

THE USE OF THE MMPI IN TEACHING PERSONALITY ASSESSMENT¹

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Before beginning to talk about the use of the MMPI in teaching personality assessment, I want to say a few words about the context in which this paper was written. I am a clinical psychologist, and I work in a prison. Furthermore, in the eyes of many of my colleagues, I am an MMPI fanatic. That is, I use the test, regularly, and have done so for many years; and over the years I have come to believe that this antiquated personality test is the best instrument available for introducing students to the art, and science, of personality appraisal.

The MMPI is a curious test. It is an old test, having been put together more than 35 years ago. For a personality inventory, it is perhaps unique in having so little to say about personality traits per se. In fact, it was originally called the "Medical and Psychiatric Inventory", and it was designed to assist in the classification of medical and psychiatric patients to the Kraepelinian psychiatric nosological system in vogue at that time. Its validity rests, however, not on that diagnostic system, or on theoretical constructs, or on personality theory, but on the accumulation of empirical correlates of scales score elevations. That is, because this test has been in wide-spread use for a long time, a certain amount of actuarial data has been accumulated regarding the probability of occurrence of particular kinds of behavior among groups with particular kinds of profiles, prognosis for response to different types of treatment, relative frequency of suicidal attempts, and so on – problems which are of some interest to psychologists working with particularly disturbed populations.

The MMPI is a long test. "At 566 items, it is perhaps the longest inventory on the market" (Gynther, 1972). It is very psychopathology oriented; it does not provide a well-balanced coverage of the entire domain of personality. Nevertheless, it does cover quite a wide territory. It provides a measure of the extent to which the individual differs from the average in three significant affects (anxiety, depression, and anger), in concern about mental and physical health, and in distrust of others. It provides one of the better measures of ego strength. It provides a measure of the extent to which the individual exerts intellectual control over his impulses, whether he is over-controlled or under-controlled with respect to impulse expression. It provides good measures of dominance and dependency. It provides information about the individual's relationship with his family, whether he feels that he is being hard done by, whether he is rebellious against authority, whether he is shy or outgoing, whether his affective relationships with others are impaired, whether he is isolated and aloof, whether there are any significant sexual problems or concerns which he may wish to express, the "masculinity" or "femininity" of his vocational interests, the nature and extent of any concerns which he may have about his health, the extent of his self-confidence and whether the front which he presents is real or, perhaps, bravado, whether his upbringing was fairly strict or lacking in discipline, whether he experiences feelings of guilt when he behaves aggressively toward others, and whether his

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orientation is pro-social or anti-social.

In fact, you can't ask a person that many questions about himself with getting to know him a little better, and my experience has been that, even in prison, most people will give you relatively straight answers to relatively straight questions. They may exaggerate a bit here-and-there, but they usually give a fairly accurate picture of where-they-are-at at the time they do the test. This is not to say that the picture which a person presents of himself in responding to the MMPI is not highly susceptible to distortion should he care to do so, but most people don't; and furthermore, the questionnaire does contain a variety of validity scales which can provide the clinician with indications of response tendencies which may have influenced the individual's self-description, notably unconscious defensiveness and a tendency to give deviant responses, so that you can usually tell whether or not to accept what he says about himself at face value, or whether to accept what he says about himself with a grain of salt, or the whole bag. Which brings me to the main point of this paper, which is that the use of any so-called objective personality questionnaire does not give you license to turn your head off:

Rodgers (1972) has observed that: "A well-publicized strength of the MMPI is its empirical derivation and forming. This empiricism tempts the uninformed professional to assume that sophistication and interpretive skills are less important for this test than for other commonly used tests. Such unfortunately is not the case. The MMPI is a very complex psychometric instrument ... and can be a greater hazard in the hands of a naive interpreter than are tests which make no claim to prima facie validity and are not so seductively normed by quantified scores in a T score distribution" (p.244). The hazard involved is the same one which tempts people to think that empty gasoline drums are less dangerous than full gasoline drums. Because the test is referred to as "objective," there is a tendency to believe that less interpretive skill is required than is the case with other types of data.

