한국심리학회지 : 임 상
The Korean Journal of Clinical Psychology
2004. Vol. 23, No. 3, 755-769

Use of the MMPI-A with Korean Adolescent Psychiatric Sample: Preliminary Investigation

Jeeyoung Lim
Seoul Digital University

Kyunghee Han
Central Michigan University

The current study was conducted to examine the utility of the Korean MMPI-A in discriminating between normal and abnormal adolescents and among different diagnostic groups. MMPI-A profiles of 85 Korean adolescent psychiatric patients were compared with those of 254 Korean adolescents and 713 American adolescent psychiatric patients. Results suggested that the Korean MMPI-A seems to be sensitive to separate general psychiatric sample from a normal group as indicated by scale level and item level comparisons. Scale means of Korean psychiatric sample were significantly higher than those of Korean normal group, with the scales F, D, Hy, Pd, Pa, Hs, DEP, HEA, and FAM showing over one standard deviation separation between the two Korean adolescent groups. Mean scores of Korean psychiatric sample were higher than those of American counterpart, with the scales F, Hs, D, Hy, A-hea, and A-sod showing the highest differences between two national samples. Scales Pd and D were effective in discriminating among conduct disorder group, depression group, and normal sample. For both diagnostic groups as well as total psychiatric sample, neurotic scales (Hs, D, and Hy) were elevated, suggesting neurotic triad may be an underlying or comorbid characteristic in all Korean adolescent psychiatric patients. Compared to normal adolescents, adolescent patients with conduct disorder more frequently reported to have school and family problems and those with depression reported more physical complaints, negative mood, isolation, and pessimism. Comparisons between American and Korean adolescent clinical samples suggested some sociocultural factors. Finally limitations of this study and suggestions for further studies were also discussed.

Keywords : MMPI-A, adolescent, psychiatric patients

---

† Corresponding Author: Jeeyoung Lim / Division of Counseling Psychology, Seoul Digital University / 634-10 Shinsa-dong, Gangnam-gu, Seoul, Korea. 135-895 / E-mail: icemachine@sdu.ac.kr

The Minnesota Multiphasic Personality Inventory (MMPI) has been widely used in the United States for assessing adolescent personality and psychopathology (Archer, Maruish, Imhof, & Pitrowski, 1991) since its development by Hathaway and McKinley (1940). Unfortunately, many researchers applied this instrument to adolescent populations without an adequate understanding of response patterns unique to that age group. Furthermore, serious limitations in the use of the MMPI with adolescents have been noticed: (a) inappropriate item content, (b) outdated norms, (c) lack of scales developed for adolescents, and (d) problems with extreme responding (e.g., F scale) (Butcher, Williams, Graham, Archer, Tellegen, Ben-porath, & Kaemmer, 1992). The Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A; Butcher et al., 1992) was published in 1992 to address issues specific to adolescents, while retaining many useful aspects of the original MMPI. The MMPI-A, unlike the old MMPI, used a contemporary normative sample of adolescents, the item pool was reduced to 478 items with some items revised or modified, and a variety of new items were constructed to reflect issues directly relevant to adolescent development and psychopathology (Butcher et al., 1992).

Since the utility of the MMPI and MMPI-A in clinical assessment is ultimately determined by its efficacy to differentiate disturbed persons from normals and to make clinically useful distinctions among individuals manifesting various types of psychopathology, studies have been conducted to evaluate the contribution of the MMPI and MMPI-A to differential diagnosis (Cashel, Rogers, Sewell, & Holliman, 1998 Cumela, Wall, & Kerr-Almeida, 1999 Herkov, Gynther, Thomas, & Myers, 1996). In most studies, the diagnostic efficiency of the MMPI and MMPI-A has been judged by group contrast approach that examines whether the mean scores on relevant test indices produced by a group of patients with a particular diagnosis differ from those produced by a comparable reference group. Herkov et al. (1996) examined MMPI responding among adolescent sex offenders accused of sexual abuse, rape, and sodomy and adolescent psychiatric inpatients without a history of sexual offending. They found significant differences between sex offenders and inpatients as well as among sex offender groups on both single-scale elevations and 2-point code types. Cumela, Wall, and Kerr-Almeida (1999) reported that the MMPI-A, like the older MMPI, successfully distinguished between adolescents with anorexia and those with bulimia. However, the MMPI-A, like the MMPI, did not appear to distinguish between the two subtypes of anorexia nervosa (restricting and binge-eating-purging types). The MMPI-A did not differentiate patients with EDNOS (eating disorder not otherwise specified) from those with bulimia nervosa. These findings suggest that, even though there are strong differences between

