Psy 423 PERSONALITY ASSESSMENT

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and

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LECTURE ONE
Personality Assessment: Definition and History.

Introduction
This lecture focuses on what personality assessment is, and the history of personality assessment. Some scholars believe that the use of psychological tests can be traced to 2200 BCE in ancient China. Most scholars agree that serious research efforts on the use and usefulness of psychological tests did not begin until the 20th century with the advent of intelligence testing. The place of history in understanding personality assessment cannot be underestimated.

Objectives
1. Students should be able to effectively understand what personality is, on one hand, and personality assessment on the other hand.
2. The history of personality assessment should be very well understood and committed to memory.

Pretest
1. What is personality?
2. What is personality assessment?
3. Write on the history of personality assessment from the 20th century.

CONTENT

What is Personality assessment?
Dozens of distinctly different definitions of “personality” exist in the psychology literature (Allport, 1937). McClelland (1951) defined personality as “the most adequate conceptualization of a person’s behavior in all its detail.” Menninger (1953) defined it as “the individual as a whole, his height and weight and love and hates and blood pressure and reflexes; his smiles and hopes and bowed legs and enlarged tonsils. It means all that anyone is and that he is trying to
become.” It has also been defined as aspects of a person that remain stable throughout a lifetime: the individual’s character pattern of behavior, thoughts, and feelings, consistency in a person’s way of being, acting and reacting as a person.

For the purpose of this lecture, we would define Personality as an individual’s unique constellation of psychological traits and states (Cohen, Montague, Nathanson, & Swerdlik, 1988). Accordingly, personality assessment entails the measurement of traits and state (Cohen, et al., 1988). Personality assessment in psychology includes the diagnosis of mental illnesses, prediction of behavior, measurement of unconscious processes, and quantification of interpersonal styles and tendencies. Rorer (1990) sees assessment in general and personality assessment in particular not just as a discrete observation and sampling of behavior but a conceptualization of on-going dispositions. Stated differently, personality assessment attempts to find out not only what a person does, but what that person is like.

**History of Personality assessment**

Since ever there has been relationships, attempts to understand through assessment, what people are like has been on. From one perspective, informal personality assessment has been around. Hippocrates recorded the first known personality model, postulating that one’s personality is based upon four separate temperaments- Sanguine, Phlegm, Cholera and Melancholy. Another Greek physician, Galen, extended Hippocrates’ theory by applying a body fluid to each temperament: blood, mucus, black bile and yellow bile, respectively. Different diseases and behaviors had roots in the four humors and the fluid that was dominant was said to be the person’s “humor.” The four humors theory became a prevalent medical theory for over a millennium after Galen’s death. The theory experienced widespread popularity throughout the Middle Ages.

Aristotle theorized that personality could be understood from a standpoint of physiognomy, the idea that physical traits could be informative about personality. Size of one’s eyes, lips, and eyebrows were thought to convey information about criminality, virtue, and thoughtfulness. Further, as the perspective of the scientific method became more widespread in the 18th and 19th
century’s physicians and philosophers attempted to classify personalities based on these physical attributes possessed by individuals.

In providing explanations for individual’s unique pattern of behaviour and thoughts, phrenology movement readily comes to mind in history. Francis Gall spearheaded this movement where their major preoccupation consisted of “reading” the contours in the skull in order to discern personality traits and attributes. By collecting data on research subjects with particular traits, Gall attempted to map these bumps and ridges into a system of measuring personality. But major flaws with this mode of assessment in history include, among others, bigoted perspectives of the developers and unscientific nature of the entire process. But a more formal and scientific attempt to classify personalities is a much more recent phenomenon.

The origin of modern psychology is intimately connected with the development of psychological tests. Starting with Alfred Binet’s work in the early 20th century developing tests to measure the cognitive abilities of children, psychology emerged as the science that best combined expertise in the measurement of human behavior and personality. However, it is a psychiatrist, Carl Jung, who is credited with creating the first “modern” personality test. His association method was a standardized list of words to which psychiatric patients were asked to free associate, or to say whatever came to mind. Jung provided interpretation guidelines by which responses could be judged and understood (Jung, 1910).

During World War I, noted psychologist Robert S. Woodworth was commissioned by the American Psychological Association to create a self-report measure that could be used to evaluate the personality of military recruits. The 116-item, true-false, self-report Personal Data Sheet (Woodworth, 1917) was created to measure neurotic symptoms that were described in the scientific literature of that time. Although it was finalized too late to be used with World War I military recruits, this measure was frequently used in early studies of psychopathology. Following the work of Woodworth, other personality measures were soon developed. Notable examples included Pressey and Pressey’s (1919) Cross-Out Test and the Bernreuter Personality Inventory (Bernreuter, 1935).
Post test
1. What notable periods characterize the history of personality assessment?
2. How does personality differ in explanation from personality assessment?
3. What is the significance of the history of personality assessment?

LECTURE TWO
Theories of Personality

Introduction
Theories of personality are about human nature and the goal of each theory is the understanding of the diversity and complexity of the whole person functioning in the real world. Theory refers to unsubstantiated hypothesis or speculation concerning reality that is not definitely known but when a theory has confirmatory data or evidence it is a fact.

Objectives
1. Students should be able to understand the different schools of thought in personality
2. Students should be able to understand and apply these theories of essence.

Pretest
1. What is a theory?
2. What differentiates the psychoanalytic perspective from the humanistic perspective of personality?
3. What are the major schools of personality, and how do they differ?

Content
Theory
Theoria is the Greek work for theory. It means the act of viewing, contemplating or thinking about something. A theory is a set of abstract concepts developed about a group of facts or events in order to explain them. A theory of personality, therefore, is an organized system of beliefs that helps us to understand human nature.
Theories of Personality

Theories of personality represent elaborate speculation or hypotheses about why people behave as they do. The following theories in personality psychology are usually explored in understanding personality.

Trait theories

According to the Diagnostic and Statistical Manual of the American Psychiatric Association, personality traits are "enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts." Theorists generally assume that:

a) Traits are relatively stable over time,

b) Traits differ among individuals, and

c) Traits influence behavior.

They consistently are used in order to help define people as a whole. (Feist, and Gregory, 2009)

The most common models of traits incorporate three to five broad dimensions or factors. All trait theories incorporate at least two dimensions, extraversion and neuroticism, which historically featured in Hippocrates' humoral theory (Aluja, García, García, and Luis, 2004).

Proponents of the trait theory of personality and their individual propositions are summarized below. A detailed description of their major contributions would be discussed in subsequent topics.

- Gordon Allport delineated different kinds of traits, which he also called dispositions. Central traits are basic to an individual's personality, while secondary traits are more peripheral. Common traits are those recognized within a culture and thus may vary from culture to culture. Cardinal traits are those by which an individual may be strongly recognized. In his book, Personality: A Psychological Interpretation, Gordon Allport...
(1937) both established personality psychology as a legitimate intellectual discipline and introduced the first of the modern trait theories (McAdams, 2009).

- Raymond Cattell's research propagated a two-tiered personality structure with sixteen "primary factors" (16 Personality Factors) and five "secondary factors." For Cattell, personality itself is defined in terms of behavioral prediction. He defined personality as that which permits a prediction of what a person will do in a given situation.

- Hans Eysenck believed just three traits—extraversion, neuroticism and psychoticism—were sufficient to describe human personality. Differences between Cattell and Eysenck emerged due to preferences for different forms of factor analysis, with Cattell using oblique, Eysenck orthogonal rotation to analyze the factors that emerged when personality questionnaires were subjected to statistical analysis. Today, the Big Five factors have the weight of a considerable amount of empirical research behind them, building on the work of Cattell and others.

- Lewis Goldberg proposed a five-dimension personality model, nicknamed the "Big Five": (Ellis, Albert; Nussbaum, Mike Abrams, 2009)
  1. Openness to Experience: the tendency to be imaginative, independent, and interested in variety vs. practical, conforming, and interested in routine.
  2. Conscientiousness: the tendency to be organized, careful, and disciplined vs. disorganized, careless, and impulsive.
  3. Extraversion: the tendency to be sociable, fun-loving, and affectionate vs. retiring, somber, and reserved.
  4. Agreeableness: the tendency to be soft-hearted, trusting, and helpful vs. ruthless, suspicious, and uncooperative.
  5. Neuroticism: the tendency to be calm, secure, and self-satisfied vs. anxious, insecure, and self-pitying. (Santrock, 2008)

The Big Five contains important dimensions of personality. However, some personality researchers argue that this list of major traits is not exhaustive. Some support has been
found for two additional factors: excellent/ordinary and evil/decent. However, no definitive conclusions have been established. (Santrock, 2008)

**Criticisms**

Trait models have been criticized as being purely descriptive and offering little explanation of the underlying causes of personality. Eysenck's theory, however, proposes biological mechanisms as driving traits, and modern behavior genetics researchers have shown a clear genetic substrate to them. Another potential weakness of trait theories is that they may lead some people to accept oversimplified classifications—or worse, offer advice—based on a superficial analysis of personality. Finally, trait models often underestimate the effect of specific situations on people's behavior.

