SE VOCATIONAL EXPERTS

Psychological Injury & Malingering:

Forensic Context, Assessment, and Vocational Implications

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GOAL:

- Provide an understanding of how psychological injuries are legally defined, measured, and assessed; as well how they relate to worker traits and characteristics for employability.

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OBJECTIVES:

- Learn the definition of Psychological Injury in the legal context.
- Review psychological protocols and tests used in assessment to measure psychological issues.
- Learn the validity scales used to determine cognitive and/or symptom malingering.
- Learn how to personally review pervious testing scores to help ensure previous evaluator's conclusions have a basis of reliability and validity.
- Review how psychological scores relate to RHAJ worker traits and characteristics and mental demands of employability to determine forensic vocational implications.

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Psychological Injury in the legal context

- Today We Are looking at 'Injury' in a more Purely

"As A Psychological/Mental Health construct"

Rather Than

Our usual construct of "Residual Functional Capacity" that is largely based on physical capacities.

Forensic Mental Health Perspective

Experts must do something more than just "rule out" other possible causes. They must explain how they were able to "rule in" the product *[in a product liability case]* in question. If all the expert does is rule out other possible causes, he or she may fail to account for other potential (and sometimes unknown or unthought of) causes. When an expert only rules out causes, the trier of fact knows only what did not cause the harm. This does not necessarily aid the trier of fact in determining what did cause the harm — and that is what the law requires in tort cases, especially those that involve allegedly toxic products.

Siharath v. Sandoz Pharmaceuticals Corp, 131 F. Supp.2d 1347 (N.D.Ga. 2001), pp. 1371–1372.

It's incumbent on the expert to try to identify probable causes of any psychopathology or psychological harm identified.

Forensic Mental Health Evaluation

Use of the term FMHE to maintain focus on this view point.

- Seeks to identify any mental disorders
- the legally relevant functional abilities affected by the allegedly traumatic incident(s)
- the nature and strength of any causal connection between the allegedly traumatic event(s) and the resultant functional abilities of the plaintiff

First Steps

Legal requirements into Psychological/Mental Health Terms

- (1) applying a biopsychosocial model
- (2) utilization of standardized procedures
- (3) use various information sources
  - standardized tests
  - other instruments
  - collateral sources
- (4) comparing the individual with relevant group data and base rates
- (5) considering iatragenic and litigation-related factors, and (6) comparison of current and premorbid levels of functioning

Kane, Andrew W.; Dvoskin, Joel A.. Evaluation for Personal Injury Claims (Best Practices for Forensic Mental Health Assessments) (Page 31). Oxford University Press. Kindle Edition

Looking at the Event and the Individual

Five Possibilities in each case:

(1) the event is sole cause of the psychological injury (rare)

(2) the event was the primary cause of the psychological injury (that is, the proximate cause), and but for the traumatic event the person would not have their present level of psychopathology, disability, or other psychological distress (e.g., grief)

(3) the traumatic event materially contributed to assessed psychopathology or other psychological distress but was not the primary cause

(4) the traumatic event had little identifiable affect on the individual

(5) the traumatic event had no identifiable affect on the individual

Pre-Trauma Functioning Vs. Post-Trauma

Record Review considerations:

medical, psychotherapy, school, arrest, employment, military, personnel, pharmacy, tax

the changes identified may not have been caused by the traumatic event but, rather, by other major life events

At the very least, the records review should go back three to five years prior to the event

Examiner Bias

" Halo effect" refers to "the tendency for a general evaluation of a person, or an evaluation of a person on a specific dimension, to be used as a basis for judgments of that person on other specific dimensions"

APA Concise Dictionary of Psychology, 2009, p. 220)

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It's incumbent on the expert to try to identify probable causes of any psychopathology or psychological harm identified.

Defining Scope of Evaluation

Looking at Psychological & Cognitive Issues

Referral Questions often are:

- Determine if symptoms are a diagnosis?
- Define reported symptoms in functional context.
- Malingering?
- Describe & Measure affect Work Capacity & ADL's
- If in treatment progress and recovery?

Clinical Assessment

Actuarial assessments are those that are statistically-based, involving the "use of data about prior instances, in order to estimate the likelihood or risk of a particular outcome"

APA Concise Dictionary of Psychology, p. 8

Such as MMPI, PAI,

Actuarial Instruments

Most instruments and the beginning of MMPI, PAI, & other tests weren't originally designed: **Forensic USE**

They are now moving into that direction but the manuals caution the use in Forensic Evaluations

Because of this they cannot 'speak' the ultimate issue before the court

Clinical interview & Clinical Judgement tied to evidence

Third-Party Presence

Individual being assessed should be alone with the examiner.

Attorneys often want to be present during an assessment, or to have someone else present.

Assessment instruments are standardized with only the examiner present

NO research literature identifying the degree to which the results of a no standardized administration may alter the results of a particular instrument.

This is also true with regard to audio- or video-recording.

There is research indicating an adverse impact on the validity of some psychological tests when a third party is present or the assessment is *recorded (Ackerman & Kane, 1998 ; Constantinou, Ashendorf, & McCaffrey, 2002 ; Constantinou & McCaffrey, 2003 ; Kehrer, Sanchez, Habif, Rosenbaum, & Townes, 2000 ; Lezak, Howieson, & Loring, 2004).*

There is no research, however, indicating that testing is as valid when a third party is present or the assessment is recorded as when it is not.

Examinees who are aware that their assessment is being recorded, either in audio only or in combined audio and video, may also alter their assessment behavior

Problem is The need for Transparency

Pitt, Spiers, Dietz and Dvoskin (1999) have argued for preserving the interview on audio- or video-tape whenever possible.

Forensic Interview Vs. Forensic Test

psychological interviews are typically unstructured or Semi-Structured

Vast Professional Individual differences:

in style and content,

U.S. Supreme Court

- The U.S. Supreme Court did not differentiate between interviews and psychological tests—they are lumped together as "evaluations"—in addressing this issue.

Estelle v. Smith (451 U.S. 454, 470, n. 14, 1981)

the Supreme Court held that the physical presence of an attorney during an evaluation "could contribute little and might seriously disrupt the examination."

A number of lower court cases have also ruled the presence of a third party, including audio- or video-taping of a psychological evaluation, is not appropriate, e.g., *Shirsat v. Mutual Pharmaceutical Co. (169 F.R.D. 68,*

Exaggeration

- *Many individuals will exaggerate their difficulties to some degree.*

- • "Exaggeration" conscious or unconscious.
- • "Feigning"
- • "Malingering" i

Handling **Malingering and Feigning**

The evaluator should choose tests that have demonstrated significant sensitivity and specificity in the assessment of feigning, and that also add incremental validity to the data that are obtained.

Sensitivity & Specificity

- Sensitivity' reflects a test's capacity to select many or most of the individuals who possess the trait or exhibit the behavior that the test is designed to measure.
- 'Specificity' is an index of the degree to which the test selects only those individuals possessing the trait or expressing the behavior that the test is designed to detect" A sensitive test will have few false negative results, and a test with high specificity will yield few false positive results.

Assessing Response Style

- True Rate of Malingering in Disability Evaluations Unknown.
- Estimates often Range from 7.5% to 33% (Samuel & Mittenberg, 2005)

Feigned Conditions

- Psychological
- Cognitive "effortful failure"
- Physical "effortful failure"
- Pain Behaviors

Specialized Tests – Feigned Psychosis

Miller Forensic Assessment of Symptoms test (M-FAST)

Structured Interview of Reported Symptoms (***SIRS***)

Structured Inventory of Malingered Symptomatology (SIMS)

Specialized Tests – Feigned Cognitive

- Validity Indicator Profile (VIP)
- Test of Memory Malingering (TOMM)
- Portland Digit Recognition Test (PDRT)
- Victoria Symptom Validity Test (VSVT)
- Word Memory Test (WMT)

Forensic Assessment: Mental Health

Most common tests used

- MMPI-2
  - MMPI- RF (Restructured Form)
- Personality Assessment Inventory(PAI)

Uses and Limitations of Clinical Assessment Instruments in Forensic Applications

- Uses:
  - Traditional clinical tests can provide a broad under standing of an individual's intellectual, emotional, and personality functioning.
    - Limitation: The original development of most traditional clinical tests focused on diagnosis and treatment planning, not on forensic applications.

How to use Clinical Tools in Forensic Settings

- Clinical assessment tools may be employed for forensic purposes when they are appropriate and relevant to the specific legal question, but evaluators must maintain an awareness of how their methods will be received by the trier of fact.
- Similarly, clinical assessment tools should not be used to address forensic questions beyond the scope of the instrument. For example, forensic evaluators are sometimes asked to reconstruct an individual's mental state at a prior point in time; however, traditional clinical tests are typically of very limited value for such reconstructions.

How to use Clinical Tools in Forensic Settings

- Fortunately, knowledgeable interpreters understand and can explain to the trier of fact that the PERSONALITY TEST results are not interpreted in isolation but ***within the context of overall test findings.***

Considerations before using MMPI/PAI in Forensic Evaluations

- An examiner must consider the following before administering any test as part of a forensic evaluation:
  - The scope of the evaluation and limitation of the test instrument.
  - The participant's perspective and need for collateral information (the participant's "agenda")
  - The "voluntariness" of the participant's involvement (are they willingly involved or court ordered? This leads to questions related to reluctance, guardedness, and possibly being uncooperative).
  - Threats to validity (related to perspective). What do they have to prove? What is their goal? What motives do they have to be false or at the very least misrepresent themselves?

MMPI

- The best known objective personality test is the MMPI. This test was created primarily to measure psychopathology. It contains several validity scales to determine if the client is responding to the questions accurately and truthfully, and it also contains ten basic clinical scales. Hundreds of additional scales have been created for the MMPI to measure virtually every personality trait and emotion
- conceivable. The MMPI was recently revised; the MMPI-2 is now the more commonly used edition. The MMPI is interpreted by looking at scale elevations and configurations. Although limited interpretation can be done by computer programs, a skilled assessor is needed to make accurate interpretation which take into account a person's background and other test data.

OG ---MMPI BACKGROUND

- Clinical Scales developed by Hathaway and McKinley in late 1930s early 1940s
- Intended to function as a differential diagnostic test
- Targeted Kraepelinian nosology
- Published 1943
- Didn't work as intended

MMPI-2-RF Overview

- Published 2008
  - Authors Ben-Porath & Tellegen
- 338 items
- Subset of MMPI-2 Item Pool
- Norms based on MMPI-2 normative sample
- 240+ peer-reviewed publications
- Used widely in mental health, medical, forensic and public safety settings

MMPI-2-RF Overview

- 51 Scales
  - 9 Validity Scales
  - 3 Higher-Order Scales
  - 9 RC Scales
  - 23 Specific Problems Scales
    - 5 Somatic/Cognitive
    - 9 Internalizing
    - 4 Externalizing
    - 5 Interpersonal
  - 2 Interest Scales
  - 5 PSY-5 Scales

MMPI-2-RF

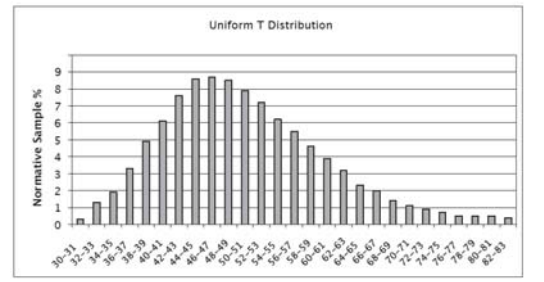
- **Qualification Level:** C
- **Age Range:** 18 years and older
- **Reading Level:** 5th grade (Lexile average), 4.5 grade (Flesch-Kincaid)
- **Administration:** Online, computer, CD, or paper and pencil.
- **Length:** 338 True-False items
- **Completion Time:** 35-50 minutes
- **Norms:** The MMPI-2-RF normative sample is drawn from the MMPI-2 normative sample and consists of 2,276 men and women between the ages 18 and 80 from several regions and diverse communities in the U.S. The MMPI-2-RF T scores are non-gendered and non-K-corrected. No new norms were collected for the MMPI-2-RF.
- **Scoring Options:** Q-global™ Scoring & Reporting, Q-Local™ Software, Hand Scoring, or Mail-in Scoring Service
- **Report Options:** Score, Interpretive and Police Candidate Interpretive
- **Publication Date:** 2008

