Assessment of Personality
Psychology 556
Lecture Note Outlines

Dr. Catherine Zois
Lecture #1: Introduction to Personality Assessment.

I. What is Personality?

"Those enduring characteristics of the person that are significant for persons interpersonal behavior."

--1) Stability of behavior across time.

--2) Behavior is a function of person, not environment, or person environment interaction.

--3) Interpersonal link.

II. Assumptions of personality assessment differ across theories.

A. Theories

1. Trait = Personality is composed of underlying traits or types.

2. Social learning = Classes of theories concerned with social-learning histories.

3. Cognitive-social learning = Classes of theories that view persons’ mental representations as organizing structure of personality.

4. Psychodynamic = Instincts, drives, motives, and needs form the basis of personality.

B. Assumptions about behavior.
1. Sign Vs. Sample = The behavior or observation is indicative of something below the surface Vs. The behavior is the behavior and is merely one of many that the person has available to him/her.


C. Classes of Measures.

1. Objective = standardized stimuli with norms for performance.
   --Criterion-keying approach.
   --Factor analytic approach.

2. Behavioral assessment = observe behavior, environmental conditions and relationships between the two.

3. Projective = project onto neutral stimuli.
<table>
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<tr>
<th>Trait/Type</th>
<th>Social Learning</th>
<th>Cog-Social Learning</th>
<th>Psychodynamic</th>
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<tr>
<td>sign or sample</td>
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<td>conscious or un-conscious</td>
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<td>content</td>
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Lecture #2: Accuracy of Clinical Judgment—Sources of Bias

I. The process of personality assessment.
   1. Gather data
   2. Combine in some ways using a series of algorithms.
   3. Make some prediction or judgment.

II. Accurate?
   A. Above formulas.
      1. In 1957 Paul Meehl (construct validity guy) posed question of when use heads vs. formulas.
      2. AEgisdottir et al. (2006) meta-analysis.
         *Based on 67 studies over the course of 56 years of research.
   B. Above lesser trained professionals.
      1. General Pardigm of 55 studies reviewed by Garb.
         a. Give information to both groups (DAP, MMPI, Rorsh, TAT).
         b. Have make a judgment.
         c. Accuracy is determined by match between verifiable behavior or panel of expert judgments.
2. Overall results.
   a. Experienced clinicians not more accurate than less experienced.
   
b. Experienced clinicians not more accurate than graduate students.
   
c. Training related to increased accuracy for some instruments.

III. Counter-argument against the use of formulas.
A. Invalid.
   1) Holt (1958) clinicians necessary to integrate and synthesize.
   
2. Intuition.
   But, Bootstrapping = The formula based on our intuition is more accurate than intuition alone.

B. Valid.
   
2. Some information is not contained in the formulas.
   
3. Actuarial prediction cannot formulate and test hypotheses.
IV. Why clinicians are so inaccurate?: Sources of bias.


   C. Hindsight bias.

   D. Overconfidence and poor hypothesis testing.

   E. Feedback not built into the assessment process.

   F. Imperfect memories.

V. Possible corrections against bias.
   A. Keep tally of predictions and results to get idea of accuracy of personal algorithms.

   B. Try to discount rather than prove hypothesis.

   C. Task clarification.

   D. Training programs that provide feedback regarding accuracy.

   E. Training programs that train in inductive reasoning and statistics.
Lecture #3--Psychometrics

I. Reliability.

A. The concept of reliability.

1. Dependability or consistency of measurement.

2. Classical Reliability theory  
   \[ X = T + E \]

B. Coefficient Alpha (This is not the alpha level of significance!!!!!!!!!!!!!!).

   1. The mean of every possible split-half reliability.

   2. Meanings of alpha.
      a. Proportion of variance due to differences in persons.

      b. How well the items are intercorrelated.

   3. Alpha is largely a function of sample size.

   4. Reliability sets an upper limit on validity.

   5. Alpha also limits test-retest.

II. Construct validity.

   A. Characteristics of constructs.
1. An idea that organizes complex phenomena.

2. No single operational definition.

3. Describes relationships with a # of other constructs.
   --this theory of relationships with other variables is what Cronbach refers to as a nomonological net.

