## Commonly used personality assessment tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Format</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota Multiphasic Personality Inventory (MMPI)*</td>
<td>566 items, true-false; self-report format; 17 primary scales (numerous special scales)</td>
<td>Provides wide range of data on numerous personality variables; strong research base *</td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory-2 (MMPI-2)*</td>
<td>567 items; true-false; self-report format; 20 primary scales</td>
<td>Current revision of MMPI with updated response booklet; revised scaling methods, and new validity scores; new normative data *</td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A)</td>
<td>478 true-false items; self report format; 7 validity scales; 10 primary clinical scales; broad range of clinical subscales</td>
<td>1992 (2006 update); for use with 14-18 year olds.</td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF)</td>
<td>338 True-False items; 3 higher order &amp; 9 restructured clinical scales; various validity scales; subscales: 5 somatic/cognitive, 9 internalizing, 4 externalizing, 5 interpersonal functioning, 2 general interests; 5 temperament scales (personality psychopathy-5 scales)</td>
<td></td>
</tr>
<tr>
<td>Beck Depression Inventory II (or earlier; BDI-II)</td>
<td>21 items self-report items on the intensity of depression. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. 1996 (revision of original BDI)</td>
<td>Items: (a) sadness, (b) pessimism, (c) past failure, (d) loss of pleasure, (e) guilty feelings, (f) punishment feelings, (g) self-dislike, (h) self-criticalness, (i) suicidal thoughts or wishes, (j) crying, (k) agitation, (l) loss of interest, (m) indecisiveness, (n) worthlessness, (o) loss of energy, (p) changes in sleeping pattern, (q) irritability, (r) changes in appetite, (s) concentration difficulty, (t) tiredness or fatigue, and (u) loss of interest in sex.</td>
</tr>
<tr>
<td>Million Clinical Multiaxial Inventory-II (MCMI-II)*</td>
<td>175 items; true-false; self-report format; 25 primary scales</td>
<td>Brief administration time; corresponds well with DSM-III-R *</td>
</tr>
<tr>
<td>Personality Assessment Inventory (PAI)*</td>
<td>344 items; Likert-type format; self-report; 22 scales</td>
<td>Includes measures of psychopathology, personality dimensions, validity scales, and specific concerns to psychotherapeutic treatment *</td>
</tr>
</tbody>
</table>

Minnesota Multiphasic Personality Inventory® (MMPI)

- Originally developed in the late 1930s at the University of Minnesota by Starke Hathaway & J. D. McKinley.
- Developed on an "a-theoretical" empirical criterion keying approach. This means that only items which differentiated “normal” from “psychiatric” populations were included on the test. Did NOT use Freudian/psychoanalytic or any other school of thought to select items.
- The most widely researched personality instrument in clinical use.
- MMPI-2 was released in 1989 after extensive revision and restandardization. For use with adults 18 years old+
- MMPI-A (Adolescent form) was released in 1992 and can be used with 14-18 year olds.

Clinical Scales

<table>
<thead>
<tr>
<th>#</th>
<th>Abbr.</th>
<th>Description</th>
<th>What is Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hs</td>
<td>Hypochondriasis</td>
<td>Concern with bodily symptoms</td>
</tr>
<tr>
<td>2</td>
<td>D</td>
<td>Depression</td>
<td>Depressive Symptoms</td>
</tr>
<tr>
<td>3</td>
<td>Hy</td>
<td>Hysteria</td>
<td>Awareness of problems and vulnerabilities</td>
</tr>
<tr>
<td>4</td>
<td>Pd</td>
<td>Psychopathic Deviate</td>
<td>Conflict, struggle, anger, respect for society's rules</td>
</tr>
<tr>
<td>5</td>
<td>MF</td>
<td>Masculinity/Femininity</td>
<td>Stereotypical masculine or feminine interests/behaviors</td>
</tr>
<tr>
<td>6</td>
<td>Pa</td>
<td>Paranoia</td>
<td>Level of trust, suspiciousness, sensitivity</td>
</tr>
<tr>
<td>7</td>
<td>Pt</td>
<td>Psychasthenia</td>
<td>Worry, Anxiety, tension, doubts, obsessiveness</td>
</tr>
<tr>
<td>8</td>
<td>Sc</td>
<td>Schizophrenia</td>
<td>Odd thinking and social alienation</td>
</tr>
<tr>
<td>9</td>
<td>Ma</td>
<td>Hypomania</td>
<td>Level of excitability</td>
</tr>
<tr>
<td>0</td>
<td>Si</td>
<td>Social Introversion</td>
<td>People orientation</td>
</tr>
</tbody>
</table>