anorexia and bulimia using the MMPI-A, the similarities among most adolescents with eating disorders are nevertheless substantial, with high points involving some combination of scales 1, 2, 3, and 0. Cashel, Rogers, Sewell, and Holliman (1998) collected MMPI-A protocols from a male adolescent delinquent sample and performed discriminant function analyses to evaluate the ability of the MMPI-A clinical scales to predict DSM-IV diagnoses accurately. Stepwise discriminant functions successfully classified MMPI-A protocols according to K-SADS-III-R diagnoses (Schedule of Affective Disorders and Schizophrenia for School-Age Children; Ambrosini, Metz, Prabucki, & Lee, 1989). Overall accuracy rates ranged from 58.2% for conduct disorder to 82.7% for generalized anxiety disorder.

Several studies have been conducted to examine the clinical utility of the MMPI in Korea. A study by Yoo, Kim, and Kim (1969) showed that adolescents with psychosis produced MMPI profiles with elevated scores (T score 60) on Hs, D, Hy, Pa, Pt, Sc, and Ma scales, or profiles with scores on 3 of the following 4 scales, Pa, Pt, Sc, and Ma, elevated at the same time. These results were considered to indicate that MMPI is useful to detect psychosis. Roh and Nam (1981a, 1981b) reported that scales L, K, Hs, D, Hy, and Pd showed significant differences between the MMPI profiles of normal adolescents and adolescents with conduct disorder. Chung (1994) reported that adolescent inpatients with inhalant addiction obtained elevated Pd scores (T score 65). Research by Yang and Park (1997) showed that whereas adolescents with conduct disorder produced elevated scores only on Pd scale, adolescents with depressive conduct disorder produced elevated scores on D and Pt scales as well as Pd scale. Jeun and Yang (1998) compared the MMPI profiles between the adolescent psychiatric inpatients with conduct disorder and those with dual diagnosis of conduct disorder and depression. Two groups were discriminated best on Ma, Si, and Hy scales, and discriminant function analyses correctly classified 82.6% of the cases.

Since the publication of the MMPI-A in the U.S., many international researchers have rapidly adapted this instrument into their cultures. The Korean version of the MMPI-A was developed by Lim and Han (1999). They first adapted the items of the Korean MMPI-2 (Han, 1996) that are common to the MMPI-2 and MMPI-A, and then independently translated into Korean the items that are unique to the MMPI-A. Discrepancies between the two independent translations were solved by mutual consensus. These items were then back translated into English by a bilingual. The original English MMPI-A items and the back-translated English items were then examined for discrepancies by Dr. James Butcher who was one of the members of the MMPI Restandardization Committee and who is an expert in MMPI cross-cultural work.

Several items were retranslated based on this review. Lim and Han (2000) conducted a preliminary investigation with this newly developed instrument and reported initial results. They compared the MMPI-A responses of 247 Korean adolescents (105 boys and 142 girls) with those of the American normative adolescent sample (805 boys and 815 girls) on the mean scale scores and item endorsement frequencies. The results provided some compelling data on the similarities and differences between two adolescent cultures, particularly in the form of item-level comparisons. Mean Korean adolescent T-scores on the MMPI-A validity, clinical, and content scales all fell within one *SD* of the U.S. adolescent means. Item endorsement differences between Korean adolescents and American adolescents were modest, and differences between boys and girls in MMPI-A item endorsement were remarkably similar cross-culturally.