**Psychoanalytic theories**

Psychoanalytic theories explain human behavior in terms of the interaction of various components of personality. Sigmund Freud was the founder of this school of thought. Freud drew on the physics of his day (thermodynamics) to coin the term psychodynamics. Based on the idea of converting heat into mechanical energy, he proposed psychic energy could be converted into behavior. Freud's theory places central importance on dynamic, unconscious psychological conflicts (Kahn, 2002).

Freud divides human personality into three significant components: the id, ego, and super-ego. The id acts according to the pleasure principle, demanding immediate gratification of its needs regardless of external environment; the ego then must emerge in order to realistically meet the wishes and demands of the id in accordance with the outside world, adhering to the reality principle. Finally, the superego (conscience) inculcates moral judgment and societal rules upon the ego, thus forcing the demands of the id to be met; not only realistically but morally. The superego is the last function of the personality to develop, and is the embodiment of parental and social ideals established during childhood. According to Freud, personality is based on the dynamic interactions of these three components (Carver, & Scheier, 2004).
The channeling and release of sexual (libido) and aggressive energies, which ensues from the "Eros" (sex; instinctual self-preservation) and "Thanatos" (death; instinctual self-annihilation) drives respectively, are major components of his theory (Carver, C., & Scheier, M., 2004). It is important to note that Freud's broad understanding of sexuality included all kinds of pleasurable feelings experienced by the human body.

Freud proposed five psychosexual stages of personality development. He believed adult personality is dependent upon early childhood experiences and largely determined at age five (Carver, & Scheier, 2004). Fixations that develop during the infantile stage contribute to adult personality and behavior.

One of Sigmund Freud's earlier associates, Alfred Adler, did agree with Freud that early childhood experiences are important to development and believed birth order may influence personality development. Adler believed that the oldest child was the individual who would set high achievement goals in order to gain attention lost when the younger siblings were born. He believed the middle children were competitive and ambitious. He reasoned that this behavior was motivated by the idea of surpassing the firstborn's achievements. He added, however, that the middle children were often not as concerned about the glory attributed with their behavior. Adler also believed the youngest would be more dependent and sociable. Adler finished by surmising that an only child loves being the center of attention and matures quickly but in the end fails to become independent.

Heinz Kohut thought similarly to Freud's idea of transference. He used narcissism as a model of how people develop their sense of self. Narcissism is the exaggerated sense of one’s self in which one is believed to exist in order to protect one's low self-esteem and sense of worthlessness.

Another important figure in the world of personality theory is Karen Horney. She is credited with the development of the "real self" and the "ideal self". She believes all people have these two views of their own self. The "real self" is how humans act with regard to personality, values, and morals; but the "ideal self" is a construct individuals implement in order to conform to social and personal norms.
Behaviorist theories

Behaviorists explain personality in terms of the effects external stimuli have on behavior. The approaches used to analyze the behavioral aspect of personality are known as behavioral theories or learning-conditioning theories. These approaches were a radical shift away from Freudian philosophy. One of the major tenets of this concentration of personality psychology is a strong emphasis on scientific thinking and experimentation. This school of thought was developed by B. F. Skinner who put forth a model which emphasized the mutual interaction of the person or "the organism" with its environment. Skinner believed children do bad things because the behavior obtains attention that serves as a reinforcer. For example: a child cries because the child's crying in the past has led to attention. These are the response and consequences. The response is the child crying, and the attention that child gets is the reinforcing consequence.

According to this theory, people's behavior is formed by processes such as operant conditioning. Skinner put forward a "three term contingency model" which helped promote analysis of behavior based on the "Stimulus - Response - Consequence Model" in which the critical question is: "Under which circumstances or antecedent 'stimuli' does the organism engage in a particular behavior or 'response', which in turn produces a particular 'consequence'?" (Cheney, David and Carl, 2008).

Richard Herrnstein extended this theory by accounting for attitudes and traits. An attitude develops as the response strength (the tendency to respond) in the presences of a group of stimuli become stable. Rather than describing conditionable traits in non-behavioral language, response strength in a given situation accounts for the environmental portion. Herrnstein also saw traits as having a large genetic or biological component as do most modern behaviorists (Cheney, David, and Carl, 2008).

Ivan Pavlov is another notable influence. He is well known for his classical conditioning experiments involving dogs. These physiological studies led him to discover the foundation of behaviorism as well as classical conditioning (Cheney, David, and Carl, 2008).

Social cognitive theories

10
In cognitive theory, behavior is explained as guided by cognitions (e.g. expectations) about the world, especially those about other people. Cognitive theories are theories of personality that emphasize cognitive processes, such as thinking and judging.

Albert Bandura, a social learning theorist suggested the forces of memory and emotions worked in conjunction with environmental influences. Bandura was known mostly for his "Bobo Doll experiment". During these experiments, Bandura video taped a college student kicking and verbally abusing a bobo doll. He then showed this video to a class of kindergarten children who were getting ready to go out to play. When they entered the play room, they saw bobo dolls, and some hammers. The people observing these children at play saw a group of children beating the doll. He called this study and his findings observational learning, or modeling.

More central to this field have been:

- Attributional style theory (Abramson, Seligman, and J. Teasdale, 1978) dealing with different ways in which people explain events in their lives. This approach builds upon locus of control, but extends it by stating we also need to consider whether people attribute to stable causes or variable causes, and to global causes or specific causes.

- Achievement style theory focuses upon identification of an individual's Locus of Control tendency, such as by Rotter's evaluations, and was found by Cassandra Bolyard Whyte to provide valuable information for improving academic performance of students (Whyte, 1978). Individuals with internal control tendencies are likely to persist to better academic performance levels, presenting an achievement personality, according to Whyte (1978).

**Humanistic theories**

Humanistic psychology emphasizes that people have free will and that this plays an active role in determining how they behave. Accordingly, humanistic psychology focuses on subjective experiences of persons as opposed to forced, definitive factors that determine behavior. Abraham Maslow and Carl Rogers were proponents of this view, which is based on the "phenomenal field" theory of Combs and Snygg (1949). Rogers and Maslow were among a group of psychologists that worked together for a decade to produce the Journal of Humanistic Psychology. This journal
was primarily focused on viewing individuals as a whole, rather than focusing solely on separate traits and processes within the individual.

Robert W. White wrote the book The Abnormal Personality that became a standard text on abnormal psychology. He also investigated the human need to strive for positive goals like competence and influence, to counterbalance the emphasis of Freud on the pathological elements of personality development (Watt, and Norman, 1981).

Maslow spent much of his time studying what he called "self-actualizing persons", those who are "fulfilling themselves and doing the best they are capable of doing". Maslow believes all who are interested in growth move towards self-actualizing (growth, happiness, satisfaction) views. Many of these people demonstrate a trend in dimensions of their personalities.

**Post-test**

1. What is the importance of theories in science?
2. What single theory best explains the concept of personality?
3. What are the major tenets of the behaviourists?
LECTURE THREE
Observation as Assessment Strategy and Their Rationale

Introduction
Behavioral assessment is often considered separately from personality assessment because of its focus on overt behaviors as opposed to internal personality dispositions and tendencies. However, if we are to conduct a thorough personality assessment, then it is also vital to understand a client’s overt behavior by observation. This is particularly true for clients unable to report for themselves, particularly younger children and those with cognitive issues that might impair accurate self-representation (e.g., dementia). In such cases, the reports of others can be a vital source of information.

Objectives
1. Students should understand the power of observation in assessing personality
2. The various means of observation most appropriate in diverse situations should be understood by students
3. Students should comprehend the justification for observation as an assessment strategy.

Pretest
1. What is observational assessment of personality?
2. What are the various methods of observing personality of individuals?
3. What are the rationale for assessing personality through observation?