RC (Restructured Clinical) Scales

- Developed by Auke Tellegen & assisted by Yossi Ben-Porath (Ben-Porath, 2012)
- "My goal in developing the Restructured Clinical Scales was to preserve the valuable predictive features of the existing Clinical Scales while attempting to improve their distinctiveness. As a first step I constructed a demoralization scale, extracting the general complaint or malaise factor represented to some degree in each of the Clinical Scales and in virtually all other MMPI-2 scales. I then identified the major dimensions of eight of the ten Clinical Scales, excepting scales 5 and 0. Based on these analyses and using the entire MMPI-2 item pool, I developed a set of scales representing these dimensions" (http://www.pearsonassessments.com/mmpi2rcs.aspx)

<table>
<thead>
<tr>
<th>RCd</th>
<th>dem</th>
<th>Demoralization</th>
</tr>
</thead>
<tbody>
<tr>
<td>RC1</td>
<td>som</td>
<td>Somatic Complaints</td>
</tr>
<tr>
<td>RC2</td>
<td>lpe</td>
<td>Low Positive Emotions</td>
</tr>
<tr>
<td>RC3</td>
<td>cyn</td>
<td>Cynicism</td>
</tr>
<tr>
<td>RC4</td>
<td>asb</td>
<td>Antisocial Behavior</td>
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</table>
Higher-Order Scales

**EID**  Emotional/Internalizing Dysfunction

**THD**  Thought Dysfunction

**BXD**  Behavioral/Externalizing Dysfunction

**Subscales (# of subscales)**

**Somatic/Cognitive** (5): Self-reported poor health & specific somatic & cognitive complaints

**Internalizing** (9): Emotional dysfunction linked to RCd (Demoralization) & RC7 (Dysfunctional Negative Emotions)

**Externalizing** (4): Behavioral dysfunction linked to RC4 (Antisocial Behavior) & RC9 (Hypomanic Activation)

**Interpersonal** (5) Specific types of interpersonal functioning: family problems, interpersonal passivity, social avoidance, shyness, disaffiliativeness

**Interest** (2) General interests: Aesthetic-literary interests; Mechanical-physical interests

**PSY-5 (Personality Psychopathology Five) Scales**: Aggressiveness, Psychoticism, Constraint, Negative Emotionality-Neuroticism, Positive Emotionality-Extraversion

**Validity Scales**

<table>
<thead>
<tr>
<th>Abbr.</th>
<th>1st appeared</th>
<th>Description</th>
<th>Assesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>?</td>
<td>1</td>
<td>&quot;Cannot Say&quot;</td>
<td>Questions not answered</td>
</tr>
<tr>
<td>L</td>
<td>1</td>
<td>Lie</td>
<td>Client &quot;faking good&quot;</td>
</tr>
<tr>
<td>F</td>
<td>1</td>
<td>Infrequency</td>
<td>Client &quot;faking bad&quot; (in first half of test)</td>
</tr>
<tr>
<td>K</td>
<td>1</td>
<td>Defensiveness</td>
<td>Denial/Evasiveness</td>
</tr>
<tr>
<td>Fb</td>
<td>2</td>
<td>Back F</td>
<td>Client &quot;faking bad&quot; (in last half of test)</td>
</tr>
<tr>
<td>VRIN</td>
<td>2</td>
<td>Variable Response Inconsistency</td>
<td>answering similar/opposite question pairs inconsistently</td>
</tr>
<tr>
<td>TRIN</td>
<td>2</td>
<td>True Response Inconsistency</td>
<td>answering questions all true/all false</td>
</tr>
<tr>
<td>F-K</td>
<td>2</td>
<td>F minus K</td>
<td>honesty of test responses/not faking good or bad</td>
</tr>
<tr>
<td>S</td>
<td>2</td>
<td>Superlative Self-Presentation</td>
<td>improving upon K scale, &quot;appearing excessively good&quot;</td>
</tr>
<tr>
<td>Fp</td>
<td>2</td>
<td>Psychiatric Infrequency</td>
<td>Frequency of presentation in clinical setting</td>
</tr>
<tr>
<td>Fs</td>
<td>2 RF</td>
<td>Infrequent Somatic Response</td>
<td>Over-reporting of somatic symptoms</td>
</tr>
</tbody>
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Assessment Validity

