New MMPI-2 Scales by David Nichols

October 29th, 2011

But you won't find his own well researched scales in his own book! (Nichols, D. S., 2011. *Essentials of MMPI-2 Assessment, 2nd Edition.*Hoboken, NJ: John Wiley & Sons.)

University of Minnesota Press wouldn't let him publish the keys to his own scales. While I could understand an argument for not publishing the keys to the main validity scales. Attorneys have been known to try to coach their clients on how to take the MMPI-2. (Although most fakers are not geniuses so it is very unlikely to help. I and my co-auther's have shown that this can back fire and produce even more clearly faked MMPI-2s). Unv. of Minn. Press however argued "ownership," not the fear of coaching. How is that for encouraging science? How can psychologists continue the tradition of developing new scales for particular needs if they only allow their own people to develop scales (such as the MMPI-RF which are some of the worse MMPI scales ever…)?

I am publishing the keys to Dr. Nichols scales here to hopefully encourage more research on these scales, which I have found very useful. I have found his "Cognitive Problems" also a good measure of possible ADD- something the MMPI-2 could use.

Revised D Subscales (Nichols, 2009a)

Dr1 – Depressed Mood (18 items)

TRUE

5 15 39 56 92 130 146 215

FALSE

9 75 95 109 140 148 188 221 223 245

Males: Mean 4.73; S.D. 2.33 Females: Mean 5.41; S.D. 2.62

Dr2 – Inhibition of Aggression (14 items)

TRUE

None

FALSE

29 37 55 68 76 134 189 212 221 226 248 260 267 330

Males: Mean 7.27; S.D. 2.39 Females: Mean 7.74; S.D. 2.22

Dr3 – Somatic Malaise (15 items)

TRUE

18 39 175 238

FALSE

2 10 20 33 45 117 118 141 142 143 181

Males: Mean 2.41; S.D. 1.84 Females: Mean 2.61; S.D. 2.04

Dr4 – Cognitive Infirmity (8 items)

TRUE

31 38 147 170 233

FALSE

43 109 165

Males: Mean 1.32; S.D. 1.38 Females: Mean 1.35; S.D. 1.48

Dr5 – Social Vulnerability (8 items)

TRUE

46 73 127 146 178

FALSE

49 109 223

Males: Mean 1.64; S.D. 1.44 Females: Mean 2.33; S.D. 1.64

Nota bene: For items 117, 176, 178, 181, and 238 the direction of scoring has

been reversed from that on Scale 2 in order to maximize thematic homogeneity/

internal consistency.

Hp – Hopelessness (12 items; Nichols, 2010)

TRUE

85 92 94 234 306 454 463 505 516 546 554

FALSE

75

Males: Mean 0.94; S.D. 1.42 Females: Mean 0.96; S.D. 1.39

Paranoia Factors (Nichols & Crowhurst (2006)

Pf1 – Resentment (6 items)

TRUE

17 22 42 145 234 484

FALSE

None

Males: Mean 0.34; S.D. 0.75 Females: Mean 0.32; S.D. 0.71

Pf2 – Ideas of Reference (6 items)

TRUE

251 259 305 333 424 549

FALSE

None

Males: Mean 1.01; S.D. 1.27 Females: Mean 1.08; S.D. 1.28

Pf3 – Delusions of Control (8 items)

TRUE

24 144 162 216 228 336 355 361

FALSE

None

Males: Mean 0.19; S.D. 0.53 Females: Mean 0.11; S.D. 0.40

Pf4 – Persecutory Ideas/Delusions (8 items)

TRUE

42 99 138 144 216 259 333

FALSE

314

Males: Mean 0.51; S.D. 0.94 Females: Mean 0.41; S.D. 0.84

Cognitive Stability Scales (Nichols, 2008)

CogProb – Cognitive Problems (12 items)

TRUE

31 147 233 299 308 325 475 482 533 565

FALSE

165 561

Males: Mean 2.10; S.D. 2.31 Females: Mean 2.19; S.D. 2.46

DisOrg – Disorganization (11 items)

TRUE

32 60 72 96 198 298 307 319 508 551

FALSE

427

Males: Mean 1.17; S.D. 1.50 Females: Mean 1.20; S.D. 1.47

Tags: MMPI-2 new scales, Nichols scales
Posted in Uncategorized | Comments Off

Dr. James Butcher MMPI-2 author, includes my MMPI/MMPI-2 outcome study in the historic top 50

July 15th, 2011

Dr. Butcher has a valuable list of studies: SIGNIFICANT CONTRIBUTIONS FOR USE OF THE MMPI/MMPI--2 IN TREATMENT
FIFTY HISTORICAL HIGHLIGHTS
July, 2011
www.umn.edu/mmpi

"Extensive research has been conducted on the use of the MMPI and MMPI-2 scales in evaluating clients for psychological treatment and there have been hundreds of publications on the MMPI and MMPI-2 in the treatment evaluation area. The following highlights describe special contributions that were made to assure that the scales on the test were appropriate, reliable, and valid in predicting symptoms and behavior relevant to psychological treatment. Major research studies of the MMPI/MMPI-2 in various treatment settings are highlighted and their findings/implications are summarized."

Tags: MMPI-2, treatment outcome, treatment planning
Posted in Uncategorized | Comments Off

Jim Butcher Reviews the MMPI-RF in his new 2011 Book

February 15th, 2011

"Departures from MMPI–2 empirical traditions: The fake bad scale, restructured clinical scales, and the MMPI–2–RF.
By Butcher, James N.
Butcher, James N., (2011). A beginner's guide to the MMPI-2 (3rd ed.), (pp. 175-194). Washington, DC, US: American Psychological Association, xi, 257 pp.
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."

Tags: MMPI-RF
Posted in Uncategorized | Comments Off

MMPI-2 Faking to Look Good

June 14th, 2010

Originally, the MMPI was used to diagnose psychiatric inpatients. Today, the MMPI-2 is largely used on non-patient populations who are motivated to under report psychopathology. They wish to get or keep a position, or have use of a lethal weapon, have a favorable custody decision, adopt a child, have a medical procedure, etc. It would be understandable for them to "fake to look good." The self-favorable validity scales become elevated in such situations. The psychologist must then determine, how much is due to situational "state" variables, such as conscious impression management; how much is due to "personality trait" variables such as neurotic level defenses such as repression, or borderline to psychotic level defenses such as denial. Although the MMPI-2 can provide a hypothesis about under-reporting psychopathology, only good diagnostic interviewing, document review, history, projectives, the DSM Defensive Functioning Scale and the PDM's assessment of Mental Functioning (M Axis) can determine the meaning of the validity scales. More scales using the same self-report methodology is unlikely to be very helpful.

