treatment. The results suggest that substance dependent clients seeking treatment at a TC exhibit considerable psychological disturbance; more so for females and the younger cohort.

Keywords: Therapeutic community; Dual diagnosis; Substance dependency; Mental health; MMPI-2

Introduction

The current study was an examination of the MMPI-2 personality profiles of individuals with substance dependencies following their first month in a Therapeutic Community (TC) treatment facility. Male and female personality profiles were compared, as were those of older and younger residents. Verheul (2001) in a literature review, reports numerous studies indicating a higher prevalence of personality disorders among substance abusers, particularly disorders involving antisocial, borderline, avoidant and paranoid personality characteristics. Stefansson and Hesse (2008) argue that substance abuse treatment is more effective if it addresses personality issues, and there are several intervention studies providing evidence that this is the case (e.g., Ball, Carroll, Canning-Ball, & Rounsaville, 2006; Conrod, Pihl, Stewart, & Dongier, 2000; Nielsen, Rojkjaer, & Hesse, 2007).

One of the most commonly used tools for assessing the personality characteristics of those with substance dependencies is the Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1942; Craig, 1983). The MMPI is a standardised questionnaire that elicits a range of self descriptions scored to give a quantitative measure of an individual’s level of emotional adjustment (Groth-Marnat, 1997). The MMPI-2, similar to its predecessor the MMPI, has three validity scales (L, lie; F, infrequency or atypicality; K, defensiveness) that provide information about a person’s approach to the test including the accuracy of their self-report (Greene, 2000). There are 10 clinical scales that assess symptom levels in specific personality and pathological domains including Hypochondriasis (Hs), Depression (D), Hysteria (Hy), Psychopathic Deviate (Pd), Masculinity–Femininity (Mf), Paranoia (Pa), Psychasthenia (Pt), Schizophrenia (Sc), Hypomania (Ma), and Social Introversion (Si) (Greene, 2000).

A review of American empirical studies suggests that typical MMPI profiles of those with heroin dependencies show high levels of psychopathology, with particularly high elevations on the F, D, Pd, Pt and Sc scales (Craig, 1979a, 1979b, 1982; Shaffer et al., 1988). Scale Si, while still in the normal range is often the lowest of the scores, representing good to adequate social skills. In order to maintain a constant drug
supply, those with substance dependencies need to establish and maintain social contacts. Accordingly, Craig (1982) observed that those with substance dependencies tend to present a sociable self-view.

DeLeon (1989) conducted a review of the research on psychopathology among those with substance dependencies in therapeutic communities. The MMPI profile was found to be deviant, demonstrating the characteristic shape of antisocial drug abusers. The prominent peaks reflected confusion (high F), character disorder (high Pd), and disturbed thinking and affect (high Sc). Smaller, but deviant peaks were evident in D, Pt and Ma. DeLeon showed that studies consistently indicate that those with substance dependencies who enter therapeutic communities reveal a considerable degree of psychological disturbance in addition to their substance abuse.

There are mixed findings regarding sex differences in the psychological characteristics of those with substance dependencies entering treatment. DeLeon and Jainchill’s (1991) review of the research literature revealed that women in therapeutic communities seem more psychologically disturbed than men. Although both male and female substance dependent clients report disturbance when they enter treatment and show similar personality profiles, females are characteristically worse, particularly on measures of depression, anxiety, and self-esteem. However, some research shows similarly deviant profiles of psychopathology for males and females entering a TC (DeLeon & Jainchill, 1981-82). With respect to age, Colligan and Offord (1992) review past literature and present data on a non-clinical sample of over 1000 individuals to show age-related changes on the MMPI. Their data suggests that depression tends to increase with age while there are noticeable declines in psychopathology as reflected in Pd, Pa, Pt and Sc scores. Whether such age differences also occur in a substance dependent population presenting for treatment is not known.