MMPI-2-RF: Standard Comparison Groups

- MMPI-2-RF Normative (Men & Women)
- Outpatient, Community Mental Health Center (Men & Women)
- Outpatient, Independent Practice (Men & Women)
- Psychiatric Inpatient, Community Hospital (Men & Women)
- Psychiatric Inpatient, VA Hospital (Men)
- Substance Abuse Treatment, VA (Men)
- Bariatric Surgery Candidate (Men & Women)
- Spine Surgery/Spinal Cord Stimulator Candidates (Men & Women)
- Chronic Pain (Men & Women)
- College Counseling Clinic (Men & Women)
- College Student (Men & Women)
- Forensic, Disability Claimant (Men & Women)
- Forensic, Independent Neuropsychological Examination (Men & Women)
- Forensic, Pre-trial Criminal (Men & Women)
- Forensic, Child Custody (Men & Women)
- Forensic, Parental Fitness Evaluees (Men & Women)
- Prison Inmate (Men & Women)
- Personnel Screening, Law Enforcement (Men, Women & Combined)
- Personnel Screening, Corrections Officer (Men, Women & Combined)
- Personnel Screening, Clergy Candidates (Men, Women, & Combined)

Administering and Scoring the MMPI-2-RF

- Scoring:
  - Normative Sample:
    - MMPI-2 Normative Sample Collected in 1980s
    - Non-gendered norms (1,138 men, 1,138 women)
    - Norms appear to be holding up well (Technical Manual Appendix C)
    - Uniform T scores
  - Comparison Groups
    - Technical Manual Appendix D
    - Embedded in scoring software



MMPI-2-RF: Specific Problems (SP) Scales

- **Externalizing**:

RC4 Facets

- JCP: **Juvenile Conduct Problems** – Difficulties at school and at home, stealing
- SUB: **Substance Abuse** – Current and past misuse of alcohol and drugs

RC9 Facets

- AGG: **Aggression** – Physically aggressive, violent behavior
- ACT: **Activation** – Heightened excitation and energy level

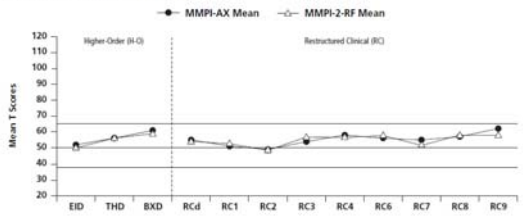
MMPI-2-RF: PSY-5 Scales

- Revised versions of dimensional model of personality pathology developed by Allan Harkness and John McNulty:
  - AGGR-r: **Aggressiveness-Revised** – Instrumental, goal-directed aggression
  - PSYC-r: **Psychoticism-Revised** – Disconnection from reality
  - DISC-r: **Disconstraint-Revised** – Under-controlled behavior
  - NEGE-r: **Negative Emotionality/Neuroticism-Revised** – Anxiety, insecurity, worry, and fear
  - INTR-r: **Introversion/Low Positive Emotionality-Revised** – Social disengagement and anhedonia

MMPI-2-RF: Higher-Order Scales

- EID – **Emotional/Internalizing Dysfunction** – Problems associated with mood and affect
- THD – **Thought Dysfunction** – Problems associated with disordered thinking
- BXD – **Behavioral/Externalizing Dysfunction** – Problems associated with under-controlled behavior

MMPI-AX/MMPI-2-RF Higher-Order (H-O) and Restructured Clinical (RC) Scales Means and Standard Deviations: Normative Comparability—Men



MMPI-AX Mean	52	56	61	55	51	49	54	58	56	55	57	62
SD	10	9	10	10	10	10	8	11	11	10	11	12
MMPI-2-RF Mean	50	56	59	54	53	49	57	57	58	52	58	58
SD	11	10	10	9	10	13	9	11	11	9	10	11

Note. MMPI-AX *N* = 103. MMPI-2-RF *N* = 89.

MMPI-2-RF: RC Scales

- Identical to MMPI-2 RC Scales
  - RCd: **Demoralization** – General unhappiness and dissatisfaction
  - RC1: **Somatic Complaints** – Diffuse physical health complaints
  - RC2: **Low Positive Emotions** – Lack of positive emotional responsiveness
  - RC3: **Cynicism** – Non-self-referential beliefs expressing distrust and a generally low opinion of others
  - RC4: **Antisocial Behavior** – Rule breaking and irresponsible behavior

MMPI-2-RF: RC Scales

- RC6: **Ideas of Persecution** – Self-referential beliefs that others pose a threat
- RC7: **Dysfunctional Negative Emotions** – Maladaptive anxiety, anger, irritability
- RC8: **Aberrant Experiences** -- Unusual perceptions or thoughts
- RC9: **Hypomanic Activation** – Over-Activation, aggression, impulsivity, and grandiosity

MMPI-2-RF: Specific Problems (SP) Scales

- **Somatic/Cognitive**
  - MLS: **Malaise** – Overall sense of physical debilitation, poor health
  - GIC: **Gastrointestinal Complaints** – Nausea, recurring upset stomach, and poor appetite
  - HPC: **Head Pain Complaints** – Head and neck pain
  - NUC: **Neurological Complaints** – Dizziness, weakness, paralysis, loss of balance, etc.
  - COG: **Cognitive Complaints** – Memory problems, difficulties concentrating

MMPI-2-RF: Specific Problems (SP) Scales

- **Internalizing (RCd Facets)**:
  - SUI: **Suicidal/Death Ideation** – Direct reports of suicidal ideation and recent attempts
  - HLP: **Helplessness/Hopelessness** – Belief that goals cannot be reached or problems solved
  - SFD: **Self-Doubt** -- Lack of self-confidence, feelings of uselessness
  - NFC: **Inefficacy** – Belief that one is indecisive and inefficacious

MMPI-2-RF: Specific Problems (SP) Scales

- **Internalizing (RC7 Facets)**:
  - STW: **Stress/Worry** -- Preoccupation with disappointments, difficulty with time pressure
  - AXY: **Anxiety** – Pervasive anxiety, frights, frequent nightmares
  - ANP: **Anger Proneness** -- Becoming easily angered, impatient with others
  - BRF: **Behavior-Restricting Fears** -- Fears that significantly inhibit normal behavior
  - MSF: **Multiple Specific Fears** -- Fears of blood, fire, thunder, etc.

MMPI-2-RF: Specific Problems (SP) Scales

- **Interpersonal**:
  - FML: **Family Problems** – Conflictual family relationships
  - IPP: **Interpersonal Passivity** – Being unassertive and submissive
  - SAV: **Social Avoidance** – Avoiding or not enjoying social events
  - SHY: **Shyness** – Bashful, prone to feel inhibited and anxious around others
  - DSF: **Disaffiliativeness** – Disliking people and being around them

MMPI-2-RF: Interest Scales

- AES: **Aesthetic-Literary Interests** – Literature, music, the theater
- MEC: **Mechanical-Physical Interests** – Fixing and building things, the outdoors, sports

MMPI-2-RF: PSY-5 Scales

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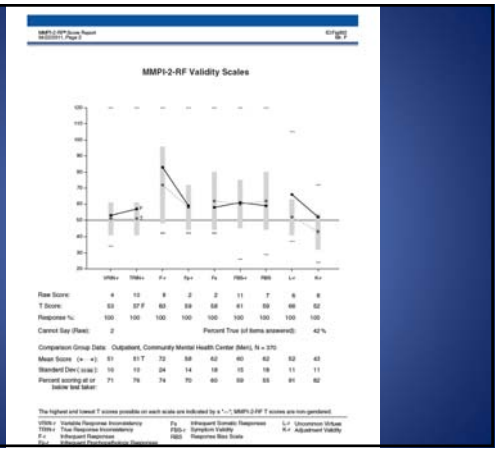


MMPI-2-RF: Validity Scales

VRIN-r: **Variable Response Inconsistency** – Random responding
TRIN-r: **True Response Inconsistency** – Fixed responding
F-r: **Infrequent Responses** – Responses infrequent in the general population
Fp-r: **Infrequent Psychopathology Responses** – Responses infrequent in psychiatric populations
Fs: **Infrequent Somatic Responses** – Somatic complaints infrequent in medical patient populations
FBS-r: **Symptom Validity** – Somatic and cognitive complaints associated at high levels with over-reporting
RBS: **Response Bias Scale** - Exaggerated memory complaints
L-r: **Uncommon Virtues** – Rarely claimed moral attributes or activities
K-r: **Adjustment Validity** – Avowals of good psychological adjustment associated at high levels with under-reporting

MMPI 2 RF in Forensic Use

- Several surveys have indicated that the MMPI-2 is more frequently used in forensic settings than any other test and is considered appropriate for most forensic questions (Lally, 2003).
- The MMPI-2 is second only to the Wechsler Intelligence Scales in forensic neuropsychological evaluations (Lees-Haley, Smith, Williams, & Dunn, 1996).

MMPI 2 RF in Forensic Use

- The test is also used quite frequently in other countries, such as Australia (Martin, Allan, & Allan, 2001), for forensic purposes.
- Given the instrument's widespread use in forensic assessments, Otto (2002) indicates that the question is not whether it is appropriate to use the MMPI-2 in forensic settings but rather for what purposes.

MMPI-2 RF Limitations

- Criterion norms now very dated.
- Confounding of categories leads to uncertainty about the severity of disorder.
- Considerable item overlap amongst scales (increasing correlations and attenuating their discriminant validity.

MMPI 2 RF Limitations

- High educational and SES of randomization sample may lead to bias against lower educated/SES.
- The number and complexity of scales makes hand scoring difficult and time consuming.
- For maximum accuracy, the test requires a 9th grade reading level.
- Length of test requires sustained attention and cooperative attitude of test taker.
- The interpretive process and set of procedures and checks are considerably more subtle, complicated, and demanding than they appear.

Limitations of MMPI-2 RF Forensic Use

- Admissibility
- In federal courts and most state courts, the applicable standards are outlined in the U.S. Supreme Court decision in Daubert v. Merrell Dow Pharmaceuticals, Inc. (1993).

Limitations of MMPI-2 RF Forensic Use

- Admissibility of MMPI-2 Testimony:
- If an expert relies on the MMPI-2 to form an opinion to be offered in testimony, the basis for this opinion may be scrutinized and admissibility denied if the testimony fails to meet certain standards.

Limitations of MMPI-2 RF Forensic Use

- Admissibility
  - In its ruling on Daubert, the Supreme Court established that trial judges must determine the validity of inferences based on a scientific technique by considering whether
  - (1) the technique can be and has been tested empirically,
  - (2) the technique has been subjected to peer review,
  - (3) the error rates of the technique are known,
  - (4) there are standards for applying the technique, and
  - (5) the technique is generally accepted in the relevant scientific discipline. The last criterion refers back to the Frye v. U.S. (1923) ruling regarding expert testimony, which still applies in several states.

Limitations of MMPI-2 RF Forensic Use

- Admissibility
  - In general, the MMPI-2 meets these criteria. It was developed through an empirical method, and much of its interpretation is based on empirical correlates derived for the scales. Moreover, the applications of the test are inheritably testable.

Limitations of MMPI-2 RF Forensic Use

- Admissibility
  - The MMPI/MMPI-2 has been studied in over 8,800 publications that have appeared in peer-reviewed journals. Psychometric techniques lend themselves well to analyses of error rates (by considering test score reliability), and numerous research studies have examined the false-positive and -negative rates of the test's scales in predicting a variety of phenomena.

Limitations of MMPI-2 RF Forensic Use

- Admissibility
  - The MMPI-2 test manual provides direct guidelines for standardized administration and scoring.
  - Finally the MMPI-2 is one of the most used psychological tests in both clinical practice (Camara et al., 2000) and forensic settings (Lees-Haley, 1992).

Limitations of MMPI-2 RF Forensic Use

- Malingering and Defensiveness: The incentive to distort one's responses on the MMPI-2 is high in both criminal and civil evaluations.
  - Several research studies have suggested that malingering is in fact common in forensic evaluations.
  - Grossman and Wasyliw (1988) estimated that almost 41% of all insanity defendants malinger during psychological evaluations.
  - In personal injury settings, it has been estimated that 18–33% of clients intentionally distort their responses (Binder, 1993; Mittenburg, Patton, Canyock, & Condii, 2002).

Limitations of MMPI-2 RF Forensic Use

- Malingering and Defensiveness
  - MMPI-2 has several scales have been designed to measure over-reporting.
  - The F scales (F, FB, FP) are quite useful for this purpose.
  - The FP scale is the most effective indicator when the base rate for psychopathology is high (Arbisi & Ben-Porath, 1998), and a recent meta-analysis (Rogers et al., 2003) indicates that it has the highest effect size of all MMPI-2 over-reporting indicators in identifying malingering protocols.

Limitations of MMPI-2 RF Forensic Use

- Malingering and Defensiveness
  - Although relatively few research studies have examined the utility of the F scales in forensic settings specifically, some studies have shown that the scales can differentiate individuals who have been asked to malinger on the MMPI-2 from forensic inpatients and criminal defendants (Bagby, Buis, & Nicholson, 1995; Bagby, Rogers, & Buis, 1994; Hawk & Cornell, 1989; Roman, Tuley, Villanueva, & Mitchell, 1990).

Limitations of MMPI-2 RF Forensic Use

- Malingering and Defensiveness
  - In a more recent study, Gallagher (1997) showed that the FP scale added incrementally to F in differentiating correctional inpatients asked to malinger from those who took the test under standard instructions.
  - Moreover, there is no reason to expect that the F scales would function any differently in forensic settings than in the multitude of other settings in which they have been studied.