L, O-D, S, Edwards SDS, Wiggins SDS all work in somewhat different ways but all intercorrelate-
The Other-Deception and Superlative Scales were best at distinguishing fake-good and honest profiles in the student sample. The Edwards Social Desirability Scale and the L scale were best at distinguishing fake-good and honest profiles in the patient sample. The Wiggins Social Desirability scale was best at distinguishing honestly responding students from patients faking good. (Effectiveness of the MMPI–2 validity indicators in the detection of defensive responding in clinical and nonclinical

samples. By Bagby, R. Michael; Rogers, Richard; Nicholson, Robert A.; Buis, Tom; Seeman, Mary V.; Rector, Neil A. Psychological Assessment, Vol 9(4), Dec 1997, 406-413.)

Some Populations Have Higher Lie Scales-

Higher L with Christians

Those immersed in a Christian subculture have higher L scale scores from the MMPI-2 norm sample. Findings suggest that a Christian subculture may interpret some MMPI-2 Lie scale items differently than others, making interpretation of their Lie scale scores questionable. (By Duris, Mark; Bjorck, Jeffrey P.; Gorsuch, Richard L. Journal of Psychology and Christianity, Vol 26(4), Win 2007, 356-366.)

Higher L with Puerto Ricans

A sample of 332 Puerto Rican power plant repairers and installers, who were administered the test in Spanish, were compared with 327 English speaking employees from the U.S. mainland. The overall MMPI-2 performance of both groups was highly similar and well within the normal range with most scales. The Lie scale (L), showed small differences with Hispanic clients scoring higher than the Anglos, a finding that has been reported in other studies. (Personality assessment in personnel selection using the MMPI-2: A cross-cultural comparison. By Zapata-Sola, Antonio; Kreuch, Tony; Landers, Richard N.; Hoyt, Tim; Butcher, James N. International Journal of Clinical and Health Psychology, Vol 9(2), May 2009, 287-298.)

The Under-reporting scales overall work well across populations-

The F, Fb, F – K, and F(p) scales of the Korean MMPI-2 (Han, 1993) were able successfully to classify faking-bad participants. The L, K, and S scales of the Korean MMPI-2 were able successfully to classify faking-good participants. Overall, the results of this study suggest that the Korean MMPI-2 works well in discriminating dishonest responses, thus confirming the

applicability of the MMPI-2 validity scales in a Korean context. (Faking Bad and Faking Good by College Students on the Korean MMPI-2. By Hahn, Jungwon
Journal of Personality Assessment, Vol 85(1), 2005, 65-73.)

Wiggins SDS, S, L and K with Custody
With a composite score derived from the Wiggins Social Desirability scale (WSD) and the Superlative scale (S), 74% of parents involved in custody dispute litigation were identified as underreporting compared with 52% identified using Lie (L) and Correction (K) scale criterion. (Defensive responding on the MMPI -2 in family custody and access evaluations. By Bagby, R. Michael; Nicholson, Robert A.; Buis, Tom; Radovanovic, Helen; Fidler, Barbara J. Psychological Assessment, Vol 11(1), Mar 1999, 24-28.)

L, Obvious-Subtle Index (O-S), the Positive Malingering (Mp) scale, F all work well-
MMPI-2 protocols were evaluated by asking college students to respond honestly, fake bad, or fake good on the MMPI-2. MMPI-2 protocols of participants asked to fake bad were compared with protocols from general psychiatric and forensic inpatient samples, and MMPI-2 protocols of participants asked to fake good were compared with MMPI-2 protocols of students asked to respond honestly. The F scale was superior in detecting faking bad, and the Obvious-Subtle Index (O-S), the Positive Malingering (Mp) scale and L scales were equally effective at detecting faking good. (Relative effectiveness of the standard validity scales in detecting fake-bad and fake-good responding: Replication and extension. By Bagby, R. Michael; Buis, Tom; Nicholson, Robert A. Psychological Assessment, Vol 7(1), Mar 1995, 84-92.)

The PSY-5 (NEO-5) or Other Such Obvious Scales are Easily Faked-
The PSY-5 measures were moderately to strongly associated with measures of positive impression management (L and K scales). The predictive effects of the PSY-5 were often observed

only in officers without significant levels of impression management (L ≤ 55T, K ≤ 65T). The PSY-5 scales were not especially useful for predicting on-the-job misconduct.
(Predictive validity of the MMPI- 2 PSY-5 scales and facets for law enforcement officer employment outcomes. By Caillouet, Beth A.; Boccaccini, Marcus T.; Varela, Jorge G.; Davis, Robert D.; Rostow, Cary D. Criminal Justice and Behavior, Vol 37(2), Feb 2010, 217-238.)

L and K work Well-
This study used 36 college students to whom the MMPI-2 was administered, first under standard conditions (control condition) in which the students responded as they ordinarily would and second, under a set of special instructions (experimental condition) which instructed them to respond as if they were police officer candidates. The two profiles were compared. As hypothesized, the Lie (L) and Correction (K) scales were elevated in the experimental condition. (Impression management in policy officer candidacy on the MMPI-2. By Weiss, William U.; Weiss, Peter A.; Cain, Scharee; Manley, Brittney Journal of Police and Criminal Psychology, Vol 24(2), Oct 2009, 120-125.)

Two Constructs: Impression Management and "self-deceptive positivity" (which I would call "repression" or "denial")-
The typology of impression management (IM), a deliberate attempt to create a positive social image, and self-deceptive positivity (SDP), an unintentional concealment of symptoms, were examined using taxometric procedures with Minnesota Multiphasic Personality Inventory–2 (MMPI-2) underreporting scales in a sample of 412 child-custody litigants, representing 206 families. IM and SDP appear to be distinct and measurable underreporting constructs on the MMPI–2. (Taxometric analysis of impression management and self-deception on the MMPI–2 in child-custody litigants. By Strong, David R.; Greene, Roger L.; Hoppe, Carl; Johnston, Terry; Olesen, Nancy Journal of Personality Assessment, Vol 73(1), Aug 1999, 1-18.)