Dropout rates tend to be high in treatments designed for substance abusers, particularly therapeutic communities which involve an intense commitment on the part of the live-in clients, who must remain drug-free and participate in a much more regimented lifestyle than most of them have been experiencing. A consistent finding in the international literature on drug and alcohol addiction is that outcome results improve with time spent in some form of treatment (Mandell, Edelen, Wenzel, Dahl, & Ehnber, 2008) and as a result, methods for improving the retention of clients in programs have been examined extensively (Simpson, 2000). Specifically, Simpson et al. (1997) reported on the findings of a large scale US treatment outcomes study which found that individuals who stayed in residential rehabilitation programs for at least 90 days had better outcomes compared to those who left earlier. There is very little data available concerning the psychological characteristics of TC dropouts; such data may assist in the development of interventions to aid retention. Consequently, the current study includes a comparison of the MMPI-2 profiles of clients who stayed in the program at least four months (90 days after their first assessment) with those who dropped out before this treatment milestone.

In this study we contribute to the Australian evidence regarding the mental health of residential clients accessing a TC, in this case Odyssey House Victoria Therapeutic Community. This treatment facility accepts substance dependent clients with a range of high prevalence mental health issues, as well as those with histories of schizophrenia, psychosis and thought disorders. The TC is funded for 79 beds, some of which are for the children (aged 0-12 years) of inpatients. Each resident develops an individual treatment plan involving self-examination and behavioural change, educational, vocational and life skills, new supportive relationships and recreational activities. Days are structured to encourage residents to develop routine, with the daily schedule including regular meals and sleeping times, meaningful work, recreation, individual and group therapy and house responsibilities. Individuals work on their treatment plan goals, typically concerning reframing past experience and enhancing capacity to cope with relationship and work-related stress. Residents are able to also engage in nationally accredited training opportunities in hospitality, horticulture, office administration, first aid, and parenting.

Research suggests that those who suffer the most severe consequences of the harms associated with their drug use, including criminal activity and social disadvantage such as homelessness, tend to find therapeutic communities an effective form of treatment (Alcohol and other Drugs Council of Australia, 2003). Those individuals attending residential drug treatment generally present with increased severity of symptoms (e.g., Budde, Rounsaville, & Bryant, 1992) and increased likelihood of more co-occurring mental health disorders (e.g., Ross et al., 2002) relative to outpatients.

The aim of the study was to describe the psychological profile, assessed by the MMPI-2, of clients tested five weeks after admission to a TC and to compare older and younger male and female profiles with respect to psychopathology. Additionally, we sought to compare the MMPI profiles of clients who subsequently stayed in treatment for at least three months after initial testing with those who dropped out prior to this.

Method

Participants
The data were drawn from Odyssey House Victoria’s Therapeutic Community files. Residential clients
Hypomania, assesses tendencies toward hypomanic tendency to have unusual thoughts or ideas. Scale Ma, Schizophrenia, measures the addition to experiencing anxiety and ruminating tendency to be rigid, phobic and self-condemning, in clinical scale in that it does not measure roles and interests are endorsed. It is not strictly compulsive. Scale Mf, Masculinity-Femininity, relates to the degree which traditional masculine and feminine physical symptoms. Scale Pd, Psychopathic Deviate, to the degree which attempts at treatment and there is a high dropout rate (about 45%) before five weeks, mostly due to inability to remain drug-/alcohol-free. Between 1997 and 2007, for 921 clients who completed the five-week assessment were available. The sample was aged between 21 to 70 years ($M = 36.8$ years, $SD = 6.9$). The majority was male ($N = 602$, 65.4%) and Australian-born (86.4%). Of these clients, 351 (38.1%) remained in treatment for at least four months and the rest prematurely terminated before the end of the first treatment module.

Clients who left prior to the five week assessment are described as ‘not engaged’, those who completed their assessment but left before completing four months are labeled ‘premature leavers’ and those who stayed longer than four months are labeled ‘stayers’.

**Measures**

The MMPI is a well-standardised self-report measure designed to assess psychopathology in personality. It has been widely used in studies of substance dependent clients (Egger, Gringhuis, DeMey, Derksen, & Hilberink, 2007; Forbey & Ben-Porath, 2007; Gerra et al., 2008). The scale comprises 567 items to which respondents answer true or false. On average the scale takes over an hour to complete. This present paper is based on results from the 10 clinical scales of the MMPI-2: Hs, D, Hy, Pd, Mf, Pa, Pt, Sc, Ma, Si.