Given the fact that the utility of the Korean MMPI-A would ultimately be determined by its efficacy to discriminate between normal and abnormal populations and among different diagnostic groups, the present study was conducted to examine if the Korean MMPI-A would show such discrimination.

Method

Subjects

Korean Clinical Sample

Our clinical sample consisted of 85 patients (41 boys and 44 girls) whose age ranged from 13 to 18 years. The mean age of patients was 14.7 years for boys and 15.3 for girls. They were inpatients at psychiatric hospitals in Seoul at the time of psychological assessment. All patients had received psychiatric diagnoses based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994), and had produced valid MMPI-A profiles with a Cannot Say raw score less than 30 and a F scale raw score less than 25. The diagnostic distribution of the sample consisted of 38% Conduct disorder, 33% Depression, 24% Schizophrenia, 2% Gender Identity Disorder, 1% Obsessive-Compulsive disorder, and 1% Bipolar disorder. No patients received dual diagnoses based on the DSM-IV.

Korean Normal sample

The Normal sample consisted of 254 Korean adolescents attending middle and high schools in Seoul and Kyungki-Do. The Korea Guidance (KG), a publishing company in Korea, placed an advertisement in an educational newspaper regarding the research, interested schools contacted the KG, and students volunteered to participate in the study. After receiving informed consent from the students and their parents, the Korean MMPI-A was administered by a school teacher or counselor in a classroom. Seven participants

were eliminated from the final sample for not meeting one or more of the following inclusion criteria: less than 30 "Cannot Say" responses a F scale raw score less than 25; participant age between 13 and 18 (Butcher et al., 1992). The final sample consisted of 247 students (105 boys and 142 girls), with a mean age of 15.8 years for boys, and 15.9 for girls. The students were predominantly in grades 8 through 11, similar to the distribution of the U.S. normative sample.

American clinical sample

The American clinical sample consisted of 420 boys and 293 girls. The average age was 18.85 for boys and 15.60 for girls. The participants were recruited from several treatment facilities in the Minnesota area, including inpatient alcohol- and drug-treatment units (299 boys and 163 girls), inpatient mental health facilities (67 boys and 96 girls), day-treatment programs (13 boys and 24 girls), and a special school program (41 boys and 10 girls). The grade level of the clinical sample ranged from 7 through 12. All participants were enrolled in school, although some were attending school in their treatment facility. The ethnicity of the participants was 75.2% White and 7.6% Black for boys; 76.8% White and 5.5% Black for girls (Butcher et al., 1992).

Analyses

Analyses were performed to examine the clinical utility of the Korean version of the MMPI-A at both scale- and item-levels. In scale level analyses, Korean adolescent psychiatric sample was compared with Korean normal adolescent sample and American psychiatric sample on mean scale scores. In item level analyses, items that best discriminated (a) between Korean normal sample and two Korean psychiatric groups (conduct disorder and depression) and (b) between Korean psychiatric and American psychiatric groups were identified. Since the current study is intended to provide initial information on the clinical utility of the MMPI-A in Korea, and the sample size in each diagnostic group is small, we used simple descriptive statistics, rather than employing multivariate statistical techniques which often require more strict assumptions.

Results

Scale Level Comparisons

The Korean raw scores on the validity, clinical, content, and supplementary scales were converted to T scores using American adolescent norms. Table 1 presents the means and the standard deviations of those scales for the Korean adolescent psychiatric sample, Korean normal adolescent sample, and American adolescent psychiatric sample. The effect size

Table 1. Descriptive Statistics and Effect Sizes: Comparison of Korean Adolescent Psychiatric Sample with Korean Normal Adolescent Sample and American Adolescent Psychiatric Sample on Validity, Clinical, Content, and Supplementary Scales

estimate, *d* (Cohen, 1988) is used to examine the extent to which two means in comparison are separated by their pooled standard deviation unit. Figure 1 displays the mean profiles of MMPI-A validity and clinical scales for the Korean normal and psychiatric adolescent samples and American adolescent psychiatric sample.