4. Construct is flexible and can change.

B. Construct validation.
   1. Reliability.

2. Content.

3. Investigating relationships in your nomonological net.

   --One way to do this is through the use of multi-trait Multi-method matrices.
   --advantage of multi-trait/ multi-method matrix, is can look at discriminant validity, convergent, and method variance simulataneously.
Lecture #4: Other Issues (Base rates, treatment utility, gender and race).

I. Base rate prediction.
   A. General Issue.
      --Base rate = the rate of occurrence of a given phenomenon.

      --For a measure to be of any value to us, it must be shown to be able to predict above base rates.

      --Meehl and Rosen (1955) asserted that the greater divergence from $p=.50$, the harder to predict better than base rates.

   B. Grids.

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<tr>
<th>Test Results</th>
<th>Truth</th>
<th>pos.</th>
<th>neg.</th>
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<td>Pos. B.R.</td>
<td>Neg.</td>
<td>B.R.</td>
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---Sensitivity = ability of the test to identify positives: true pos/pos b.r.

---Specificity = ability of the test to identify negatives: true neg/neg b.r.

---Compare hits to largest base rate (negative or positive) to get the success of test above base rates.

---Whether you want a sensitive or specific test depends on your objectives.

II. Treatment utility.
   = how much does information gained from test add to treatment?

---If doing testing as a prelude to treatment, you want think about how/whether the information obtained from a test can add to effective treatment.

III. Gender and Race biases.
   A. Bias in assessment instrument.
      1. Content.

      2. Pattern of regression lines.

      3. Is there different patterns of relationships with different variables?

   B. Bias in diagnosis.
--Need to distinguish between **differential diagnosis** and **inaccurate diagnosis**.

--Need to distinguish between bias in the **diagnostic criteria** and **clinician bias in diagnosis**.

--Garb (1997). A review of studies where initial levels of psychopathology are statistically controlled.

1. Race Bias.
   a. demonstrated.
   b. not demonstrated.

2. Social Class.
   a. demonstrated.
   b. not demonstrated.

3. Gender.
   a. demonstrated.
   b. not demonstrated.

4. Limitation of analogue studies.
   a. social desirability.
   b. However, well-replicated biases have been found using the analogue method.
C. Bias in interpretation.
--If your test finds a difference and there is a difference in standing on construct, you're fine. Interpret it as such. However, if your test finds a difference and there is evidence the test is measuring a different construct for the different groups, interpret in terms of the construct it is measuring in the group you are testing.
Lecture #5: Interviewing, Hypothesis Testing, Behavioral Observations, and Writing Assessment Results.

I. Clinical Interview.

A. The Mock Personality Assessment interview.
   * Comprehensive and unstructured.

B. Hypothesis testing.
   1. What is the phenomenon that are trying to understand? i.e. What is the referral question?

   2. What are possible hypotheses going in (or while in)?

   3. Think of information that would pit against each other and ask those questions.

II. Behavioral Observations & Mental Status.

A. Mini-mental Status.
   1. Attention and concentration (serial sevens).

   2. Brief memory screen (hat-car-tree).

   3. Abstract reasoning (proverbs).

   4. Orientation x 3.

B. Other key observations.
1. Communication style.

2. Presence of psychomotor abnormalities.

3. Mood/affect distinction.

4. Response to testing.

III. Report Writing

A. Integration of findings in results section.
   1. Avoid adjective lists!!!

   2. List the core characteristics and then fill in details within specific domains.

B. Treatment planning in the discussion section.
   1. Avoid overly broad recommendations!!!

   2. 6-step approach by Longsma & Peterson (1999).

Addendum Lecture # 5: Suicide Assessment

IV. Things to Ask
   A. If they say they are depressed, but deny suicidal ideations…
   
   B. Presence of a plan:
   
   C. Amount of detail in the plan and furtherance:
   
   D. Reasons not to:
   
   E. Intention:
   
V. Options
   A. Contract.
   
   B. Immediate Plans.
   
   C. Hospitalization.
      
      a. Voluntary.
      
      b. Involuntary.
Lecture #6: The NEO-PI-3

I. Background of the five factors (i.e., Neuroticism, Extraversion, Openness, Conscientiousness, & Agreeableness).
   A. General Comments.

