Preparing for Court Testimony Based on the MMPI-2

Guide

6th Edition 1/24/16

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About the Author

James N. Butcher, Ph.D. is a Professor Emeritus in the Department of Psychology at the University of Minnesota where he continues to maintain an active research program in the areas of personality assessment, abnormal psychology, cross-cultural personality factors, and computer-based personality assessment. He has published over 64 books and over 250 articles in these areas. He is the first author of the MMPI-2 and MMPI-A.

He was awarded Doctor Honoris Causa, from the Free University of Brussels, Belgium, in 1990 and awarded a Laurea Honoris Causa in Psicologia, from the University of Florence, Italy in 2005. He was presented with the Bruno Klopfer Award for Lifetime Contribution to Personality Assessment from the Society for Personality Assessment in 2004.

Dr. Butcher is a former member of the Board of Trustees of the Society for Personality Assessment, and he served on the Executive Committee of Division 5 (Division of Measurement and Evaluation) of the American Psychological Association and served as a member of the Executive Board of Division (General Psychology). Dr. Butcher served as the Editor of *Psychological Assessment* for six years and currently serves as consulting editor for numerous other journals in psychology and psychiatry.

In 1965 he founded the Symposium on Recent Developments in the Use of the MMPI, based in the Department of Psychology of the University of Minnesota, to promote and disseminate research information on the MMPI. Dr Butcher organized this conference for 38 years. He also founded the International Conference on Personality Assessment, a program devoted to facilitating international research on personality assessment. Eighteen international conferences have been held in numerous countries. In 2003, he handed over his leadership of the MMPI-2 symposium and workshops to others. Also in 2003, in what turned out to be his last presentation at these meetings, Professor Butcher included descriptions of problems with the newly developed Restructured Clinical Scales. The new coordinators of the symposium and workshop series told him not to include these concerns in future workshops. Professor Butcher then chose not to participate further in the meetings he founded.

Dr. Butcher has been extensively involved in the use of the MMPI-2 in forensic settings; he has testified in many cases, both criminal and civil, in which the MMPI-2 played a pivotal role. He has also published several articles and books in the forensic assessment field and recently published the book: Butcher, J. N., Hass, G. A., Greene, R. L. & Nelson, L. D. (2015). *Using the MMPI-2 in Forensic Assessment.* Washington, D.C.: American Psychological Association.

(Disclosure Statement available at http://www1.umn.edu/mmpi/disclosure.php).

General Introduction

This guide has been designed as an aid to professionals who are appearing in court to give testimony involving the MMPI/MMPI-2.

This guide begins with a brief presentation of the features of the MMPI/ MMPI-2, which is also followed by a suggested outline for explaining the MMPI/MMPI-2 in court, strategies for dealing with subpoenas and requests for the release of raw data, scoring, guidelines, clinical scale interpretation guidelines, a description of clinical scale correlates a description of MMPI-2 Content Scales, and guidelines for interpreting addiction potential indicators. The final section of this guide contains a detailed and handy MMPI/ MMPI-2 reference list. The references are divided under subheadings to help you target your specific areas of interest and find the references most relevant to each case. A comprehensive summary of forensic references can be found on this website.

Features of the MMPI/ MMPI-2

- When testifying, you may be required to justify the use of the MMPI/ MMPI-2 over other tests. This section outlines the key advantages of the MMPI/ MMPI-2.
- The MMPI-2 is the most frequently used clinical personality test. It is also the most widely employed test to provide personality information on defendants or litigants in court cases where psychological adjustment factors are considered important to the case.
- The MMPI-2 is self-administered and usually takes between one hour and one and a half hours to complete. The client simply responds T (True) or F (False) to each item on the basis of whether the statement applies to him/her. The inventory can be administered from a printed booklet, by audiocassette, or by computer. The items are written at a sixth grade reading level.
- The MMPI-2 is easy to score by counting item responses for each scale and recording them on a profile sheet or by using a computerized scoring program. The objective scoring procedures for the MMPI-2 assure reliability in the processing of the client's responses.
- The MMPI-2 has been translated into many languages so that it may be used with individuals from different cultural backgrounds. Available translations include, for example, Arabic, Farsi, French Canadian, Hispanic, Thai, Vietnamese, Chinese, Greek, Norwegian, Japanese, Dutch, Hebrew, Korean, Italian and Russian. In cases where the client does not speak or read English, a foreign language version of the instrument can be administered and in many cases appropriate national norms used (see below for a list of available translations).
- The MMPI-2 possesses a number of response attitude measures that appraise the test taking attitudes of the client. Any self-report instrument can be susceptible to manipulation, either conscious or unconscious. Thus, it is imperative to have a means of knowing what the client's test-taking attitudes were at the time the responses were given.
- The MMPI-2 is an objectively interpreted personality instrument with empirically validated scales. A high score on a particular clinical scale is associated with certain behavioral characteristics. These scale "meanings" are objectively applied to clients. The established correlates for the scales ensure objective interpretations.
- MMPI-2 scale scores are highly reliable over time (see the "Reliability" section of the reference list of this guide). Well-established scale reliability data support the use of the scales as identifying likely stable personality characteristics.

- The MMPI-2 provides clear, valid descriptions of people's problems, symptoms, and characteristics in a broadly accepted clinical language. Scale elevations and code type descriptions provide a terminology that enable clear client descriptions.
- MMPI-2 scores enable the practitioner to estimate potential future behaviors.
- The MMPI-2 is quite easy to explain effectively to lay audiences. The personality variables (e.g., a client's similarity to a particular group such as 4-9 profiles) and the structure for making score comparisons are relatively comprehensive.
- Psychologists need to be aware of possibly conflicting conclusions that can result from the MMPI-2 and the new MMPI-2-RF.

Suggested Outline for Explaining the MMPI-2 in Court

This section describes the most effective strategy for explaining the MMPI in court. These steps are listed in an order that usually facilitates understanding. With proper discretion, however, the order of presentation may be changed as dictated by the style of the person testifying or by judicial requirements.

1. Describe the scientific basis of the MMPI instruments in terms of being an objective, paper-and-pencil personality inventory that has been widely researched and validated since 1940.

2. Describe how widely used the MMPI-2 is in clinical assessment and cite references to support its broad use. The MMPI/MMPI-2 is the most widely used instrument in clinical and research applications. Pope, Butcher, & Seelen (2006) provide a listing of the extensive use of the MMPI-2 in court (i.e., 320 federal and state citations since 2000). (See also Butcher, Hass, Greene & Nelson, 2015)

3. Discuss the rationale for the original development of the MMPI as an objective means of classifying psychological problems using an empirically based scale construction approach.

4. Describe and illustrate how the MMPI-2 has been validated and explain the extensive research base for correlates for the clinical scales.

5. Illustrate how the MMPI-2 is used in personality description and clinical assessment.

6. Describe and illustrate how the clinical scales of the revised versions (MMPI- 2/MMPI-A) are composed of largely the same items and possess the same psychometric properties as the original version of the scales. Traditional scale reliabilities and validities have been assured in the revised version.

7. Explain how the credibility and validity of a particular MMPI-2 profile can be determined.

8. Explain what the MMPI/MMPI-2/MMPI-A measures for the particular client.

Suggestions for Handling Requests for MMPI-2/MMPI-A

Raw Test Data

When using the MMPI-2/MMPI-A in forensic settings, you may face an ethical dilemma if you are called upon to release raw data to nonpsychologists such as attorneys or other court personnel. Release of test information can result in a violation of copyright agreements.