Scale means of Korean psychiatric sample are significantly higher than those of Korean normal group (mean d = .66 for standard scales, mean d = .54 for content and supplementary scales). The scales that show over one standard deviation separation between two Korean groups are F, D, Hy, Pd, and Pa (d= 1.16, 1,01, 1,14, 1.07, and 1.04, respectively). In comparison to Korean normals, Korean psychiatric sample show

Figure 1. Group Mean MMPI-A Standard Scale Profiles for Korean Adolescent Psychiatric Patients Compared with Korean Normal Adolescent and American Adolescent Psychiatric Samples

substantial mean score elevations on Hs, DEP, HEA, and FAM.

As expected from the previous studies (e.g., Archer, 1997, Archer, Handel, & Lynch, 2001) on MMPI-A profiles of American adolescent psychiatric samples, our American psychiatric sample show relatively low mean scale scores. Exceptions are found on Pd and several measures of alcohol and drug problems (MAC-R, ACK, PRO). On average, mean scores of Korean psychiatric sample are higher than American counterpart by .61 standard deviations. Highest differences between two national samples are found on F, Hs, D, Hy, A-hea, and A-sod (d = 1.07, 1.41, 1.37, 1.22, 1.11, and 1.02, respectively).

Figure 2. Group Mean MMPI-A Standard Scale Profiles for Korean Adolescent Psychiatric Patients with Conduct Disorder and Depression Compared with Korean Normal Adolescent Sample

Figure 2 displays the mean profiles of MMPI-2 standard scales for the Korean normal adolescent sample, Korean adolescent patientswith conduct disorder, and Korean adolescent patients with depression. Only these two diagnostic groups are selected because they are the major diagnostic groups with substantial sample size. The patients with conduct disorder scored significantly higher on Pd and Pa than did the patients with depression (d = .78 for Pd and d = .94 for Pa). Neurotic triad (Hs, D, and Hy) and Pa Scales are elevated as well as Pd. Psychiatric group with depression show high mean scores on Hs, D, Hy, and Pd. Scale D seems effective in discriminating patients with conduct disorder from those with Depression (d= .63), though both diagnostic groups show significantly elevated scores than the normal sample on D.

Item Level Comparisons

Intra-cultural and cross-cultural comparisons were made on the MMPI-A item level. Items that best discriminated between Korean normal adolescents and two Korean psychiatric adolescent groups (conduct disorder and depression) were identified. True item endorsement frequencies were also compared between Korean and American psychiatric samples. According to Butcher and Han (1996), one simple way to establish cross-cultural equivalence of a test is a comparison of item endorsement frequencies between groups, and endorsement percentage differences below 25% are considered negligible.

Between the normal adolescent and conduct disorder groups 72 items showed a 25% or greater difference in endorsement. Table 2 shows the 10 items that discriminated best Korean normal adolescents from Korean adolescent psychiatric patients with conduct disorder. The greatest item endorsement difference was found in item 101, indicating that adolescent patients with conduct disorder more frequently reported that in school they have sometimes been sent to the principal for bad behavior. Item endorsement difference on item 380 ("Often I have not gone to school even when I should have") also suggested that adolescent patients with conduct disorder have more school problems than normal adolescents. Items 57 ("My parents do not like my friends"), 191 ("My parents often object to the kind of people I go around with"), 460 ("I have never run away from home"), 451 ("We don't have trouble about talking to each other in my family"), and 51 ("My family doesn't like the kind of work I plan to do") discriminated well between Korean normal adolescents and conduct disorder group, which suggested that conduct disorder group had more family discord than normal adolescents. Between the normal adolescent and depression groups 46 items showed a 25% or greater endorsement difference. As displayed in Table 3, the item showing the

Table 2. The 10 MMPI-A Items that Discriminate Best Between Korean Normal Adolescents and Psychiatric Adolescents with Conduct Disorder

Table 3. The 10 MMPI-A Items that Discriminate Best Between Korean Normal Adolescents and Psychiatric Adolescents with Depression

greatest difference in endorsement was item 18, with normal adolescents reporting more frequently that they are very seldom troubled by constipation. The content of the ten items that best discriminated between the two groups appeared to center around themes of physical complaints (18, 42, and 168), negative mood/ isolation/ pessimism (91, 27, 71, 142, and 204), and attitude toward school (153 and 380).