Different Kinds of Deception-

This study discusses the multifaceted nature of deception in personality assessment-(1) consistency vs accuracy of item endorsement, (2) simulation vs dissimulation, (3) generic vs specific deception, (4) crude vs sophisticated deception, (5) intentional vs nonintentional deception, (6) self-deception vs impression management, and (7) selectivity vs inclusiveness, as these dimensions may be encountered using the MMPI-2. (Dimensions of deception in personality assessment: The example of the MMPI-2. By Nichols, David S.; Greene, Roger L. Journal of Personality Assessment, Vol 68(2), Apr 1997, 251-266.)

SOL in Custody

The Solomon Scale (SOL) considerably increases the statistical power of other MMPI-2 validity scales K and Positive Malingering (Mp) that have been shown in previous research to be of assistance in the use of the MMPI-2 in custody disputes. (A new MMPI-2 scale for custody disputes. By Posthuma, Allan American Journal of Forensic Psychology, Vol 21(4), 2003, 51-64.)

Knowledge and Intelligence Help in Out Smarting MMPI-2-

Results indicate that intelligence and MMPI-2 knowledge contribute significantly to the likelihood of successfully escaping detection as a malingerer. (The relationship between malingerers' intelligence and MMPI-2 knowledge and their ability to avoid detection. By Pelfrey, William V., Jr. International Journal of Offender Therapy and Comparative Criminology, Vol 48(6), Dec 2004, 649-663.)

The Subtle subscales-

In a sample of 1,240 inpatient and outpatient psychiatric patients at a large Army medical center, it was found that these subscales had strong positive correlations with other scales on the MMPI-2 related to denial, repression, or both. In addition, ratings of the Subtle items on D and Hy by clinical psychology residents were consistent with the hypothesis that these items

reflect a denial of psychological or physical dysfunction.(An examination of the MMPI-2 Wiener-Harmon subtle subscales for D and Hy: Implications for parent scale and neurotic triad interpretation. By Jones, Alvin Journal of Personality Assessment, Vol 77(1), Aug 2001, 105-121.)

I originally spoke of this in 1987 and 1989. Gordon, R. M. (1987). Interpreting Weiner's obvious and subtle scales in terms of the psychodynamics of conflict and defense. The10th International Conference on Personality Assessment: Brussels, Belgium.
Gordon, R. M. (1989). Interpreting MMPI subtle scales as representing defense mechanisms. Paper presented at the 24th Annual Symposium on Recent Developments in the Use of the MMPI, Hawaii. Both found in Gordon, R.M. (2008). An expert look at love, intimacy and personal growth. Second Edition, IAPT Press, Allentown, Pa.)
Jim Butcher thought that most the Subtle Items were mistakes from the original sample- assuming a cognitive-behavioral model of personality. I understood them psychodynamically. I eventually found a way to publish my ideas on the subtle items in my 2006 article on the MMPI-RF. (Gordon, R.M. (2006). False assumptions about psychopathology, hysteria and the MMPI-2 restructured clinical scales. Psychological Reports, 98, 870–872.)

L+K-F May Assess Primitive Defenses -
We used two MMPI-2 indexes to measure primitive defenses: L + K – F and (L + Pa + Sc) – (Hy + Pt). We found that mothers and fathers who were alienators in custody arrangements had higher (clinical range) scores indicating primitive defenses such as splitting and projective identification, than control mothers and fathers (normal range scores) in both our indexes. Target parents were mostly similar to the control parents. (MMPI-2 findings of primitive defenses in alienating patients. By Gordon, Robert M.; Stoffey, Ronald; Bottinelli, Jennifer

American Journal of Family Therapy, Vol 36(3), May-Jun 2008, 211-228.)

Tags: defensiveness, MMPI-2 Faking to look good
Posted in Uncategorized | 2 Comments »

New Malingering Scales for the MMPI-2 (Better to look at external data)

June 13th, 2010

I am often asked about faking on the MMPI-2. Let me start with Faking to Look Bad. Detecting Malingering is hard on any Self-Report. Adding more scales from more self report methodology is of little real help. (I mainly use the F scale, and then look outside of the test.) It is much better to do a good document check and get a detailed history. Here are some studies on some of the newer "malingering scales."

F-r and FP-r on the MMPI–2-RF (Restructured Form) may show promise. Too soon to tell. But the MMPI-RF is not an MMPI. There is also not enough research behind it to take it to court at the present time. (By Sellbom, Martin; Toomey, Joseph A.; Wygant, Dustin B.; Kucharski, L. Thomas; Duncan, Scott Psychological Assessment, Vol 22(1), Mar 2010, 22-31.)

M-DFI not better than F
The malingering discriminant function index (M-DFI), recently developed by Bacchiochi and Bagby tested with Logistic regression analysis (LRA) revealed that the MMPI-2 infrequency (F) scale had the best predictive utility of the traditional infrequency scales. Although the M-DFI did significantly differentiate the malingering from the not malingering groups, it did not add significantly to the predictive utility of the MMPI-2 F scale. (The utility of the MMPI-2 Malingering Discriminant Function Index in the detection of malingering: A study of criminal defendants. By Toomey, Joseph A.; Kucharski, L. Thomas; Duncan, Scott
Assessment, Vol 16(1), Mar 2009, 115-121.)

The MMPI-2 Malingering Discriminant Function Index (M-DFI) was designed to detect malingerers educated about MMPI-2 validity indicators. Logistic regression analyses indicated that although the M-DFI performed better than several individual indicators, results were mixed for combinations of indicators, and the M-DFI did not outperform different sets of existing indicators. (Diagnostic accuracy of the MMPI-2 Malingering Discriminant Function Index in the detection of malingering among inmates. By Steffan, Jarrod S.; Morgan, Robert D.
Journal of Personality Assessment, Vol 90(4), Jul-Aug 2008, 392-398.)

High F and extremely high clinical scores that are not clinically observable-
The MMPI-2 validity scales differentiated malingerers from non malingerers with a high degree of accuracy. Hypochondriasis and Hysteria were also effective. For all variables except Scale L, more extreme scores were associated with higher specificity. (Classification accuracy of MMPI-2 validity scales in the detection of pain-related malingering: A known-groups study. By Bianchini, Kevin J.; Etherton, Joseph L.; Greve, Kevin W.; Heinly, Matthew T.; Meyers, John E. Assessment, Vol 15(4), Dec 2008, 435-449.)