B. Factor Analytic Approaches.

C. History of the Big 5.

1. Thurstone (1934) analysed 60 adjectives and found 5 factors.

2. Cattell (1945) originally found 35 factors. & 12 underlying.

3. Fiske (1949) reduced Cattell's 12 down to 5.

4. Tupes and Christal (1958). Found 5 (Surgency, Agreeableness, Conscientiousness, Emotional Stability, and Culture). Most importantly, found that standing on these factors predicted work performance of cadets.

5. Norman (1963). Used Thurstone's approach, but with a list of **18,125 adjectives**. Found 5 factors closely resembling Tupes and Christal's.
He developed the "master list" of terms that are still used today.

6. McCrae and Costa (1987, 1990, 1994). The majority of variance in personality ratings can be accounted for by the Big-5 personality traits. In addition, standing on these personality traits is quite stable over decades.

II. Overview of Test.
   A. Nuts and Bolts.

   B. Administration.

   C. Scoring.
      1. I have tried to answer all of these questions honestly and accurately.

      2. Have you responded to all of the statements?

      3. Have you entered you responses in the correct area?

III. Interpretation.
   A. Ranges.
      --34 and lower = very low.
      --35 - 44 = low.
      --45-55 = average.
--56-66 = high.
--67 and above = very high.

B. Domains.
   1. Neuroticism.
   2. Extraversion.
   3. Openness.
   5. Agreeableness.

C. Facets.

D. Integration of findings.
   Model 1: Simple--Domain by domain & discuss what is high and low in terms of facets.

   Model 2: Integrative--looking for patterns across domains and facets.

E. Personality disorders.

IV. Psychometrics.
   A. Good internal consistency.

   B. Factor structure is consistent with a five-factor model of personality.
C. Costa and McCrae (1988) found scores on the NEO-PI to be high over the course of six years. Coefficients ranged from .60 to .95 for the five domains.


V. Evaluation:
A. Pros:
   1. Simple model with a lot of research backing.
   2. Facets allow for a rich idiographic, sketch of person.
   3. Can look at normal personality, but also gives Axis I and II.

B. Cons:
   1. Not as much rich, process based information.
Lecture #7: MMPI-2--Background History

I. General.
   --Developed by Hathaway and McKinley and published in 1943.

   --Purpose was to develop a self-report psychodiagnostic instrument.

A. The Criterion-Keying Approach.
   1. Gather a standardization sample of normals and pre-identified members of various diagnostic categories.

   2. All participants complete a large number of items.

   3. Scales are the constructed using items that best distinguish the groups.

   4. Cross-validate on a new sample with the same groups represented in your original sample.

B. Specifics of MMPI Development.
   1. The standardization sample.
      a. More than 800 psychiatric patients from the University of Minnesota Hospitals.
b. 750 "normals."

2. Given 504 items taken from a number of sources including social and personal attitude scales.

3. Looked at frequency of endorsement using a $\chi$ goodness of fit.


5. Raw scores converted to T-scores. With mean of 50, s.d.=10.

C. Diagnostic Categories.
   1--> Hypochondrias.
   2--> Depression.
   3--> Hysteria.
   4--> Psychopathic Deviate.
   6--> Paranoia.
7 --> Psychothemia.

8 --> Schizophrenic.

9 --> Hypomania.

D. Validity Scales.
   1. Cannot say.

   2. Lie.


   4. Fake Bad.

E. Other.
   5 --> Masculinity-Feminity.

   0 --> Social Introversion.

II. A Different Use of the Test.
   A. Why did MMPI fail to differentiate well between diagnostic groups?
      1. Scales intercorrelated b/c of Item overlap.

      2. Unreliability of diagnostic criteria used to diagnose the clinical groups.
B. The cookbook approach.
   --Discovered what the scales measured through clinical experience and empirical research.

   --Over 10,000 studies have been conducted using the MMPI or MMPI-II.

   --A cookbook approach. Look up scale or profile of scales and see what research suggests that they are related to.

III. The MMPI-II (1989).
1. Changed or deleted items that were sexist, Christian-bias, dated terms, grammatically tedious for undereducated, referred to body functions.