First, analyzing scores without fully understanding psychological concepts of confidence intervals and different types of reliability and validity can lead to misinterpretation of test data. Second, release of test protocols, manuals, and answer sheets can violate the security and integrity of psychological tests and lead to the unauthorized reproduction of test materials (Frumkin, 1995).

The following are some suggestions for resolving the issue of test security. Please be aware that regulations on this matter may vary from state to state. Therefore, you are advised to seek legal counsel before applying the recommendations outlined in this section.

1. If subpoenaed, first determine whether the request for information is a legally valid demand for disclosure. If a demand is not legally enforceable for any reason, you have no legal obligation to comply with it (APA, 1996).

2. Contact the client (or his/her legal guardian) and discuss the implications of the demand with the client. When appropriate, you may consult with the client's attorney (APA, 1996).

3. Write a letter to the court, with a copy to the attorneys for both parties, stating that it is a violation of the Ethical Principles of Psychologists of the American Psychological Association to release the raw psychological test material to nonpsychologists. Explain that nonpsychologists are not in a position to provide interpretation and explanation of the test data. Also, explain that providing the test materials to non-psychologists violates the security of the tests and copyright law (Frumkin, 1995). Suggest that the court direct you to provide test data only to another appropriately qualified psychologist designated by the court or by the party seeking such information (APA, 1996).

4. If you are prohibited from seeking guidance in the form of a letter, determine if the client's attorney is willing to file a motion to quash the subpoena in part, or in its entirety, or for its protective order (APA, 1996).

5. In the case of a court hearing, bring the following documents related to ethical principles and standards of practice.

    i) Ethical Principles of Psychologists and Code of Conduct (APA, 2002).

    ii) American Psychological Association. (2013b). Specialty guidelines for forensic psychology. *American Psychologist, 68,* 7–19. doi:10.1037/ a0029889

    iii) Specialty Guidelines for Forensic Psychologists" (Committee on Ethical Guidelines for Forensic Psychologists, 1991), Section VII. A.2a.

    iv) American Psychological Association (2013). Guidelines for Psychological

Evaluations in Child Protection Matters. *American Psychologist, 68,* 20-31.

v) Standards for Educational and Psychological Testing (APA, 1985), Standard 6.5, Standard 6.6 and Standard 15.7.

vi) American Psychological Association. (2010b). Ethical principles and psychologists and code of conduct: Including 2010 ammendments. Retrieved from http://www.apa.org/ethics/code/index.aspx.

It is useful to bring to court a copy of the actual ordering information from the catalogs of the companies that distribute the MMPI-A/ MMPI-2. Purchasers are required to meet certain credentialing criteria. In addition, as part of the contract to purchase the test, it is required that the psychologist maintains test security and not in any way violates copyright regulations (Frumkin, 1995).

You or your attorney may present to the court relevant case law and statutes pertinent to the release of such data to the court (Frumkin, 1995)

6. If the judge, after hearing all testimony, orders the material to be released directly to the attorney, you can either release the data (which, in following a lawful court order, would not be in violation of the ethics code), appeal the decision to another court, or refrain from releasing the data and risk being held in contempt of court (Frumkin, 1995).

7. Pertinent paragraphs from the most current APA ethics code are listed below:

Standard 9.04a: Release of Test Data

The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data.* Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

Standard 9.11: Maintaining Test Security

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

Letter of Richard Campanelli, JD director, Office for Civil Rights, HHS:

"[A]ny requirement for disclosure of protected health information pursuant to the Privacy Rule is subject to section 1172(e) of HIPAA, 'Protection of Trade Secrets.' As such, we confirm that it would not be a violation of the Privacy Rule for a covered entity to refrain from providing access to an individual's protected health information, to the extent that doing so would result in a disclosure of trade secrets."

"...test instruments such as test question booklets and instruction forms are not, of themselves, protected health information, and therefore are not subject to an individual's right of access under the Privacy Rule. The right of access is limited to protected health information maintained in a designated record set..."

References

Committee on Legal Issues, American Psychological Association (1996). Strategies for private practitioners coping with subpoenas or compelled testimony for client records and/or test data, *Professional Psychology: Research and Practice, Vol 27* (3), 245-251. Washington: APA.

Frumkin, B. I. (1995). How to handle attorney request for psychological test data. In L. VandeCreek, S. Knapp, and T.L. Jackson (Eds.), *Innovations in Clinical Practice: A Source Book, Vol*(14). Sarasota, FL: Professional Resource Press.

See Pope et al., (2006) for guidelines for release of test information under HIPPA about here.

Scoring Guidelines

When using the MMPI-2 in court, it is extremely important that mistakes that could render the test inaccurate are not made in the scoring. The most reliable method of scoring the MMPI-2 is by computer rather than by manual scoring (Allard, Butler, Faust & Shea, 1995). Psychologists who choose to rely upon hand scored test results should assure accuracy by rescoring the test. Moreover, it is important not to be selective in scoring, that is by choosing only a few scales to score. The client may have responded to the items indicating problem areas that were not scored thus the assessment would be incomplete. If hand scoring of the test is used be aware that some research has suggested that this approach is not as accurate as computer scoring (see Allard, & Faust, 2000; Simmons, Goddard, & Patton, 2002).

Allard, G., Butler, J., Faust, D., & Shea, M. T. (1995). Errors in hand scoring objective personality tests: The case of the Personality Diagnostic Questionnaire-Revised (PDQ-R). *Professional Psychology, 26,* 304-308.

Simmons, R., Goddard, R. & Patton, W. (2002). Hand-scoring error rates in psychological testing. *Assessment, 9*, 292-300.

MMPI/MMPI-2 Translations

The following is a list of MMPI/MMPI-2 translations. Note that only the Hispanic translation of the MMPI/MMPI-2 is published and available for sale in the U.S. Requests for all other translations should be directed to the University of Minnesota Press at 1-800- 388-3863.

Arabic; Castilian (Spanish); Chilean (Spanish); Chinese; Croatian; Czech; Dutch; Ethiopian; Flemish; French; German; Greek; Hebrew; Hispanic (U.S.); Hmong; Icelandic; Indonesian; Japanese; Korean; Latvian; Mexican/Nicaraguan; Norwegian; Persian (Farsi); Rumanian; Russian; Thai; Turkish; Vietnamese

Validity Scale Interpretation Guidelines

The most crucial assessment consideration in psychological assessment of forensic cases is to determine the extent of cooperation the client has shown in responding to the items on the test. Did the individual respond to all the items? Were the items endorsed in a consistent manner? Where there any response sets evident in the pattern of item responding, for example, did he or she respond in an "all or mostly true" or "all or mostly false" manner? Did the client attempt to provide an extremely virtuous or glowing view of his or her personality adjustment that is not credible? Did the client attempt to appear more psychologically disturbed than they actually are or to influence the outcome of the evaluation? These, and other, response set approaches can be effectively evaluated by examination of the MMPI-2 validity scales. A number of sources can be consulted to obtain up-to-date information about assessing MMPI-2 protocol validity, see:

Butcher, J. N. (2011). *MMPI-2: A beginner's guide* (3rd Ed.). Washington, DC: The American Psychological Association.

Butcher, J. N., Hass, G. A., Greene, R. L. & Nelson, L. D. (2015). *Using the MMPI-2 in Forensic Assessment.* Washington, D.C.: American Psychological Association.