FBS has problems-
FBS were able to distinguish only the noncoached participants instructed to fake from the PTSD claimants; in contrast, the F, FB, and Fp scales were able to distinguish both the noncoached and the validity-scale-coached participants from the PTSD claimants. (The utility and comparative incremental validity of the MMPI-2 and Trauma symptom Inventory validity scales in the detection of feigned PTSD. By Efendov, Adele A.; Sellbom, Martin; Bagby, R. Michael
Psychological Assessment, Vol 20(4), Dec 2008, 317-326.)

The results indicate that the FBS is more likely to measure general maladjustment and somatic complaints rather than malingering. The rate of false positives produced by the scale is

unacceptably high, especially in psychiatric settings. The scale is likely to classify an unacceptably large number of individuals who are experiencing genuine psychological distress as malingerers. (The construct validity of the Lees-Haley Fake Bad Scale: Does this scale measure somatic malingering and feigned emotional distress?
By Butcher, James N.; Arbisi, Paul A.; Atlis, Mera M.; McNulty, John L.
Archives of Clinical Neuropsychology, Vol 23(7-8), Nov-Dec 2008, 855-864.)

RBS scale may be helpful with exaggerated memory complaints-
Exaggerated memory complaints are a common feature of cognitive response bias. Response Bias Scale (RBS) is sensitive to memory complaints and was tested against other MMPI-2 validity scales and indices. Regression analyses indicated that the RBS was a better predictor of the mean memory complaints score than the F, FB, and FP validity scales and the FBS. (Differential sensitivity of the Response Bias Scale (RBS) and MMPI-2 validity scales to memory complaints. By Gervais, Roger O.; Ben-Porath, Yossef S.; Wygant, Dustin B.; Green, Paul The Clinical Neuropsychologist, Vol 22(6), Dec 2008, 1061-1079.)

MMDS
A new 15-item MMPI-2 subscale, the Malingered Mood Disorder Scale (MMDS), was empirically derived from the original 32-item Malingered Depression Scale (MDS) of Steffan, Clopton, and Morgan (2003). The MMDS was superior to the original MDS in identification of symptom exaggeration in personal injury litigants and disability claimants compared to non-litigating head-injured controls. (Empirical derivation of a new MMPI-2 scale for identifying probable malingering in personal injury litigants and disability claimants: The 15-item Malingered Mood Disorder Scale (MMDS) By Henry, George K.; Heilbronner,

Robert L.; Mittenberg, Wiley; Enders, Craig; Roberts, Darci M. The Clinical Neuropsychologist, Vol 22(1), Jan 2008, 158-168.)

Underreporting, over-reporting neurotic level symptoms, insufficient cognitive effort, over-reporting psychotic level symptoms-

The four factors were designated as follows: Factor I, with large loadings from L, K, and S–underreporting of psychological symptoms; Factor II, with large loadings from FBS, RBS, and Md–overreporting of neurotic symptoms; Factor III, with large loadings from VSVT, TOMM, and LMT–insufficient cognitive effort; and Factor IV, with the largest loadings from F, Fp, and Dsr2–overreporting of psychotic/rarely endorsed symptoms. Results reflect the heterogeneity of response validity in forensic samples referred for neuropsychological evaluation. (Response validity in forensic neuropsychology: Exploratory factor analytic evidence of distinct cognitive and psychological constructs.

By Nelson, Nathaniel W.; Sweet, Jerry J.; Berry, David T. R.; Bryant, Fred B.; Granacher, Robert P.Journal of the International Neuropsychological Society, Vol 13(3), May 2007)

Fc scale in criminal settings-

E. I. Megargee (2004) developed a Minnesota Multiphasic Personality Inventory (MMPI-2) Infrequency scale for use in criminal settings called the Criminal Offender Infrequency (Fc) scale. Results from this study suggest Fc may be a useful addition to the MMPI-2 for detecting malingering in criminal settings. (Accuracy of Megargee's Criminal Offender Infrequency (FC) Scale in detecting malingering among forensic examinees. By Gassen, Michael D.; Pietz, Christina A.; Spray, Beverly J.; Denney, Robert L. Criminal Justice and Behavior, Vol 34(4), Apr 2007, 493-504)

Fp

P. A. Arbisi and Y. S. Ben-Porath (1995) originally proposed that the Infrequency Psychopathology scale, F(p), be used as the final step in an algorithm to determine the validity of a Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

protocol. These results support Arbisi and Ben-Porath's original proposal to use F(p) to identify a distinct subgroup of overreported MMPI-2 protocols within forensic psychiatric examinees with high elevations on F. (Evaluating the latent structure of the MMPI-2 F(p) scale in a forensic sample: A taxometric analysis.
By Strong, David R.; Glassmire, David M.; Frederick, Richard I.; Greene, Roger L. Psychological Assessment, Vol 18(3), Sep 2006, 250-261.)

Fptsd scale
The Infrequency-Posttraumatic Stress Disorder scale (Fptsd) was developed with combat-exposed PTSD patients. Based on the results, Fptsd may be more appropriate for combat trauma victims, and Fp may be more appropriate for civilian trauma victims. (Discriminating malingered from genuine civilian posttraumatic stress disorder: A validation of three MMPI-2 infrequency scales (F, Fp, and Fptsd). By Elhai, Jon D.; Naifeh, James A.; Zucker, Irene S.; Gold, Steven N.; Deitsch, Sarah E.; Frueh, B. Christopher
Assessment, Vol 11(2), Jun 2004, 139-144.)

Finally, do not think in terms of a malingering-honest dichotomy-

These results were more consistent with dimensional latent structure than with taxonic latent structure. On the basis of these findings, it is concluded that feigned psychopathology forms a dimension (levels of fabrication or exaggeration) rather than a taxon (malingering-honest dichotomy) and that malingering is a quantitative distinction rather than a qualitative one. (Malingering as a categorical or dimensional construct: The latent structure of feigned psychopathology as measured by the SIRS and MMPI-2.
(By Walters, Glenn D.; Rogers, Richard; Berry, David T. R.; Miller, Holly A.; Duncan, Scott A.; McCusker, Paul J.; Payne, Joshua W.; Granacher, Robert P., Jr. Psychological Assessment, Vol 20(3), Sep 2008, 238-247.)