2. Change in the way they did the t-scores.

3. New, more representative standardization sample.

4. Added items to create scales of specific clinical interest.
Lecture #8: Administration & Scoring

I. Administration.
   --Paper and pencil & also computer administrations.
   --Materials for paper and pencil administration:
      1. Test Booklets (Sign out from G.A.).
      2. Response Sheets.

II. Scoring.
    A. Template.
       1. Call G.A. for appointment to use template.

       2. Carefully line up template with scanton.

       3. Count and put raw score in profile--convert to standard score.

       4. Make certain that you use the right scoring record forms for gender.

       5. Mark "double marks" with red pencil. and count as "cannot says"

       6. K-correction. Done in terms of the raw scores of K and basic scale.

       7. You will only score the Basic Scales and Harrison-Lingoes Subscales.

    B. Computer Score.
Lecture # 9: Interpretive Strategies and Writing the Results

I. Interpretive Approach (note you do this in order).
   A. Steps.
      1st: interpret validity scales.
      
      2nd: 2 or 3 point code types.
      
      3rd: single scale elevations (generally, focus on the highest relative to others)
      
      4th: content and supplemental.
      
      5th: individual item level.
   
   B. Use of the cookbook approach: Basically apply principles from Integration Worksheet.
      1. Go to chapters 4-7 and pull out summary statements.
      
      2. Not randomly. **Choose statements that "fit" based on interview.**
      
      3. Place more confidence in higher level of analysis.
      
      4. Integrate information from the 4 levels of analysis. Where there is overlap, have more confidence.
II. Interpretive Principles.
   A. Intensity.
      = Higher the score on a scale, higher the probability that the patient exhibits traits associated with the scale.
   
   B. Dominance.
      = Behavioral characteristics reflected by a given scale depend also on the elevation on that scale relative to other scales. More confidence in an interpretation if the scale is a lot higher than the other scales.

   C. Scatter.
      = More differences among scores lead to greater confidence in your interpretation.

III. Summary of Scales.
   -- See Chapter 4 in book.

IV. Common code-types.
   -- See Chapter 5 in book

V. Common Response Sets.
   -- See next page and Chapter 3 in book

VI. Interpretive examples.
   -- See handouts
MMPI-2 Common Response Sets

Random responding:  High F
                    K around 50 T
                    Moderately high L (60 - 70 T)
                    High 6 & 8
                    Very high VRIN

All-True:          Very high F
                    Very Low L & K
                    High 6 & 8
                    Very High TRIN (True)

All-False:         High L, F, & K
                    High left-side clinical scales
                    Very high TRIN (False)

Faking Bad:        Very high F
                    Normal VRIN & TRIN
                    Very high clinical scales especially 6 & 8
                    F-K > 9 (or 11)

Faking Good:       High L & K
                    Very low F
Addendum Lecture—The Restructured Clinical scales of the MMPI-II (Tellegen, Ben-Porath, McNulty, Arbisi, Graham, & Kaemmer, 2003)

I. Rationale for development.
   A. Item overlap and intercorrelations among scales.

   B. Butcher et. al, (1989) (these results were replicated on a college sample by Quereshi & Kleman, 1996):
      1. General maladjustment. F, 4, 1, 7,8 = 35% of the variance
      2. Repression. K, 3 = 16%
      3. Depressive, avoidant, lack of energy. 2, -9, 0 = 12.6% of variance
      4. Masculinity/Femininity. 5 = 8.5%

   *Taken together, these two observations posed an interpretive dilemma....

II. Test development strategy.

III. Interpretations of the RC Scales.
   A. If neither a basic and corresponding RC scale are elevated:

   B. If both a basic and corresponding RC scale are elevated:
C. If a basic scale **IS** elevated, but not the corresponding RC scale:

D. If basic scale **IS NOT** elevated, but the corresponding RC scale is elevated:
Lecture # 10: Psychometrics and Use with Special Populations

I. Reliability.
   A. Internal consistency **handout table 8.5**.
      --Lower than would expect b/c the scales tend to be fairly heterogeneous.

      --But, the basic scales have generally have high number of items.