Additionally, data from the three validity scales (L, F, K) are discussed. These scales assess response biases and distortions rather than personality dimensions per se; they are considered useful adjuncts to interpretation of the personality dimensions.

Scale Hs, Hypochondriasis, measures the tendency to complain of physical symptoms, express hostility indirectly and be critical of others. Scale D, Depression, determines the tendency to experience depression or pessimism. Scale Hy, Hysteria, assesses the propensity to experience psychological conflict through specific physical symptoms. Scale Pd, Psychopathic Deviate, measures the tendency to be antisocial, rebellious or compulsive. Scale Mf, Masculinity-Femininity, relates to the degree which traditional masculine and feminine roles and interests are endorsed. It is not strictly a clinical scale in that it does not measure psychopathology but it can provide a tone to the interpretation of the other scales. Scale Pa, Paranoia, measures the tendency to be suspicious or place blame on others. Scale Pt, Psychasthenia, assesses the tendency to be rigid, phobic and self-condemning, in addition to experiencing anxiety and ruminating thoughts. Scale Sc, Schizophrenia, measures the tendency to have unusual thoughts or ideas. Scale Ma, Hypomania, assesses tendencies toward hypomanic symptoms, such as cyclic periods of excessive energy. Scale Si, Social Introversion, evaluates the tendency to be shy and self-effacing, with low scorers tending to be sociable and outgoing (Greene, 2000; Groth-Marnat, 1997).

**Interpretation of the MMPI-2 profile**

Interpretation of the MMPI-2 profile also involves configural analysis of subsets of the validity and clinical scales (Greene, 2000). Groups of scales are examined at the same time, for example, the validity scales (L, F, K), the neurotic triad (Hs, D, Hy), and the psychotic tetrad (Pa, Pt, Sc, Ma). It is argued that the overall elevation of the clinical scales presents a reasonably accurate presentation of the degree of distress the client is experiencing (Greene, 2000). Interpretations of the slope of the MMPI-2 profile are also made, based largely on the relationship between the neurotic triad and the psychotic tetrad. A positive slope indicates that the psychotic triad is more elevated than the neurotic triad, and a negative slope indicates the opposite relationship between these two groups of scales (Greene, 2000). Phasicity is a measure of the number of peaks in the profile, with various interpretations attaching to different configurations of peaks and flat areas. A saw-toothed profile in which Scales D, Pd, Pa and Sc are significantly elevated indicates serious psychotic disorder (Greene, 2000).

**Procedure**

All Odyssey House TC residents are routinely administered the full version of the MMPI-2 by a trained psychologist at approximately five weeks post entry to treatment. This is not a baseline measure of psychopathology, as residents have already been supported through preparation and behavioural assessment phases of treatment, and some have been prescribed medication, if necessary, prior to entering the TC. In addition, they already have been living in a structured and drug-free environment for five weeks. Thus, it could be expected that at least some of the chaos and confusion related to their lifestyle and drug use has begun to subside by the time they complete the MMPI-2. The reason baseline data prior to entry to treatment is not collected is due to its likely unreliability. Such testing is potentially influenced by intoxication or motivation to respond in a way that
clients think may enhance their chances of being admitted to treatment.

Data analysis
Client profile: An MMPI-2 profile of the total sample is presented in graphical form. MMPI-2 scores of male and female clients and younger (up to 35 years) and older (35 and over) clients were compared via two-way ANOVAS. The capacity of MMPI-2 clinical and validity scores, age and gender to predict who stayed in treatment for four months and who prematurely left treatment was assessed by discriminant function analysis. Analyses were conducted using the Statistical Package for the Social Sciences (SPSS) Version 17.

Results
Figure 1 shows that the sample illustrated a codetype known as 4-8, that is, Scales Pd and Sc were the two highest elevated clinical scales. The configuration of the three validity scales (L, F, K) was one frequently encountered in clinical settings, indicating that the sample was admitting to personal and emotional difficulties and requesting assistance with these problems (low Lie Scale, high atypicality of response, low defensiveness) (Caldwell, 1997). Figure 1 also shows the psychotic tetrad (Scales Pa, Pt, Sc, Ma) was somewhat more elevated than the neurotic triad (Scales Hs, D, Hy). There was a “saw toothed profile” in which scales D, Pd, Pa and Sc were significantly elevated above the other clinical scales. Clients within this sample were within the clinical range on the validity scales and clinical scales D, Pd, Pa, Pt and Sc.