Pope, K. S., Butcher, J. N., & Seelen, J. (2006) (3rd Ed). *The MMPI/MMPI-2/MMPI-A in court: Assessment, testimony, and cross- examination.* Washington, DC: American Psychological Association.

Graham, J. R. (2012). *MMPI-2: Assessing personality and psychopathology (5th edition).* New York: Oxford University Press.

Greene, R. L. (2011). *MMPI-2/MMPI-2-RF: An Interpretive Manual, 3rd Edition.* Boston: Allyn & Bacon.

Nichols, D. S. (2011). Essentials of MMPI-2 assessment, 2nd Edition. New York, NY: John Wiley & Son.

Friedman, A. F., Bolinskey, P. K., Levak, R., & Nichols, D. S. (2015). *Psychological assessment with the MMPI-2/RF* (3rd ed.). New York: Routledge/Taylor & Francis.

Description of Clinical Scale Correlates

If the MMPI-2 validity scales are determine to be valid then the next step in interpretation of the MMPI-2 is to summarize the client's performance on the traditional MMPI-2 clinical scales.

The following is a brief description of the clinical scale correlates for Hypochondriasis (Scale 1),

Depression (Scale 2), Hysteria (Scale 3), Psychopathic Deviate (Scale 4), Masculinity-Femininity (Scale 5), Paranoia (Scale 6), Psychasthenia (Scale 7), Schizophrenia (Scale 8), Hypomania (Scale 9), and Social Introversion (Scale 0). The description for each scale includes the characteristics typical of high scorers (and in some cases those of moderate or low scorers). Not all correlates/descriptors will be applicable, but all should be considered when interpreting scale scores.

Scale 1 — Hypochondriasis

High Scorers: High scorers present excessive somatic symptoms that tend to be vague and undefined; for example, they may present epigastria complaints; fatigue, pain, weakness, and a lack of manifest anxiety. In addition, high scorers also show chronic personality features such as selfishness; self-centered and narcissistic behavior; and a pessimistic, defeatist, cynical outlook on life. They tend to be dissatisfied and unhappy and may make others miserable through their whining and complaining. They are often demanding and critical of others and may express hostility indirectly. They rarely act out. They show longstanding health concerns and function at a reduced level of efficiency without major incapacity. They tend not to be open to therapy since they seek only medical solutions to problems.

Scale 2 — Depression

High Scorers: High scorers on Scale 2 are described as being depressed, unhappy, and dysphoric; being pessimistic and self-deprecating; feeling guilty; feeling sluggish; having somatic complaints; feeling weak, fatigued, and lacking energy; acting agitated, tense, high-strung, and irritable; being prone to worry; lacking self-confidence; feeling useless and unable to function; feeling like a failure at school or on the job; being introverted, shy, retiring, timid, and reclusive; acting aloof; being psychologically distant; avoiding interpersonal involvement; being cautious and conventional; having difficulty making decisions; being nonaggressive; acting over controlled, denying impulses; and making concessions to avoid conflict. They tend to be motivated to seek therapy because of their distress.

Scale 3 — Hysteria

High Scorers: High scorers tend to react to stress and avoid responsibility through development of physical symptoms such as having headaches, chest pains, weakness, and tachycardia. Their symptoms often appear and disappear suddenly. These individuals tend to lack insight about causes of symptoms and their own motives and feelings. They tend to lack anxiety, tension, and depression and rarely report delusions, hallucinations, or suspiciousness. They are viewed as psychologically immature, childish, and infantile; self-centered, narcissistic, and egocentric; attention-seeking and needing great affection from others. They tend to use indirect and devious means to get attention and affection. They are usually socially involved, friendly, talkative, and enthusiastic but superficial and immature in interpersonal relationships. They might be initially enthusiastic about treatment and may respond well to direct advice or suggestion, but show slow progress in gaining insight into the causes of their own behavior. They tend to be resistant to psychological interpretations. High Hy scores have been found to be associated with chronic pain and with compensation claims.

Scale 4 — Psychopathic Deviate

High Scorers: High scorers are found to engage in antisocial behavior and are rebellious toward

authority figures. They show stormy family relationships and usually blame others for their problems. They show a history of underachievement in school and a poor work history and may have marital problems. They are considered to be impulsive, and they strive for immediate gratification of impulses. They do not plan well and act without considering the consequences of their actions. They show impatience, limited frustration tolerance, poor judgment, and high risk- taking. They do not appear to profit from experience. They are immature, childish, narcissistic, self-centered, and selfish. Their behavior is often described as ostentatious, exhibitionistic, and insensitive. They tend to be interested in others in terms of *how* they can be used. They are often thought to be likeable and usually create a good first impression but are shallow and superficial in relationships and unable to form warm attachments. They are described as extroverted, outgoing, talkative, active, energetic, spontaneous, intelligent, self-confident, hostile, aggressive, sarcastic, cynical, resentful, and rebellious. They tend to act out and have antagonistic behavior and aggressive outbursts. Some are assaultive and may show little guilt over negative behavior.

Scale 5 — Masculinity–Femininity

Males

High (T-score > 80): Men who attain high scores on this scale show conflict about sexual identity. They are insecure in their masculine role; are effeminate; have aesthetic and artistic interests; are intelligent and capable; value cognitive pursuits; are ambitious, competitive, and persevering; are clever, clear thinking, organized, and logical; and show good judgment and common sense. They are curious; creative, imaginative, and individualistic in their approach to problems; sociable; sensitive to others; tolerant; capable of expressing warm feelings toward others; and passive, dependent, submissive, and peace loving. They make concessions to avoid confrontations. They have good self-control and they rarely act out.

High Scorers (T-score 70–79): Males in this range on the Masculinity-Femininity scale may be viewed as sensitive, insightful, tolerant, effeminate, broad in cultural interests, submissive, and passive. (In clinical settings, the patient might show sex role confusion or heterosexual adjustment problems.)

Low Scorers (T-score < 35): Men who score low on this scale are often viewed as having a "macho" self-image. They present themselves as extremely masculine; strong and physically adept, aggressive, thrill-seeking, adventurous, and reckless; coarse, crude, and vulgar; and doubtful about their own masculinity. They have a narrow range of interests, an inflexible and unoriginal approach to problems, and seem to prefer action to thought.

Females

High Scorers (T-score > 70): Females who score high on this scale tend to reject traditional female roles and activities. They show masculine interests in work, sports, and hobbies. They are described as active, vigorous, and assertive; competitive, aggressive, and dominating; coarse, rough, and tough; outgoing, uninhibited, and self-confident; easy-going, relaxed, and balanced; logical and calculated; and unemotional and unfriendly.

Low Scorers (T-score < 35): These women describe themselves in terms of the stereotyped female role and show doubts about their own femininity. They tend to be passive, submissive, and yielding

in relationships. They defer to males in decision- making. They may show self-pity through complaining and/or faultfinding. They are seen as constricted, sensitive, modest, and idealistic.

Scale 6 — Paranoia

Extremely High Elevations (T-score > 80): High scorers may show frankly psychotic behavior, disturbed thinking, delusions of persecution and/or grandeur, and ideas of reference. They feel mistreated and picked on and angry and resentful. They harbor grudges, use projection as a defense, and are most frequently diagnosed as schizophrenic or paranoid.