Tags: malingering MMPI-2
Posted in Uncategorized | Comments Off

Butcher's New Article: A Great Historical Review of Personality Assessment

April 15th, 2010

Jim Butcher has a new article which includes a great historical review of personality assessment. He goes back to "…the Old Testament when Gideon used observations of his men trembling with fear as well as observations of how they chose to drink water from a stream as a means of selecting soldiers for battle…Other early efforts to evaluate personality can be found in the work of Carl Jung (1907), who studied associations to words in order to evaluate a person's thought processes and personality…The U.S. Office of Strategic Services (OSS), a predecessor to the present Central Intelligence Agency, performed extensive psychological evaluations on persons who were to be assigned to secret overseas missions. The program, supervised by Henry Murray, evaluated more than 5000 candidates for special duty assignment. The assessment team used more than one hundred different psychological tests and specially designed procedures to perform the evaluations. The operations of this extensive assessment program were described after the war, when the project was declassified (Off. Strat. Serv. Assess. Staff 1948) [see also a review by Handler (2001) for a discussion of the OSS]. The military service implemented several programs in which tests such as the Minnesota Multiphasic Personality Inventory (MMPI) were used in personnel selection for positions…"

"Research on the MMPI-2 and MMPI-A continues to this day. More than 19,000 articles and books have been published on the MMPI, the MMPI-2, and MMPI-A."

Dr. Butcher takes us up to new developments and missteps such as the MMPI-RF. He summarizes the data showing the MMPI-RF was ill conceived and is not an improvement over the MMPI-2:

"…critics of the RC Scales, including the current author, have been resolute in descriptions of their limitations and the underlying theory and methodology that led to their creation (see Butcher &Williams 2009)…Several problems have been reported with the RC Scales. The theoretical model to develop the scales has been questioned (Butcher &Williams 2009, Gordon 2006, Nichols 2006, Ranson et al. 2009). In addition, the majority of the RC scales do not address the personality constructs from the original MMPI clinical scales but are simply redundant measures of several other MMPI-2 Content and Supplemental Scales (Caldwell 2006, Greene et al. 2009, Nichols 2006, Rogers et al. 2006, Rouse et al. 2008). The RC Scales show a low sensitivity to mental health problems (Binford & Liljequist 2008, Butcher et al. 2006, Cumella et al. 2009, Gucker et al. 2009, Megargee 2006, Rogers &Sewell 2006, Wallace & Liljequist 2005)…"

Jim Butcher concludes with this important warning:

"Assessment psychologists need to be aware that many of the available personality assessment measures are owned and managed by commercial rather than scientific organizations and need to be alert that commercial interests can sometimes "prevail over scientific needs" (Adams 2000)."

Personality Assessment from the Nineteenth to the Early Twenty-First Century: Past Achievements and Contemporary Challenges

James N. Butcher

Annu. Rev. Clin. Psychol. 2010. 6:1–20

The *Annual Review of Clinical Psychology* is online

at clinpsy.annualreviews.org

Tags: History of psychological testing, MMPI-2, MMPI-RF
Posted in Uncategorized | 1 Comment »

MMPI Expert Dave Nichols Reviews the MMPI-RF on Listserv

February 9th, 2010

Dave Nichols gave me permission to copy his recent post to a Rorschach Listserv. This is a great response, typical of Dave.

Dr. Edelson writes: "My first course of action in this situation would be to administer the MMPI-2 and/or MMPI-RF."

Although Dr. Edelson may well not intend it so, her statement could be misleadingly read to indicate a rough equivalence between the MMPI-2 and the MMPI-2-RF. This would be unfortunate. The MMPI-2-RF is only tenuously related to the MMPI-2, amounting largely to the two tests sharing 338 items and the 1989 Restandardization norms. The use of the familiar MMPI acronym in the MMPI-2-RF, while understandable as a means of commercial promotion given the established reputation of the MMPI/MMPI-2, risks (or intends?) distraction from the differences between the two forms. These are substantial, including the elimination of the 10 standard Clinical Scales from the RF, and their substitution by the new Restructured Clinical (RC) scales.

A close examination of the literature of the MMPI-2-RF and the RC scales will reveal a level of arrogance and sloppiness in their construction that some may find disconcerting.

Arrogance: Rather than taking the necessary pains to fully describe the development of each of the 28 new scales (out of 50) in the MMPI-2-RF for the benefit of customers, users and, especially, researchers, the authors of the new form state: "In the following we do not report the particulars of scale derivation in the same detail as we have provided for the RC

scales (noting, as we did in the case of the RC scales, that ultimately what is most important is the results, the content, structure, correlates, and functions of each new scale). Instead we offer a narrative summary." (Tellegen & Ben-Porath, 2008, MMPI-2-RF Technical Manual, p. 18)

Possible translations: 1) Trust us. 2) None of your business.

Sloppiness: One possible reason for avoiding the detailed description of the development of these 28 new RF scales is the sloppiness that was evident in these authors' previous description of the development of the RC scales. Examples:

1) Their failure to provide in the RC Monograph (2003) a complete scoring key for the preliminary Demoralization scale (Dem), the version of the scale used in their factor analyses of the original Clinical Scales in order to identify a core construct for each (Step 2).

2) Their failure to confirm the results of these analyses after having dropped 5 items from Dem and added 6 new items to create the revised and final version of the Demoralization scale (RCd).

3) The contamination that resulted from appending Dem to the items of Scales 2 and 7, respectively, in their Step 2, after having previously recruited the Dem items exclusively from these same two scales in Step 1, thereby essentially ruling out any items overlapping Dem and either of Scales 2 or 7 as candidates for the latter scales' core constructs. Unlike the Step 2 procedures followed to determine the core constructs of Scales 1, 3, 4, 6, 8, & 9, applying the same procedure to Scales 2 & 7 would have the effect of extracting the very same factor these scales had earlier been recruited to enlist!

4) Their failure to factor the final RC scales in any of their developmental samples to confirm that the core construct for each scale as embodied in the seed scales selected from each parent Clinical Scale survived as the dominant factor in its RC counterpart, or at least to report such analyses.