Figure 1. Mean MMPI-2 validity and clinical scale scores for TC residents after five weeks in treatment

ANOVA indicated that females were significantly higher on the validity scale F, the clinical scales Hs, D, Pd, Hy, Pa and Sc, as well as the Mf scale. The sexes did not differ on L, K, Pt, Ma or Si (Table 1). For the validity scales, the older group (35 and over) was significantly higher on L and K and significantly lower on F. They also scored lower than the younger group on the clinical scales of Pd, Pa, Pt, Sc and Ma (Table 2). There were no significant interactions between age and gender.

Table 1
Means, standard deviations and univariate F for gender differences on MMPI-2

<table>
<thead>
<tr>
<th>Scale</th>
<th>Total Mean (SD)</th>
<th>Male Mean (SD)</th>
<th>Female Mean (SD)</th>
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<tr>
<td>M (SD)</td>
<td>N = 602</td>
<td>N = 318</td>
<td></td>
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</tr>
<tr>
<td>L (9.66)</td>
<td>48.44</td>
<td>48.52</td>
<td>48.32</td>
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<tr>
<td>F (20.82)</td>
<td>75.77</td>
<td>73.50</td>
<td>80.01</td>
<td>20.79***</td>
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<tr>
<td>K (9.57)</td>
<td>41.53</td>
<td>41.62</td>
<td>41.36</td>
<td>.16</td>
</tr>
<tr>
<td>Hs (12.72)</td>
<td>60.50</td>
<td>59.50</td>
<td>62.31</td>
<td>10.33**</td>
</tr>
<tr>
<td>D (13.21)</td>
<td>66.32</td>
<td>65.65</td>
<td>67.58</td>
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<td>57.99</td>
<td>56.54</td>
<td>60.69</td>
<td>20.20***</td>
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<td>D (13.22)</td>
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<td>70.26</td>
<td>75.38</td>
<td>35.69***</td>
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<td>Hs (11.88)</td>
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<td>50.87</td>
<td>54.41</td>
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<td>D (10.35)</td>
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<td>67.63</td>
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<tr>
<td>Hs (12.01)</td>
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<tr>
<td>M (SD)</td>
<td>(11.09)</td>
<td>(12.01)</td>
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Note: L = Lie; F = Infrequency; K = Defensiveness; Hs = Hypochondriasis; D = Depression; Hy = Hysteria; Pd = Psychopathic Deviate; Mf = Masculinity-Femininity; Pa = Paranoia; Pt = Psychasthenia; Sc = Schizophrenia; Ma = Hypomania; Scale Si = Social Introversion; *Gender not available for one participant; **p <.05; ***p <.01; ****p <.001.
Who stayed in treatment? Discriminant function analysis was conducted to assess which variables (age, gender dummy coded, MMPI-2 validity and clinical scales) differentiated between the premature leavers (N = 568) and those who stayed in treatment at least four months (N = 349). The function was significant ($\chi^2$ (15) = 38.51, $p = .001$). The structure matrix indicated that female gender, younger age, lower K scores and higher Ma scores were the strongest discriminants. The pooled within-group correlations between the discriminant variables and the standardized canonical discriminant function were gender (.53), age (.47), K (.37) and Ma (.34). For each of these variables, univariate ANOVAs showed that the differences between the premature leavers and stayers were statistically significant. F and Pa were the next strongest discriminants with pooled within-group correlations of -.28 and -.26 respectively, indicating that premature leavers tended to score higher on these variables. However the univariate ANOVAs showed that the differences between the two groups approached but did not reach significance for these two scales. Table 3 shows the means and univariate ANOVAs for differences between premature leavers and stayers.

Discussion

The present study contributes to the Australian evidence regarding the mental health profiles of residential clients accessing Odyssey House Victoria TC. Consistent with the literature (DeLeon & Jainchill, 1991), the sample profile demonstrated high levels of pathology, with clinical levels of depression (D), character disorder (Pd), paranoia (Pa), psychasthenia (Pt) and schizophrenia (Sc). As well, the validity scale F was well outside the normal range, indicating high levels of 'infrequency' or unusualness of experience, such providing validation for the relative abnormality of the clinical scales.