Limitations of MMPI-2 RF

- Personal Injury/Malingering
- A frequently studied scale in personal injury contexts is the Fake Bad Scale (FBS; Lees-Haley, English, & Glenn, 1991). It was proposed as an alternative to the F Scales as the latter set are sensitive to "acting crazy" exaggeration, which presumably does not frequently occur in personal injury settings in which the individual "acts hurt" (Larrabee, 2003a).

Limitations of MMPI-2 RF

- Personal Injury/Malingering
  - The FBS focuses primarily on somatic embellishment.
  - Empirical support, particularly for identifying individuals who perform sub-optimally on cognitive tasks (Greiffenstein, Baker, Gola, Donders, & Miller, 2002; Larrabee, 2003b, Larrabee, 2003c).

Limitations of MMPI-2 Forensic Use

- Personal Injury/Malingering
  - Questioned its construct validity as scores on the FBS have been found to be potentially confounded with genuine somatic problems, possibly limiting its ability to differentiate between litigants who have suffered genuine physical injuries and those attempting to malinger such conditions

(Bury & Bagby, 2002; Butcher, Arbisi, Atlis, & McNulty, 2003; Dearth et al., 2005; Rogers et al., 2003)

Limitations -Personal Injury/Malingering

– Some questions have also been raised regarding its utility in detecting spurious PTSD complaints

Bury & Bagby, 2002; Elhai, Gold, Frueh, & Gold, 2000.

MMPI-2RF Personal Injury/Malingering

- Underreporting of Problems/Defensiveness
  – Some individuals undergoing forensic assessments may minimize or deny psychological problems.
  – Examples include parents undergoing a child custody evaluation or patients seeking early release from a forensic hospital. Several MMPI-2 scales mentioned earlier (L and K) can be useful in identifying underreporting.

Administering and Scoring the MMPI-2-RF

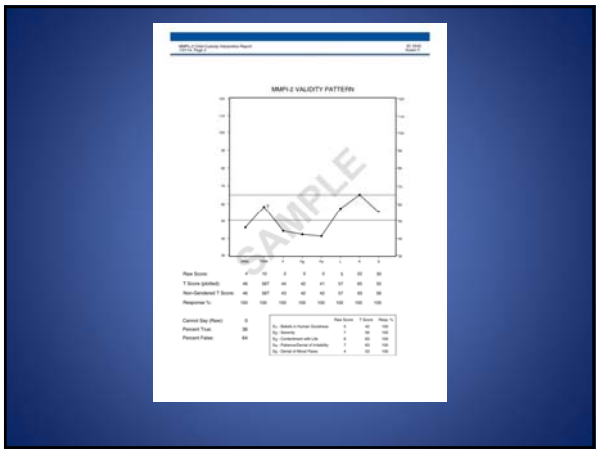
- Standard Procedures delineated in *Manual for Administration, Scoring, and Interpretation*
- Administration:
  - Before Testing
    - Consider age
    - Inquire about prior testing experience
    - Assess Testability
      - Cognitive wherewithal
      - Vision
      - Reading Level: Grade 4.5 (Flesch Kincaid) 6 (Lexile)
  - Use Standard Administration Modalities
    - Booklet and answer sheet
    - Computer

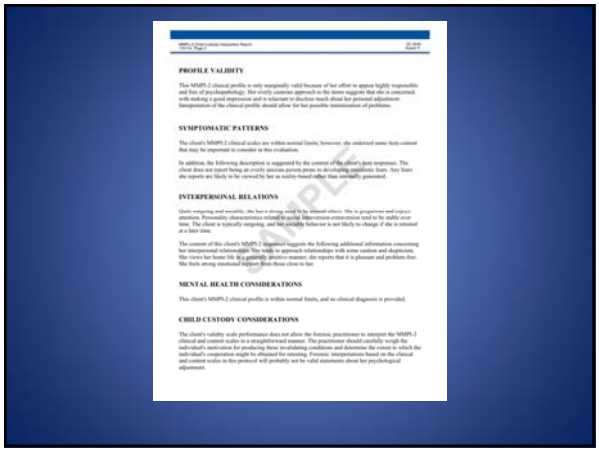
Administering and Scoring the MMPI-2-RF

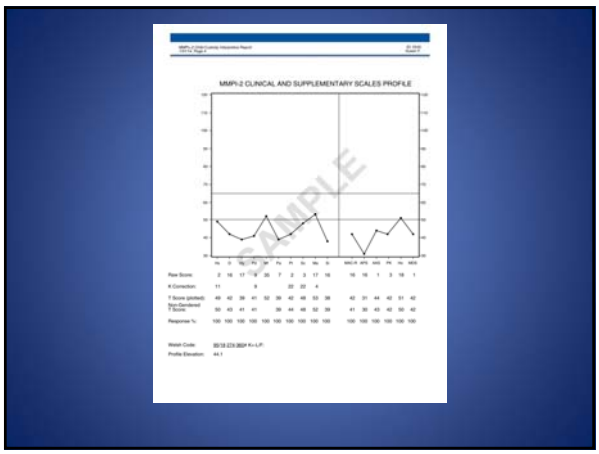
- Scoring:
  - Normative Sample:
    - MMPI-2 Normative Sample Collected in 1980s
    - Non-gendered norms (1,138 men, 1,138 women)
    - Norms appear to be holding up well (Technical Manual Appendix C)

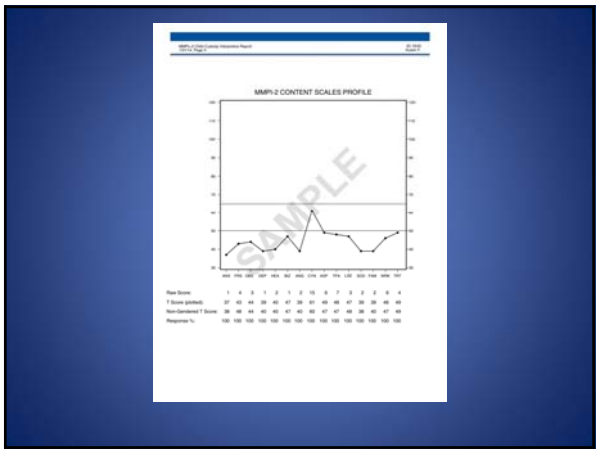
MMPI-2 Sample Reports

- MMPI-2 Sample Reports


MMPI-2 VALIDITY PATTERN
SAMPLE


PROFILE VALIDITY
SYMPTOMATIC PATTERNS
INTERPERSONAL RELATIONS
MENTAL HEALTH CONSIDERATIONS
CHILD CUSTODY CONSIDERATIONS
SAMPLE


MMPI-2 CLINICAL AND SUPPLEMENTARY SCALES PROFILE
SAMPLE


MMPI-2 CONTENT SCALES PROFILE
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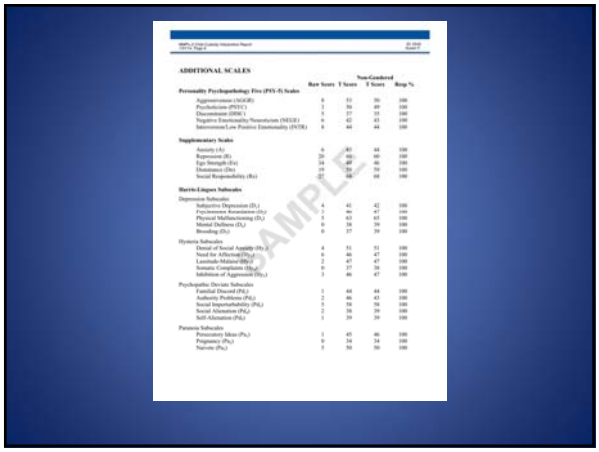
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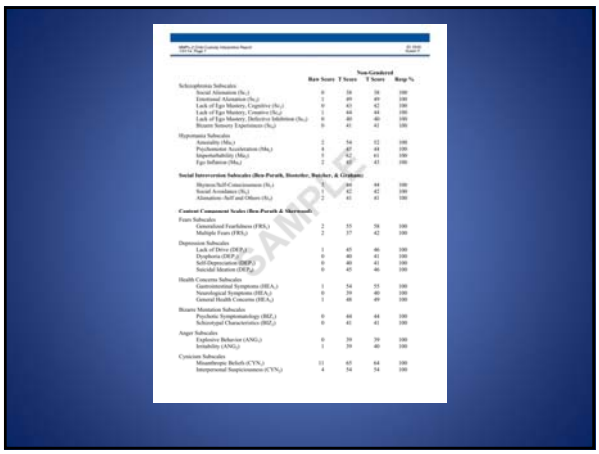
SAMPLE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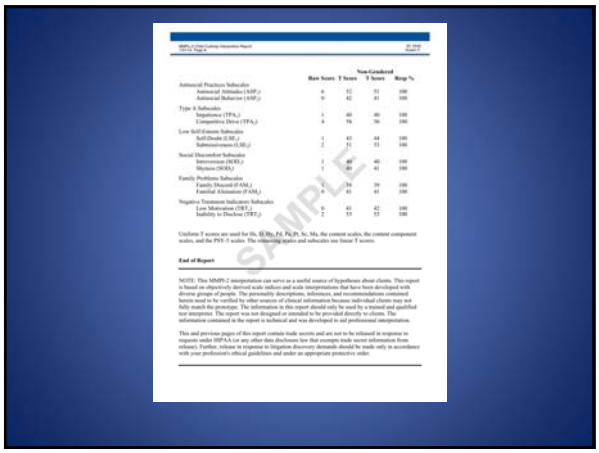
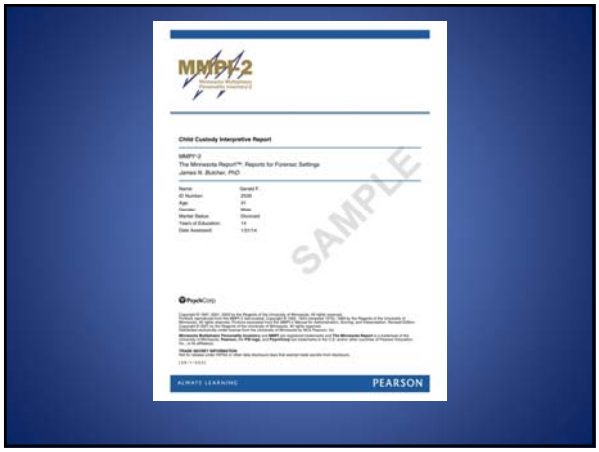
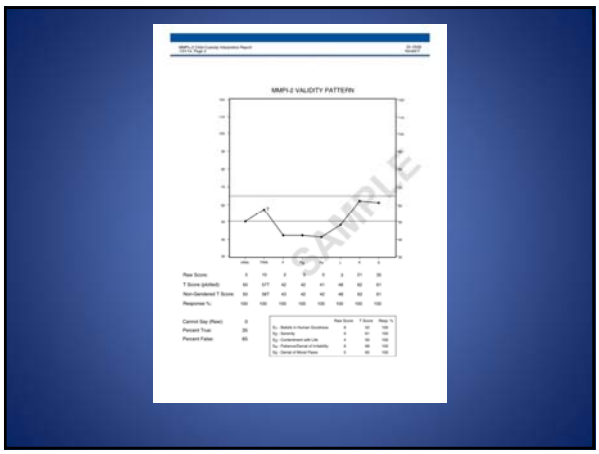


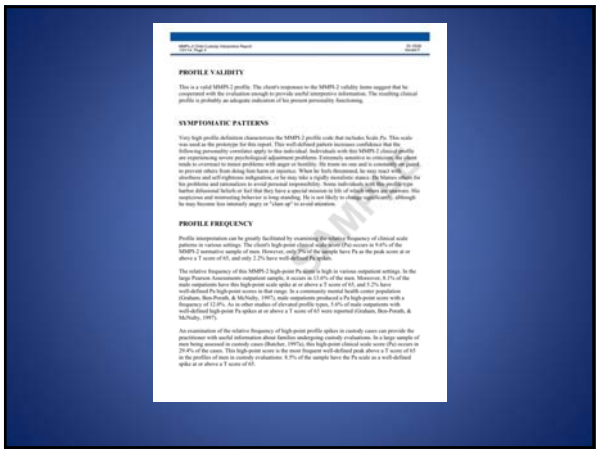
End of Report

NOTE: This MMPI-2 interpretation can serve as a useful source of hypotheses about clients. This report is based on objectively derived scale indices and scale interpretations that have been developed with diverse groups of people. The personality descriptions, inferences, and recommendations contained herein need to be verified by other sources of clinical information because individual clients may not fully match the prototype. The information in this report should only be used by a trained and qualified test interpreter. The report was not designed or intended to be provided directly to clients. The information contained in the report is technical and was developed to aid professional interpretation.