Recently, I had a colleague tell me that he rarely uses the MMPI because what it tells him about his patients rarely agrees with his interview-based clinical impression. In fact, however, the MMPI will never tell you anything about a person. It doesn't stand up and yell, "This is schizophrenic". You may tell yourself some things about a person who has answered the questionnaire, but whether or not you will be right depends on whether or not you stop to think about what you are doing. Let's just run through that process briefly to see how it goes, and I hope to show you how such a process can be useful in teaching personality assessment.

There is a theory extant that psychologists are trained in science. Now, there is some controversy about just what "science" means, with the controversy centering around the extent to which experimental method must be invoked in the investigation of empirical events. But whatever this science which we are so quick to espouse involves, at the very least, it has to refer to the observation of events and attempts to explain them. And yet we typically fall down on both counts. First, few clinicians are competent observers, certainly not in the same league with

Kraepelin. More of that later. Second, we don't do so well on interpretation either; and in this regard I would like to quote from Sheldon Korchin's recent text "Modern Clinical Psychology". Korchin (1976) cites the famous case of Theodore Reik (1948):

"One session at this time took the following course. After a few sentences about the uneventful day, the patient fell into a long silence. She assured me that nothing was in her thoughts. Silence from me. After many minutes she complained about a toothache. She told me that she had been to the dentist yesterday. He had given her an injection and then had pulled a wisdom tooth. The spot was hurting again. New and longer silence. She pointed to my bookcase in the corner and said, 'There's a book standing on its head.' Without the slightest hesitation and in a reproachful voice I said, 'But why did you not tell me that you had had an abortion?' (p.263). His inference was correct." (p.261) In the same vein, a study by Margaret T. Singer illustrates what an astute clinician can do with Rorschach protocols in clinical research. "The ... case concerned the differentiation of ulcer patients from those with ulcerative colitis, two medical conditions for which psychodynamic correlates have been proposed. An earlier research study had reported that of the many individual Rorschach scores only the total number of responses reliably distinguished the two groups (Krasner and Kornreich, 1954). In the face of these negative findings, Singer did a blind sorting of the same protocols, on the basis of her extensive experience both with psychosomatic patients and with the Rorschach. She predicted correctly in fifty out of fifty-four cases." (Korchin, p.261). This degree of accuracy doesn't follow specifically from the choice of the Rorschach, but from the application of Singer's clinical acumen. The same type of accuracy should be expected of clinicians using the MMPI as their data base.

Quoting again from Korchin (1976), "The essential task facing the clinician is the synthesis of diverse and sometimes fragmentary bits of information into a coherent picture of the individual. Toward this end, interpretation is needed to fit the given facts together into a meaningful and useful conceptual scheme that can account for the patient's thoughts, feelings, and actions. In the multiprocedure, multilevel model of clinical assessment, the available 'raw data' include the clinician's first-hand observations, impressions, and empathic reactions, the reactions of others as viewed by the patient and/or reported to the clinician, the patient's self-description in interviews and tests, his performance in test situations, both in terms of idiosyncratic responses and scores or profiles which allow comparison with others. With all this before him, the clinician must develop hypotheses which encompass and make sense of as much of the information as possible." (p. 261, 2). The same type of interpretive magic as that illustrated by Reik and by Singer is available to all experienced clinicians who will take the time to think about what they are doing, and I have seen many cases of MMPI interpretation similar to the above. However, interpretation is not the purpose of this paper. My main interest has been in that part of the assessment which is concerned with the observation of the empirical events that serve as the basis for the psychologist's interpretive endeavours, and in the development of a computer program which will facilitate a detailed analysis of MMPI responses. Copies of the

listing of that program are available for any of you who may be interested in it.

No matter how “objective” a personality test may be, all it is is a more-or-less standardized stimulus situation to which a subject has to respond. In so responding, he may tell you something about himself directly, and you are at liberty to make other inferences about him as well. If he chooses to provide you with a self-description – that is, if he doesn’t chew up the questionnaire or answer sheet, or doesn’t tell you to stuff it in your ear – his self-description may be compared with the self-descriptions of patients with a wide variety of diagnoses: neurotics, psychotics, and character disorders. But first, you have to do your scientific thing.