Content
Observational methods in psychological research entail the observation and description of a subject's behavior, in this case specific personality traits. Researchers utilizing the observational method can exert varying amounts of control over the environment in which the observation takes place.

Observation without Intervention
If researchers wish to study how subjects normally behave in a given setting, they will want to utilize observation without intervention, also known as naturalistic observation. This type of observation is useful because it allows observers to see how individuals act in natural settings, rather than in the more artificial setting of a laboratory or experiment. A natural setting can be defined as a place in which behavior ordinarily occurs and that has not been arranged specifically for the purpose of observing behavior (Zechmeister, Zechmeister, and Jeanne, 2009).

Observation without intervention may be either overt or obtrusive (meaning that subjects are aware they are being observed) or covert or unobtrusive (meaning that subjects are not aware).

Observation with Intervention
Most psychological research use observation with some components of intervention. Reasons for intervening include: to precipitate an event that normally occurs infrequently in nature or is difficult to observe; to systematically vary the qualities of a stimulus event so as to investigate the limits of an organism’s response; to gain access to a situation or event that is generally closed.
to scientific observation; to arrange conditions so that important antecedent events are controlled and consequent behaviors can be readily observed; and to establish a comparison by manipulating independent variables to determine their effects on behavior (Zechmeister, Shaughnessy, Zechmeister, Jeanne, 2009).

There are three different methods of direct observation with intervention: participant observation, structured observation, and field experiments.

**Participant Observation**

Participant observation is characterized as either undisguised or disguised. In undisguised observation, the observed individuals know that the observer is present for the purpose of collecting information about their behavior. This technique is often used to understand the culture and behavior of groups or individuals (Zechmeister, et al, 2009). In contrast, in disguised observation, the observed individuals do not know that they are being observed. This technique is often used when researchers believe that the individuals under observation may change their behavior as a result of knowing that they were being recorded (Zechmeister, et al, 2009).

There are several benefits to doing participant observation. Firstly, participant research allows researchers to observe behaviors and situations that are not usually open to scientific observation. Furthermore, participant research allows the observer to have the same experiences as the people under study, which may provide important insights and understandings of individuals or groups.

However, there are also several drawbacks to doing participant observation.

- Firstly, participant observers may sometimes lose their objectivity as a result of participating in the study. This usually happens when observers begin to identify with the individuals under study, and this threat generally increases as the degree of observer participation increases.

- Secondly, participant observers may unduly influence the individuals whose behavior they are recording. This effect is not easily assessed, however, it is generally more prominent when the group being observed is small, or if the activities of the participant observer are prominent.
Lastly, disguised observation raises some ethical issues regarding obtaining information without respondents' knowledge. The dilemma here is of course that if informed consent were obtained from participants, respondents would likely choose not to cooperate.

Structured Observation
Structured observation represents a compromise between the passive nonintervention of naturalistic observation, and the systematic manipulation of independent variables and precise control characterized by laboratory experiments (Zechmeister, et al, 2009). Structured observation may occur in a natural or laboratory setting. Within structured observation, often the observer intervenes in order to cause an event to occur, or to “set up” a situation so that events can be more easily recorded than they would be without intervention (Zechmeister, et al, 2009). Such a situation often makes use of a confederate who creates a situation for observing behavior. One benefit to structured observation is that it allows researchers to record behaviors that may be difficult to observe using naturalistic observation, but that are more natural than the artificial conditions imposed in a laboratory. However, problems in interpreting structured observations can occur when the same observation procedures are not followed across observations or observers, or when important variables are not controlled across observations.

Field Experiments
In field experiments, researchers manipulate one or more independent variables in a natural setting to determine the effect on behavior. This method represents the most extreme form of intervention in observational methods, and researchers are able to exert more control over the study and its participants. Conducting field experiments allows researchers to make causal inferences from their results, and therefore increases external validity. However, confounding may decrease internal validity of a study, and ethical issues may arise in studies involving high-risk (Zechmeister, et al, 2009).

Indirect Observational Methods
Indirect observation can be used if one wishes to be entirely unobtrusive in their observation method. This can often be useful if a researcher is approaching a particularly sensitive topic that
would be likely to elicit reactivity in the subject. There are also potential ethical concerns that are avoided by using the indirect observational method.

**Physical Trace Evidence**

The investigation of physical trace evidence involves examining the remnants of the subject’s past behavior. These remnants could be any number of items, and are usually divided into two main categories. Use traces indicate the use or non-use of an item. Fingerprints, for example, fall into the category of use traces, along with candy wrappers, cigarette cartons, and countless other objects. In contrast, products are the creations or artifacts of behavior. An example of a product might be a painting, a song, a dance or television. Whereas use traces tell us more about the behavior of an individual, products speak more to contemporary cultural themes.

Examining physical trace evidence is an invaluable tool to psychologists, for they can gain information in this manner that they might not normally be able to obtain through other observational techniques. One issue with this method of research is the matter of validity. It may not always be the case that physical traces accurately inform us about people’s behavior, and supplementary evidence is needed when acquiring physical trace evidence in order to substantiate your findings.

**Archival Records**

Archival records are the documents that describe the activities of people at a certain time point or time period. Running records are continuously updated. Episodic records, on the other hand, describe specific events that only happened once.

Archival records are especially useful since they can be used as supplementary evidence for physical trace evidence. This keeps the whole data collection process of the observational study entirely unobtrusive. However, one must also be wary of the risk of selective deposit, which is the selective addition and omission of information to an archival record. There could be easily overlooked biases inherent in many archival records.

**Post-test**

1. How does observation technique of assessment differ from other means of assessment?
2. Participant observation is more effective in personality assessment. Discuss
3. What limitations do observational technique portend?

LECTURE FOUR
Assessment Interview

Introduction
Groth-Marnat (2003) states that the single most important means of data collection during psychological evaluation is the assessment interview. Without interview data, most psychological tests are meaningless. The interview also provides potentially valuable information that may be otherwise unattainable, such as behavioral observations, idiosyncratic features of the client, and the person’s reaction to his or her current life situation. In addition, interviews are the primary means of developing rapport and can serve as a check against the meaning and validity of test results.
Objectives

1. Students should know what approaches can be taken in conducting a clinical interview and how they differ from each other.
2. Students should understand what client information is, and how it can be obtained during the clinical interview.
3. The place of clinical interview in assessing personality should be understood by students.

Pretest

1. What is clinical interview?
2. What is the best method of clinical interview?
3. How does clinical interview differ from other methods of personality assessment?

Content

The primacy of the clinical interview over other means used to gather assessment information cannot be stressed enough. Information from other sources are important, but often they are indirect, second-hand information that have either been colored by others’ perceptions of the client, inferred from other information, or lack the degree of detail or specificity that the clinician would have pursued if the clinician were the one who personally gathered the information.

Other sources of information cannot provide the same sense of the patient and his or her circumstances that comes from the clinical interview. Furthermore, as Mohr and Beutler (2003) point out, the interview is usually the first assessment procedure administered because,

(1) It is the method in which most clinicians place the most faith in
(2) It is the easiest method of facilitating the patient’s cooperation, and
(3) It is readily adapted to providing a context in which other instruments can be selected and interpreted.

Generally speaking, a clinician can take one of three approaches in conducting the clinical interview. The first is what is referred to as the unstructured interview.
Unstructured Interview

The approach taken here is just as the term implies, it is one that follows no rigid sequence or direction of inquiry; rather, it is tailored more to the individual’s problems and relies heavily on the clinician’s skills and creativity (Mohr & Beutler, 2003). The reliance on individual clinician skills makes the unstructured interview the least reliable and possibly the least valid of the assessment procedures. In addition, the unstructured interview allows for the introduction of interviewer bias, (e.g., halo effect, primacy effect) from both perceptual and interactional processes (Groth-Marnat, 2003).

Structured Interview

At the other end of the continuum is the structured interview. As defined by Mohr and Beutler (2003), the structured interview format is one in which the patient is asked a standard set of questions covering specific topics or content, including a finite list of signs and symptoms. Beutler (1995) previously identified two types of structured interview. The first is the one in which decision trees are used to determine which among a pool of potential questions the patient should be asked. In essence, the responses to previous questions guide the clinician in selecting which questions to ask next. Two examples are the Diagnostic Interview Schedule, Version IV (Robins, Cottler, Bucholz, & Compton, 1995) and the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)-Clinician Version (First, Spitzer, Gibbon, & Williams, 1997).

The second type of structured interview is focused more on assessing a broad or narrow array of symptomatology and its severity rather than being tied closely to a diagnostic system. Examples include the structured versions of the broad-based Mental Status Examination (Amchin, 1991) and the narrowly focused Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967).