Moderate Elevations (T-score = 65–79 for males; T-score = 71–79 for females): In this range, individuals show a paranoid predisposition. They are sensitive and overly responsive to reactions of others, they feel they are getting a raw deal from life, and they rationalize and blame others. These individuals are likely to be suspicious and guarded, hostile, resentful, and argumentative. They tend to be moralistic and rigid, and they over-emphasize rationality. They are poor therapy risks because they do not like to talk about emotional problems and have difficulty in establishing rapport with therapists.

Extremely Low Scorers (T-score < 35): In some settings, low paranoia scores (in the context of a defensive response set) may suggest potentially psychotic disorders such as delusions, suspiciousness, ideas of reference, and symptoms less obvious than high scorers. They are evasive, defensive, guarded, shy, secretive, and withdrawn. This interpretation should be made only with great caution.

Scale 7 — Psychasthenia

High Scorers: High scores on this scale suggest anxious, tense, and agitated behavior. High scorers show high discomfort and are worried and apprehensive, high strung and jumpy, and have difficulties in concentrating. They are overly ruminative, obsessive, and compulsive. They feel insecure and inferior; lack self-confidence; and are self-doubting, self-critical, self-conscious, and self-derogatory. They are rigid and moralistic; maintain high standards for self and others; are overly perfectionistic and conscientious; and are guilty and depressed. They are neat, orderly, organized, meticulous, persistent, and reliable. They lack ingenuity and originality in problem-solving, are dull and formal, are vacillating and indecisive, distort importance of problems, overreact, are shy, do not interact well socially, are hard to get to know and worry about popularity and acceptance. They are sensitive and have physical complaints, show some insight into problems, intellectualize and rationalize, are resistant to interpretations in therapy, express hostility toward therapist, remain in therapy longer than most patients, and make slow but steady progress in therapy.

Scale 8 — Schizophrenia

Very High Scorers (T-score > 79): Very high scores suggest blatantly psychotic behavior including confusion, disorganization, and disoriented behavior. Unusual thoughts or attitudes, delusions, hallucinations, and poor judgment are likely to be present.

High Scorers (T-score = 65–79): High scores on this scale suggest a schizoid lifestyle. They do not feel a part of a social environment. They report feeling isolated, alienated, and misunderstood. They feel unaccepted by peers, withdrawn, reclusive, secretive, and inaccessible. They avoid dealing with

people and new situations. They are shy, aloof, and uninvolved and experience generalized anxiety. They are often resentful, hostile, aggressive, and unable to express feelings. They tend to react to stress by withdrawing into fantasy and daydreams. They have difficulty separating reality and fantasy. They show great self-doubts and feel inferior, incompetent, and dissatisfied. They may show marked sexual pre-occupation and sex role confusion. They are often seen as nonconforming, unusual, unconventional, and eccentric. They may report vague, long- standing physical complaints. Others view them as stubborn, moody, opinionated, immature, and impulsive. They tend to lack information for problem solving and show a poor prognosis for therapy.

Scale 9 — Hypomania

***High Scorers (T-score > 80)*:** Very high scorers on this scale show over-activity and accelerated speech. They may have hallucinations or delusions of grandeur. They tend to be very energetic and talkative, prefer action to thought, show a wide range of interest, and do not utilize energy wisely. They do not see projects through to completion. They show little interest in routine or detail and become easily bored and restless. They have a low frustration tolerance and difficulty in inhibiting expression of impulses. They have episodes of irritability, hostility, and aggressive outbursts and are often seen as possessing unrealistic, unqualified optimism and grandiose aspirations. They tend to exaggerate self-worth and self-importance and are unable to see their own limitations. They are viewed as outgoing, sociable, and gregarious. They like to be around other people; create good first impressions; and are friendly, pleasant, and enthusiastic; however, their relationships are likely to be superficial. They tend to be manipulative, deceptive and unreliable. They may be agitated and may have periodic episodes of depression.

***Moderately elevated scorers (T = 65 – 79)*:** Moderate scorers show overactivity and an exaggerated sense of self-worth. They are energetic and talkative, prefer action to thought, and have a wide range of interests. They do not utilize energy wisely and do not see projects through to completion. They are enterprising and ingenious and lack interest in routine matters. They easily become bored and restless and have a low frustration tolerance. They are impulsive and have episodes of irritability, hostility, and aggressive outbursts. They are unrealistic and overly optimistic at times. They show some grandiose aspirations and are unable to see their own limitations. They are outgoing, sociable, and gregarious. They like to be around other people. They create good first impressions and are friendly, pleasant, enthusiastic, poised, and self-confident. They have superficial relationships and are manipulative, deceptive, and unreliable. They have feelings of dissatisfaction and agitation, and they view therapy as unnecessary. They are resistant to interpretations in therapy and attend therapy irregularly. They may terminate therapy prematurely and repeat problems in a stereotyped manner.

Scale 0 — Social Introversion

***High Scorers (T-score > 65)*:** High scorers on this scale are socially introverted people who are more comfortable alone or with a few close friends. They are reserved, shy, and retiring; serious; uncomfortable around members of the opposite sex; hard to get to know; sensitive to what others think; troubled by lack of involvement with other people; over controlled; not likely to display feelings openly; submissive and compliant; and overly accepting of authority. They have a slow personal tempo and they are reliable, dependable, cautious, and conventional and have unoriginal approaches to problems. They are rigid and inflexible in attitudes and opinions, and they have difficulty making even minor decisions.

***Low Scorers (T-score < 45)*:** Low scorers on this scale tend to be sociable and extroverted as well as outgoing, gregarious, friendly and talkative. These people have a strong need to be around other people; they mix well and are intelligent, expressive, verbally fluent, and active as well as energetic, vigorous, and interested in status, power and recognition. They seek out competitive situations, have problems with impulse control, and act without considering the consequences of actions. They are immature, self-indulgent and superficial, and have insincere relationships. They are manipulative and opportunistic and arouse resentment and hostility in others.

Description of the MMPI-2 Content Scales

The following is a brief description of the characteristics typical of high scorers for each of the MMPI-2 Content Scales. Consider the applicability of the characteristics described when interpreting the content scales.

Anxiety (ANX):

High scoring individuals on this scale report general symptoms of anxiety including tension, somatic problems, sleep difficulties, worries, and poor concentration. They fear losing their minds, find life to be a strain, and have difficulty making decisions. They appear to be readily aware of these symptoms and problems and are willing to admit to them.

Fears (FRS):

A high score on FRS suggests an individual with many specific fears. These specific fears can include blood; high places; money; animals such as snakes, mice, or spiders; leaving home; fire; storms and natural disasters; water; the dark; being indoors; and dirt.

Obsessiveness (OBS):

High scorers on OBS have great difficulties making decisions. They are likely to ruminate excessively about issues and problems, causing others to become impatient. They do not like to make changes, and they may report some compulsive behaviors like counting or saving unimportant things. They worry excessively and frequently become overwhelmed by their own thoughts.

Depression (DEP):

High scores on DEP indicate individuals with significant depressive thoughts. They report feeling blue, uncertain about their future, and uninterested in their lives. They are likely to brood, be unhappy, cry easily, and feel hopeless and empty. They may report thoughts of suicide or wishes that they were dead. They may believe that they are condemned or that they have committed unpardonable sins. Other people may not be viewed as a source of support.

Health Concerns (HEA):

Individuals with high scores on this scale show many physical symptoms across several body systems. Included are gastro-intestinal symptoms (e.g., constipation, nausea and vomiting, and stomach trouble), neurological problems (e.g., convulsions, dizziness and fainting spells, and paralysis), sensory problems, cardiovascular symptoms (e.g., heart or chest pains), skin problems,

pain, and respiratory troubles. They worry about their health and feel sicker than most people.