Table 4 shows the 10 items that discriminated best between Korean and U.S. adolescent psychiatric patients. Between these two national clinical samples 61 items showed a 25% or greater difference in endorsement. The item that showed the greatest item endorsement difference was item 80, indicating that American patients reported more frequently school related problems. The item 51 ("My family doesn't like the kind of work I plan to do"), with 44% endorsement difference, suggests that Korean patients have more conflicts with their family members. The items that discriminated well between the two national clinical samples and that likely reflect a cultural difference are items 467 ("I enjoy using marijuana"), 247 ("I have used alcohol excessively"), and 366 ("I have gotten many beatings"). In addition, Korean adolescents appear to report more health problems, as indicated by endorsement differences on the items 169 ("My hands have not become clumsy or awkward") and 157 ("I seldom or never have dizzy spells").

Table 4. The 10 MMPI-A Items that Discriminate Best Between Korean and American Adolescent Psychiatric Samples

Discussion

Although scale elevations did not reach clinical significance (T65) except D, Korean psychiatric group scored much higher than American counterpart. Some researchers attributed normal range of scale scores among American adolescent psychiatric groups to ineffectiveness of MMPI-A items in discriminating a psychiatric sample from a normal group (e.g., Archer, Handel, & Lynch,2001). Although further studies are needed to make definite conclusion, our finding partly evidences that Korean MMPI-A seems to be sensitive to separate general psychiatric sample from a normal group.

Although scale Pd is effective in discriminating adolescent group diagnosed with conduct disorder from depression group and normal sample, Hy was as elevated as Pd. Our finding of low Ma score of this diagnostic group is inconsistent with the results from previous studies that showed 4/9 code type of the delinquent population (Bannen, 2000) or 4/8/9 elevations of the patients with conduct disorder (Kuehl, 1996). Scale D of the Korean MMPI-A was significantly elevated among depressive patients than normal sample and the group with conduct disorder, and exceeded a cut-off of T score 65 (T = 69). For both diagnostic groups as well as total psychiatric sample, neurotic scales (Hs, D, and Hy) are elevated, suggesting neurotic triad may be an underlying or comorbid characteristic in all Korean adolescent psychiatric patients.

Although this study is preliminary, the clinical utility of the MMPI-A in Korea appears to be promising as indicated by the results of item level comparisons. In other words, item level comparisons between Korean normal adolescents and the two diagnostic groups (conduct disorder and depression) clearly showed expected differences. Adolescent patients with conduct disorder more frequently reported to have problems in school and the family than normal adolescents. Item endorsement differences indicated that depressed adolescents reported more physical complaints, school related problems, negative mood, feeling isolated, and pessimism.

Cross-cultural comparisons between American and Korean adolescent inpatients showed that American adolescents had more substance abuse problems and experienced less physical abuse. Item response differences between the two national psychiatric samples were likely due to sociocultural factors. Alcohol and drug problems have been more prevalent in American society and thus American youngsters are likely to have been more exposed to alcohol and drug use, although a growing number of Korean adolescents are reported to use alcohol and other drug and problematic use of these substances has recently become one of the most important adolescent issues in Korean society. High endorsement rates among American clinical sample on the items measuring substance abuse may also be due to

the fact that a large proportion of subjects were from alcohol- and drug-treatment facilities.

Whereas violent behavior toward adolescents, by their peer groups, parents, or school teachers, is prohibited strictly by law in American society, school violence(violence among adolescents in school) is allegedly very serious and parents and teachers have traditionally been allowed to beat their children and students for educational purpose in Korean society. In addition, Korean adolescents reported more health problems, which is considered to result from Koreans' tendency toward somatization as pointed out by Kim (1974).