While the structured interview provides the best means of obtaining valid and reliable information about the patient, there are drawbacks to its use. As Mohr and Beutler (2003) point out, structured interviews generally tend to be viewed as rather lengthy, constraining, and relying too much on patient self-report. It is perhaps for these reasons that structured clinical interviews
are more often used in research settings where standardization in data gathering and empirical demonstration of data validity and reliability are critical (Beutler, 1995).

**Semi-structured Interview**

When interviews are unstructured, clinicians may overlook certain areas of functioning and focus more exclusively on presenting complaints. When interviews are highly structured, clinicians can lose the forest for the trees and make precise but errant judgments. Such mistakes may occur when the clinician focuses on responses to specific interview questions (e.g., diagnostic criteria) without fully considering the salience of these responses in the patient’s broader life context or without adequately recognizing how the individual responses fit together into a symptomatically coherent pattern (Meyer et al., 2001). Based on the dilemma posed by the structured and unstructured interview, the solution is a compromise between the two, that is, the semi-structured interview.

Employing a semi-structured interview provides clinicians with a means of ensuring that all important areas of investigation are addressed while allowing them the flexibility to focus more or less attention to specific areas, depending on their relevance to the patient’s problems. In essence, the clinician conducts each interview according to a general structure addressing common areas of bio-psychosocial functioning. At the same time, the clinician is free to explore in greater detail the more salient aspects of patient’s presentation and history as they are revealed. Moreover, the semi-structured approach allows for the insertion of therapeutic interventions if such opportunities arise during the course of the interview (Summerfeldt & Antony, 2002).

**Keys to Good Clinical Interviewing**

Conducting a good, useful clinical interview requires more than just knowing what areas in which to query the patient, it requires skills. Mohr and Beutler (2003) provide several recommendations pertaining to conducting the clinical interview, regardless of the setting or circumstances in which it is conducted. Such keys to a good clinical interview are:
✓ **Avoid a mechanical approach to questioning**: Maintain a conversational approach to asking questions and eliciting information, modifying the inquiry (as necessary) to ensure a smooth flow or transition from one topic to another.

✓ **Move from open-ended inquiries to closed-ended inquiries**: Begin exploration of content areas with open-ended inquiries and proceed to closed-ended questions as more specificity and detail are required.

✓ Move from general topics to specific topics.

✓ **Invite the patient to add information and ask questions**: At the end of the interview, invite the individual to add other information that he or she feels is important for the clinician to know. Also, invite questions and comments about anything related to the interview or the assessment process.

✓ Provide feedback to the patient.

**Outline for a Recommended Semi-structured Clinical Interview**

1. Identifying information
2. Presenting problem/chief complaint
3. History of the problem
4. Family/social history
5. Educational history
6. Employment history
7. Mental health and substance abuse history
8. Medical history
9. Important patient characteristics
   a. Functional impairment
   b. Subjective distress
   c. Problem complexity
   d. Readiness to change
   e. Potential to resist therapeutic influence
   f. Social support
   g. Coping style
h. Attachment style
10. Patient strengths
11. Mental status
12. Risk of harm to self and others
13. Motivation to change
14. Treatment goals

The manner in which personality assessment is conducted will vary from one clinician to another, depending on any number of factors related to the patient, the clinician, and the situation. But in all cases, the clinical interview should serve as the core of the information gathering process. A semi-structured format is recommended as the best means of gathering the information from the patient. This approach ensures that all interview information that is generally helpful or needed in formulating a clinical picture of the patient is obtained; at the same time, it allows the clinician flexibility in the manner in which information is gathered.

Post test
1. In what significant way does clinical interview differ from other methods of assessment?
2. Only clinicians can conduct clinical interviews. How true is this assertion?
3. Treatment goals are least important in clinical interview. How true?

LECTURE FIVE

Purposes of Personality assessment

Introduction
The lecture present various reasons why personality assessment is conducted, this includes description of psychopathology and differential diagnosis, description and prediction of everyday
behavior, monitoring of treatment, inform psychological treatment, and use of personality assessment as treatment.

**Objectives**

Students should understand the various settings where personality assessment can be done

Students should be able to know why personality assessment is necessary

**Pretest**

1. Why is personality assessment necessary?
2. Who may or may not conduct a personality assessment?

**Content**

Although personality assessment is used in several different settings, there are five primary reasons to conduct personality assessment (Meyer et al., 2001).

1. **Description of Psychopathology and Differential Diagnosis**
   
   From the very first personality assessment tools devised in the early to mid-1900s, psychologists have hoped to use tests and measures to diagnose psychopathology in their clients. Compared to unstructured diagnostic interviews, psychological tests have the benefit of normative bases from which to begin interpretation. This characteristic, coupled with standardized administration procedures, yields diagnostic information that is often more predictive and robust than that obtained by interview alone.

2. **Description and Prediction of Everyday Behavior**
   
   As Rorer (1990) described, the goal of personality assessment is to describe what people are like. Although often used to examine issues of pathological behavior and mental illnesses, a comprehensive personality assessment should not focus solely on these aspects of functioning. The quality of a client’s interactions, their expectations of relationships, their personal strengths and attributes, and their typical means of coping with stress is all components of everyday behavior that should be included in a comprehensive personality assessment.
3. Inform Psychological Treatment
The interpersonal, intrapersonal, dispositional, and situational descriptors of a psychotherapy client yielded by personality assessment can be an immensely helpful and cost-effective way of planning mental health treatment (Miller, Spicer, Kraus, Heister, & Bilyeu, 1999). Given the diversity of psychological treatments available, including different modalities of psychotherapy and medication, personality assessment might offer some insights into which of these might be most effective. For example, if assessment indicates that a client is uncomfortable expressing emotion, they might be more appropriate for a cognitive form of psychotherapy. Furthermore, because of the impact of personality factors in treating Axis I disorders such as depression and anxiety, personality assessment might be particularly helpful in describing these important features that might call for a more complex treatment program. In addition to informing treatment, research indicates that personality assessment prior to psychotherapy can enhance alliance early in treatment (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hilsenroth, Peters, & Ackerman, 2004).

4. Monitoring of Treatment
Personality assessment tests have shown to be sensitive to the changes that clients experience in psychotherapy (Abraham, Lepisto, Lewis, Schultz, & Finkelberg, 1994; Gronnerod, 2004). Some measures, such as the Beck Depression Inventory (BDI; Beck & Steer, 1987), were specifically designed to be used as adjuncts to treatment by measuring change. Personality assessment results can be used as baseline measures, with changes reflected in periodic retesting. Clinicians can use this information to modify or enhance their interventions based on test results.

5. Use of Personality Assessment as Treatment
The Therapeutic Assessment model (TA; Finn & Tonsager, 1997) was developed to increase the utility of personality assessment and feedback by making assessment and feedback a therapeutic endeavor. Based on the principles of self and humanistic psychology, and the work of Fischer (1994, 2000), the Therapeutic Assessment model views assessment as a collaborative endeavor in which both the client and the assessor work together to arrive at a deeper understanding of the
client’s personality, interpersonal dynamics, and present difficulties. The client becomes an active collaborator in a mutual process to better understand the nature of his or her concerns and the assessor discusses (rather than delivers) test results in a manner that is comfortable and understandable to the client. This approach stands in contrast to the more typical information-gathering approach to assessment often used in neuropsychological and/or forensic psychology practice, where clients are less engaged in the process of assessment, and feedback may be provided in only a brief summary or written format.

**Post test**

1. Personality assessment can serve as a useful tool for treatment. Discuss.
2. Why is personality assessment important to individuals and group?
Neuropsychological assessment is a direct application of cognitive psychology, as knowledge of modern concepts of such functions as attention, memory, and language are necessarily interpreted and explained correctly by the use of most neuropsychological instruments or test (Armstrong, Beebe, Hilsabeck, & Kirkwood, 2008). Neuropsychological assessment requires that practitioners be able to evaluate and recognize behavioral, personality, and psychiatric consequences of neurological disorders and attribute correctly behavioral or cognitive symptoms to neurological versus non-neurological causes, or a combination of these.

**Objective:**
To help student understand what neuropsychological test are and as well help them to have insight into what neuropsychological assessment entails.