Bizarre Mentation (BIZ):

Psychotic thought processes characterize people who score high on the BIZ scale. They may report auditory, visual, or olfactory hallucinations and may recognize that their thoughts are strange and peculiar. Paranoid ideation (e.g., the belief that they are being plotted against or that someone is trying to poison them) may be reported as well. These individuals may feel that they have a special mission or powers.

Anger (ANG):

Individuals who score high on the ANG scale report problems in anger control. These individuals report being irritable, grouchy, impatient, hotheaded, annoyed, and stubborn. They sometimes feel like swearing or smashing things. They may lose control and report having been physically abusive towards people and objects.

Cynicism (CYN):

High scores on CYN are associated with misanthropic beliefs. These individuals expect hidden, negative motives behind the acts of others (e.g., believing that most people are honest simply for fear of being caught). They believe other people are to be distrusted, for people use each other and are only friendly for selfish reasons. They likely hold negative attitudes about those close to them, including fellow workers, family, and friends.

Antisocial Practices (ASP):

In addition to holding misanthropic attitudes like the high scorers on the CYN scale, individuals who score high on the ASP scale report problem behaviors during their school years and other antisocial practices such as being in trouble with the law, stealing, or shoplifting. They acknowledge sometimes enjoying the antics of criminals and believe that it is acceptable to get around the law, as long as it is not broken.

Type A (TPA):

People who score high on TPA report being hard-driving, fast-moving, and work- oriented individuals who frequently become impatient, irritable, and annoyed. They do not like to wait or to be interrupted. There is never enough time for them to complete their tasks. They are direct and may be overbearing in their relationships with others.

Low Self-Esteem (LSE):

High scores on LSE suggest that these individuals have low opinions of themselves. They do not feel important or liked by others. They hold many negative attitudes about themselves, including beliefs that they are unattractive, awkward and clumsy, useless, and a burden to others. They lack self-confidence and find it hard to accept compliments from others. They may be overwhelmed by all the faults they see in themselves.

Social Discomfort (SOD):

People who score high on SOD are very uneasy around others, preferring to be by themselves. In social situations, they are likely to sit alone rather than joining the group. They see themselves as shy and they dislike parties and other group events.

Family Problems (FAM):

Family discord is reflected in high scores on FAM. High scorers describe their families as loveless, quarrelsome, and unpleasant. They even may report hating family members. They portray their childhood as abusive, and marriages are seen as unhappy and lacking in affection.

Work Interference (WRK):

Those who score high on WRK report behaviors or attitudes likely to contribute to poor work performance. Some of the problems relate to low self-confidence, concentration difficulties, obsessiveness, tension and pressure, and decision-making problems. Others suggest lack of family support for their career choice, personal questioning of career choice, and negative attitudes towards co-workers.

Negative Treatment Indicators (TRT):

High scores on TRT indicate individuals who have negative attitudes toward doctors and mental health treatment. High scorers do not believe that anyone can understand or help them. They have issues or problems that they are not comfortable discussing with anyone. They may not want to change anything in their lives, nor do they feel that change is possible. They prefer giving up rather than facing a crisis or difficulty.

Description of the PSY-5 Scales

The Personality Psychopathology Five (PSY-5) Scales

Harkness, McNulty, Ben-Porath, and Graham (2002) described the Psychopathology Five (PSY-5) scales for the MMPI-2. The selection of the PSY-5 constructs was based on research to determine how lay people classified or discriminated personality characteristics or personality problems (Harkness, 1992). The items used in the initial analyses were derived from the selective diagnostic criteria from the DSM-III-R, from personality disorders as described by Cleckley (1982) as a means of describing severe personality disorders, psychopaths, and 26 clusters were developed from the primary factors of Tellegen's MPQ. These initial clusters contained items that were found to measure five distinct personality dimensions. These measures were then refined to be assessed by items on the MMPI-2in order to address the following characteristics as noted by Harkness et al.:

Aggressiveness (AGGR): This scale measures offensive and instrumental aggression and not reactive aggression. Individuals high on this scale tend to intimidate others and use aggression as a means of accomplishing their goals. PSY-5 high AGGR scorers show characteristics of dominance and hate.

Psychoticism (PSYC): This scale assesses mental disconnection from reality and focuses upon unusual sensory and perceptual experiences, delusional beliefs, and other odd behaviors. Alienation

and unrealistic expectation of harm is also characteristic of persons high on this scale. People with high PSYC scores tend to have a higher probability of experiencing delusions of reference, disorganized thinking, bizarre behavior, and disoriented, circumstantial, or tangential thought processes. Inpatients with high scores on PSYC have been found to be more likely to be diagnosed as being psychotic for example showing paranoid suspicious-ness, ideas of reference, loosening of associations, hallucination, or flight of ideas.

Disconstraint (DISC): Persons high on this scale show (a) higher levels of physical risk- taking, (b) have a style characterized more by impulsivity than control, and (c) are less bound by traditional moral constraints. High scorers tend to have difficulty "creating mental models of the future that contain negative emotional cues, that is, do not seem to learn from punishing experiences."

They tend to be high risk-takers and show an impulsive and less traditional life style. They tend to be easily bored with routine.

Negative Emotionality/Neuroticism (NEGE): This scale focuses on problematic features of processing incoming information, for example, to worry, to be self-critical, to feel guilty, and to develop worst-case scenarios are common features.

Introversion/Low Positive Emotionality (INTR): High scorers show little capacity to experience joy and positive engagement. They have low "hedonic capacity." They tend to be introverted and depressed.

Guidelines for Interpreting Addiction Potential Indicators

The MAC-R, APS, and AAS addiction scales can be used together to more effectively identify substance abusers from normal individuals than any of the scales alone. The APS operates in a manner similar to the MAC-R Scale in that it assesses lifestyle problems and characteristics associated with the development of habit disorders such as alcohol and drug use or abuse. Individuals endorsing the behaviors assessed by these scales show a strong tendency to develop negative habits even though they may not, at present, be alcoholics or drug abusers. A low score on the AAS takes on special meaning in the context of known alcohol or drug problems or when the individual has a very high score on the APS or the MAC-R. If substance abuse problems are likely and awareness or acknowledgment of the problems is low, the individual's motive in the assessment is questioned.

The following is a brief description of the interpretive potential for each of the three addiction scales.

MAC-R *(MacAndrew Alcoholism-(Revised Scale)* :

This measure is a 49-item scale developed with the original MMPI to distinguish alcoholic psychiatric patients from nonalcoholic psychiatric patients. A high MAC-R Scale score is associated with substance abuse potential and other addictive problems such as pathological gambling. A T score cutoff of 60 on the MAC-R Scale is suggestive of high addiction potential. The scale was constructed empirically, using methods similar to those employed in the construction of the APS discussed below.

APS (*Addiction Potential Scale)*:

The Addiction Potential Scale was developed as a measure of the personality characteristics and life situations associated with substance abuse. Research data for this purpose were obtained from three large samples collected as part of the MMPI Restandardization Project: the MMPI-2 normative sample, a sample of psychiatric inpatients, and a sample of inpatient residents of a substance-abuse treatment program. Every MMPI-2 item was examined for its potential to improve discrimination over the original MMPI items. A total of 39 items comprise the Addiction Potential Scale.