This and previous pages of this report contain trade secrets and are not to be released in response to requests under HIPAA (or any other data disclosure law that exempts trade secret information from release). Further, release in response to litigation discovery demands should be made only in accordance with your profession's ethical guidelines and under an appropriate protective order.







PROFILE VALIDITY

This is a valid MMPI-2 profile. The client's responses to the MMPI-2 validity items suggest that he cooperated with the evaluation enough to provide useful interpretive information. The resulting clinical profile is probably an adequate indication of his present personality functioning.

SYMPTOMATIC PATTERNS

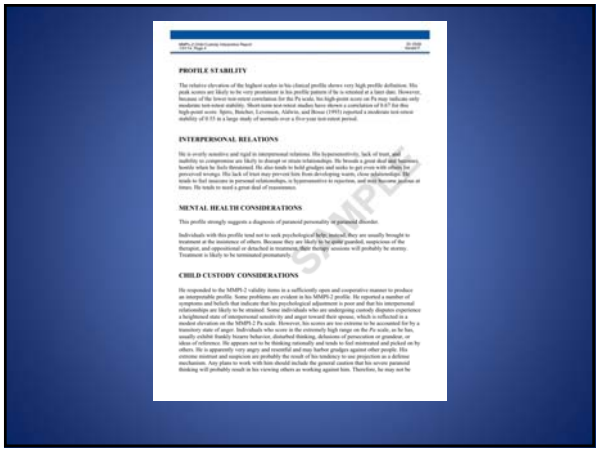
Very high profile definition characterizes the MMPI-2 profile code that includes Scale *Pa*. This scale was used as the prototype for this report. This well-defined pattern increases confidence that the following personality correlates apply to this individual. Individuals with this MMPI-2 clinical profile are experiencing severe psychological adjustment problems. Extremely sensitive to criticism, the client tends to overreact to minor problems with anger or hostility. He trusts no one and is constantly on guard to prevent others from doing him harm or injustice. When he feels threatened, he may react with relentless and self-righteous indignation, or he may take a rigidly moralistic stance. He blames others for his problems and rationalizes to avoid personal responsibility. Some individuals with this profile type harbor delusional beliefs or feel that they have a special mission in life of which others are unaware. His suspicious and mistrusting behavior is long-standing. He is not likely to change significantly, although he may become less intensely angry or "clam up" to avoid attention.

PROFILE FREQUENCY

Profile interpretation can be greatly facilitated by examining the relative frequency of clinical scale patterns in various settings. The client's high-point clinical scale score (Pa) occurs in 9.6% of the MMPI-2 normative sample of men. However, only 2% of the sample have Pa as the peak score at or above a T score of 65, and only 2.2% have well-defined Pa spikes.

The relative frequency of this MMPI-2 high-point Pa score is high in various outpatient settings. In the large Pearson Assessments outpatient sample, it occurs in 13.4% of the men. Moreover, 8.1% of the male outpatients have this high-point scale spike at or above a T score of 65, and 5.2% have well-defined Pa high-point scores in that range. In a community mental health center population (Graham, Ben-Porath, & McNulty, 1997), male outpatients produced a Pa high-point score with a frequency of 12.0%. As in other studies of elevated profile types, 5.6% of male outpatients with well-defined high-point Pa spikes at or above a T score of 65 were reported (Graham, Ben-Porath, & McNulty, 1997).

An examination of the relative frequency of high-point profile spikes in custody cases can provide the practitioner with useful information about families undergoing custody evaluations. In a large sample of men being assessed in custody cases (Butcher, 1997a), this high-point clinical scale score (Pa) occurs in 29.4% of the cases. This high-point score is the most frequent well-defined peak above a T score of 65 in the profiles of men in custody evaluations. 8.5% of the sample have the Pa scale as a well-defined spike at or above a T score of 65.



PROFILE STABILITY

The relative elevation of the highest scales in his clinical profile shows very high profile definition. His peak scores are likely to be very prominent in his profile pattern if he is retested at a later date. However, because of the lower test-retest correlation for the Pa scale, his high-point score on Pa may indicate only moderate test-retest stability. Short-term test-retest studies have shown a correlation of 0.87 for this high-point score. Spiro, Butcher, Levenson, Aldwin, and Bosse (1993) reported a moderate test-retest stability of 0.55 in a large study of normals over a five-year test-retest period.

INTERPERSONAL RELATIONS

He is overly sensitive and rigid in interpersonal relations. His hypersensitivity, lack of trust, and inability to compromise are likely to disrupt or strain relationships. He breeds a great deal and becomes hostile when he feels threatened. He also tends to hold grudges and seeks to get even with others for perceived wrongs. His lack of trust may prevent him from developing warm, close relationships. He tends to feel insecure in personal relationships, is hypersensitive to rejection, and may become jealous at times. He tends to need a great deal of reassurance.

MENTAL HEALTH CONSIDERATIONS

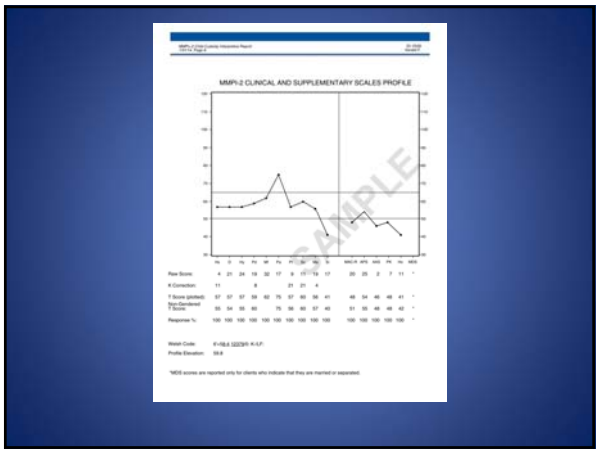
This profile strongly suggests a diagnosis of paranoid personality or paranoid disorder.

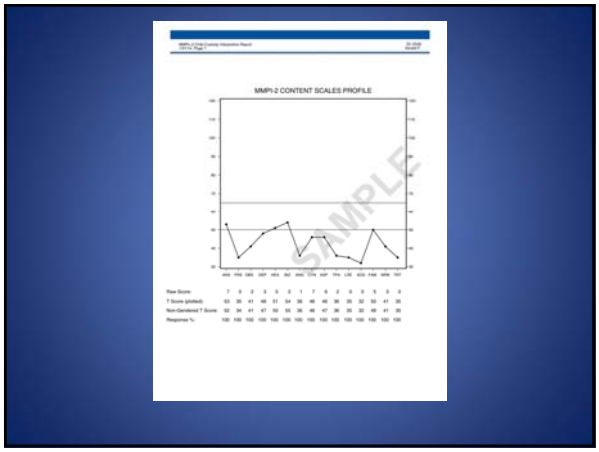
Individuals with this profile tend not to seek psychological help; instead, they are usually brought to treatment at the insistence of others. Because they are likely to be quite guarded, suspicious of the therapist, and oppositional or detached in treatment, their therapy sessions will probably be stormy. Treatment is likely to be terminated prematurely.

CHILD CUSTODY CONSIDERATIONS

He responded to the MMPI-2 validity items in a sufficiently open and cooperative manner to produce an interpretable profile. Some problems are present in his MMPI-2 profile. He reported a number of symptoms and beliefs that indicate that his psychological adjustment is poor and that his interpersonal relationships are likely to be strained. Some individuals who are undergoing custody disputes experience a heightened state of interpersonal sensitivity and anger toward their spouse, which is reflected in a modest elevation on the MMPI-2 Pa scale. However, his scores are too extreme to be accounted for by a transitory state of anger. Individuals who score in the extremely high range on the *Pa* scale, as he has, usually exhibit frankly bizarre behavior, disturbed thinking, delusions of persecution or grandeur, or ideas of reference. He appears not to be thinking rationally and tends to feel mistreated and picked on by others. He is apparently very angry and resentful and may harbor grudges against other people. His extreme mistrust and suspicion are probably the result of his tendency to use projection as a defense mechanism. Any plans to work with him should include the general caution that his severe paranoid thinking will probably result in his viewing others as working against him. Therefore, he may not be

very open to changing his own thinking.


MMPI-2 CLINICAL AND SUPPLEMENTARY SCALES PROFILE
SAMPLE


MMPI-2 CONTENT SCALES PROFILE
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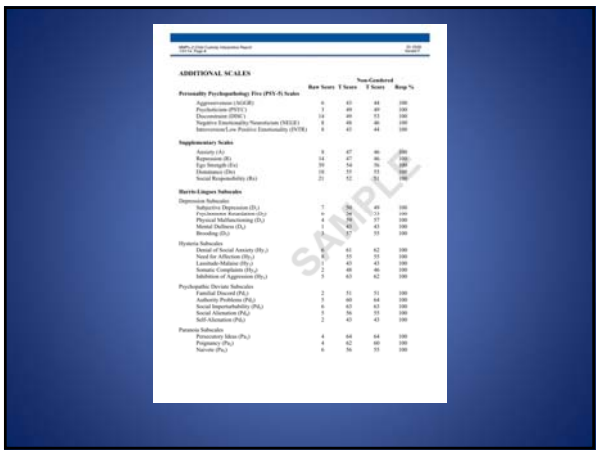
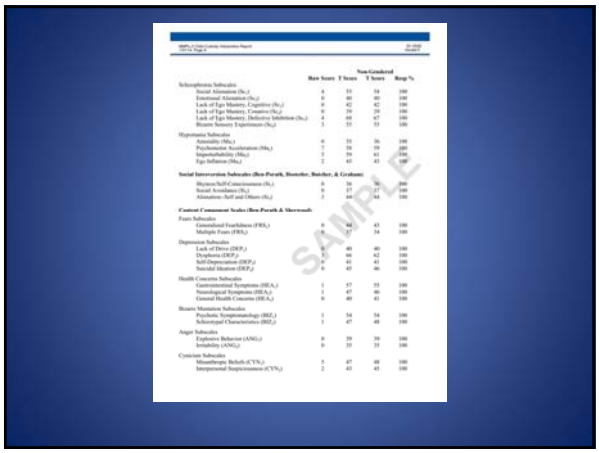
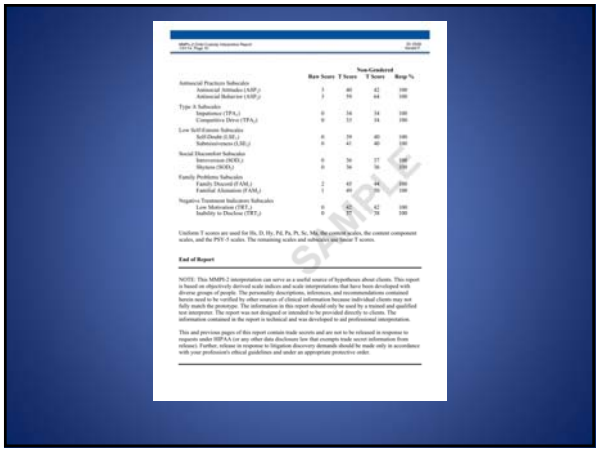

ADDITIONAL SCALES
SAMPLE





Personality Assessment Inventory(PAI)

- Released in 1991
- Intended to compete with the MMPI-2 as it was not a solid tool psychometrically
- Self-Administered, 344 Likert type items forming 22 nonoverlapping scales
  - 4 validity scales, 11 clinical scales, 5 treatments scales and 2 interpersonal scales
  - Most scales can be broken down further

Personality Assessment Inventory (PAI)

- Authored by Leslie Morey, PhD, the PAI is a multi-scale test of psychological functioning that assesses constructs relevant to personality and psychopathology evaluation (depression, anxiety, aggression) in various contexts including psychotherapy, crisis/evaluation, forensic, personnel selection, pain/medical, and child custody assessment.