**Pre-test:**
1. What is neuropsychological assessment
2. What are neuropsychological tests;

**Content**
Neuropsychological tests can be used in a clinical context to assess impairment after an injury or illness known to affect neurocognitive functioning. When used in research, these tests can be used to contrast neuropsychological abilities across experimental groups. Neuropsychological tests consist of specifically designed tasks used to measure a psychological function known to be linked to a particular brain structure or pathway (Grant & Adams, 2009). The clinical interview is an important source of obtaining other information relevant to the interpretation of neuropsychological tests. The clinical neuropsychological interview is one of the best sources of information regarding a patient’s affect and mood, insight, and motivation for testing (Heilman, 2003).

**USES OF NEUROPSYCHOLOGICAL ASSESSMENT**

i. Identifying changes and disturbances in psychological functioning (cognition, behavior, emotion) in terms of presence/absence and severity.
ii. Children and adolescents who have experienced a traumatic brain injury, brain damage, or other organic neurological problems, are administered neuropsychological tests to assess their level of functioning and identify areas of mental impairment.

iii. Assessing changes over time and developing a prognosis - neuropsychological tests can be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological injury or illness.

iv. Offering guidelines for rehabilitation, vocational, or educational planning, or a combination of these.

v. Providing guidelines and education for family and caregivers.

vi. Planning for discharge and treatment implementation.

vii. Determining whether changes or dysfunction is associated with neurological disease, psychiatric conditions, developmental disorders, or nonneurological conditions especially for children who are suffering from developmental delays and/or learning disabilities.

TYPES OF NEUROPSYCHOLOGICAL TESTS

- **Neuropsychological Assessment Battery**
  The Neuropsychological Assessment Battery (NAB) (Stern & White, 2003) was designed to assess a comprehensive array of cognitive functions in adults. It consists of a screening module (12 tests) and five main modules: Attention, Language, Spatial, Memory, and Executive Functions. The modules can be combined into a fixed or flexible battery or any of the 33 individual tests can be administered alone. There are two parallel, equivalent forms. The entire battery can be administered in about 4 hours. The test is designed for adults aged 18 to 97 years.

- **Repeatable Battery for the Assessment of Neuropsychological Status**
  The Repeatable Battery for the Assessment of Neuropsychological Status (RBANS) was developed by Christopher Randolph (1998) as a quick measure of cognitive function in adults aged 20 to 90 with neurological disorders, such as degenerative diseases, vascular accidents, and traumatic brain injury. The RBANS comprises 12 subtests: List Learning, Story Memory, Figure
Copy, Line Orientation, Picture Naming, Semantic Fluency, Digit Span, Coding, List Recall, List Recognition, Story Memory Recall, and Figure Recall. The subtests factor into five domains: Immediate Memory; Visuospatial/Constructional; Language; Attention; and Delayed Memory. There are parallel forms, allowing re-administration to track progression and recovery. Administration time is about 30 minutes.

- **Premorbid Assessment**

Patients are often referred for assessment after an injury or a decline in ability, but in most instances, no preinjury test scores are available that allow a specific determination of the level of decline or change. Premorbid function therefore has to be estimated on the basis of known demographic variables, including educational and vocational achievement, and performance on tests resistant to decline from injury and predictive of cognitive ability. Vocabulary, fund of general information, and other skills such as word reading are highly correlated with intelligence and are often the best test means for estimating premorbid mental ability. Premobid tests includes; National Adult Reading Test—2, The Speed and Capacity of Language Processing Test, Wechsler Test of Adult Reading, Wide Range Achievement Test—4—Word Reading.

**INTELLIGENCE TEST**

Administering a general measure of intelligence or cognitive ability is an important part of the neuropsychological test battery for several reasons. The results of the IQ test set the baseline against which other test results are measured.

- **Kaufman Adolescent and Adult Intelligence Test**

The Kaufman Adolescent and Adult Intelligence Test (KAIT) (Kaufman & Kaufman, 1993) is a multisubtest intelligence test designed for individuals aged 11 through 85+. From the Core Battery, which consists of six subtests, three scores are obtained: Fluid IQ, Crystallized IQ, and Composite IQ. The Crystallized Scale contains three subtests that measure the ability to solve problems using knowledge: Auditory Comprehension, Double Meanings, and Definitions. The Fluid Scale contains three subtests that measure novel problem solving: Rebus Learning, Mystery Codes, and Logical Steps. The Core Battery can be expanded to four more subtests, which permit comparison of immediate versus delayed memory.
Stanford–Binet Intelligence Scales—Fifth Edition

The Stanford–Binet Intelligence Scale—Fifth Edition (SB5) (Roid, 2003) consists of 10 tasks measuring five cognitive areas organized according to the Cattell–Horn–Carroll factor-analytic framework: Fluid Reasoning, Knowledge, Quantitative Reasoning, Visual–Spatial Processing, and Working Memory. Within each factor, there is a verbal and a nonverbal domain. Fluid Reasoning includes tests of object series/matrices, and early reasoning, verbal absurdities, and verbal analogies. Knowledge includes tests of procedural knowledge and picture absurdities and vocabulary, and Quantitative Reasoning includes tests of quantitative knowledge, math reasoning skills, and word problems. Visual–Spatial Processing includes tests of pattern analysis and paper folding and cutting, along with understanding directions and word problems involving spatial information. The fifth factor of Working Memory includes tests of object memory, visual span, sentence memory, and “last word” memory. Summary scores consist of scaled scores for the subtests and the subtest scores combine to form a factor index, two domain scales (Nonverbal IQ and Verbal IQ). All 10 subtests combine to form the Full Scale IQ. An abbreviated IQ is also available based on performances on Object Series/Matrices and Vocabulary. The Fifth Edition of the Stanford–Binet was standardized on 4,800 individuals aged 2 to 85+. Administration time varies but is estimated to be about 5 minutes per subtest.

The Wechsler Scales

The intelligence scales most often used is the David Wechsler scale. The current adult measure (for ages 16–90) is the WAIS-IV, which was published in 2008 (Wechsler, 2008). For children aged 6 through 16 years, 11 months, the current test, published in 2003 (Wechsler, 2003), is the WISC-IV. For children aged 2 years, 6 months, through 7 years, 3 months, the current test, published in 2002 (Wechsler, 2002), is the Wechsler Preschool and Primary Scale of Intelligence—Third Edition (WPPSI-III). The WAIS-IV and WISC-IV provide Full Scale IQ, index, and age-scaled subtest scores. On the WAIS-IV, the Verbal Comprehension Index (VCI) comprises age-scaled scores on subtests of Information, Vocabulary, and Similarities; on the WISC-IV, the VCI comprises age-scaled scores on subtests of Vocabulary, Similarities, and Comprehension. On the WAIS-IV, the Working Memory Index (WMI) comprises age-scaled scores on subtests of Arithmetic and Digit Span, and on the WISC-IV, the WMI comprises age-
scaled scores on subtests of Digit Span and Letter–Number Sequencing. The Perceptual Reasoning Index (PRI) comprises age-scaled scores on subtests of Block Design, Matrix Reasoning and Visual Puzzles (WAIS-IV), or Picture Concepts (WISC-IV). The Processing Speed Index (PSI) comprises age-scaled scores on subtests of Coding and Symbol Search. Administration time of the core subtests from the WAIS-IV and the WISC-IV is shorter than their predecessors.

**Process of Neuropsychological test selection**

When selecting the tests to administer in a neuropsychological assessment, the clinician should pay attention to the referral question, the appropriateness of a test for a given individual, the normative data available for a test, and the comprehensiveness of a test battery. Select a comprehensive array of tests measuring:

- Arousal and attention
- Executive functions
- Intelligence/achievement
- Learning and memory
- Language ability
- Sensory and motor skills
- Emotion, behavior, and personality
- Effort and compliance

**Steps in Test Administration**

- Establish rapport
- Maintain cooperation
- Provide encouragement
- Probe ambiguous responses
- Have test materials accessible
- Use stopwatch inconspicuously
• Observe behavior
• Administer test items in organized, smooth, and steady fashion
• Record responses verbatim
• Score responses as responses occur

Post – Test
1. What is neuropsychological assessment?
2. What are the uses of neuropsychological testing?
3. Enumerate five types of neuropsychological test?
4. What are the steps in neuropsychological test administration?
LECTURE SEVEN
Millon Clinical Multiaxial Inventory-III

Introduction

The MCMI is now the second most frequently used personality test in civil (Boccaccini & Brodsky, 1999) and criminal cases (Borum & Grisso, 1995), and it continues to be used in child custody evaluations (Quinnell & Bow, 2001). The MCMI–III is a 175-questionnaire-based self-report inventory designed to diagnose personality disorders (PD) and major psychiatric syndromes in adult patients who are being evaluated for or receiving mental health services.