   B. Test-retest reliability.
      --Values within a week are relatively high.

      --Can also look in terms of whether the relative elevations are stable.

II. Validity.
--Validity coefficients of .20 are respectable if multi-causal model of behavior.

   A. Couples validity study.
      --Compared spouses' behavioral description of partners correlated w/ persons own rating.

      --Found correlations around .20.

   B. Relations to other constructs.
      --Literally thousands of studies.

      --The average validity coefficient is around .46.
III. Use with Special Populations.
A. Elderly.
   --Slightly higher scores on 1,2,3 & 0, and lower scores of scales 4 and 9.

   --Likely that this reflects realistic concerns about growing old rather than greater levels of pathology in the elderly.

B. Minorities.
   --Found for some minority groups in the standardization sample, slightly higher scores across the board. However, interpret with caution because not matched on demographics.
   --Some studies suggest that the MacAndrew Alcoholism scale is not that hot in identifying African American alcoholics.

C. Medical patients.
   1. Screening for psychopathology.
      --Normative for this population is scales 1,2, & 3 between 55-60 and everything else around 50.

   2. Screening for substance abuse.
      --4: 2/4 for male alcoholics: 4/6 for female alcoholics.
      --2/9 for chronic pain populations that abuse narcotics
--MacAndrew Alcoholism Scale Revised--
->we don't know much about how good of job it does assessing prescription drug abuse.

3. Homogeneous subtypes.
   --4 consistent clusters of chronic pain patients:
     i. Conversion V (1,3,2).
     ii. Neurotic triad.
     iii. The normal limits profile.
     iv. General elevations profile.

   --Adjustment before predicts adjustment afterward.

   --Is also a treatment indicator content scale.

D. Use on normals.
   --Aside from personnel selection, is not a lot of research.

   --Defensiveness may be a problem with this population.

   --Some suggest that you merely omit the pathological descriptors, but more research needs to be done on normals.

E. Adolescents: the MMPI-A
--General.

--Rationale.

--Differences between MMPI-2 and MMPI-A.

1:

4:

5:

9:

0:
F. Children: the Personality Inventory for Children (PIC)
   --General.

   --Interpretation.
   --4 validity scales and 12 major scales.

   Achievement (ACH):

   Intellectual Screening (IS):

   Development (DVL):

   Somatic Concern (SOM):

   Depression (D):

   Family Relations (FAM):

   Delinquency (DLQ):

   Withdrawal (WDL):

   Anxiety (ANX):

   Psychosis (PSY):

   Hyperactivity (HPR):
Social Skills (SSK):

--Also can classify into 12 discrete types.
The MCMI-III

I. Overview.
   A. General comments.
   B. Distinguishing features/Core assumptions.
      1. Theory based.
      2. Categorical system.
      3. Personality pathology is on a continuum.
         --Further, personality disorder results from a bad match between a person's traits and the nature of the situation.
   C. Appropriate uses.
      1. Caution with persons with fewer than eight years of education.
      2. Must be 17 or older.
      3. Can the test be used with normals?
         --Millon says no. Was normed on psychiatric patients.
         --Choca & Denberg say yes. Wording of items is extreme. Also, what constitutes a psychiatric population?
   C. Administration
      --See computer administration handout.
   D. Scoring.
      1. Advantages.
2. Interpretation of base rates.

"the probability that the examinee has the particular characteristics being measured rather than the simple position that she or he occupies in the normal distribution."

--low scores can be mostly disregarded.

--BR=35 defined as the median for normal/nonpsychiatric population.
--BR=60 set as a median for psychiatric population.
--BR=75 anchor point for the definite presence of the trait.
--BR=85 point at which trait is the most prominent characteristic of their personality.
--Low BR does not mean absence of the trait.

II. Millon's Theory of Psychopathology.

III. Interpretation.
   A. Scale makeup.
      --See profile sheet of computer generated report.

      --1 validity.
      --3 response styles.
      --11 personality styles.
      --3 severe personality patterns.
      --7 clinical syndromes.
      --3 severe syndromes.

   B. Interpretative Tips.
      1. Examine the issue of validity and defensiveness.
         --Validity (V) scale=3 items that are blatantly
5. Integrate all of this into a **wholistic picture** of the person.