More extensive critical analysis of the RC scales and, by extension, the MMPI-2-RF, may be found in: Nichols (2006). The trials of separating bath water from baby: A review and critique of the MMPI–2 Restructured Clinical scales. Journal of Personality Assessment, 87, 121-138; Rouse, Greene, Butcher, Nichols, & Williams (2008). What do the MMPI–2 Restructured Clinical scales reliably measure? Answers from multiple research settings. Journal of Personality Assessment, 90, 435-442; Greene, Rouse, Butcher, Nichols, & Williams (2009). The MMPI–2 Restructured Clinical (RC) scales and redundancy: Response to Tellegen, Ben-Porath, and Sellbom. Journal of Personality Assessment, 91, 222-226; and in Ranson, Nichols, Rouse, & Harrington (2009). Changing or replacing an established psychological 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.

Dave Nichols

Tags: MMPI-2, MMPI-RF, RC scales
Posted in Uncategorized | 1 Comment »

Are we getting crazier? What do the MMPI norms say about that?

January 30th, 2010

From: "Robert M. Gordon"
Date: January 13, 2010 9:30:02 PM EST
To: PPA@LISTS.APAPRACTICE.ORG
Subject: Re: [PPA] college students, the MMPI and pathology
Reply-To: "Robert M. Gordon"

Eric,
Thanks for this study comparing MMPI scores from students in 1938 and 2007. This is a good example of the problems of

interpreting causative hypotheses form correlational data. Their assumption is that students are more mentally ill now.

I noticed the same differences in adults when the MMPI-2 first came out in 1989. But I looked at not just the scale differences but also what items within the scales were meaningfully different (I would not worry about "significant" differences in p values since the N is 77,576. They were right to speak in terms of %)

Of course I have a completely different take than these authors after my studying the subscales and actual item differences. I do not think that there were the "good old days" and that now students are more mentally ill.
When comparing the MMPI norms of 1938 to the MMPI-2 norms of the late 1980's, the specific increased means in K, Hy, Pd, Pa, Ma and Mf in males, I believe, reflect not only the higher SES and education of the MMPI-2 sample over the original sample, but that overall, people today are more psychologically sophisticated than in 1938. The higher scores in Hy and Pa are due to the higher means in Hy2 Need for Affection and Pa3 Naivete, K, Hy2 and Pa3 measure confidence, trust and honesty in normals. The higher Pd is associated with admitting to common faults (being more honest), e.g. stealing something as a child, or being disappointed in love. The elevation in Ma is due mainly to Ma2 Psychomotor Acceleration. The pace of life is faster today than in 1938, and people today seek more stimulation. The higher Mf for men is associated with items that show that men are more sensitive today than in their grandfather's time, e.g. men today are less likely to think that teasing animals is fun, or exploit friends, and more likely to admit to feelings and talk about them.

The MMPI-2 manual lists the percent of males and females answering "true" to each item. The biggest difference is that today 77% of females and 70% of males say that they are an important person. However, over forty years ago, only 9% of females and 17 percent of males said "true" to item 61. That

item is on the Hypomania scale to assess egotism. It was a valid item then, but is it now, when 70-77% of the sample today say that they are an important person? Are people much more egotistical today, or are people interpreting the meaning of an "important person" differently? I think it is mainly the latter, though the issue is up for debate. In the past, individuals associated an important person with position and wealth. Today, with the popularization of psychology, people are told that they are intrinsically important regardless of position, wealth or other external factors.

The responses to the items indicate that people today are more psychologically minded, confident, open, trusting, thrill seeking and interested in looking attractive than two generations ago. There have been changes toward healthier sex role attitudes. Men are less likely to see friends in terms of how useful they are (item 254). This went from 50% "true" to 24% "true". Men are less likely to say that it is better to keep their mouth shut when in trouble (item 26, from 68% to 47%). Men are also more likely to admit to being disappointed in love (item 219, 24% to 51%), to feel more intensely than most others (item 271, 23% to 39%) and are less likely to think that teasing animals is a lot of fun (item 68, 45% to 28%). Overall, men are more sensitive and open than in the past.

Women also are responding in a direction indicating a healthy change in sex role behavior. Women are more likely to say that they should have as much sexual freedom as men, than they did in the past (item 88, 52% to 83%). (Interestingly, it was women that were judgmental of women, men remained high in their beliefs that there should not be a double standard, 83% to 89%.) More women today believe it is ok to laugh at a dirty joke (item 260, from, 78% to 90%), and more likely to talk up in a group of people (item 262, from 55% to 72%).

People are more open and honest about sex according to their responses. People in the MMPI-2 sample were more likely to say that they like to flirt, talk about sex, like sexual stories and

jokes, and are less likely to believe that a large number of people are guilty of bad sexual conduct.

The differences also indicate that people are more psychologically minded today. For example, the item #13 on the MMPI-2 that one should try to understand what dreams mean and be guided by them is keyed “true” on scales 6, 7, and 8 (Paranoia, Psychasthenia and Schizophrenia). Once, this was a crazy thought. Not today, when dream research is often in the press stating that dreams can not only tell us about past traumas, but also tell us how we may react to certain situations. Fifteen percent of the females responded “true” in 1938, now females respond “true” 34% of the time. Males went from 13% to 27%. People are more likely to say that they do dream, and admit that they have dreams about sex. People are less likely to state that they wish that they were a child again, less likely to state that they cannot understand why they get angry, less likely to feel that they are misunderstood, or feel that stepping on the sidewalk cracks is something to be avoided. People in the MMPI-2 sample were more likely to state that the hardest battles are with themselves, and that they know who is responsible for their problems. All these changes indicate greater insight about dreams, feelings, ones own responsibility for personal problems and less superstition.

The MMPI-2 sample indicates that people today have a more benign attitude towards others. They are less likely to feel that: people exaggerate a lot to get sympathy, that it is safer to trust no one, that most people do not want to know the truth and that it is better to be on guard with people who seem friendlier than one would expect. People in the MMPI-2 sample are more likely to state that: they are important, would be a good leader, and if they had the chance, that they would be a benefit to the world.

Overall, I believe that the changes in the MMPI-2 sample’s responses to the items as compared to the original sample from 1938 indicates that people are more open with their

emotions and feelings, have more confidence, have less rigid sex roles and are more psychologically minded than in the past.