Objective:

To enlighten the student on what the MCMI objective personality test is, its administration, scoring and interpretation, and its usefulness to psychologists.

Pre-test:

1. What is the MCMI;
2. How was the test developed?
3. How is it administered and scored?
4. What is its usefulness to the field of psychology?

Content:

TEST DEVELOPMENT

Millon wrote initial items largely from his theoretical model of personality. Ultimately, 1,100 items were generated and then divided into two equivalent form lists. These items were administered to two clinical samples and revisions were made until the final item pool reached
175. For the MCMI-II, Millon developed a provisional form with 368 items and added two other scales (Sadistic and Self-Defeating).

A preliminary working version of the test was initially called the Millon Illinois Self Report Inventory. The name was changed to the Millon Multiaxial Clinical Inventory and then initially published as the Millon Clinical Multiaxial Inventory (MCMI) (Millon, 1983), which coincided with the revision of DSM-II. It was revised in 1987 (Millon, 1987), which coincided with the publication of DSM-III-R. The inventory was again revised in 1994 (Millon, 1994) which coincided with the publication of DSM-IV. The MCMI-III manual was revised in 1997 (Millon, 1997) to address problems with the validity study. The current iteration contains three modifying indices (i.e., validity scales), 11 clinical personality patterns (i.e., personality disorders), three severe personality pathology disorders, 7 clinical syndromes (i.e., Axis I disorders) and three severe clinical syndromes.

THE SCALES IN MCMI-III

I. Clinical Personality Patterns

- Schizoid
- Avoidant
- Depressive
- Dependent
- Histrionic
- Narcissistic
- Antisocial
- Compulsive
- Schizotypal
- Borderline
- Paranoid
II. Severe personality pathology disorders

- Negativistic
- Masochistic
- Aggressive/Sadistic

III. Clinical Syndromes

- Anxiety
- Somatoform
- Bipolar: Manic
- Dysthymia
- Alcohol
- Drug
- Post-Traumatic Stress
- Thought Disorder
- Major Depression
- Delusional Disorder

TEST ADMINISTRATION

The MCMI was designed to be used with adults 18 years and older who are currently being evaluated or treated in mental health settings. Use of this test with patients who do not meet these criteria will result in inaccurate assessments and personality description. The test should not be used for people in non-clinical (i.e., industrial, personnel) settings. Also, one needs a firm grounding in understanding personality theory, psychopathology, and in tests and measurement, in order to render a professional, competent interpretation of this test.
The test is generally administered in a single sitting. No group administrations of this test have been reported. It may be hand scored or computer scored. Hand scoring is time-consuming, burdensome, and leads to scoring errors due to the multiple adjustments required of this test.

Test Scoring

The MCMI can be hand scored or computer scored. The latter requires mail in service through Pearson Assessments, the test’s publisher. Hand scoring takes almost 30 minutes and can result in scoring and transformation errors. Do not give this test to non-clinical populations. The test cannot be computer-scored if gender is not provided, if the patient is under age 18, or more than 12 items have been left unanswered. Before proceeding with scoring, check the Validity Index Items to ensure proper responding. Most clinicians prefer computer scoring, though this adds to the cost. There are two computer narrative interpretive reports. Pearson Assessments publishes an interpretive report, while Psychological Assessment Resources (Craig, 2006b) publishes a computer narrative report but not a scoring report.

Test Interpretation

Because personality disorders are not normally distributed in the general population, it is inappropriate to use a transformed score, which assumes an underlying normal distribution. Instead, Millon discovered that point in the distribution of raw scores which matched the prevalence rate of the disorder and assigned that point a value of Base Rate (BR) 85.

A BR score of 60 represents the average score of all psychiatric patients and a raw score of 30 represents the average score of non-clinical respondents in the standardization sample. He then interpolated the remaining values. A BR score of 85 or 115 means exactly the same thing. The patient has all of the traits of the disorder at the diagnostic level. BR scores between 75 and 84 indicate that the patient has some but not all of the traits to warrant a diagnosis.

DSM-IV (1994) requires that four of possible seven criteria must be met for a diagnosis of Schizoid PD. Similarly, a Borderline PD diagnosis requires five of nine criteria, and an
Antisocial PD diagnosis requires three of seven to be met. It is possible and even probable that two patients with the same PD diagnosis will manifest different personality behavior patterns.

Millon and Craig developed a prototype behavior of a “typical” patient. With the recent advances of the Grossman subscales (Grossman & del Rio, 2006), we are now able to refine our personality description of the basic diagnostic style.

Millon has described each PD prototype in terms of its structural and functional properties. These are behavioral domains (expressive acts and interpersonal conduct), phenomenological domains (cognitive style, object representations, self image), intrapsychic domains (regulatory mechanisms, morphological organization), and biophysical domains (mood and temperament).

The Grossman facet subscales were derived from items that represent the three most salient domains of each PD. For example, Millon argues that the Avoidant PD would be most troubled in the domains of social interaction (behavioral domain), with self esteem issues, and with their perceptions of others (phenomenological domain). Hence the Grossman facet scales for the Avoidant PD are “interpersonally aversive,” “alienated self image,” and “expressively passive.” Grossman has developed three subscales for the Antisocial scale. These are Expressively Impulsive, Acting-Out Mechanism, and Interpersonally Irresponsible.

The addition of the Grossman scales and the development of ways to use the MCMI-III to diagnose personality disorder subtypes are perhaps the most useful refinements of the test since its publication.

Usefulness of The Mcmi- Iii

The MCMI was designed as a measure to be used with adults who are receiving mental health services. The MCMI has been used in both inpatient and outpatient psychiatric hospitals and clinics. It has been frequently used with substance abusers (alcohol and drug), spouse abusers, patients with PTSD and, patients with anxiety and depressive disorders. It has also been used in correctional settings and in forensic applications. Other commonly used psychological tests (e.g., MMPI-2, Rorschach) do not provide the same degree of diagnostic accuracy for Axis I and II disorders that is available with the MCMI.
Limitations of The Mcmi-Iii

On the other hand, it was not meant to provide an assessment of patient strengths and ego resources; other tools are necessary to determine those important aspects of personality functioning. Use of this instrument with other populations is inappropriate and will lead to inaccurate assessment.

Post – Test

- Describe the MCMI personality test
- Explain the MCMI test administration, scoring and interpretation
- Enumerate its usefulness and setbacks
LECTURE EIGHT
Minnesota Multiphasic Personality Inventory (MMPI-2)

Introduction

The MMPI was conceived in the 1930s by psychologist Starke R. Hathaway and psychiatrist/neurologist John C. McKinley as an aid in assessing the mental health of patients seen in medical practice, a test first called the “Medical & Psychiatric Inventory” was renamed when published by the University of Minnesota Press in 1941 as the “Minnesota Multiphasic Personality Inventory” (MMPI). Hathaway reminisced that “It was difficult to persuade a publisher to accept the MMPI” (Dahlstrom & Welsh, 1960, p. vii), though the test quickly gained popularity among psychologists and has become the single most widely used objective personality test (Lubin, Larsen, & Mattarazzo, 1984).

Objective:

Ensure that students have a full grasp to what the MMPI personality test is all about. And as well help them to have insight into the tests description, administration, scoring and interpretation.

Pre-test:

1. How was the MMPI developed;

2. How is the MMPI administered and scored;
3. How is it useful to the field of psychology?

Content:

TEST DEVELOPMENT

The MMPI consists of 550 statements to which the examinee responds “true” or “false. In one form of the test, statements are printed on cards, and a third category, “cannot say,” is included (Dahlstrom, Welsh, & Dahlstrom, 1972). For the group-administered version of the test, all unanswered items in the test booklet are scored in the “cannot say” category. The MMPI may be used with persons 16 or older who have at least a sixth-grade education (or an IQ of 80). Tape-recorded and foreign-language versions of the inventory have also been constructed. As reported by the test authors (Hathaway & McKinley, 1940, 1951), research preceding the final selection of items involved the study of psychiatric textbooks, psychiatric reports, and previously published personality test items. The test items that were ultimately selected reflected 26 content categories, including general health, family issues, religious attitudes, sexual identification, and psychiatric symptomatology (Hathaway & McKinley, 1951). These items were then presented to both criterion groups and a control group. Lanyon and Goodstein (1971, p. 76) described the normal control group as follows: “. . . 1500 control subjects were drawn from hospital visitors, normal clients at the University of Minnesota Testing Bureau, local WPA workers, and general medical patients.” The criterion group was eight clinical groups of psychiatric in-patients from the University of Minnesota hospital. Those items reflecting statistically significant differences between the responses of the clinical criterion group and the control subjects were retained. Analysis of the clinical groups’ responses in contrast to the control group made it possible to develop “scales” that corresponded to each disorder.