AAS *(Addiction Acknowledgment Scale)*:

The development of the AAS began with a rational search through the MMPI-2 item pool for items with content indicating substance-abuse problems. Fourteen such items were found. Items not contributing to internal consistency were dropped and replaced by two items that improved scale internal consistency. The Addiction Acknowledgment Scale is made up of 13 items. Research has shown that both the APS and the AAS discriminate well between substance abuse samples and samples of either psychiatric patients or normals. In addition they discriminate between samples considerably more effectively than MAC-R.

The AAS assesses the frank acknowledgment of alcohol or drug abuse problems. Individuals who obtain elevations on this scale are acknowledging problems with alcohol or drug use. A T-score of 60 or higher reflects an awareness of their substance use or abuse problems and their openness to discussing their problems. Low scores on the AAS can mean one of two things: either there is no substance abuse problem or the individual is denying such problems.

Cautions about Using Controversial MMPI-2

Measures For Forensic Evaluations

Lees-Haley Fake Bad Scale (FBS)

The Fake Bad Scale (FBS) (Lees-Haley, English & Glenn, 1991) was developed for use in personal injury litigation using items from MMPI-2. Although the measure is controversial, the FBS was included on the MMPI-2 Extended Score Report distributed by Pearson Assessments in January 2007 and was renamed as Symptom Validity Scale (FBS) in late 2007.

The FBS scale was not developed for general clinical use but was constructed by the authors to assess malingering in neurological assessment as defined using cases from Lees-Haley's forensic practice. The scale was developed by rational procedures and was not empirically validated as a validity measure. The FBS test manual (Ben-Porath, Graham & Tellegen, 2009) follows the interpretive recommendations provided by Greiffenstein, Fox & Lees-Haley (2007) that employ vague and conflicting cut-off scores.

In considering the "construct validity" of the FBS, psychologists should be aware of an earlier publication by Lees-Haley (Lees-Haley, P. R. (1988). Litigation Response Syndrome. *American Journal of Forensic Psychology*, 6(1), 3-12) that incorporated a large number of the items used in the construction of the FBS in 1991. This scale was considered to measure, an anxiety condition produced by the stress of associated by being involved in litigation.

The FBS is not recommended for use in forensic assessments because of its tendency to predict malingering when a client is presenting genuine health problems, that is, the scale has a high false positive rate among genuine clinical cases. The over-prediction of "malingering" results from the use of items that address genuine physical or stress-related symptoms (Butcher, Arbisi, Atlis, & McNulty, 2003; Butcher, Gass, Cumella, Kally, & Williams, 2008; Gass, Williams, Cumella, Butcher & Kally, 2010; Williams, Butcher, Gass, Cumella, Kally, 2009). (see also discussion by Friedman, Bolinskey, Levak & Nichols, 2015).

Although the test manual (Ben-Porath et al. 2009) concludes that the FBS is not biased against women the scale has been shown to have different endorsement patterns in men and women because some of the symptoms selected as items are more frequently endorsed by women. (See studies by Butcher, Arbisi, Atlis, & McNulty, 2003; Butcher, Gass, Cumella, Kally & Williams, 2008; Dean, Boone, Kim, Curiel, Martin, Victor, Zeller, & Lang, 2008; Nelson, Hoelzle, Sweet, Arbisi & Demakis, 2010; Nichols, Greene & Williams, 2009). These gender differences in endorsement patterns can result in bias against women especially when the same cut-off scores are used for both men and women.

The FBS scale has been excluded from testimony in several recent court decisions:

Court Opinions and Challenges to Use of FBS in Expert Testimony:

Cases in which FBS has been challenged resulting in Frye or Daubert Rulings to exclude the scale from testimony

John Sanford and John M. Sanford v. Hampton Resources, Inc. Case No. 10C19963. Circuit Court of the State of Oregon for the (2015) County of Marion.

Anderson, M. et al. v. E & S International Enterprises, Inc et al. Case #RG05-211076, California Superior Court for the County of Alameda (2008).

Thomas R. Bowes and Robin Tucker v Blake Hunter Landis and Ian Landis, Case # 562009CA006624, The Circuit Court Of The Nineteenth Judicial Circuit In Mtd For St. Lucie County, Florida (2011).

Brian and Denae McGann v State Farm Mutual Automobile Insurance. Circuit Court of the 9th Judicial District. Osceola, Florida, Case No: 2011-CA-783.

Davidson v. Strawberry Petroleum et al., Case #05-4320, Hillsborough County, Florida, (2007).

Limbaugh-Kirker & Kirker v Dicosta, Case 06-CA-00706, Florida 20th Circuit in and for Lee County, Florida, 2009.

Stith v State Farm Mutual, Case No. 50-2003 CA 010945AG, Beach County, Florida, 2008).

Vandergracht v. Progressive Express et al., Case #02-04552, (Hillsborough County, Florida, 2007).

Williams v. CSX Transportation, Inc., Case #04-CA-008892 (Hillsborough County, Florida, 2007).

The Fake Bad Scale also failed to survive evidentiary challenges in work compensation claims:

Davis v. Bellsouth Short Term Disability Plan for Non-Salaried Employees, 2012 U.S.Dist.LEXIS 33395 (M.D. N.C., March 12, 2012).

Thomas Amadio, Et Al. V. John Glenn, Et Al. Civil Action No. 09-4937 United States District Court For The Eastern District of Pennsylvania, ***February 1, 2011***

Cases in which the Court ruled against using the FBS at Trial:

JoAnn Rodriguez vs. Miller Coors, LLC Civil Action No: I OC VO09 19 RPMCBS. Colorado, In The United States District Court For The District Of Colorado (2012).

James Nason and Claudia Nason V Darrell Shafranski, Neil Shafranski and Marie Shafranski. In The Circuit Court of The Nineteenth Judicial Circuit In And For St. Lucie County, Florida, for, Indian River, Florida. Case No. 2006-0515-CA-10 (2008).

Cases in which attorney chose to take the FBS in front of the jury or judge and court ruled in favor of the plaintiff:

Rather than challenge FBS-based testimony through a Daubert or Frye hearing some attorneys have chosen to challenge the FBS during trial (See discussion by Hsieh, S., 2008a, April 7, Defense experts are using controversial 'malingering' test. Lawyers USA, pp. 1, 32).

Upchurch v School Board of Broward Co., OJCC #98-024122KSP, Florida Division of Administrative Hearings, Judges of Compensation Claims, Broward District, 2009 (Order and Adjudged 3/10/09) approving settlement.

Behrmann & Behrmann v. Liberty Mutual Insurance Company & RLI Insurance Company, Case #06-005057, Florida 13th Circuit, In and For Hillsborough County, 2009. Verdict for plaintiff.

Solomon & Solomon v T. K. Power & Goodwin, Case 06-CA-00388, Florida 4th Circuit, in and for Duval County, Florida, 2008. Case settled.

Several recent newspaper articles discussing problems in using the FBS in court cases have been published (See: Armstrong, 2007; Hsieh, 2008a, 2008b).