VI. Integration with the MMPI-II.
   --See table.

   --Separate sections in Tests Results section.

   --In Summary and Conclusions, talk about the tests as a unified entity, highlighting inconsistencies (if any) between the tests.

V. Psychometrics
   A. Reliability.
      1. Internal consistency: generally acceptable. Ranges from .66 (Compulsive Scale) to .90 (Major Depression Scale).

      2. Test-retest: Also good. Ranging from .82 for the Debasement scale to .90 for the Somatoform scale.

      3. Stability of the highest elevations: Millon reported that patients had the same first or second highest scale on two administrations in about 70% of cases. Approximately 50% of the patients had the same highest 2-point code in either the same or reverse order.

   B. Validity.
      1. Of the measure.
         --High face validity.

         --Positive Predictive Values.
         Gibertini et al. (1986).
implausible.

If invalid on this index, won’t print the rest!!!

--Disclosure Index.

--Desirability Index.

--Debasement Index.

--Benchmark is 35 & 75 for disclosure and 75 for other two.

2. Characterize the individual’s basic personality style.

   --Limit scale only to highest two or three especially if greater than 75.

   Do not interpret under 60.

   --Salients.

3. Evaluate with both MCMI and historical data, the level of functionality of the personality style.

   --With severe personality scales, view each separately (so if all elevated, can talk about all).

   --Again less than 60 is not diagnostic.

   --75-85 suggest chronic and moderately severe level of personality pattern.

4. Describe the clinical syndrome or Axis I symptoms that the person appears to be experiencing.

   --BR inclusive of 75-84 suggest presence of disorder.

   --GR>85 strong support for the presence of the disorder
Eight were good (Avoidant, Dependent, Histrionic, Negativistic, Borderline, Anxiety, Dysthymia, and Drug Abuse)

9 were fair (Scizoid, Narcissistic, Antisocial, Compulsive, Schizotypal, Paranoid, Somatoform, Hypomania, and Alcohol Abuse; and 3 were poor (Psychotic Thinking, Psychotic Depression, and Psychotic Delusions).

A potential big problem in when using in settings where the base rates are different from the standardization sample.

2. Of the NCS interpretive report.
   --Diagnostic accuracy of the computer-generated MCMI diagnoses have been found to be deficient every time used.


   Do not use this in your report.
LECTURE # 12--THE RORSCHACH INKBLOT TEST

I. Uses.
   A. Hermann Rorschach (a Swiss psychiatrist in the 1900s).
      --Used as a tool to assess perceptual processes. Not concerned with content so much as formal features of the response.

   B. The projective hypothesis.
      =Blank screen that project unconscious needs, motives, and desires, and fears.

   C. Scoring systems.
      --Klofer (50's) and Beck (60's) were of some of the popular scoring systems.

      --In 1970's Exner undertook the task of unifying a number of systems under one standardized system.

II. Administration.
   A. Set up and materials.
      --Ten inkblots: seven black and white, three color.

      --Is best done side by side.

      --Cards are laid face down.

      --Start timing the moment they get the card.
B. Instructions and recording.
   --The larger idea is that you are trying to give minimal encouragement-direction.

   --First time through record: position of card, verbatim response, and time before first response to card.

   --Each separate response to the card has a subordinate numbering.

C. Inquiry.
   --Are trying to see where and why they see a given image without asking directly.

   --Use their words to further inquiere about something.

III. Scoring and interpretation using a scoring system.
   A. Overview.
      1. Derive scores for the following nine domains: Location, developmental quality, determinants, form quality, pairs, content, populars, z-scores, and special scores.

      2. Fill out structural summary on the basis of a series of formulas.

      3. Compare the scores with norms.
4. Interpretations based on an interpretative workbook, or Exner text.

B. The Nine Domains.
   1. Location:

   2. Developmental quality:

   3. Determinants:

   4. Form quality:

   5. Pairs:

   6. Content:

   7. Popular:

   8. Z-scores:

   9. Special scores:
      1. Deviant verbalization.
2. Deviant response.

3. Incongruous combinations.

4. Inappropriate logic.

5. Fabulized combinations.

6. Contamination.

7. Perseveration.

8. Confabulation.


11. Morbid content.


IV. Interpretation of Some of the Major Indices:

**Lambda:** Number of pure form responses/Total R-Pure form

**Coping Style:**
**Erlebnistypus (EB):** Sum of human Movement: Weighted sum of color (a pure color response is weighted the heaviest).