PAI

- Uses Linear T-Scores
- Norm group of college students, clinical sample, community persons and census matched
  - Community sample is SES matched for 1995
- Reading level is 4th to 6th grade
- Adults only: 40 minutes
- 5 Broad Areas:
  - validity, clinical, interpersonal style, treatment complications &subject environment

Norm Group Characteristics

Sample	***N***
Census-Matched Standardization	1,462
Representative Clinical Sample	1,265
College Students Sample	1,051

Sample	***White***		***Black***		***Others***	
	Males	***Female***	***Males***	***Females***	***Male***	***Female***
Census	41.1%	44.0%	5.4%	6.3%	1.5%	1.7%
Total	85.1%		11.7%		3.2%	

Note: *Use of clinical sample with other samples allows comparisons to both typical and clinical groups for better differential diagnosis.*

PAI Norms

Education	*Census*	*Clinical*	*College*
< HS	11.3%	19.2%	0.5%
HS	31.4	31.5	36.3
Some Col.	52.4	28.9	56.0
Col.	19.3	11.3	6.6
Some Grad.	12.6	9.2	0.8
Marital Status			
Never mar.	21.5	31.0	96.2
Married	52.2	26.4	2.5
Remarried	8.5	6.2	0.2
Separated	1.1	8.7	0.0
Divorced	9.5	24.5	0.8
Widowed	6.2	1.9	*NA*
Other	1.1	1.4	0.2

Norms Con't

Race	*Clinical*	*College*
White	78.8%	92.5%
Black	12.6	2.8
Other	8.6	4.7
Setting		
Outpatient MH	34.6	
Inpatient MH	24.9	
Outpatient Med.	1.3	
Inpatient Med.	0.6	
Alc. Program	13.6	
Drug Prog.	1.8	
Corrections	10.2	
Pain Clinic	0.2	
Other	12.2	
Voluntary Tx	94.8	
Invol. Tx	5.2	

Test-Retest Reliabilities (24-28 Days)

Scale Name	Community	College
Inconsistency	**.29**	**.32**
Infrequency	**.43**	**.55**
Neg. Impression	**.71**	**.80**
Pos. Impression	**.81**	**.75**
Somatic Complaints	**.86**	**.81**
Anxiety	**.88**	**.88**
Anxiety Related Dis.	**.85**	**.84**
Depression	**.91**	**.86**
Mania	**.85**	**.76**

Test-Retest Reliabilities

Scale Name	Community	College
Paranoia	.88	.83
Schizophrenia	.87	.79
Borderline Features	.90	.82
Antisocial Features	.90	.87
Alcohol Problems	.94	.90
Drug Problems	.88	.66
Aggression	.85	.78
Suicidal Ideation	.71	.85
Stress	.88	.72
Nonsupport	.81	.74

Test-Retest Reliabilities

Scale Name	Community	College
Treatment Rejection	.83	.73
Dominance	.77	.60
Warmth	.74	.79

Remember 24-28 days compared to 7 to 14 for MMPI-2

Validity Indicators

- **INC**: 10 item pairs, each with related content. Pairs correlated with one another, but no overall content.
  - Measures respondent consistency.
  - INC below 64T suggests consistent responding.
  - 65T to 72T indicates some inconsistency. Use caution.
  - 73T or more suggests inattentive or inconsistent responding. Call invalid.

Note: Can have no more than 17 blank/mismarked items.

Validity Continued

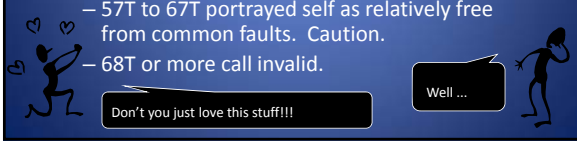
- **INF**: 8 items very low endorsed items. 4 very true and 4 false. No theme to the content. Impact of pathology was minimized.
  - Measures random responding, indifference, carelessness, confusion, or reading difficulties
  - 59T or less suggests appropriate attention and comprehension.
  - 60T to 74T indicates some atypical responding. Caution
  - 75T or more call invalid

Validity Continued

- **NIM (Negative Impression):**
  - 9 items answered differently by those told to "Fake bad" from normals. Clinical groups are somewhat higher.
  - 72T or less indicate no appreciable impact from negative responding.
  - 73T to 91T indicates some exaggeration , cautious interpretation. Cry for help?
  - 92T or more especially negative presentation, or malingering. Call invalid.

Validity Continued

- **PIM (Positive Impression):**
  - 9 items which were answered differently by normals & clinicals in contrast to those instructed to **"Fake good."** Normals score slightly higher.
  - 56T or less no appreciable favorable impression
  - 57T to 67T portrayed self as relatively free from common faults. Caution.
  - 68T or more call invalid.



Validity Correlations for the PAI Validity Scales

Correlate	*ICN*	*INF*	*NIM*	*PIM*
MMPI:Scale L[a]	.03	.13	-.16	.41
MMPI:Scale F[a]	.09	.11	.54	-.37
MMPI: Scale K[a]	-.14	-.09	-.36	.47
Marlowe-Crowne[b]	-.30	.08	-.26	.44
Marlowe-Crowne[c]	-.24	.02	-.23	.56

Note. *ICN* = Inconsistency scale; *INF* = Infrequency scale; *NIM* = Negative Impression scale; *PIM* = Positive Impression scale.
[a] = Clinical sample, *n* = 91; [b] = Community sample, *n* = 95; [c] = College student sample, *n* = 83.

PAI Scales

- 344 items
- Comprising 22 nonoverlapping full scales
- 4 Validity scales
- 11 Clinical scales
- 5 Treatment Consideration scales
- 2 Interpersonal scales

Clinical Scales

- Linear, non-transformed t-scores.
- common ranges (but each scale may differ to some extent)
  - 59T or less (no difficulty)
  - 60T to 69T (No to Moderate difficulty)
    - Upper end is 65T to 68T (mild to moderate difficulty)
  - 70T or more (moderate difficultly)
  - 82T or more (significant difficulty)

Clinical Scales

- **Somatic Complaints** (SOM) (24 items):
  - Items focus on preoccupation with health matters and somatic complaints specific to somatization and conversion disorders. Has 3 subscales: Conversion, Somatization & Health Concerns.
  - 59T or less indicates few bodily or somatic complaints.
  - 60T to 69T some concerns; medical patients, or elderly

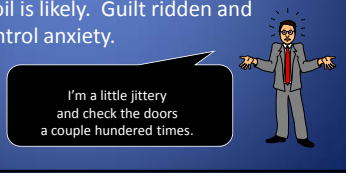
- ***SOM Continued***
  - 70T or more significant concerns and impairment from somatic concerns. Unhappy and pessimistic
  - 88T or more indicates a wide array of somatic concerns, involving several biological systems. In most cases these people will have diagnosable somatoform disorders. Little insight., poor prognosis.

- **Anxiety** (ANX) (24 items):
  - Items focus on phenomenology and observable signs of anxiety with an emphasis on assessment across different response modalities. 3 subscales are: Cognitive, Affective and Physiological.
  - 59T or less reflects a person with few complaints of anxiety, worry or tension.
  - 60T to 69T indicates some worry, sensitivity and/or tension.

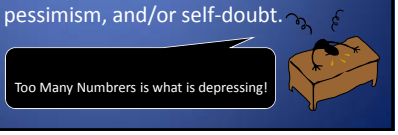
- ***ANX Continued***
  - 70T or more indicate significant anxiety, worry and/or tension.
  - 91T or more usually indicates generalized impairment associated with anxiety. Serious constriction in life. Trouble meeting minimal role expectations. Mild stressors often precipitation a crisis. Generally a diagnosable anxiety disorder.
  - If elevated but ARD (next considered) is not suggest free floating. If ARD has an elevation specific area is indicated.

- **Anxiety-Related Disorders** (ARD) (24 items)
  - Items focus on symptoms and behaviors related to specific anxiety disorders. 3 Subscales: Obsessive-Compulsive, Phobias, and Traumatic Stress.
  - 59T or less indicates little distress across many situations
  - 60T to 69T indicates a specific area of concern, little confidence and worry.

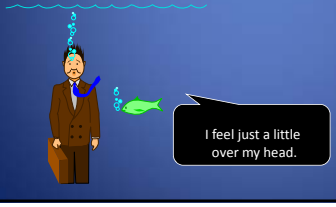
- ***ARD Continued***
  - 70T or more suggest impairment associated with anxiety related condition(s). Insecure, self-doubting and ruminative.
  - 91T or higher is likely to reflect multiple anxiety disorder diagnosis, broad impairment in functioning due to anxiety related conditions. Severe turmoil is likely. Guilt ridden and unable to control anxiety.



- **Depression** (DEP) (24 items):
  - Items focus on symptoms and phenomenology of depressive disorders (unipolar). 3 subscales: Cognitive, Affective, and Physiological
  - 59T or less reflects a person with few complaints about unhappiness or distress. Stability, self-confidence, active, and relaxed.
  - 60T to 69T indicates some unhappiness, sensitivity, pessimism, and/or self-doubt.



- ***DEP Continued***
  - 70T or higher indicates significant dysphoria. Despondency, withdrawal, ahedonia, moody, dissatisfied and/or guilt-ridden.
  - 81T or more is indicative or a major depressive episode.

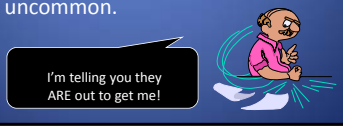


- **Mania** (MAN) (24 items)
  - Items focus on the affective, cognitive, and behavioral symptoms of mania and hypomania. 3 subscales include: Activity level, Grandiosity, and Irritability.
  - 54T or less few endorsed items relating the the features of mania or hypomania.
  - 55T to 64T may be seen as active, outgoing, ambitious, and self-confident. But, by the time they reach the upper end of this range, they are likely to be impatient, or hostile with a quick temper.

- ***MAN Continued***
  - 65T to 74T is associated with increasing restlessness, impulsivity, and high energy levels. Often seen as unsympathetic and hotheaded.
  - 75T or more are typically associated with disorders such as mania, hypomania or cyclothymia. Take on more than they can handle, react with hostility to restrictions on their activities, impulsive, poor delay or gratification. Judgment is often poor and impairment in functioning is likely. Flight of ideas, grandiosity, and inflated sense or self-importance is likely. Narcissism.

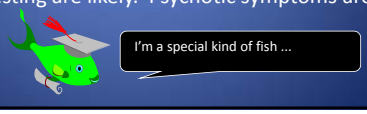
- **Paranoia** (PAR) (24 items):
  - Items focus on the symptoms of paranoid disorders and more enduring characteristics of paranoid personality. 3 subscales include: Resentment, Hyperviglance and Persecution.
  - 59T or less indicates a person is likely to be open and forgiving in relationships.
  - 60T to 69T are indicative of individuals who may bee seen as sensitive, tough-minded, and skeptical. Towards the upper end, wary or cautious in relationships.

- ***PARANOIA***
  - 70T or higher person is likely to be overtly suspicious and hostile. Very distrustful.
  - 84T or higher typically associated with paranoia of a potentially delusional proportion. Veery bitter and resentful of their treatment by others. Expect others to be trying to exploit them. Very jealous in close relationships. Ideas of reference, delusions of persecution are not uncommon.



- **Schizophrenia** (SCZ) (24 items):
  - Items focus on symptoms relevant to the broad spectrum of schizophrenic disorders. 3 subscales include: Psychotic Experiences, Social Detachment & Thought Disorder.
  - 59T or less reflects a person who reports being effective in social relationships and who has not trouble with concentration or attention.
  - 60T to 69T indicates a person who may be withdrawn, aloof and/or unconventional. At the upper end they are likely to be very cautious and hostile in their few relationships.

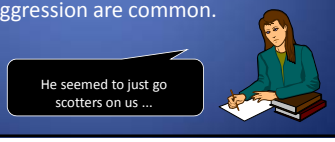
- ***SChizophrenia***
  - 70T or more are likely to be isolated, feel misunderstood and alienated from others. Some difficulties in thinking, concentration, attention or decision-making are likely. May present unusual perceptions or beliefs with psychotic qualities.
  - 90T or more are typically associated with an active schizophrenic episode. Confusion, withdrawal and suspiciousness along with poor judgment and reality-testing are likely. Psychotic symptoms are likely.



- **Borderline Features** (BOR) (24 items)
  - Item content focuses on attributes of borderline type personality functioning. This includes unstable and fluctuating interpersonal relations, impulsivity, affective liability, emotional instability, and uncontrolled anger. 4 subscales include: Affective Instability, Identity Problems, Negative Relations, and Self-Harm.
  - 59T or less suggests the person reports being emotionally stable, and in stable relationships.

- ***BORDERLINE Features***
  - 60T to 69T indicate the person may be moody, sensitive, with uncertainty about life goals. Young adults often score in this range. At the upper end of this range anger and dissatisfaction with relationships increases.
  - 70T or more the person is likely to be impulsive and emotionally labile, feeling misunderstood with difficulty maintaining close relationships. Others often see this person as egocentric. A combination of anger-hostility and anxiety-dependence make them difficult to deal with.

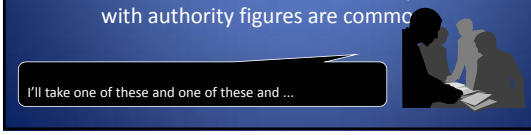
- ***BORDERLINE FEATURES***
  - 92T or more are typically associated with personality functioning within the borderline range. Often in state of crisis, generally due to relationships. Hostility, anger and feeling betrayed are common. Often depressed, impulsive, anxious, self destructive, or sabotage their own goals. Use of chemicals, suicide or aggression are common.



- **Antisocial Features** (ANT) (24 items)
  - Content focuses on a history of acts and authority problems, egocentrism, lack of empathy/loyalty, instability and excitement-seeking. 3 subscales include: Antisocial Behaviors, Egocentricity and Stimulus-Seeking.
  - 59T or less reflects a person who reports being reasonable empathetic and warm in their relationships. These people often have reasonable control over their impulses have an internalized set or standards and do not take great risks.