The finding that the sample as a whole had a code type of 4-8 was consistent with a number of American empirical studies (Craig, 1979a, 1979b, 1982; Shaffer et al., 1988), and DeLeOn’s (1989) review of the research which indicates that the MMPI profiles of those with substance dependencies show prominent peaks.
reflecting character disorder (high Psychopathic Deviate scores) and disturbed thinking and affect (high scores on Schizophrenia). The finding is also consistent with DeLeon’s (1988, 1995) description of clients typically entering a TC. Individuals with a 4-8 codetype typically exhibit chronic, marginal schizophrenia or are diagnosed as schizophrenic (Greene, 2000). Behaviour is characteristically unpredictable and nonconforming, and clients show frequent social and legal difficulties due to poor judgment and problems in logic and thinking. It is common for individuals to have a history of criminal activity with numerous arrests. Their crimes are often poorly planned and carried out and may involve bizarre or violent behaviour. These 4-8 code-type individuals are also likely to abuse substances, and are considered chronically maladjusted (Greene, 2000). Again, they present a very similar picture to the substance abusing TC clients described by DeLeon (1989, 1995) as having often lived rebelliously or antisocially. They are likely to show poor judgement, impulse control and reality testing in relation to the consequences of their actions.

Individuals with a 4-8 code-type experience a moderate to severe level of emotional distress that is characterised by dysphoria, agitation and anhedonia (Greene, 2000). They often feel resentful or angry, and have difficulty concentrating or expressing anger appropriately. They are also likely to feel insecure, isolated, rejected and unwanted, and threatened by a world perceived as hostile and dangerous (Greene, 2000). This profile supports DeLeon’s (1995) descriptions of TC clients as likely to have poor self-esteem and an inability to manage feelings, particularly guilt, hostility and anxiety.

This code-type is associated with difficulty concentrating and focusing on tasks. Individuals exhibit poor judgement and are often unpredictable and impulsive. They are often suspicious of the motives of others and hyper-vigilant, and may report a number of symptoms reflecting psychotic processes (Greene, 2000). Similarly, DeLeon (1995) states that TC clients typically have poor impulse control and a variety of cognitive deficits.

Finally, Greene (2000) indicates that individuals with a 4-8 code-type are likely to have difficulty with close emotional relations. They lack basic social skills and tend to be socially withdrawn and isolated. They tend to feel rejected by others, often leading to hostility and conflict, which in turn exacerbates their feelings of being alienated from others. They also have the tendency to perceive their family as extremely uncaring and critical (Greene, 2000). In line with Greene’s description, DeLeon (1995) states that the past social relationships of residents in TCs are characterised by personal isolation and unhealthy or destructive relationships. Family histories show disturbance, abuse and deprivation. Even among those from socially advantaged backgrounds and relatively functional families, their loss of self-control and disordered lifestyle has estranged them from others.

The configuration of the three validity scales (L, F, K) shown by the current sample is the most frequently encountered validity scale configuration of the MMPI. It occurs in about 12% of the psychiatric population who have taken the MMPI-2 (Caldwell, 1997). Clients with this validity scale configuration are said to be admitting to personal and emotional difficulties, requesting assistance with these problems, and unsure of their own capabilities, a description which makes intuitive sense for the current sample, a group of individuals seeking treatment. Current findings are also consistent with a number of studies (Craig, 1979a, 1979b, 1982; DeLeon, 1989; Shaffer et al., 1988) that demonstrate that the MMPI profile of substance abusers shows a prominent peak in the F scale, reflecting confusion. As the F score increases, clients are diagnosed as experiencing more problems and thus feeling worse. The current sample shows F scores around 70 to 80, which suggest that the residents may have unusual thoughts, be rebellious, and have difficulty establishing an identity (Groth-Marnat, 1997). Consistent with DeLeon’s (1988, 1995) description of clients entering a TC, Greene (2000) states that in an inpatient setting, clients with elevated F scores are likely to show poorer impulse control and a greater frequency of inappropriate and destructive behaviours than clients with other types of validity scale configurations.