Limitations of this study include a relatively small sample size in each diagnostic group of the Korean sample, which kept us from applying more advanced and rigorous statistical techniques to examine discriminant validity of the Korean MMPI-A across diagnostic groups. Second, data from each diagnostic group of American adolescent psychiatric sample were not available, which made it impossible to make cross-cultural comparisons within each diagnostic group. Third, the diagnostic distribution of the current sample was limited to several mental disorders and the data of patients with dual diagnoses were not included. Last, external validity indicators such as therapists' ratings need to be included to explore criterion validity of the MMPI-A. Further studies are called for to examine the utility of the Korean MMPI-A in clinical settings.

References

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Ambrosini, PJ., Metz, C., Prabucki, K., & Lee, J.C. (1989). Videotape reliability of the third revised edition of the K-SADS-III-R. *Journal of the American Academy of Children and Adolescent Psychiatry, 28,* 723-728.

Archer, R. P. (1997). *MMPI-A: Assessing adolescent psychopathology* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum, Associates, Inc.

Archer, R. P., Handel, R. W., & Lynch, K. D. (2001). The effectiveness of MMPI-A items in discriminating between normative and clinical samples. *Journal of Personality Assessment, 77,* 420-435.

Archer, R.P., Maruish, M., Imhof, E.A., & Piotrowski, C. (1991). Psychological test usage with adolescent clients: 1990 survey findings. *Professional Psychology: Research and Practice, 22,* 247-252.

Bannen M. A. (2000). The clinical utility of the MMPI-A in the assessment of disruptive disordered adolescent girls. *Dissertation Abstracts International: Section B*: The Sciences & Engineering, 61 (2-B).

Butcher, J. N., & Han, K. (1996). Methods of establishing cross-cultural equivalence. In J. N. Butcher (Ed.), *International adaptations of the MMPI-2: A handbook of research and clinical applications* (pp. 44-63). Minneapolis, Minnesota: University of Minnesota Press.

Butcher, J. N., Williams, C. L., Graham, J. R., Archer, R. P., Tellegen, A., Ben-Porath, Y. S.,

& Kaemmer, B. (1992). *MMPI-A: Manual for administration, scoring, and interpretation.* Minneapolis: University of Minnesota Press.

Cashel, M. L., Rogers, R., Sewll, K. W., Holliman, N. B. (1998). Preliminary Validation of the MMPI-A for a Male Delinquent Sample: An Investigation of Clinical Correlates and Discriminant Validity. *Journal of Personality Assessment, 71(1),* 49-69.

Chung, W. (1994). Study on clinical characteristics of adolescent inpatients in psychiatric hospitals for the treatment of bond and butane fuel inhalation. *Neuropsychiatry, 33,* 32-38.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* . Hillsdale, NJ:Lawrence Erlbaum Associates, Inc.

Cumella, E. J., Wal, D., & Kerr-Almeida, N. (1999). MMPI-A in the Inpatient Assessment of Adolescents with Eating Disorders. *Journal of Personality Assessment, 73(1),* 31-44.

Han, K. (1996). The Korean MMPI-2. In J. N. Butcher (Ed.), *International adaptations of The MMPI-2: A handbook of research and clinical applications* (pp. 88-136). Minneapolis, Minnesota: University of Minnesota Press.

Hathaway, S. R., & Mckinley, J. C. (1940). A multiphasic personality schedule (Minnesota): I. Construction of the schedule. *Journal of Psychology, 3,* 424-426.

Herkov, M. J., Gynther, M. D., Thomas, S., & Myers, W. C. (1996). MMPI differences among adolescent inpatients, rapists, sodomists, and sexual abusers. *Journal of Personality Assessment, 66(1),* 81-90.

Jeon, D. & Yang, I. (1998). MMPI Characteristics of Conduct Disorder and Conduct Disorder combined with Depression. *Korean Journal of Clinical Psychology, 17(1),* 273-284.