- ***ANTISOCIAL FEATURES***
  - 60T to 69T suggests a person who may be seen as impulsive and a risk taker. Young adults often score in this range (particularly males). At the upper end of this range there may be increasing self-centeredness, skepticism of others and unsympathetic attitudes.
  - 70T or more hostility and impulsiveness are likely. There is often a history of antisocial actions. Others may see them as exploitive, and they often have difficulty with long-term relationships.

- ***ANTISOCIAL FEATURES***
  - 82T or more are typically associated with prominent features of antisocial personality disorder. Often seen as unreliable, irresponsible, and having little sustained success in sustained occupational or social activities. Often these people are coldly pragmatic, and exploitative for their own needs. recklessness and a history of conflicts with authority figures are commo



- **Alcohol Problems** (ALC) (12 items)
  - Items focus directly on problematic consequences of alcohol use and features of alcohol dependence. Questions are obvious so denial can easily suppress the scale.
  - 59T or less indicates a person who reports little to moderate alcohol use and few adverse consequences related to drinking.
  - 60T to 69T are indicative of a person who may drink regularly and may have experienced some adverse consequences of drinking. As the score in this range increase the likelihood of difficulties increases.

- ***ALC Continued***
  - 70T or more indicate responses which generally suggest alcohol abuse. Significant difficulties due to drinking are likely. Relationships and/or work with possible general functioning likely to have suffered from drinking.
  - 84T or more (average scores for those in treatment centers) are typically associated with alcohol dependence. Typically these folks are unable to cut down on their drinking, feel guilty about use and may have had blackouts.
  - 98T or more are associated with an extreme degree of alcohol dependence.

- **Drug Problems** (DRG) (12 items)
  - Items focus directly one problematic consequences of drug use (prescription and illicit) and features of drug dependance. Content is obvious so it is easily distorted.
  - 59T or lower indicates responses suggesting a person who uses infrequently or not at all.
  - 60T to 69T are indicative of a person who may use drugs on a fairly regular basis, and may experienced some adverse consequences as a result. Toward the upper end of the range increasing likelihood of past or current history of difficulties related to use.

- ***DRG Continued***
  - 70T or more the person is likely to meet the criteria for drug abuse. Difficulties in work or social performance are common. General functioning may be compromised.
  - 80T or more (average scores for treatment centers) are typically associated with drug dependence. Folks are likely to have trouble reducing use, and feel unable to control use. dependence and withdrawal are likely. Social and occupational interference are likely.

- ***DRG Continued***
  - 96T or more are associated with extreme drug dependance.

Treatment Consideration Scales

- **Aggression** (AGG) (18 items)
  - Items tap characteristics and attitudes related to anger, hostility and aggression. This includes a history of aggression (verbal or physical) and attitudes conducive to aggressive behavior. 3 subscales include: Aggressive Attitude, Verbal Aggression and Physical Aggression. Content is obvious and so easily distorted.

- ***AGG Continued***
  - 40T or less may indicate a meek and unassertive person.
  - 59T or less reflect a reasonable control over the expression of anger and hostility.
  - 60T to 69T are indicative of someone who may be seen as impatient, irritable and quick-tempered. Upper end of range increasing anger and angry reactions likely.
  - 70T or more are associated with chronic anger and free expression of this anger or hostility. The modality of expression should be examined closely.

- ***AGG Continued***
  - 83T or more are typically associated with considerable anger and potential for aggression. These people are easily provoked, are are often explosive. Poor frustration tolerance. People are often afraid of their temper, and close relationships are suffering from it. History of fights, and other episodes are likely. Legal difficulties, or occupational difficulties are common. If AGG-V is low and AGG-P is high there is often little or no warning before actions.

- Suicidal Ideation (SUI) (12 items)
  - Items focus on suicidal ideation, ranging from hopelessness through general and vague thoughts of suicide, to thoughts representing distinct plans for the suicidal act.
  - 59T or less generally reflects a person who has few (or no) thoughts about suicide and death.
  - 60T to 69T are indicative of a person who entertains periodic and transient thoughts of suicide and is pessimistic and unhappy about the future. Follow-up is suggested.

- ***SUI Continued***
  - 70T or more indicate responses of significant suicidal ideation. Individuals are typically anxious or depressed. Generally see themselves as without support. "cries for help" are sometimes seen in this range. Careful evaluation is indicated.
  - 84T or more (average scores for suicidal inpatients) are associated with imminent plans for self-harm. Immediate evaluation is indicated. Generally have little hope, feel unsupported, despair, feel useless, feel ineffectual, feel bitter.
  - 101T or more are rare and suggest a morbid preoccupation with thought or suicide.

- **Stress** (STR) (8 items)
  - Items focus on the impact of current or recent stressors in the areas of family, health, employment, finances, and other major life areas.
  - 59T or less reflects a person who reports his or her life as being stable, predictable, and uneventful.
  - 60T to 69T indicates a moderate degree of stress as a result of difficulties in some major life area.

- ***STR Continued***
  - 70T or more the stress related to significant difficulties is likely to be significant. At risk for adjustment or reactive disorders.
  - 77T to 91T indicate people who perceive themselves as surrounded by crisis in nearly all major life area. Their life is in turmoil. Often feel powerless to control their life.

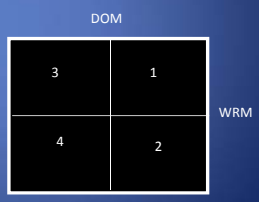
- **Treatment Rejection** (RXR) (8 items):
  - Items focus on attributes theoretically predictive of interest and motivation to make changes of a psychological or emotional nature: feelings of distress and dissatisfaction, willingness to participate, recognition of need for change, openness to new ideas and a willingness to accept responsibility for actions.
  - 42T or less indicates the respondent recognizes major difficulties in his/her functioning and sees an acute need for help.

- ***RXR Continued***
  - 43T to 52T reflects a person who acknowledges the need to make some changes, has a positive attitude toward personal change, and accepts personal responsibility. The scores at the upper end of this range are not generally found for those with some type of impairment.
  - 53T to 62T are found for those who are generally satisfied with their themselves as they are and see little need for major change. At the upper end of this range generally have little motivation to enter therapy and are at risk for early termination..

- ***RXR Continued***
  - 63T or more reflects a person who admits to few difficulties and has no desire to change the status quo. These people rarely seek therapy on their own, and are resistant to therapy. Often these people see little value in treatment and will not invest (emotionally or financially) in it.

Interpersonal Scales

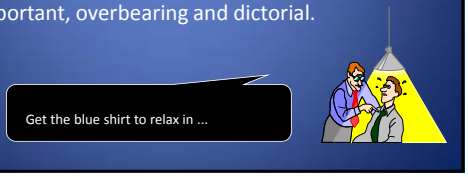
- This pair of scales are generally seen as serving as intersecting axis. There are 4 basic quadrants:
  - DOM Hi-WRM Hi
  - DOM Lo-WRM Hi
  - DOM Hi-WRM Lo
  - DOM Lo-WRM Lo



- **Dominance** (DOM) (12 items)
  - An interpersonal scale assessing the extent to which a person is controlling and independent in personal relationships. Conceptualized as a bi-polar dimension, with a dominant interpersonal style at the high end and a submissive style at the low end.
  - 29T or less indicates a very submissive style. The person has little confidence in social situations. Often have difficulty getting their needs met in personal relationships. May be exploited by others.

- ***DOM Continued***
  - 30T to 39T suggests individuals who are rather modest and retiring. They are generally self-conscious in social situations, and are not skilled at asserting themselves when needed. Generally uncomfortable if the focus of attention.
  - 60T to 69T suggests an individual who is self-assured, confident, and forceful. Not unfriendly, but may be very self-reliant and controlling. Generally comfortable in social settings but prefers settings where they are in control.

- ***DOM Continued***
  - 70T or more the person's need for control is generally quite pronounced. This probably taxes the endurance of those who are close to the respondent. Person tends to be domineering. low tolerance for those who disagree. Others often see the person as self-important, overbearing and dictorial.



- **Warmth** (WRM) (12 items):
  - An interpersonal scale assessing the extent to which a person is supportive and empathetic in personal relationships. Conceptualized as a bi-polar dimension, with a warm, outgoing interpersonal style at the high end and a cold, rejecting interpersonal style at the low end.
  - 29T or less indicates a person who has little interest or investment in social interactions. These people are often seen as cold and unfeeling, and they have little patience with the faults of others. Difficulty displaying emotions, few (if any) close relationships.

- ***WRM Continued***
  - 30T to 39T indicates the person is somewhat distant in personal relationships. Often this person sees little need for close, lasting relationships. Often seen as unsympathetic and stern. Less concerned about others opinions than is usually true.
  - 60T to 69T suggest and individual who is warm, sympathetic, and supportive. Generally eager to be liked with being critical is often hard for them even when needed. Ready to forgive and may be taken advantage of by others.

- ***WRM Continued***
  - 70T or more indicates a need for acceptance which is very pronounced. May be very dependent. Others see them as too trusting, and supportive of others for their own good.

Cluster Profiles

- **Cluster 1**: Flat profile. No scales above 60T. May be lower significant elevations on a scale or STR.
- **Cluster 2**: Prominent elevations of DEP and SUI with some elevations of SOM, ANX, ARD, SCZ, STR, NON and BOR.
  - Suicide Risk
- **Cluster 3**: Prominent elevations of ALC and SOM, with some elevations of DEP STR and ANX.

Cluster Profiles Con't

- **Cluster 4**: Prominent elevations of ALC and DRG with elevations of DEP, BOR, SUI, STR, and ANX. Mean NIM was 70T.
  - Assault Risk
- **Cluster 5**: Elevations on ANX and STR with some elevation of BOR. Often no clinical scales above 70T.

Cluster Profiles Con't

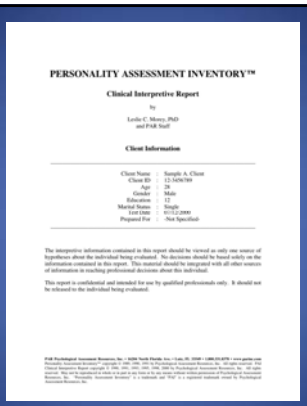
- **Cluster 6**: Moderate elevations of SCZ and BOR. Often STR, NON, and ANT above 60T. Often no prominent elevations.
- **Cluster 7**: Marked elevations of DEP, ANX, ARD, and SUI, with BOR and STR often above 70T.
  - High Suicide Risk

Cluster Profiles Con't

- **Cluster 8**: Marked Elevations of SOM with DEP and ANX often above 70T.
- **Cluster 9**: marked elevations on DRG with DRG also prominent.
- **Cluster 10**: Marked elevations on SUI, BOR, and DEP with SCZ, PAR, NON, ANX and ARD also elevated. NIM was prominent. SCZ or BOR most common high point.
  - Confusion, High Suicide Risk. Borderline features. Schizoaffective Features.

Short Form

- Rarely a need.
- 1st 160 items of the inventory.
- All scales but ICN and STR are made. Median Correlation of .91 with full length
- Uses Census matched sample.
- Invalid if more than 8 blank.
- Do not use if an important decision needs to be made



PERSONALITY ASSESSMENT INVENTORY™

Clinical Interpretive Report

by

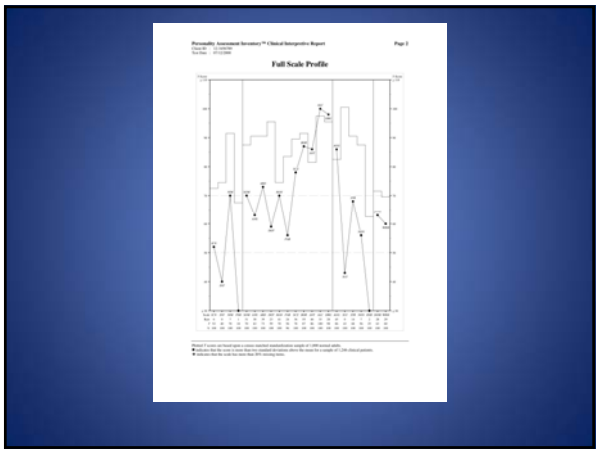
Leslie C. Morey, PhD
and PAR Staff

Client Information

Client Name	:	Sample A, Client
Client ID	:	12-3456789
Age	:	28
Gender	:	Male
Education	:	12
Marital Status	:	Single
Test Date	:	01/12/2000
Prepared For	:	Not Specified

The interpretive information contained in this report should be viewed as only one source of hypotheses about the individual being evaluated. No decisions should be based solely on the information contained in this report. This material should be integrated with all other sources of information in reaching professional decisions about this individual.