The MMPI is ultimately valid, as an indicator of something, and your problem is to decide just what it is a valid indicator of. Assuming that your tests are being machine-scored, the scored (and perhaps analyzed) test which you get back from the computer is probably a reasonably valid indicator of what was put into the computer, if they didn’t get the names mixed up, or something like that. What was submitted to the computer is probably a reasonably valid indicator of what was marked on the answer sheet, if there weren’t too many key-punching errors. And what was marked on the answer sheet is probably fairly close to what the subject intended to mark, if he didn’t get the instructions mixed up, or lose his place, or answer randomly, and assuming always that he can read well enough to make his responses meaningful.

But let us assume for the moment that what you get back from the computer is some representation of the subject’s self-description. That self-description is probably best thought of as “what the subject wanted to tell us that he is like”. Now, that does not imply either that he knows what he is like, or that he is able to tell anybody what he does know about himself, or even that he would want you to believe what he does tell you about himself. So you never take anything at face value unless you have some reason to feel that it is fairly safe to do so.

So first you check the validity scores. Scale F is a measure of the extent to which the subject has given responses which are infrequently given by the normal population. Scores of 26 and above are likely to have resulted from marking the responses at random. Scores of 21 are likely to reflect indiscriminant responding to say the least. And anything above 17 has to be taken with a grain of salt. Scale K is a measure of how well defended the individual is. Scores of 10-15 are about average. Anything above that is well-defended and anything below that is poorly-defended, with respect to the admission of psychological problems. If validity scale scores are within reasonable limits, the person’s self-description is probably fairly accurate. In any event, you are probably fairly safe in reporting on his self-description. That is, “just give me the facts, ma’am” and we can perhaps begin to speculate about what they mean afterwards. (I believe that it is very important to teach would-be clinicians to distinguish between facts and opinions, which is what any interpretation of those facts is. Even facts exist only with some degree of probability, but opinions are acknowledged to be not even of the same order of probability. They are much less likely to be correct and should be stated as

opinions rather than facts).

Let us begin, therefore, by an examination of the facts. One of the most fruitful places to start making sense of what a subject has said about himself is to see what it was that he said about himself that made his responses similar to or different from the responses given by the patients on whom the original clinical scales were derived, partly because in doing so you will gain an insight into the characteristics of patients with these different diagnostic labels.

Content analysis of the Hypochondriasis Scale won't tell you very much about hypochondriasis except that it has something to do with physical health. Actually, hypochondriasis is characterized by a lack of emotional investment in the outside world and a focusing of attention on internal, bodily sensations, often with resultant anxiety. Hypochondriacs tend to be conflicted regarding dependency - they both seek and resent dependent relationships - but you won't find out about that from an examination of the items in the scale, which involve health concerns only, not because hypochondriacs don't endorse other kinds of items with sufficient frequency for their inclusion in the scale but, rather, because other kinds of items were arbitrarily eliminated in the final stage of the construction of this scale for the sake of having a scale which was composed of purely somatic items, although the original Hypochondriasis label was retained.

Examination of the content of the items which go to make up most of the other clinical scales, on the other hand, provides a valuable insight into the diagnostic groups from which they were empirically derived. The Depression Scale, for example, contains a number of items which are related to the denial of aggressive impulses - an idea with considerable theoretical support and of considerable theoretical implication - in addition to the mood-related items which one would expect to find in such a scale. The Hysteria Scale contains a group of items related to sociability, trust, and friendliness, and reflecting the well-known repressiveness of the hysterical population from which the scale was derived. The Psychopathic Deviate Scale was not derived from the responses of Psychopaths in the traditional Clecklian (1964) sense, as the name would seem to imply, but from a group of "small p" psychopaths, young criminals with a long history of minor delinquencies, whose behavior appeared poorly motivated and poorly concealed. Gilberstadt and Duker (1965) found that their high Pd Scale patients more closely fit the description of personality trait disturbance, aggressive type, and were characterized by irresponsibility, immaturity, impulsiveness, emotional instability, alcoholism, and low frustration tolerance resulting in assaultiveness. "They showed evidence of underlying insecurity, guilt, and self-depreciatory attitudes" (p.59). And this is not surprising when you consider that the bulk of the scale is made up of items which are related to family discord, feelings of being hard done by, rebelliousness, depression and guilt.