When a person is being evaluated by a neuropsychologist (or any clinician for that matter), an important question arises: Are the responses of the testee valid? Do they really represent what that testee has experienced and is a truthful reflection of the testee’s situation? In some fashion, the question is simple: Is the testee telling the truth in the way in which they have responded to the tasks and questions posed to them?

Rogers (2008) introduced his edited volume on *Clinical Assessment of Malingering and Deception* with this observation:

> Complete and accurate self-disclosure is a rarity even in the uniquely supportive context of a psychotherapeutic relationship. The most involved clients may intentionally conceal and distort important data about themselves. Issues of sexuality, procreation, and body image are rarely discussed fully in the therapeutic context...Beyond therapy and intimacy, decisions to disclose or deceive are also common in health care and social settings. Most individuals, including mental health professionals, are selective about how much they share with others; their concealments may be either passive omissions or active distortions. (p. 3)

The range of topics in Roger’s (2008) text illustrate multiple ways in which patients may engage in either malingering or deception. They include:

- Malingering psychosis
- Malingering traumatic brain injury
- Denying or misreporting personal substance abuse
- Feigning medical conditions

Consider that there are aspects of self-presentation that may reflect a life influenced by criminological, pathogenic, and other forces. In child custody cases, parents may try to turn children against each other or fail to acknowledge children’s difficulties. Individuals who report a range of “factitious disorders” (made-up medical complaints) or, more likely, are engaged in legal suits for damages may have financial incentives to present as more impaired than they really are.

How might neuropsychologists approach the issue of assessment validity? Over time a variety of approaches have been put forward and these are regularly employed now in assessment work. Lippa (2017) put it this way:

> When conducting a psychological or neuropsychological evaluation, assessment of response bias is crucial. Two means of detecting response bias have been developed: symptom validity testing and performance validity testing (Larrabee, 2012c). Symptom validity tests (SVTs) assess fabrication or over-reporting of symptoms, generally with self-report measures or structured interviews. Performance validity tests (PVTs) detect underperformance on neuropsychological tests.

Larrabee & Kirkwood (2020) offer a slightly different perspective:

> *Performance validity tests or measures (PVTs) allow determination of whether examinees are demonstrating their actual level of ability, while symptom validity tests or measures (SVTs) allow determination of whether examinees are presenting an accurate report of their actual subjective experience.* (p. 214)

The notion of malingering has always been a concern within both medicine and psychiatry. For neuropsychologists “malingering is defined as the fabrication and/or exaggeration of deficits in pursuit of an external incentive, such as potential monetary reward in personal injury litigation or avoidance or mitigation of punishment in criminal settings” (Larrabee & Kirkwood, 2020, p.
218, emphasis added). Thus, a diagnosis of malingering cannot be made if there is no incentive for the patient to engage in the fabricated or exaggerated behavior.

While it is beyond the scope of this review to go into the many issues involved in symptom validity testing and malingering, I will note a couple of issues briefly:

- Many individuals who picture others with psychological disorders rely upon grossly wrong media images and other sources of misconception. As a result, people with psychoses and significant other mental disorders are often thought of as far more impaired that they are or behave in real life. Hence, in someone who malinger or attempts to deceive, that person may so exaggerate their symptoms in ways that clinicians recognize as improbable.

- An example of exaggerated performance on a neuropsychological test would be someone whose test performance is even lower than that of grossly brain impaired patients who cannot perform many rudimentary tasks that the malinger has demonstrated that he/she can do.

- There are various neurological and psychological conditions for which neuropsychologists must be very sensitive in describing test results as invalid. These include individuals with significant intellectual disabilities, dementia, or those for whom English is a second language (Lippa, 2017).

References