The Restructured Clinical Scales (the RC Scales)

The RC scales were developed by Tellegen, et al. (1993) in an effort to improve the discriminant

validity of the clinical scales by eliminating item overlap and removing a general factor referred to as "demoralization" from the scales. Although these measures are made available through MMPI-2 scoring systems they have not been widely researched in medical and personal injury settings—applications that are important in forensic evaluations. Moreover, some of the clinical scales (for example the Hy scale that is important to forensic assessment) have been extremely altered from the original scale and bear no relationship to the underlying test constructs. Nichols (2006) has referred to this problem as "construct drift." The restructured scale, RC3, measures cynicism rather than the original somatization and problem denial dimensions originally considered important by McKinley and Hathaway (1944), and Butcher, Hamilton, Rouse, and Cumella, 2006). (See also discussion of the RC scales in forensic assessment by Pope, Butcher, & Seelen, 2006).

Recent evaluations of the relationships of the RC scales with the traditional clinical scales and other MMPI-2 based measures have shown the RC scales to be more highly related to content and PSY-5 scales than to the original clinical scales from which they were derived. For example, Rouse, Greene, Butcher, Nichols, & Williams (2008), using 49 clinical samples from diverse settings (N=78,159) reported that over half of the RC scales show a stronger relationship with content-based measures and are essentially redundant measures of some existing scales, for example:

Highest Correlation Mean:

RC1 and HEA .90 RC2 and INTR .78 RC3 and CYN .91 RC4 and AAS .78 RC6 and PSYC .76 RC7 and A .88 RC8 and BIZ .89 RC9 and Ho .66 RCd and A .92

See Greene, Rouse et al., 2009; Rouse, Greene, et al., (2008) for more information on the RC scale interrelationships with MMPI-2 based measures.

Greene, R. L., Rouse, S. V., Butcher, J. N., Nichols, D. S., & Williams, C. L. (2009). The MMPI-2 Restructured Clinical (RC) Scales and Redundancy: Response to Tellegen, Ben-Porath, and Sellbom. *Journal of Personality Assessment, 91*(3)*,* 1- 5.

Rouse, S.V., Greene, R.L., Butcher, J.N., Nichols, D.S & Williams, C.L. (2008). What do the MMPI-2 Restructured Clinical Scales reliably measure? Journal *of Personality Assessment, 90,* 435-442.

Several investigators have criticized the RC scales as being insensitive to mental health problems. See reference list below.

Binford, A., & Liljequist, L. (2008). Behavioral correlates of selected MMPI-2 clinical, content, and restructured clinical scales. Journal *of Personality Assessment, 90:* 608-614.

Cumella, E., Kally Z. & Butcher J. N. (2009, March). *MMPI-2 Restructured Clinical Scales with Eating Disorder Patients.* Paper given at the at the Society for Personality Assessment, Chicago, March, 2009.

Gordon, R.M. (2006). False assumptions about psychopathology, hysteria and the MMPI- 2 restructured clinical scales. *Psychological Reports*, 98, 870–872.

Gordon, R.M. and Stoffey, R.W. and Perkins, B.L. (2013) Comparing the Sensitivity of the MMPI-2

Clinical Scales and the MMPI-RC Scales to Clients Rated as Psychotic, Borderline or Neurotic on the Psychodiagnostic Chart, *Psychology: Special issue on Criminal Investigative Psychology, 4, 9A, 12-16.*

Gucker, D. K, Kreuch, T, Butcher, J.N.(2009). *Insensitivity of the MMPI-2 Restructured Clinical Scales in personnel assessment.* Paper given at the at the Society for Personality Assessment, Chicago, March, 2009.

McCullaugh, J. M., Pizitz, T. D., Stolberg, R. & Kropp, J. (2009, March). A comparison study between the MMPI-2-RF profiles of convicted stalkers. Society for Personality Assessment, Chicago, IL.

Wallace, A., & Liljequist L. 2005. A comparison of the correlational structures and elevation patterns of the MMPI-2 Restructured Clinical (RC) and Clinical Scales. *Assessment, 12,* 290-294.

Given the lack of substantiating research in forensic and medical applications the RC scales are not recommended for use in forensic evaluations.

MMPI-2-RF

Although the name suggests that this instrument contains scales that assess the constructs from the original MMPI, the scales included in this abbreviated form do not include the measures that were developed for the MMPI and retained in the MMPI-2. The new MMPI-2-RF is a 338-item instrument that uses as its core measures the Restructured Clinical (RC) Scales. The norms used for these measures are the 1989 MMPI-2 norms collected by Butcher, Dahlstrom & Graham in the MMPI revision project (see Butcher, Dahlstrom et al., 1989).

As noted above, the core measures in MMPI-2- RF, the Restructured Clinical scales, do not capture the constructs measured by the traditional clinical scales but are essentially redundant measures of several content scales and PSY-5 scales. In addition, there are several other content-based scales included in MMPI-2-RF (*e.g*. a 4 item scale of Self- Doubt and a 5 item Hopelessness Scale). However, little empirical research is available to address the validity and reliability of these new measures. Some research shows that many of these scales show low statistical reliability (Butcher, 2011; Tellegen & Ben- Porath, 2008; van der Heijden, Egger & Derksen, 2010) that would limit the confidence in their use in forensic evaluations. Moreover, the MMPI-2-RF developers included a brief version of the Fake Bad Scale referred to as Symptom Validity Scale (FBS-r) as a validity scale. Given the high false positive rate and potential for bias in the FBS (Butcher, Gass, et al. 2008) this measure is likely to result in a situation in which a high number of people with genuine medical problems or women would be characterized as malingering (Williams, Butcher et al., 2009).

A number of the new scales, as acknowledged by Tellegen and Ben-Porath (2008), show very low reliability coefficients for personality measures perhaps, in part, because of their scale length (e.g., 4-6 items). For example, the reliability coefficient for the Helplessness or HLP scale (5 items) was only .39 for men and .50 for women in the normative sample; the Behavior-Restricting Fears or BRF scale (9 items) had reliability coefficients of only .44 for men and .49 for women and scale Suicidal/Death Ideation or SUI (5 items) had correlations of only .41 for men .34 for women (Tellegen & Ben-Porath, 2008).

The MMPI-2-RF uses non-gendered T scores rather than the gender specific norms in the original MMPI and MMPI-2. The gender differences that have been reported for some scales such as D (Hathaway & McKinley, 1942) and the FBS-r could result in biased assessments given that men and women respond differently to a number of items (Butcher & Williams, 2009).

The developers of MMPI-2-RF deleted 229 items from MMPI-2 to provide an abbreviated test. Many of the items that were dropped to shorten the assessment actually address important problem areas in forensic assessment. Butcher (2011) provided an analysis of the content that was deleted from the MMPI-2 to develop MMPI-2-RF, for example, the following content categories pertinent to forensic evaluations have not been included in MMPI-2-RF: 21 items dealing with anti social attitudes 15 items assessing family problems; 21 items dealing with work functioning 11 items dealing with negative life events.

Carlton Gass (2009), pointed out:

> "The elimination of over 200 MMPI-2 items that are "working items" has additional implications for information loss and its potentially adverse impact on clinical use of the MMPI- 2 . . . It is clear, however, that if clinicians abandon the original Clinical Scales and body of code-type information, they will sacrifice the most impressive body of empirically based interpretive material ever amassed in the history of personality assessment." (p. 442).

Gass, C. S. (2009). Use of the MMPI-2 in Neuropsychological Evaluations. J. N. Butcher (Ed). *Oxford Handbook of Personality Assessment,* 432-456. New York: Oxford University Press.

Five recent MMPI-2 textbooks have pointed out serious problems with the use of the MMPI-2-RF in forensic evaluations:

Butcher, J. N. (2011). *A beginner's guide to the MMPI-2* (Third Edition). Washington, DC: The American Psychological Association.