TEST DESCRIPTION

The MMPI consists of eight clinical scales that were developed in this fashion (as well as two additional scales, Masculinity-Femininity and Social Introversion- Extraversion, that employed nonpsychiatric Criterion groups in their development). A brief description of each criterion group used in the development of the ten clinical scales and more detailed information concerning the construction and validation of the MMPI can be found in Welsh and Dahlstrom (1956).
VALIDITY SCALES

In addition to ten clinical scales, the MMPI contains three "validity scales" that were designed to serve as indicators of factors such as the operation of response Sets, attitudinal factors, or misunderstanding of directions that may influence test results. These include the L scale (sometimes referred to as the “Lie” scale), the F scale (sometimes referred to as the “Infrequency” scale), and the K (correction) scale. The L scale contains 15 items that are somewhat negative but that apply to most people, such as "I do not always tell the truth,” or "I gossip a little at times” Dahlstrom et al., 1972, p. 109). The preparedness of the examinee to reveal anything negative about himself or herself will be called into question if the score on the L scale does not fall within certain limits.

The 64 items on the F scale (1) are infrequently endorsed by members of nonpsychiatric populations (that is, normal people) and (2) do not fit into any known pattern of deviance. A response of “True” to an item such as the following would be scored on the F scale: “It would be better if almost all laws were thrown away” Dahlstrom et al., 1972, p. 115). An elevated F score may mean that the respondent did not take the test seriously and was just responding to items randomly. Alternatively, the individual with a high F score may be a very eccentric individual or someone who was attempting to “fake bad.” Malingers in the armed services, people intent on committing fraud with respect to health insurance, and criminals attempting to “cop a psychiatric plea” are some of the groups of people who might be expected to have elevated F scores on their profiles. Like the L score and the F score, the K score is a reflection of the frankness of the test taker’s self-report. An elevated K score is associated with defensiveness and the desire to present a favorable impression. A low K score is associated with excessive self-criticism, desire to detail deviance, and/or desire to fake bad. A “True” response to the item “I certainly feel useless at times” and a “False” response to “At times I am all full of energy” Dahlstrom et al., 1972, p. 125) would be scored on the K scale. The K scale is sometimes used to “correct” scores on five of the clinical scales; the scores are statistically corrected for an individual’s overwillingness or unwillingness to admit deviancy.

CLINICAL SCALES
1. Hipochondriasis (Hs) - The criterion group for this scale was patients who showed exaggerated concerns about their physical health.

2. Depression (D) - The criterion group for this scale was clinically depressed patients; unhappy and pessimistic about their future.

3. Hysteria (Hy) - The criterion group for this scale included patients with conversion reactions.

4. Psychopathic deviate (Pd) - The criterion group for this scale was patients who had had histories of delinquency and other antisocial behavior.

5. Masculinity-femininity (Mf) - The criterion group for this scale was Minnesota draftees, airline stewardesses, and male homosexual college students from the University of Minnesota campus community.

6. Paranoia (Pa) - The criterion group for this scale was patients who exhibited paranoid symptomatology such as ideas of reference suspiciousness, delusions of persecution, and delusions of grandeur.

7. Psychasthenia (Pt) - The criterion group for this scale was anxious, obsessive-compulsive, guilt-ridden, and self-doubting patients.

8. Schizophrenia (Sc) - The criterion group for this scale was patients who were diagnosed as schizophrenic (various subtypes)

9. Hypomania (Ma) - The criterion group for this was patients, most diagnosed as manic-depressive, who exhibited manic symptomatology such as elevated mood, excessive activity, and easy distractibility.

10. Social introversion (Si) - The criterion group for this scale was college students who had scored at the extremes on a test of introversion-extraversion.

TEST SCORING AND INTERPRETATION
The MMPI may be hand-scored, computer-scored, and even computer-interpreted; computerized reports range in detail from simply a numerical score for each scale to long and detailed narrative reports. Whether computer-scored or hand-scored, the raw test scores are converted to standard scores that have a mean of 50 and a standard deviation of 10. Standard scores of 70 or greater on the clinical scales are considered to indicate a problem that must be investigated. For example, a score of 88 on the Depression scale would suggest an extremely depressed and pessimistic individual, while an 85 on the hypochondriasis scale would be reflective of an individual who has frequent physical complaints and excessive concern with bodily functioning. Interpretations on the MMPI are generally made, however, on the basis of the entire test pattern or profile, not on the basis of a score on any one scale.

In contemporary usage, MMPI scales are referred to by number rather than their original name. This is so because literal interpretation of the names of the scales would be inaccurate. A high score on the Schizophrenia (Sc) scale does not necessarily mean that the test taker would be diagnosed as schizophrenic; the test taker might well be diagnosed as suffering from some other form of psychosis. It might even be possible for an individual with an elevated Sc scale to be diagnosed as normal. In practical usage, the scales are viewed as continuums with respect to particular personality traits associated with the criterion group the scale was based on. For example, a person scoring high on the Paranoia scale would be regarded as high in suspiciousness, feelings of persecution, and distrust. Note that this use is inconsistent with the purpose of the test as conceived by the test authors (to be an instrument used for classification and differential diagnosis).

USEFULNESS OF THE MMPI

Since its inception in the early 1940s, the MMPI has been used in clinical and research settings with a variety of individuals. The consequence of decades of use and research is a proliferation of new MMPI scales based on the test patterns of various populations. Researchers have examined and compared not only the MMPI responses of normal’s, persons with various psychiatric diagnoses, but also the test protocols of members of more “offbeat” populations as well. The MMPI remains the most used and researched of all the existing personality inventories. Its use as a tool to describe aspects of one’s personality has found application in a variety of
clinical, counseling, educational, worksite, and research settings. The large and ever-expanding literature on this test provides a library of reference material to MMPI users. Although the test is seldom used in the way it was designed to be used as a measure of differential diagnosis. It is no doubt of value to clinicians in their everyday work with psychiatric patients; MMPI results provide insight into the extent and magnitude of patients’ problems. The test results are frequently viewed as tentative hypotheses about the examinee’s psychopathology that await clarification and validation from other sources of data.

CRITICISM OF THE MMPI

The MMPI has been cited with limitations relating to the test construction and use. In light of the widespread use of this instrument, the original normative sample has been criticized as being deficient in terms of size and the representativeness of the general population. Other criticism has been leveled at the sheer change of the norms overtime and it’s inappropriateness with different ethnic groups. The MMPI has been criticized for having some of the same items used in the different scales making it cumbersome and difficult to administer. Also its conservative approach to profile interpretation has been a course of concern to researchers.

Post – Test

- What are the validity scales of the MMPI?
- What are the clinical scales of the MMPI?
- How is the MMPI scored and its profile interpreted?
LECTURE NINE
Thematic Apperception Test (TAT)

Introduction
A projective test is a psychological personality test designed to let a person respond to ambiguous stimuli. Proponents of this technique assert that a person's responses reveal underlying motives, concerns, and the way they see the social world through the stories they make up about ambiguous pictures of people. This is sometimes contrasted with the objective tests. The responses to projective tests are content analyzed for meaning, rather than being based on presuppositions about meaning as is the case with objective tests. Projective tests have their origins in psychoanalytic psychology, which argues that humans have conscious and unconscious attitudes and motivations that are beyond or hidden from conscious awareness. It is believed that in attempting to understand an ambiguous or vague stimulus, individuals often, express their needs, feelings, experiences, prior conditioning thought processes e.t.c. on to the vague picture.