This report is confidential and intended for use by qualified professionals only. It should not be released to the individual being evaluated.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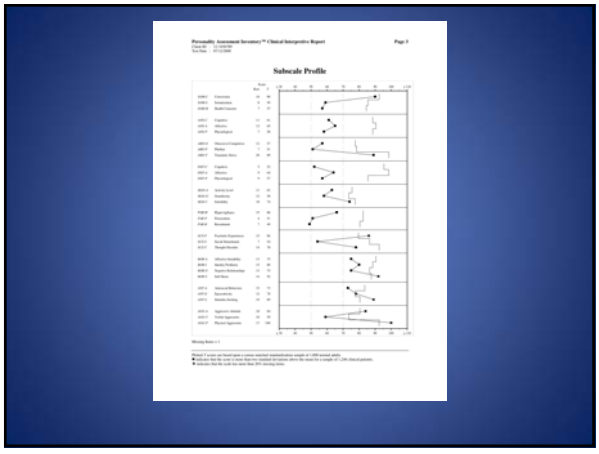
Full Scale Profile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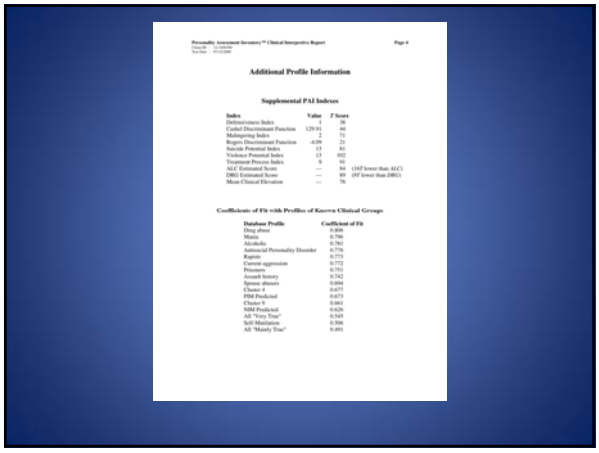
Subscale Profile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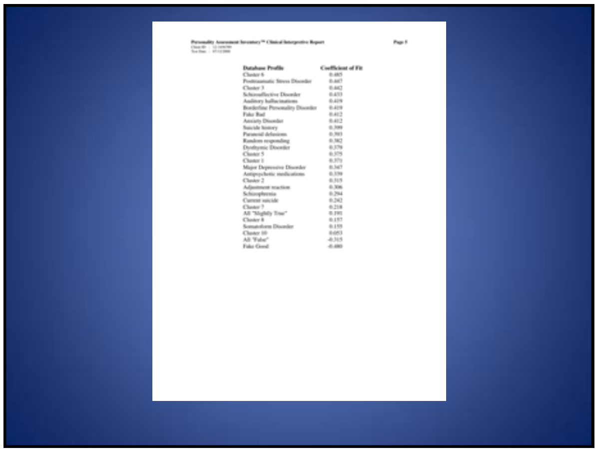
Additional Profile Information

Supplemental PAI Indexes

Index	Value	T Score	
Dehumanness Index	2	38	
Cashel Discriminant Function	129.91	44	
Malingering Index	2	71	
Rogers Discriminant Function	-4.09	21	
Suicide Potential Index	13	81	
Violence Potential Index	13	102	
Treatment Process Index	9	91	
ALC Estimated Score	—	84	(16T lower than ALC)
DRG Estimated Score	—	89	(9T lower than DRG)
Mean Clinical Elevation	—	76	

Coefficients of Fit with Profiles of Known Clinical Groups

Database Profile	Coefficient of Fit
Drug abuse	0.808
Mania	0.786
Alcoholic	0.781
Antisocial Personality Disorder	0.776
Rapists	0.773
Current aggression	0.772
Prisoners	0.751
Assault history	0.742
Spouse abusers	0.694
Cluster 4	0.677
PIM Predicted	0.673
Cluster 9	0.663
NIM Predicted	0.628
All "Very True"	0.545
Self-Mutilation	0.506
All "Mainly True"	0.491



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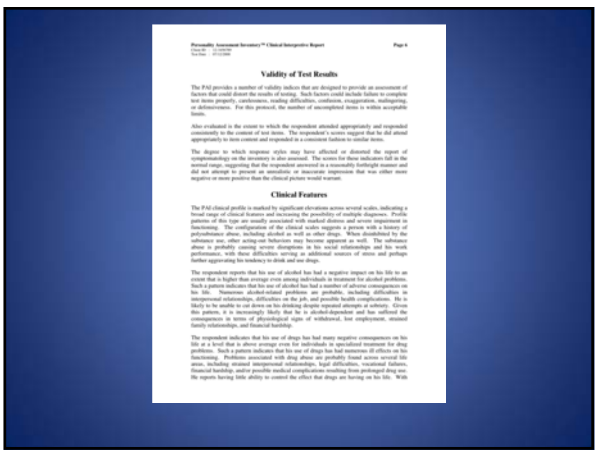
Database Profile	Coefficient of Fit
Cluster 6	0.485
Posttraumatic Stress Disorder	0.447
Cluster 3	0.442
Schizoaffective Disorder	0.433
Auditory hallucinations	0.419
Borderline Personality Disorder	0.419
Fake Bad	0.412
Anxiety Disorder	0.412
Suicide history	0.399
Paranoid delusions	0.393
Random responding	0.382
Dysthymic Disorder	0.379
Cluster 5	0.375
Cluster 1	0.371
Major Depressive Disorder	0.347
Antipsychotic medications	0.339
Cluster 2	0.315
Adjustment reaction	0.306
Schizophrenia	0.294
Current suicide	0.242
Cluster 7	0.218
All "Slightly True"	0.191
Cluster 8	0.157
Somatoform Disorder	0.155
Cluster 10	0.053
All "False"	-0.315
Fake Good	-0.480



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Validity of Test Results

The PAI provides a number of validity indices that are designed to provide an assessment of factors that could distort the results of testing. Such factors could include failure to complete test items properly, carelessness, reading difficulties, confusion, exaggeration, malingering, or defensiveness. For this protocol, the number of uncompleted items is within acceptable limits.

Also evaluated is the extent to which the respondent attended appropriately and responded consistently to the content of test items. The respondent's scores suggest that he did attend appropriately to item content and responded in a consistent fashion to similar items.

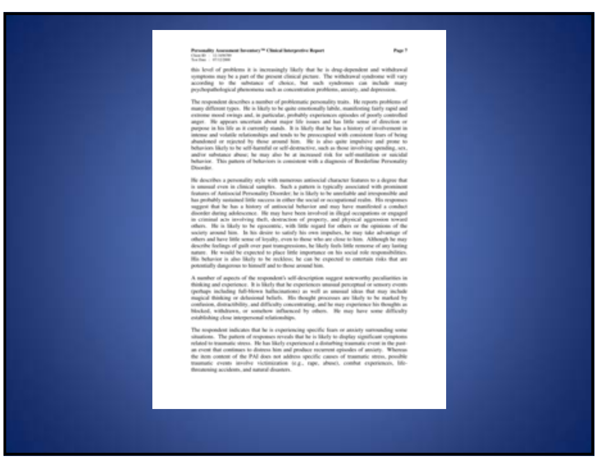
The degree to which response styles may have affected or distorted the report of symptomatology on the inventory is also assessed. The scores for these indicators fall in the normal range, suggesting that the respondent answered in a reasonably forthright manner and did not attempt to present an unrealistic or inaccurate impression that was either more negative or more positive than the clinical picture would warrant.

Clinical Features

The PAI clinical profile is marked by significant elevations across several scales, indicating a broad range of clinical features and increasing the possibility of multiple diagnoses. Profile patterns of this type are usually associated with marked distress and severe impairment in functioning. The configuration of the clinical scales suggests a person with a history of polysubstance abuse, including alcohol as well as other drugs. When disinhibited by the substance use, other acting-out behaviors may become apparent as well. The substance abuse is probably causing severe disruptions in his social relationships and his work performance, with these difficulties serving as additional sources of stress and perhaps further aggravating his tendency to drink and use drugs.

The respondent reports that his use of alcohol has had a negative impact on his life to an extent that is higher than average even among individuals in treatment for alcohol problems. Such a pattern indicates that his use of alcohol has had a number of adverse consequences on his life. Numerous alcohol-related problems are probable, including difficulties in interpersonal relationships, difficulties on the job, and possible health complications. He is likely to be unable to cut down on his drinking despite repeated attempts at sobriety. Given this pattern, it is increasingly likely that he is alcohol-dependent and has suffered the consequences in terms of physiological signs of withdrawal, lost employment, strained family relationships, and financial hardship.

The respondent indicates that his use of drugs has had many negative consequences on his life at a level that is above average even for individuals in specialized treatment for drug problems. Such a pattern indicates that his use of drugs has had numerous ill effects on his functioning. Problems associated with drug abuse are probably found across several life areas, including strained interpersonal relationships, legal difficulties, vocational failures, financial hardship, and/or possible medical complications resulting from prolonged drug use. He reports having little ability to control the effect that drugs are having on his life. With



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this level of problems it is increasingly likely that he is drug-dependent and withdrawal symptoms may be a part of the present clinical picture. The withdrawal syndrome will vary according to the substance of choice, but such syndromes can include many psychopathological phenomena such as concentration problems, anxiety, and depression.

The respondent describes a number of problematic personality traits. He reports problems of many different types. He is likely to be quite emotionally labile, manifesting fairly rapid and extreme mood swings and, in particular, probably experiences episodes of poorly controlled anger. He appears uncertain about major life issues and has little sense of direction or purpose in his life as it currently stands. It is likely that he has a history of involvement in intense and volatile relationships and tends to be preoccupied with consistent fears of being abandoned or rejected by those around him. He is also quite impulsive and prone to behaviors likely to be self-harmful or self-destructive, such as those involving spending, sex, and/or substance abuse; he may also be at increased risk for self-mutilation or suicidal behavior. This pattern of behaviors is consistent with a diagnosis of Borderline Personality Disorder.

He describes a personality style with numerous antisocial character features to a degree that is unusual even in clinical samples. Such a pattern is typically associated with prominent features of Antisocial Personality Disorder; he is likely to be unreliable and irresponsible and has probably sustained little success in either the social or occupational realm. His responses suggest that he has a history of antisocial behavior and may have manifested a conduct disorder during adolescence. He may have been involved in illegal occupations or engaged in criminal acts involving theft, destruction of property, and physical aggression toward others. He is likely to be egocentric, with little regard for others or the opinions of the society around him. In his desire to satisfy his own impulses, he may take advantage of others and have little sense of loyalty, even to those who are close to him. Although he may describe feelings of guilt over past transgressions, he likely feels little remorse of any lasting nature. He would be expected to place little importance on his social role responsibilities. His behavior is also likely to be reckless; he can be expected to entertain risks that are potentially dangerous to himself and to those around him.

A number of aspects of the respondent's self-description suggest noteworthy peculiarities in thinking and experience. It is likely that he experiences unusual perceptual or sensory events (perhaps including full-blown hallucinations) as well as unusual ideas that may include magical thinking or delusional beliefs. His thought processes are likely to be marked by confusion, distractibility, and difficulty concentrating, and he may experience his thoughts as blocked, withdrawn, or somehow influenced by others. He may have some difficulty establishing close interpersonal relationships.

The respondent indicates that he is experiencing specific fears or anxiety surrounding some situations. The pattern of responses reveals that he is likely to display significant symptoms related to traumatic stress. He has likely experienced a disturbing traumatic event in the past-an event that continues to distress him and produce recurrent episodes of anxiety. Whereas the item content of the PAI does not address specific causes of traumatic stress, possible traumatic events involve victimization (e.g., rape, abuse), combat experiences, life-threatening accidents, and natural disasters.

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The respondent describes significant problems frequently associated with aspects of a manic episode. It appears that his clinical picture is primarily characterized by irritability. Others are likely to view him as impatient and hostile. As a result, his relationships with others are probably under stress due to his frustration with the inability or unwillingness of those around him to keep up with his plans and possibly unrealistic demands. At its extreme, this irritability may result in accusations that significant others are attempting to thwart his plans for success and achievement. Grandiosity and abnormal levels of activity do not appear to be prominent features of the clinical picture at this time.

The respondent demonstrates an unusual degree of concern about physical functioning and health matters and probable impairment arising from somatic symptoms. He is likely to report that his daily functioning has been compromised by one or more physical problems. While he may feel that his health is good in general, he is likely to report that the health problems that he does have are complex and difficult to treat successfully. Physical complaints are likely to focus on symptoms of distress in neurological and musculoskeletal systems, such as unusual sensory or motor dysfunction. In psychiatric populations, such symptoms are often associated with conversion disorders, although they may be a result of numerous neurological conditions as well.

The respondent mentions that he is experiencing some degree of anxiety and stress; this degree of worry and sensitivity is still within what would be considered the normal range.

According to the respondent's self-report, he describes NO significant problems in the following areas: undue suspiciousness or hostility; unhappiness and depression.