The present finding that the psychotic tetrad (Scales Pa, Pt, Sc, Ma) is more elevated than the neurotic triad (Scales Hs, D, Hy) is consistent with a number of American empirical studies (Craig, 1979a, 1979b, 1982; Shaffer et al., 1988), and DeLeon’s (1989) review of the research. This indicates that the sample is distressed by behaviours or symptoms related to psychotic disorders or psychological disorders in which the client is experiencing limited impulse control, disorientation and confusion (Greene, 2000). The study results also show a “saw toothed profile” in which scales D, Pd, Pa and Ma are elevated above the other clinical scales. This indicates a particularly malignant profile, where individuals are likely to be experiencing very serious psychotic disorders (Greene, 2000).

The finding that Social Introversion was one of the lowest scoring scales in the profile is also consistent with past research (DeLeon, 1989; Craig, 1982; Shaffer et al., 1988). Craig (1982) states that those with substance dependencies tend to present a friendly persona as they need to establish and preserve social contacts in order to maintain a continuous drug supply.

Although males and females showed similar MMPI profiles, women reported significantly higher scores on most of the MMPI-2 scales, indicating more confusion (high F), hypochondriasis (high Hs), depression (high D) hysteria (high Hy), character disorder (high Pd), paranoia (high Pa), anxiety/ruminative thoughts (high
Polimeni, Moore & Gruenert: MMPI-2 profiles of substance dependent clients.

One limitation of the present research was that it was not possible to obtain client information on the type of medication administered prior to entering the TC. It would be worthwhile for future research to take medication into account, to determine the extent to which it may affect psychopathology. It is also important to note that the MMPI-2 profiles presented here represent score averages across TC residents. These averages, while presenting an overall picture of psychopathology for the group, mask the many different types of personality and psychopathology among residents. Individualised treatment plans must of course be shaped around individual pathology profiles; however the averaged data gives clues as to some of the more common problems likely to be faced in therapy. Finally, while some information has been collected on the premature leavers, we have no data available on the personality profiles of the unengaged – those who left the TC before initial testing. Comment has already been made on the difficulties of obtaining ‘baseline’ data on this client group, who are unable for whatever reason to stay in treatment long enough to complete an initial psychological assessment.

In conclusion, the results show that clients who seek treatment at Odyssey House Victoria’s TC are a complex population. As well as their substance dependence (their reason for seeking treatment) the MMPI-2 profiles show a considerable degree of psychological disturbance associated with mental health issues, including clinical levels of severe symptoms such as psychosis and thought disorder. These symptoms were most severe in female clients and younger clients, and were at clinical levels even in the 38% of clients who later went on to be engaged for at least four months in treatment. Future research to track changes in personality profiles associated with treatment and the characteristics of those who were difficult to engage, would be of value.

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References


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**Research Profile**  
Dr. Anne-Maree Polimeni, BA (Hons) PhD (Swinburne), is a registered psychologist and works as a research and clinician in private practice. For the past two years she has provided research and evaluation support across Odyssey House Victoria. She has also been an active researcher on a range of health related projects such as post-natal depression, breast cancer, gender issues, trauma and sexual abuse that has lead to a number of journal articles in international peer reviewed journals.
Professor Susan Moore, BSc(Hons) MEd (Melb) PhD (Florida State), is a developmental/social psychologist who has worked in Victorian Universities for over thirty years. Her research interests include adolescent development, particularly sexuality and risk taking behaviour, gambling and health promotion. In recent years she has been investigating the impact of chronic illness conditions on individuals and their families. Professor Moore has had more than 100 articles published and several books.

Dr. Stefan Gruenert, DPsych (Counselling) BA (Hons) Diploma Community Services (Alcohol and Other Drugs), is a registered psychologist with more than 8 years experience in the Alcohol and Other Drug sector as a clinician, supervisor, researcher, and manager. He is currently the Chief Executive Officer for Odyssey House Victoria. His clinical and research interests include intimacy and sexual coercion, community alcohol use and treatment interventions, parenting, especially the role of fathers, and the experiences and needs of children with substance dependent parents. Stefan has developed a number of resources for workers, provides advice to Government, and regularly presents his work at National and International conferences.