Objectives
Students should be able to appreciate the benefits of the TAT over the objective tests
At the end of this lecture, students should understand the role of the TAT in personality assessment
Pretest

1. What is the meaning of TAT
2. What differentiates the TAT from the MMPI
3. The TAT is only as important as the user can see. Discuss

CONTENT

Thematic Apperception Test was developed by Henry A. Murray and Christiana D. Morgan at the Harvard Clinic at Harvard University in 1935. A widely held belief is that the idea for the TAT emerged from a question asked by one of Murray's undergraduate students, Cecilia Roberts. She reported that when her son was ill, he spent the day making up stories about images in magazines and she asked Murray if pictures could be employed in a clinical setting to explore the underlying dynamics of personality. By the time the TAT was being developed, the Rorschach was beginning to gain popularity. The creators of the TAT, C. Morgan and H. Murray, utilized storytelling about pictured scenes to elicit motives, intentions, and expectations (Teglasi, 2001). Murray developed a theoretically based system for interpreting the stories told, but the variability of the storytelling technique eventually led to many interpretive approaches for the TAT pictures (Teglasi 2001). Other storytelling assessment instruments include Robert’s Apperception Test for Children, Tell-Me-A Story, and the Children’s Apperception Test.

DESCRIPTION AND TRANSFORMATION

The TAT consists of 31 black-and-white picture cards, most containing people, and one card completely blank (Hood & Johnson, 1997). Examples include a boy thinking about a violin and a confused woman holding an open door. Typically, 20 cards are presented in a test administration. The selection of cards presented to respondents varies with clinicians (Lilienfeld et al., 2001). Examinees are asked to tell a story about each picture including as much detail as possible (Hood & Johnson). Murray and Morgan spent the 1930s selecting pictures from illustrative magazines and developing the test. After 3 versions of the test (Series A, Series B, and Series C), Morgan and Murray decided on the final set of pictures, Series D, which remains in use today. After World War II, the TAT was adopted more broadly by psychoanalysts and clinicians to evaluate
emotionally disturbed patients. Later, in the 1970s, the Human Potential Movement encouraged psychologists to use the TAT to help their clients understand themselves better and stimulate personal growth.

PROCEDURE
The TAT is popularly known as the picture interpretation technique because it uses a series of provocative yet ambiguous pictures about which the subject is asked to tell a story. The TAT manual provides the administration instructions used by Murray, although these procedures are commonly altered. The subject is asked to tell as dramatic a story as they can for each picture presented, including the following: what has led up to the event shown, what is happening at the moment, what the characters are feeling and thinking, what the outcome of the story was. If these elements are omitted, particularly for children or individuals of low cognitive abilities, the evaluator may ask the subject about them directly. Otherwise, the examiner is to avoid interjecting and should not answer questions about the content of the pictures. The examiner records stories verbatim for later interpretation. The complete version of the test contains 32 picture cards. Some of the cards show male figures, some female, some both male and female figures, some of ambiguous gender, some adults, some children, and some show no human figures at all. One card is completely blank and is used to elicit both a scene and a story about the given scene from the storyteller. Although the cards were originally designed to be matched to the subject in terms of age and gender, any card may be used with any subject. Murray hypothesized that stories would yield better information about a client if the majority of cards administered featured a character similar in age and gender to the client. Although Murray recommended using 20 cards, most practitioners choose a set of between 8 and 12 selected cards, either using cards that they feel are generally useful, or that they believe will encourage the subject's expression of emotional conflicts relevant to their specific history and situation. However, the examiner should aim to select a variety of cards in order to get a more global perspective of the storyteller and to avoid confirmation bias (i.e., finding only what you are looking for). Many of the TAT drawing consists set of themes such as success and failure, competition and jealousy, feeling about relationships, aggression and sexuality. These are usually depicted through picture cards.
SUB-SCALES
Social Cognition and Object Relations SCOR scale.
This assesses four different dimensions of object relations: Complexity of Representations of People, Affect-Tone of Relationship Paradigms, Capacity for Emotional Investment in Relationships and Moral Standards, and Understanding of Social Causality. Examiners are encouraged to explore information obtained from the TAT stories as hypotheses for testing rather than concrete facts.

SCORING SYSTEMS
When he created the TAT, Murray also developed a scoring system based on his need-press theory of personality. Murray's system involved coding every sentence given for the presence of 28 needs and 20 presses (environmental influences), which were then scored from 1 to 5, based on intensity, frequency, duration, and importance to the plot. However, implementing this scoring system is time-consuming and was not widely used. Rather, examiners have traditionally relied on their clinical intuition to come to conclusions about storytellers. Although not widely used in the clinical setting, several formal scoring systems have been developed for analyzing TAT stories systematically and consistently. A common method that is currently used in research is the: Defense Mechanisms Manual DMM. This assesses three defense mechanisms: denial (least mature), projection (intermediate), and identification (most mature). A person’s thoughts/feelings are projected in stories involved.

STANDARDIZATION
Reliability
Inter-rater reliability of the TAT is similar to that of the Rorschach. Because storytelling responses are open-ended, the task of finding evidence for inter-rater reliability is not easy. Inter-rater reliability for thematic techniques tend to be high when interpretive criteria are clearly designated and interpreters are well trained in the rating procedure. Under these conditions, agreement between raters often exceeds the .80 to .85 range, which is generally considered adequate (Lundy, 1985). There are two important considerations regarding test-retest reliability:
whether the focus is on similarity of story content or similarity of the clinician’s judgment (Lundy, 1985), and whether the personality construct under consideration is relatively stable or fluctuating (Cramer, 1996). The reliability of the specific content is less relevant than consistency of the interpretive meaning of the response (Teglasi, 2001). Stories of the TAT tend to remain stable, at least for short periods of time (Locraft & Teglasi, 1997). However, other research has indicated that some of the standardized scoring systems display weak test-retest reliability over longer periods of time (Lilienfeld et al., 2001).

Validity
Tomkins (1947) did not believe it was appropriate to ask if the TAT is a valid test. Rather, he thought it was important to question whether inferences based on the test are likely to be true. In other words, to what extent do scores from a particular TAT measure relate to other criteria in a predicted manner? To demonstrate forms of construct validity, a relationship must exist between the TAT measure and some independent measure of personality (Cramer, 1996). Measures of the TAT are often criticized because correlations obtained are not as high as those obtained from self-report questionnaires.

Researchers of the TAT note that although questionnaire scores tend to correlate well with scores from other similar questionnaires, they are less successful in predicting real behavior. Research has indicated that TAT scores do correlate with independent measures of behavior in meaningful ways (Cramer). The TAT and self-report measures of achievement motivation both correlate with external criteria, but the patterns of correlations are different. These differences support the conclusion that self-report and storytelling measure different achievement-related constructs, and they cannot be used interchangeably (Teglasi, 2001). Other studies have questioned TAT validity. Several scoring systems have been unable to differentiate normal individuals from those who are psychotic or depressed. Other standardized scoring systems for the TAT do appear to be accurate in determining aspects of personality, notably the need to achieve and a person’s perceptions of others (Lilienfeld et al., 2001).

Interpretation
There are no formal, normative standards for the TAT. The simplest procedure for studying TAT responses is the inspection technique. Most clinicians interpret the TAT stories informally; repetitive patterns or themes become apparent by reading through a subject's stories. It is useful to know the typical themes and stories that are elicited by each of the cards. Deviations from these may offer rich interpretive value. Typical themes are presented in Groth-Marnat (2003) Chapter 10, in Bellak (1997) Chapter 4, and in Teglasi, (2001). It is important to look for corroboration of patterns in other stories, other test results, or in background information. Bellak (1997) says "A repetitive pattern is the best assurance that one does not deal with an artifact".

One main thing to consider in the interpretation of the TAT is that the pictures are best seen psychologically as a series of social situations and interpersonal relations. Another way to consider them is that all characters in the stories are projected aspects of the self, keeping in mind that they may represent the ideal self, the real self, the feared self, etc.

**Things to look for in card responses:**

1. Following the task directions
2. Card pull: Manifest content (Descriptive)
   Latent content (Interpretive)
3. Initial reactions to cards and to themes presented: Card 1 may provide key issues; also note initial reaction to each card
4. Personality Conflicts: Interpersonal, Intrapersonal
5. Themes, plots introduced
6. Characters
7. Supportive figures – who is brought in to story?
8. Affect
9. Action
10. Final outcome or resolution
11. Intercard relationship
12. Ego functions - defenses
13. Language usage
14. Identification issues: Usually identify with same gender; if not, may indicate gender identity issues or may indicate vulnerability and need to project onto gender different person in order to distance the issue from self.

15. Indicators for therapeutic progress and outcome

16. Personality structural analysis: id, ego, superego

17. Psycho-sexual development stage: oral, anal, phallic, latency, genital

**Posttest**

1. What are the things to look out for in administering the TAT

2. Who may administer the TAT and why?

3. The TAT can never outlive its relevance. Do you agree?

**BIBLIOGRAPHY**