Bob (the MMPI guy)

Study: More of today's US youth have serious mental health issues than previous generations
By Martha Irvine

CHICAGO A new study has found that five times as many high school and college students in the U.S. are dealing with anxiety and other mental health issues than youth of the same age who were studied in the Great Depression era.

The findings, culled from responses to a popular psychological questionnaire used as far back as 1938, confirm what counsellors on campuses nationwide have long suspected as more students struggle with the stresses of school and life in general.

"It's another piece of the puzzle – that yes, this does seem to be a problem, that there are more young people who report anxiety and depression," says Jean Twenge, a San Diego State University psychology professor and the study's lead author. "The next question is: what do we do about it?"

Though the study, released Monday, does not provide a definitive correlation, Twenge and mental health professionals speculate that a popular culture increasingly focused on the external – from wealth to looks and status – has contributed to the uptick in mental health issues.

Pulling together the data for the study was no small task. Led by Twenge, researchers at five universities analyzed the responses of 77,576 high school or college students who, from 1938 through 2007, took the Minnesota Multiphasic Personality Inventory, or MMPI. The results will be published in a future issue of the Clinical Psychology Review.

Overall, an average of five times as many students in 2007 surpassed thresholds in one or more mental health categories,

compared with those who did so in 1938. A few individual categories increased at an even greater rate – with six times as many scoring high in two areas:

-"hypomania," a measure of anxiety and unrealistic optimism (from 5 per cent of students in 1938 to 31 per cent in 2007)

Tags: MMPI-2 norms, MMPI-A norms, psychopathology
Posted in Uncategorized | 2 Comments »

More on What is the Best Psychotherapy? The APA Press Release

January 28th, 2010

The Efficacy of Psychodynamic Psychotherapy

January 25, 2010

Psychodynamic Psychotherapy Brings Lasting Benefits through Self-Knowledge.

Patients Continue to Improve After Treatment Ends, New Study Finds—Psychodynamic psychotherapy is effective for a wide range of mental health symptoms, including depression, anxiety, panic and stress-related physical ailments, and the benefits of the therapy grow after treatment has ended, according to new research published by the American Psychological Association. Psychodynamic therapy focuses on the psychological roots of emotional suffering. Its hallmarks are self-reflection and self-examination, and the use of the relationship between therapist and patient as a window into problematic relationship patterns in the patient's life. Its goal is not only to alleviate the most obvious symptoms but to help people lead healthier lives. "The American public has been told that only newer, symptom-focused treatments like cognitive behavior therapy or medication have scientific support," said study author Jonathan Shedler, PhD, of the University of Colorado Denver School of Medicine. "The actual scientific evidence shows that psychodynamic therapy is highly effective.

The benefits are at least as large as those of other psychotherapies, and they last." To reach these conclusions, Shedler reviewed eight meta-analyses comprising 160 studies of psychodynamic therapy, plus nine meta-analyses of other psychological treatments and antidepressant medications. Shedler focused on effect size, which measures the amount of change produced by each treatment. An effect size of 0.80 is considered a large effect in psychological and medical research. One major meta-analysis of psychodynamic therapy included 1,431 patients with a range of mental health problems and found an effect size of 0.97 for overall symptom improvement (the therapy was typically once per week and lasted less than a year). The effect size increased by 50 percent, to 1.51, when patients were re-evaluated nine or more months after therapy ended. The effect size for the most widely used antidepressant medications is a more modest 0.31. The findings are published in the February issue of American Psychologist, the flagship journal of the American Psychological Association. The eight meta-analyses, representing the best available scientific evidence on psychodynamic therapy, all showed substantial treatment benefits, according to Shedler. Effect sizes were impressive even for personality disorders—deeply ingrained maladaptive traits that are notoriously difficult to treat, he said. "The consistent trend toward larger effect sizes at follow-up suggests that psychodynamic psychotherapy sets in motion psychological processes that lead to ongoing change, even after therapy has ended," Shedler said. "In contrast, the benefits of other 'empirically supported' therapies tend to diminish over time for the most common conditions, like depression and generalized anxiety." "Pharmaceutical companies and health insurance companies have a financial incentive to promote the view that mental suffering can be reduced to lists of symptoms, and that treatment means managing those symptoms and little else. For some specific psychiatric conditions, this makes sense," he added. "But more often, emotional suffering is woven into the fabric of the person's life and rooted in

relationship patterns, inner contradictions and emotional blind spots. This is what psychodynamic therapy is designed to address." Shedler acknowledged that there are many more studies of other psychological treatments (other than psychodynamic), and that the developers of other therapies took the lead in recognizing the importance of rigorous scientific evaluation. "Accountability is crucial," said Shedler. "But now that research is putting psychodynamic therapy to the test, we are not seeing evidence that the newer therapies are more effective." Shedler also noted that existing research does not adequately capture the benefits that psychodynamic therapy aims to achieve. "It is easy to measure change in acute symptoms, harder to measure deeper personality changes. But it can be done." The research also suggests that when other psychotherapies are effective, it may be because they include unacknowledged psychodynamic elements. "When you look past therapy 'brand names' and look at what the effective therapists are actually doing, it turns out they are doing what psychodynamic therapists have always done—facilitating self-exploration, examining emotional blind spots, understanding relationship patterns." Four studies of therapy for depression used actual recordings of therapy sessions to study what therapists said and did that was effective or ineffective. The more the therapists acted like psychodynamic therapists, the better the outcome, Shedler said. "This was true regardless of the kind of therapy the therapists believed they were providing." Article: "The Efficacy of Psychodynamic Psychotherapy," Jonathan K. Shedler, PhD, University of Colorado Denver School of Medicine; American Psychologist, Vol. 65. No.2.

The American Psychological Association, in Washington, D.C., is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. APA's membership includes more than 150,000 researchers, educators, clinicians, consultants

and students. Through its divisions in 54 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting health, education and human welfare.

Tags: best psychotherapy, psychoanalytic, psychodynamic psychotherpy

Posted in Uncategorized | Comments Off

What is the best psychotherapy? What does the MMPI-2 say about it?