> A person being introduced to the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) for the first time may be confused by two MMPI-2- labeled products available for use: the MMPI-2 and the MMPI-2- Restructured Form (MMPI-2-RF). These are very different assessment instruments with different scales and highly different research backgrounds. The MMPI-2–RF is made up of a subset of 338 items from the MMPI-2 item pool and relies on a number of new scales that have been the subject of considerable controversy when they first appeared as supplemental measures on MMPI-2. In this chapter, I describe the development of the MMPI-2-RF and then explain why I do not recommend using the instrument (p. 175).

Graham, J. R. (2012). *MMPI-2: Assessing personality and psychopathology (5th edition)*. New York: Oxford University Press.

> In settings where the goal of assessment is a comprehensive understanding of test takers, this author would choose the MMPI-2 because it is his opinion that interpretations based on the MMPI-2 can yield a more in-depth analysis of personality and psychopathology. In forensic settings, the acceptance of a relatively new assessment instrument is predicated on

accumulated research supporting the use of the instrument and the extent to which the instrument is accepted by the professional community as a whole. Consequently, the professional who uses the MMPI-2-RF in forensic settings should be prepared to address challenges based on the instrument's novelty. (p. 414-415)

Greene, R. L. (2011). *MMPI-2/MMPI-2-RF: An Interpretive Manual, 3rd Edition.* Boston: Allyn & Bacon.

The MMPI-2-RF has a number of disadvantages to the MMPI-2. First, the absence of the MMPI-2 clinical scales from the MMPI-2-RF makes it impossible to utilize code type interpretation that has been the core of the MMPI/MMPI-2 interpretation for over 50 years. Second, none of the MMPI-2 content and supplementary scales can be scored on the MMPI-2-RF, and so all of this research and clinical usage also is lost. Third, the "MMPI-2" in the MMPI-2-RF is a misnomer because the only relationship to the MMPI-2 is its use of a subset of the MMPI-2 item pool, its normative group, and similar validity scales. The MMPI-2-RF should *not* be conceptualized as a revised or restructured form of the MMPI-2, but as a *new* self-report inventory that chose to select its items from the MMPI-2 item pool and to use its normative group. As a new self-report inventory, it makes little sense to have used items that are over 70 years old (Humm & Wadsworth, 1935; Hathaway & McKinley, 1940) and a normative group (Butcher et al., 1989) that is over 20 years old. This statement is not meant to impugn the psychometric integrity of the MMPI-2-RF, which appears to be quite acceptable based on the information provided in the *MMPI-2-RF Technical Manual* (Tellegen & Ben-Porath, 2008), only that it has minimal relationship to the extant MMPI-2. Clinicians who choose to use the MMPI-2-RF should realize that they have forsaken the MMPI-2 and its 70 years of clinical and research history, and they are learning a new self-report inventory (p. 22).

Nichols, D. S. (2011). Essentials of MMPI-2 assessment, 2nd Edition. New York, NY: John Wiley & Son.

Several problems and criticisms have emerged following the release of the

MMPI-2-RF . . .

1. The justification and adequacy of the theory recruited for the approach taken to construct the central scales of the RF form, the RC scales (Ranson et al., 2009)

2. The limited sensitivity of the scales on the new form for the assessment of clinical problems (Binford & Liljequist, 2008; McCullaugh et al., 2009; Megargee, 2006; Rogers et al., 2006; Sellbom et al., 2006; Wallace & Liljequist, 2005), as described in the previous section

3. Low internal consistency reliabilities for some of the RF scales (Butcher, 2011)

4. The absence of or confusing and/or misleading empirical correlates for many of the RC

scales (Butcher, 2011; Greene, 2011a), raising questions about their construct validity

5. Combining the norms of men and women by the adoption of nongendered norms, thereby affecting scales' sensitivity to some clinical problems, e.g., depression (Hathaway & McKinley, 1942/2000), and contributing to gender bias (Dean, et al., 2008; Nichols, Greene, & Williams, 2009).

6. The loss of information from the deleted items, particularly in areas that may be related to work adjustment, family problems, antisocial attitudes, mood, and interests—topics that may be important in employment screening, child custody, and forensic evaluations .

Friedman, A. F., Bolinskey, P. K., Levak, R., & Nichols, D. S. (2015). *Psychological assessment with the MMPI-2/RF* (3rd ed.). New York: Routledge/Taylor & Francis.

Friedman, Bolinsky, Levak, and Nichols (2015) in the 3rd edition of their textbook point out:"Despite the MMPI-2 designation for both the standard MMPI-2 and MMPI-2-RF versions, the RF form should be considered to be an essentially new instrument, as distinct from a mere revision or updating of the MMPI-2, as was the case in its transition from the original MMPI. To be sure, the RF does have its roots in the MMPI-2 item pool, the 1989 norms gathered for the MMPI-2, similar (and in at least one case probably improved, see Fp-r) validity scales, and revisions of the MMPI-2 PSY-5 scales. However, the substitution of a theory-driven for an empirically-driven methodology in the construction of the RF's central set of scales, the RC scales, marks a significant departure from MMPI/MMPI-2 tradition and, in turn, a significant obstacle in applying to the RF form the vast research literature for the MMPI/MMPI-2 that has accumulated over the past 70 years. In short, the MMPI-2-RF is a new and, to this point, largely untested psychometric instrument, with its strengths and weaknesses, and the patterns thereof, to be clarified in research efforts that the future must await"

For a discussion of the potential problems with the MMPI-2-RF see:

Butcher, J.N. & Williams, C.L. (2009). Personality Assessment with the MMPI-2: Historical Roots, International Adaptations, and Current Challenges. *Applies Psychology, Health and Well-Being, 1*(1)*,* 105-135.

Nichols, D. S. (2011). Essentials of MMPI-2 assessment, (2nd Ed.). New York, NY: John Wiley & Son.

Ranson, M., Nichols, D. S., Rouse, S.V., Harrington , J. (2009). Changing or Replacing an Established Personality Assessment Standard: Issues, Goals, and Problems, with Special Reference to Recent Developments in the MMPI-2. In J. N. Butcher (Ed). *Oxford handbook of Personality Assessment* (pp. 112-139). New York: Oxford University Press.

Non-K Corrected Profiles

Meehl and Hathaway (1946) developed the K scale as a means of assessing test defensiveness that

was not detected by other scales such as the L scale. In addition, the authors developed a procedure by which defensive clients might be more adequately assessed by "correcting" for their defensiveness. That is, a percentage of the K score was added to several MMPI scales (Hs, Pd, Pa, Pt, and Sc) in order to correct for this tendency to underreport symptoms. Research has shown that while K operates well as a measure of test defensiveness it does not work well as a correction factor to improve discrimination (Weed, 1993). Thus, K corrected scores do not significantly improve interpretations, however, they do not appear to make decisions worse.

Why then do we not simply eliminate the K correction and interpret non-K profiles that are available? The main problem with interpreting non-K corrected scores in forensic settings is that virtually all of the empirical research studies supporting the clinical scales were K corrected. Butcher and Tellegen (1978) and Butcher, Graham, & Ben-Porath (1995) pointed out the problems with K and non-K scores and recommended that researchers include non-K scores in their empirical research in order to develop a research basis for these variables. Research, to date, has not been forthcoming to the point to support forensic evaluations. Thus, even though they do not substantially improved clinical discriminations the K scores are still the strongest measures to use in court cases because the empirical research supports them.

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