Scale 6, Paranoia, was derived from responses of patients judged to have paranoid symptoms. These individuals tend to be lacking in basic trust in themselves and others (frequently due to perceived rejection by parents), chronically angry at having been mistreated and the expectation that they are

going to be mistreated again, and hypervigilant for censure. Slight elevations on this scale (T-scores within the 60-70 range) suggest interpersonal sensitivity and some personality rigidity. Such individuals are likely to be somewhat disillusioned with others and a bit self-righteous. As elevations on this scale increase above 70, however, it is noted that these individuals tend to become more touchy, stubborn, and difficult. They tend to be suspicious of the motives of others and may misinterpret the words and actions of others to support their attitude towards them. They are prone to brooding, harbouring grudges, and feeling that in some way they are not getting what is due to them. They often project their own negative feelings onto others and then rationalize their resistance or rebellion against them by claiming that they are only responding to other people's attitudes toward them. They are prone to keep themselves aloof, which reflects their fear of vulnerability, dependency, etc. Basic issues of distrust of self and others, fear of underlying dependency needs, and need for control in relationships (generated by relationships with cruel, sadistic, or rejecting parents) all need to be attended to in dealing with these individuals.

As the elevation on any scale increases, so does the likelihood that the individual has endorsed the overtly pathological items in the scale. Individuals rarely obtain a score of 80 or more on the Paranoia scale without endorsing overtly persecutory paranoid items. Persecutory paranoid reactions imply regression to both neurotic and psychotic levels, in which relationships with others are used as a forum in which to act out primitive sado-masochistic fantasies. The repression which normally serves as the paranoid individual's main defense against awareness of unacceptable impulses is impaired as he regresses to less mature levels of organization under stress. Rather than accepting in himself the strong, primitive impulses which have been stimulated in him and incorporated as a part of his own personality through identification with rejecting parent figures, and which might well threaten his personality integration if admitted to consciousness, he defends himself through denial and through projection of these traits onto selected others ("selected" others perhaps because his hypervigilance prevents him from admitting that he feels everybody is out to get him, but more likely because his denial of his own unacceptability prevents him from seeing the whole world as allied against him, since the scale, in addition to a large number of items of a paranoid nature, such as "Someone has it in for me," "I believe I am being plotted against," and "At times I hear so well it bothers me," contains a considerable number of items which would characterize as reflecting an expectation that people behave morally. Thus an individual may be situationally paranoid as, for example, when he has just been admitted to prison and says that everybody is conspiring against him, or he may be more characterologically paranoid as when he allows that people are basically O.K. but it is just that that son-of-a-bitch is out to get him).

Psychasthenia is a category which, since this test was developed, has been dropped from the American Psychiatric Association diagnostic manual. Nevertheless, the scale retains some usefulness as a general measure of anxiety and ruminative self-doubt. It is mainly of interest in relation to the elevation on Scale 8, Schizophrenia.

Recall that the Schizophrenia scale was derived from the responses of groups of schizophrenic patients, whatever that means, and what it means in this case is that the diagnostic construct is defined by the items on the Schizophrenia scale in addition to any other kinds of criteria which may have been used to establish the diagnosis. Thus, "schizophrenicness" is a function of the items which make up the Sc scale: sensory and motor disturbances, social isolation, feelings of being hard done by, alienation from family, sadness and apathy, sexual problems, feelings of guilt, and problems in controlling thinking, emotions, and behaviour.

And finally, the Hypomania scale, composed of items related to sociability and ease, denial of inferiority, accelerated thinking, the use of excitement as a defense against depression, family discord, feelings of being hard done by, egocentrism, psychophysiological disturbance, restlessness, and emotionality. I tend to think of these characteristics as developing in opposition to the feelings of self-depreciation, and apathy, and sadness, and the inhibition of aggressive impulses, identified by the Depression scale, often within the context of a parental environment which provides conditional acceptance for the achievements required to meet the parents' own needs for esteem.

Now, I have referred to these Basic Clinical Scales by name as well as numbers, partly because doing so has given me an opportunity to show how you can use these diagnostically-labelled scales to begin to explicate the diagnostic "entities" which underlie them, and partly because I want to say a few words about the idea of diagnostic entities itself.