January 23rd, 2010

In Matt Jarvis's text (2004) "Psychodynamic Psychology-Classical Theory & Contemporary Research" he refers to my 2001 study using the MMPI as a treatment outcome measure. CBT and other non-psychoanalytic treatments use outcome measures of just the surface symptoms. They do not use the MMPI, which measures the personality traits and syndromes underneath the psychological symptoms. The MMPI does not react to CBT and other shallow treatments. Psychoanalytic-psychodynamic treatments aim at the underlying personality traits and should show changes in the MMPI scores. Jarvis wrote:

"The most widely used measure of psychopathology, the Minnesota Multiphasic Personality Inventory (MMPI), generally reveals quite small changes in response to brief psychological therapies. Gordon (2001) set out to test whether long-term psychoanalytic psychotherapy would show greater change as assessed by the MMPI: 55 outpatients with multiple symptoms were tracked and retested on the MMPI. Personality change took an average of two years, but by the end of treatment all the patients had decreased significantly in psychopathology, entering the normal rage of MMPI scores. This is a highly significant finding as it suggests that there is something unique

about the effects of long-term psychoanalytic psychotherapy above and beyond those of briefer psychological therapies." (p. 184)

In 2010, Jonathan Shedler had his article, "The Efficacy of Psychodynamic Psychotherapy", published in psychology's main journal, the American Psychologist. In his review of the best research available, psychodynamic therapy (PDT) (this includes all the psychoanalytic treatments) was found to be better than CBT and other non-psychoanalytic treatments for: depression, anxiety, panic, somatoform disorders, eating disorders, substance related disorders, and personality disorders. The effects did not decay over time as with the more surface treatments, and the patients continued to grow by using the insights they had learned in PDT (See my review 2010).

Tags: best psychotherapy, CBT, outcome measures in psychotherapy,psychoanalysis, psychoanalytic, psychodynamic
Posted in Uncategorized | Comments Off

Is the new MMPI-RF Really an MMPI? Is it better?

January 21st, 2010

Don't use the MMPI-RF when an MMPI-2 is required. They are not the same test. In fact, the MMPI-RF has poor sensitivity to psychopathology and is a poor diagnostic instrument. When the MMPI-RC scales first came out, I was very critical of them. I had a hard time getting my paper published. I had to fight with Psych. Reports and I won. The editor agreed to publish it finally in 2006 over the reviewers unanimous criticism of it. Later Jim Butcher and Carolyn Williams wrote (2009) "Gordon (2006) indicated that the RC Scales are based on false assumptions about psychopathology (i.e. that consistent items are needed to assess all psychopathologies), pointing to complex diagnostic conditions like Hysteria, Post Traumatic Stress Disorder, and Borderline Personality Disorder that are better understood with

a psychodynamic formulation recognizing internal conflicts and contradictions. He indicates that a simplistic behavioral approach with an insistence on more internally consistent and distinct scales does not produce more external validity or useful measures for many of the complex disorders found in clinical practice."

The MMPI RC scales became the main clinical scales of the MMPI-RF. Now most the leading MMPI experts agree that the MMPI-RF is a flawed test. So stick with the MMPI-2.

Tags: MMPI-2, MMPI-RF
Posted in Uncategorized | 3 Comments »

Can someone take an MMPI-2 home?

January 20th, 2010

Gordon, R.M. (2010), Test at Home Not Unethical per se, The National Psychologist, January/February, p.24.

Dear Editor,

Often you can let patients that you trust and with strict instructions, take an MMPI-2 home to complete. It is not automatically unethical. We don't want psychologists to think of ethics in such black and white terms (Gordon, 2006). Dr. Jeffery E. Barnett's ethical reasoning in the Nov-Dec. 2009 issue of The National Psychologist misses the letter and intent of Standard 9.11 by stating that it "should never occur." He responded with an unequivocal "unethical." He referred to Standard 9.11 "Psychologists make reasonable efforts to maintain the integrity and security of test materials and other assessment techniques consistent with law and contractual obligation and in a manner that permits adherence to this Ethics Code."

The intent of this standard is to remind us of our obligation to protect the validity of our testing instruments and try to get the most valid results from each situation as well as to honor legal, contractual and ethical standards. We do not want the test

answers published on the Internet, and we do not want a particular testee to give us invalid results. The psychologist might not know who took the test and if the testee got help in answering the questions. Certainly, we should never let a forensic client or job applicant take a test home, but patients have very different motivations. Even so, it would be foolish to give an MMPI-2 to take home if the patient has a problem with responsibility or passive aggressiveness. These are serious concerns to be considered, but it is not inherently unethical.

Dr. Barnett is worried about distractions affecting the test scores at a patient's home. If the MMPI-2 were so fragile, it would not be a reliable and valid instrument of personality traits.

However, within the office, testees can take pictures of the test questions with their smart phones and later post them on Internet. There are web sites to help people "pass" such tests as the MMPI-2, which is also available on smart phones. The intent of 9.11 is that we all try to address these concerns-regardless of venue. The greater good and least likely harm may at times be allowing a patient to take an MMPI-2 home. The testee may have a medical condition that makes it more humane to take it at home, or someone may wish for more privacy. Quite testing rooms may not be available. Also Dr. Barnett assumes that seeing the MMPI-2 items outside of the office will compromise the test validity. As I just stated, the items are already out there, but that does not help a person who wants to cheat the test. Self report personality tests such as the MMPI-2 are not based on 'right' answers such as an ability test. In fact there are several self report personality tests that can be taken over the Internet. True a testee can fake to look good or bad, but that will happen regardless of venue. There is also a difference between the test items versus the scoring keys. The later is not available on test booklets and therefore there is no issue about the loss of validity.

There are no contractual or legal issues to letting patients take a self report personality test at home. I have been doing this for over 35 years.

I am an ethics educator and an MMPI-2 expert. My effectiveness research on 55 patients in long-term psychotherapy would have been very hard to do if I did not allow my patients to take the MMPIs home (Gordon, 2001). I do agree that we need to understand the intent of ethical standards and then weight the pros and cons. The issue is one of concern and caution, but not a matter of simply being labeled "unethical." The last thing we need is another reason for licensing boards to go after psychologists.

Gordon, R.M. (2001) MMPI/MMPI-2 Changes in Long-Term Psychoanalytic Psychotherapy, Issues in Psychoanalytic Psychology, 23, (1 and 2), 59-79.

Gordon, R.M. (2006) The APA Ethics Code as a Projective Test. Psychologist-Psychoanalyst, XXVI, 1, 67-68.

Tags: ethics, MMPI-2, psychologcial testing ethics
Posted in Uncategorized | 3 Comments »