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MINNESOTA MULTIPHASIC INVENTORY

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I. General considerations
   A. Defects of most personality tests
      1. Too obvious
      2. Unimportant traits
      3. No check on cooperation, etc.
      4. Too short
      5. Too hard for average person to understand
      6. Theoretical rather than experimental in development
   B. Construction of Multiphasic test
      1. Sources: Clinical experience, previous tests, books on abnormal behavior, psychiatric examination, neurologic examination, hunches, etc.
      2. Pool of around 1000 whittled down to 550 by eliminating overlap, very unclear items, items answered alike by everyone, and so on
      3. Vocabulary simplified. Sentence structure understandable to low normals
      4. For hospital use, printed on cards--no writing required. Advocate use of card form whenever feasible.
   C. Method of developing scales
      1. We do not look upon the answers as "accurate" self-ratings. This is the most fundamental point to see about MMPI. The reactions of the subject are taken as samples of his verbal activity. Whether what he says is in agreement with what others would conclude from observing him is not the question. Problem: what kinds of people (defined by external and "practical" behaviour differences) tend to answer certain questions in certain ways? This is an empirical problem.
      2. Select a carefully diagnosed group of abnormal persons. Find out how they answer these questions. Compare their answers with the answers of a large number (over 800) "normal" people in Minnesota. Find the questions which are responded to differently by these two groups. Then such "differentiating" questions are put on one scoring key and called a <u>scale</u> for the particular abnormal tendency in question.
      3. Notice that this procedure is a straight forward solution to the practical problem of telling people apart. You give them a lot of chances to react differently, and you find out empirically which of the chances are taken more by one group than another. There are no assumptions here concerning the meaning of the questions, accuracy of self-observation, insight, and the like.
      4. Furthermore, a procedure such as this tend to develop scales which are more "subtle." That is, if the psychologist could not have told before hand how certain kinds of people will answer these questions, it is not easy for the layman to know this when he takes the test. Thus we have a test which is relatively less susceptible to faking, lying, etc.

II. Scales on the Multiphasic Inventory
   A. Validity scales
      1. Validity scales are scales not devoted primarily to personality traits as such, but to the question, "Was this subject cooperative? Did he understand the questions? Was he trying deliberately to put himself in a good or bad light? Is his language comprehension adequate?" In other words, the validity scales aim to determine whether we should accept the other scores.

2. Question score: To how many items did subject refuse to respond, i.e. sort into the "Cannot say" category? Naturally, if too many items are left unanswered, the total amount of information on which scale scores are based is decreased.
3. L score. (L means lie, but this is too strong a term here.) Represents the tendency of subject to put self in a favorable light. Method is to present some very good traits, see if subject claims them. "I never laugh at a dirty joke" "I never put things off till tomorrow" "I like everyone I know" "I am never more irritable when sick" and so on. If a person claims too many of these desirable traits, we assume he is either kidding himself or is actually trying to fake the test, look good in our eyes. Therefore, the rest of the scores are viewed with suspicion and if somewhat abnormal, we sort of correct for this tendency and assume them to be even more abnormal than they appear.
4. F score. Based upon the number of very rare responses given. If a person says many unusual, peculiar things about himself, it may be that he is being careless in reading the questions, or does not understand them, or is not cooperating at all, or is trying to make himself look worse than he is, etc. This score is also a check on gross clerical errors in scoring, recording, etc.
5. K scale. A more "subtle" scale which attempts to get at the attitude a person takes toward the test; it functions somewhat like F at one end, like L at the other. We at present have introduced a mechanical method of using F so that the correction for attitudes of defensiveness or self-criticism may be made mathematically without any human judgment.

B. Personality scales proper (See Manual for description of meaning)
1. Hypochondriasis: Bodily preoccupation, vague symptoms, peculiar feelings, etc.
2. Depression: A "mood" scale. How blue is the person at the time? What is the level of his morale, energy level, attitude toward the future, and so on.
3. Hysteria: Tendency to develop bodily symptoms on psychological basis. Such as a headache when you don't want to work, vomiting with disgust, etc. Also a tendency of these people to deceive themselves, conceive selves as very well-adjusted. Solve problems by hiding from them.
4. Psychopathic deviate: Dack of responsibility, impulsive, egotistical, no consideration for others. Poor integration of life goals. Often seems to be a friendly, likeable person, until you have to depend upon him for something. Basically cold, unemotional in spite of superficial ease and extraversion. A serious problem because he is hard for the unskilled to spot. Makes a good impression but gets into trouble later; seems unable to learn by experience.
5. Masculinity-femininity: Extent to which interests and attitudes resemble those of own versus opposite sex. Chiefly aimed at detection of homosexual trends in men, but not apparently specific for this.
6. Paranoia: In extreme form, delusion that people persecute you and so on. But a milder form, involving merely suspiciousness, sensitivity, rigidity, stubbornness, tendency to blame others, think one is unfairly treated. Such people are likely to be trouble-makers either in a subservient or dominant position.

7. Psychasthenia: In full-blown form, refers to people who have morbid fears, irrational forced thoughts and impulses, constant anxiety and so on. But there are milder forms, involving chiefly a worrisome, anxious, insecure attitude toward the future, toward other people, and toward the self.
8. Schizophrenia: A tendency to bizarre, disjointed, peculiar thoughts and feelings or actions. Often involves an excessive introversion, lack of concrete practical orientation, inability to come to grips with real life problems.
9. Mania (hypomania): Elated mood, press of activity, ebullience, drive, high spirits. Often inadequate control and failure to follow through. There is evidence that successful salesman are elevated on this scale. Also that people selected by interviews tend to be elevated on it (probably because such persons make a good interview impression).

C. Interpretation

1. These scores plotted on a standard scale so that the average person gets a score of 50, and around 1 person in 20 - 40 will score above 70. These scores are represented by means of a profile.
2. Although fairly short definition can be given as above for each component, there are complex patterning considerations which require a great deal of clinical skill and experience to utilize. At present, we are trying to reduce these to more objective status, so that a less thoroughly trained person may be able to utilize them with profit.
3. As always, it is necessary to interpret test results with the other data in mind.
4. It should be stressed that this test was developed specifically for use in mental hospitals. The scales are based upon psychiatric patients. For this reason, we are very cautious in recommending its use for industrial purposes. We are very interested in personnel and industrial applications, and welcome studies of its validity in this situation. Thus far, the letters we have received and the personal conversations we have had with personnel men suggest that it has some degree of usefulness in these situations. But I wish very strongly to stress that we do not advocate its use here as a valid test, or make claims in its behalf. Only recently have we even collected any actual quantitative data indicating whether it can be meaningfully applied within the normal (non-hospital) range at all. So far, results are encouraging.
5. Some of the problems of frankness and deception are undoubtedly different both in quality and degree in the industrial situation. These should be directly attacked in that real life situation by psychologists or personnel men who are competent to evaluate the problem and the results of a careful study. We do not feel that as clinical psychologists, we can or should undertake studies in this area. Theoretically, the method of construction of the test should lead to its being a more useful instrument in business and industry than tests based on other principles.