Neophyte clinicians have a tendency to reify, if not deify, diagnostic constructs. They need to be specifically taught that the main purpose of psychological assessment is understanding, not classification (and this is particularly true within the prison system). Diagnoses are constructs, not entities. And individuals with the same diagnosis may be less similar in many ways than individuals with different diagnoses. In fact, that is one more advantage to the use of the MMPI in teaching personality assessment. These clinical scales are most frequently elevated in combination, mainly because the underlying diagnostic groups are not entirely dissimilar from each other. Marks and Seeman (1963), for example, found that about 70% of their psychiatric patients were depressed and anxious; and in fact, we find depression and anxiety items in most of these scales. So it is unlikely that one scale will be elevated and the others within normal limits. If that does happen, you are away to the races. But even if several scales are elevated, there is no need to despair, for two reasons. First, the frequent occurrence of clinical scale elevations in combination and the marvelous array of patterns which typically emerge serves as a reminder that the diagnostic labels associated with these basic clinical scales may capture something important about the psychology of the individual who obtains a high score on one of these scales, but they don't begin to do justice to the complexity of personality. And second, the well-known empirical correlates of the various scale score elevations, singly or in combination, may provide an excellent basis for the beginning of a description of the individual in question but they can't compare to the understanding which is

available to the clinician who will take the time to examine in detail just what the individual has actually indicated about himself.

For example, the modal description of the 4-9 personality might be somewhat as follows: "Individuals with high scores on both Scales 4 and 9 are generally extroverted rather than introverted. They tend to respond to obvious events in the world around them; they are not introspective by nature and do not appreciate this characteristic in others. Their reactions to people tend to be influenced by their feelings of the moment rather than by any studied or careful analysis either of their own emotions or those of others. They like to have lively and stimulating people around them. They readily accept praise and seek out people who give it, but when others impose standards of performance or criticize their behaviour, they are likely to reject them and may even turn against them. In many ways they seem immature, both intellectually and emotionally. They need immediate gratification and do not enjoy the delay of working toward long-term goals. They usually seek to influence others by their own efforts and personal charm rather than by logical arguments. In turn, they are more readily influenced by superficial appearance and short-term gain than by remote consequences. Heavy drinking and marital discord are the rule. Among adolescents, the 4-9 pattern is associated with both sexual and aggressive delinquencies and with prolific drug use."

The appropriateness of this description for a given individual, however, is bound to depend upon at least three factors: (1) the absolute and relative elevations of each of these two highest scales, (2) the items which he has endorsed, in each of these scales and others, in order to obtain this type of profile, and (3) the suitability or the appropriateness of the reference group from which this modal description was derived. That is, a high 4-9 is likely to be different from a low 4-9; and a difference of 10-15 scale score points between the two scales, in either direction, is likely to make some difference as well. Furthermore, it makes a difference whether Scale 4 is elevated by endorsement of items related to family discord, feelings of being hard done by, rebelliousness (possibly impulsiveness), or depression and guilt, or by some combination of the above; and it makes a difference whether Scale 9 is elevated by endorsement of items related to sociability and ease, denial of inferiority, or egocentrism. And finally, the delinquencies of 4-9 psychologists are likely to be less blatantly anti-social than the delinquencies of many other 4-9 groups, notably criminals. Most of the available modal descriptions were developed on hospitalized psychiatric patients and may not be appropriate to the population which you happen to be dealing with.

The student clinician, therefore, must be taught that there is no excuse for not looking at and thinking about the subject's responses, to see in what ways this particular individual is similar to and different from the individuals on which these basic clinical scales and subsequent code types were developed, regardless of how many well-turned phrases are available among the descriptive statements for the scale elevations which he may find. He can then present what information he has regarding the normative group whose profiles were similar to the one at hand, the ways in which this individual's self-description compares to that of the

reference group, and his own speculation about what that might mean for this person, taking into account the extent to which the reference group comparison is appropriate, the likely validity of the subject's self-description, everything he knows about what people can be like, the probable effect of what he says in his psychological report, and anything else which comes to mind. And it is at that point that you have become engaged in the process of personality assessment.

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