Kim, K. (1974). Culture and mental illness in Korea. *Korean Journal, 13(4),* 41-47.

Kuehl, S. E. (1996). Using the Minnesota Multiphasic Personality Inventory-Adolescent in the identification of conduct disorder: A concurrent validation study. *Dissertation Abstracts International: Section B*: The Sciences & Engineering, 567 (11-B).

Lim, J., & Han, K. (1999, April). *Korean adolescent performance on the Korean translation of the MMPI-A.* Paper presented at the 34th Annual Symposium on Recent Developments in the Use of the MMPI-2/MMPI-A. Huntington Beach, CA.

Lim, J., & Han, K. (2000). Korean adolescent performance on the Korean translation of the MMPI-A. *Korean Journal of Clinical Psychology, 19(4),* 863-872.

Roh, N. & Nam, K. (1981a). MMPI responses of adolescents with larceny. *Sunchonhyang University Collection of Articles, 4,* 9-19.

Roh, N. & Nam, K. (1981b). MMPI responses of adolescents with a crime of violence. *Sunchonhyang University Collection of Articles,4,* 21-32.

Yang, E. & Park, J. (1997). Preliminary Study of Characteristics of Adolescent MMPI. *Korean Journal of Clinical Psychology,16(1)* , 151-162,

Yoo, J., Kim, Y., & Kim, Z. (1969). Clinical diagnosis and MMPI responses of adolescent psychiatric Patients. *Neuropsychiatry, 8,* 37-43.

원고접수일 : 2004. 1. 6
게재결정일 : 2004. 6. 21

한국심리학회지 : 임 상
The Korean Journal of Clinical Psychology
2004. Vol. 23, No. 3, 755-769

한국판 청소년용 미네소타 다면적 인성검사의 임상적 유용성 연구

임 지 영 한 경 희

서울디지털대학교 상담심리학부 Central Michigan University 심리학과

본 연구는 한국판 청소년용 미네소타 다면적 인성검사 (MMPI-A)의 임상적 유용성을 검토하기 위해 이루어졌다. 이를 위해 85명의 한국 청소년 정신과 환자의 MMPI-A 결과를 254명의 한국 정상 청소년집단과 713명의 미국 청소년 정신과 환자집단의 MMPI-A 프로파일과 비교하였다. 척도 수준과 문항수준의 비교를 실시한 결과, 한국판 청소년용 미네소타 다면적 인성검사가 정상집단과 임상집단을 변별하는데 유용한 것으로 나타났다. 한국 청소년 정신과 환자집단의 MMPI-A 척도 평균점수는 정상 청소년집단보다 높게 나타났는데, 특히 F, D, Hy, Pd, Pa, Hs, DEP, HEA, FAM 척도에서는 1 표준편차 이상의 차이가 관찰되었다. 한국 청소년정신과 환자들의 MMPI-A 척도 평균점수는 미국 청소년 정신과 환자들보다 높았는데, 특히 F, Hs, D, Hy, A-hea, A-sod 척도들에서 점수가 가장 크게 나타났다. 또한 한국 청소년행동장애 환자집단과 우울증 환자집단, 그리고 정상 청소년 집단간의 변별에서는 Pd와 D척도가 유용하였다. 행동장애나 우울증 집단 뿐 아니라 모든 정신과 환자집단에서 신경증 척도들(Hs, D, Hy) 의 점수가 높게 나타나이들 세 척도 점수들의 상승이 한국 청소년정신과 환자집단 전체에서 관찰되는 공통적인 특징인 것으로 고려된다. 미국과 한국 청소년 정신과 환자집단의 MMPI-A 응답을 비교한 결과 사회문화적 차이가 반영된 것으로 보였다. 마지막으로 본 연구의 제한점과 후속 연구를 위한 제안 사항들이 논의되었다.

주요어 : 미네소타 다면적 인성검사, MMPI-A, 청소년 정신과 환자