If \( M > W\text{sumC} \) = Introversive.

If \( M < W\text{sumC} \) = Extratensive.

If \( M = W\text{sumC} \) = Ambitent.

**Resources to handle stress:**

**Experience Actual (EA):** The sum of the \( M \) and \( W\text{sumC} \).

**Stress**

**Experienced stimulation (es):** Sum of Animal movement, inanimate movement, all achromatic color, texture, shading, and vista responses.

**Stress tolerance**

**Experienced Distress (D Score):** An index that represents \( EA - es \), and is converted through the use of tables.

**Affective Ratio (Afr):** Number of responses to Card VIII + IX + X / Number of responses to all cards.

**Characteristics of Perception**

\( X+\% \): the sum of form quality + and 0 / # of responses.
X-%: the sum of form quality -/# of responses.

W: D ratio: D is economical whereas W is sophisticated.

V. Psychometrics of the Rorschach.
   A. Stability.
      --Reliability studies show good test-retest reliability of 19 scores and 5 ratios.

      --Studies suggest that the indices that are suppose to measure stable characteristics, are in fact, stable, and vice versa.

      --Similarly, as one would some indices are more stable in adulthood.

   B. Inter-rater reliability: Two controversies.
      1. Did not correct for base rates.

      2. I think should calculate reliability of inquiry.

   C. Construct Validity.
      --It appears that there is evidence for validity of specific indices.

      --The major point is that, given the diverse range of constructs measured in the test, one should avoid making blanket statements about the test.
D. Incremental validity.
   --Does not add over face sheet and interview in prediction.

VI. Advantages/disadvantages of projective assessment:

   Pros:
   1. Stimulus less obvious in content, so less subject to faking & response sets.

   2. Recent refinements in scoring & interpretation.

   3. May be able to get at deeper layers of personality of which even the examinee may be unaware.

   4. Can be used, even without good psychometrics, the same way we use ourselves in interview, dream interpretations, etc.

   5. Some techniques (e.g., drawings) can be an extension of the interview.

   Cons:
   1. Imagination of the interpreter may be what's being measured; some think that's all that's measured.

   2. Very dependent on skill & care of examiner.

   3. Poor psychometrics of most projectives.
Lecture #13--Behavioral Assessment

I. Historical Background/Conceptual Placement of the Approach.
   A. Traditional assessment approaches assume the following:
      1. A person's responses reflect underlying personality processes or traits.
      2. Following from #1, one's response on a given measure is a "sign" of the phenomenon of interest.
      3. The primary goal is to measure personality or psychopathology.
   B. Walter Mischel
      1. In the 60's, wrote a highly influential article criticizing trait theory.
      2. Claimed that aggregate measures do a very poor job at predicting behavior in specific situations.
      3. Rather, should take an idiographic approach in which you examine past behavior in similar situations.
      4. The treatment implications stem directly from the results of the behavioral assessment.
II. Functional Analyses of Behavior.

A. Recording of the Behavior.
   1. The client records instances of the behavior, as well as instance of non-occurrence, throughout the day.

   2. You can have them record simple counts of the behavior or ratings of intensity. You also want them to briefly describe the situation.

   3. You want them to make records no less than 4 hours apart & discourage them from summarizing at the end of the day!

   4. Limit the number of different things that they record & reinforce them for completion of the assignment.

   5. Have them make frequent ratings at first, then taper.

B. What to assess.
   1. Conditions that give rise to the problem in question for that individual.

   2. Stimulus events
      Organismic variables
      Response
      Consequences
3. Situations where there are similar stimulus conditions, but the behavior does not occur.

4. Structure your interview to obtain this information. Use the information the self-monitoring data as a jumping off point for the interview.

5. The ultimate goal is to develop an understanding of the mechanism through which symptoms develop for this specific individual.

6. The treatment plan will directly stem from your understanding of these mechanisms involved.