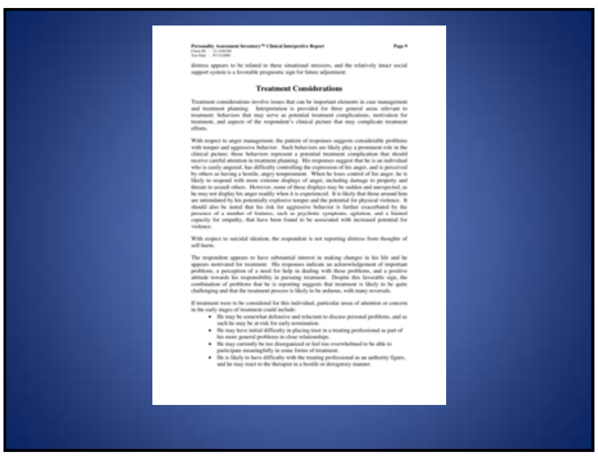
Self-Concept

The self-concept of the respondent appears to be imperfectly established, with considerable uncertainty about major life issues and goals. Although outwardly he may appear to have adequate self-esteem, this self-esteem is likely to be fragile and he may be self-critical and self-doubting. His self-esteem may be particularly vulnerable to slights or oversights by other people, arising from a self-image that depends unduly upon the current status of his close relationships.

Interpersonal and Social Environment

The respondent's interpersonal style seems best characterized as friendly and extraverted. He will usually present a cheerful and positive picture in the presence of others. He is able to communicate his interest in others in an open and straightforward manner. He usually prefers activities that bring him into contact with others, rather than solitary pursuits, and he is probably quick to offer help to those in need of it. He sees himself as a person with many friends and as one who is comfortable in most social situations.

In considering the social environment of the respondent with respect to perceived stressors and the availability of social supports with which to deal with these stressors, his responses indicate that he is likely to be experiencing a mild degree of stress as a result of difficulties in some major life area. He reports that he has a number of supportive relationships that may serve as some buffer against the effects of this stress. The respondent's current level of



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distress appears to be related to these situational stressors, and the relatively intact social support system is a favorable prognostic sign for future adjustment.

Treatment Considerations

Treatment considerations involve issues that can be important elements in case management and treatment planning. Interpretation is provided for three general areas relevant to treatment: behaviors that may serve as potential treatment complications, motivation for treatment, and aspects of the respondent's clinical picture that may complicate treatment efforts.

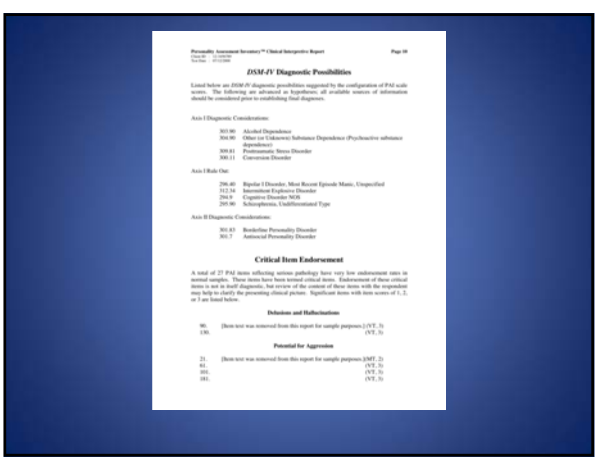
With respect to anger management, the pattern of responses suggests considerable problems with temper and aggressive behavior. Such behaviors are likely play a prominent role in the clinical picture; these behaviors represent a potential treatment complication that should receive careful attention in treatment planning. His responses suggest that he is an individual who is easily angered, has difficulty controlling the expression of his anger, and is perceived by others as having a hostile, angry temperament. When he loses control of his anger, he is likely to respond with more extreme displays of anger, including damage to property and threats to assault others. However, some of these displays may be sudden and unexpected, as he may not display his anger readily when it is experienced. It is likely that those around him are intimidated by his potentially explosive temper and the potential for physical violence. It should also be noted that his risk for aggressive behavior is further exacerbated by the presence of a number of features, such as psychotic symptoms, agitation, and a limited capacity for empathy, that have been found to be associated with increased potential for violence.

With respect to suicidal ideation, the respondent is not reporting distress from thoughts of self-harm.

The respondent appears to have substantial interest in making changes in his life and he appears motivated for treatment. His responses indicate an acknowledgement of important problems, a perception of a need for help in dealing with these problems, and a positive attitude towards his responsibility in pursuing treatment. Despite this favorable sign, the combination of problems that he is reporting suggests that treatment is likely to be quite challenging and that the treatment process is likely to be arduous, with many reversals.

If treatment were to be considered for this individual, particular areas of attention or concern in the early stages of treatment could include:

- He may be somewhat defensive and reluctant to discuss personal problems, and as such he may be at-risk for early termination.
- He may have initial difficulty in placing trust in a treating professional as part of his more general problems in close relationships.
- He may currently be too disorganized or feel too overwhelmed to be able to participate meaningfully in some forms of treatment.
- He is likely to have difficulty with the treating professional as an authority figure, and he may react to the therapist in a hostile or derogatory manner.



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***DSM-IV* Diagnostic Possibilities**

Listed below are *DSM-IV* diagnostic possibilities suggested by the configuration of PAI scale scores. The following are advanced as hypotheses; all available sources of information should be considered prior to establishing final diagnoses.

Axis I Diagnostic Considerations:

303.90 Alcohol Dependence
304.90 Other (or Unknown) Substance Dependence (Psychoactive substance dependence)
309.81 Posttraumatic Stress Disorder
300.11 Conversion Disorder

Axis I Rule Out:

296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified
312.34 Intermittent Explosive Disorder
294.9 Cognitive Disorder NOS
295.90 Schizophrenia, Undifferentiated Type

Axis II Diagnostic Considerations:

301.83 Borderline Personality Disorder
301.7 Antisocial Personality Disorder

Critical Item Endorsement

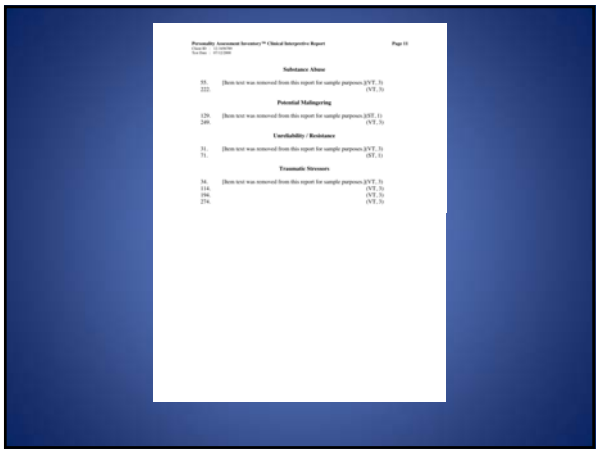
A total of 27 PAI items reflecting serious pathology have very low endorsement rates in normal samples. These items have been termed critical items. Endorsement of these critical items is not in itself diagnostic, but review of the content of these items with the respondent may help to clarify the presenting clinical picture. Significant items with item scores of 1, 2, or 3 are listed below.

Delusions and Hallucinations

90. [Item text was removed from this report for sample purposes.] (VT, 3)
130. (VT, 3)

Potential for Aggression

21. [Item text was removed from this report for sample purposes.](MT, 2)
61. (VT, 3)
101. (VT, 3)
181. (VT, 3)



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Substance Abuse

55. [Item text was removed from this report for sample purposes.](VT, 3)
222. (VT, 3)

Potential Malingering

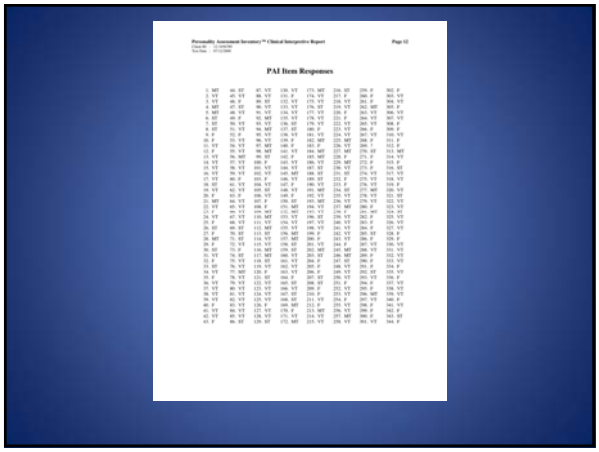
129. [Item text was removed from this report for sample purposes.](ST, 1)
249. (VT, 3)

Unreliability / Resistance

31. [Item text was removed from this report for sample purposes.](VT, 3)
71. (ST, 1)

Traumatic Stressors

34. [Item text was removed from this report for sample purposes.](VT, 3)
114. (VT, 3)
196. (VT, 3)
274. (VT, 3)



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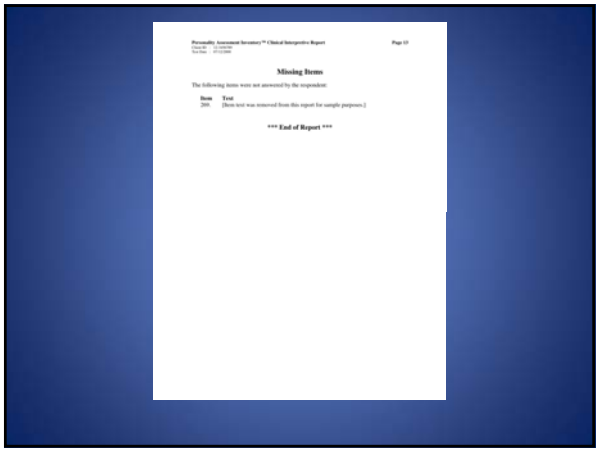
PAI Item Responses

1	MT	44	ST	87	VT	130	VT	173	MT	216	ST	259	F	302	F
2	VT	45	VT	88	VT	131	F	174	VT	217	F	260	F	303	VT
3	F	46	F	89	MT	132	VT	175	VT	218	VT	261	ST	304	VT
4	MT	47	ST	90	VT	133	VT	176	ST	219	VT	262	MT	305	F
5	MT	48	VT	91	VT	134	VT	177	VT	220	F	263	VT	306	VT
6	ST	49	F	92	MT	135	VT	178	VT	221	F	264	VT	307	VT
7	ST	50	VT	93	VT	136	ST	179	VT	222	VT	265	VT	308	F
8	F	51	VT	94	VT	137	VT	180	F	223	VT	266	VT	309	F
9	F	52	F	95	VT	138	VT	181	VT	224	VT	267	VT	310	VT
10	F	53	VT	96	VT	139	F	182	MT	225	MT	268	F	311	F
11	VT	54	VT	97	MT	140	F	183	F	226	VT	269	F	312	F
12	F	55	VT	98	MT	141	VT	184	MT	227	MT	270	ST	313	MT
13	VT	56	VT	99	F	142	VT	185	VT	228	VT	271	F	314	F
14	VT	57	VT	100	F	143	VT	186	VT	229	MT	272	F	315	F
15	VT	58	VT	101	VT	144	VT	187	ST	230	VT	273	F	316	ST
16	VT	59	VT	102	VT	145	MT	188	ST	231	ST	274	VT	317	VT
17	VT	60	F	103	F	146	VT	189	ST	232	F	275	VT	318	VT
18	VT	61	F	104	VT	147	F	190	ST	233	F	276	VT	319	F
19	VT	62	VT	105	ST	148	VT	191	MT	234	ST	277	MT	320	VT
20	F	63	F	106	VT	149	F	192	VT	235	VT	278	VT	321	ST
21	MT	64	VT	107	F	150	ST	193	MT	236	VT	279	VT	322	VT
22	VT	65	VT	108	F	151	MT	194	VT	237	MT	280	F	323	VT
23	VT	66	VT	109	MT	152	VT	195	VT	238	F	281	F	324	VT
24	VT	67	VT	110	MT	153	VT	196	ST	239	VT	282	F	325	VT
25	F	68	VT	111	VT	154	VT	197	VT	240	VT	283	F	326	VT
26	MT	69	F	112	VT	155	VT	198	VT	241	VT	284	F	327	VT
27	F	70	ST	113	ST	156	MT	199	VT	242	VT	285	ST	328	F
28	MT	71	ST	114	VT	157	MT	200	F	243	VT	286	F	329	F
29	F	72	VT	115	VT	158	ST	201	VT	244	F	287	VT	330	VT
30	ST	73	F	116	MT	159	ST	202	MT	245	MT	288	VT	331	VT
31	F	74	VT	117	VT	160	VT	203	MT	246	MT	289	VT	332	VT
32	F	75	VT	118	ST	161	VT	204	F	247	ST	290	F	333	VT
33	ST	76	VT	119	VT	162	VT	205	F	248	VT	291	F	334	F
34	VT	77	MT	120	F	163	VT	206	F	249	VT	292	ST	335	VT
35	F	78	VT	121	ST	164	F	207	ST	250	VT	293	VT	336	F
36	VT	79	VT	122	VT	165	VT	208	F	251	VT	294	VT	337	VT
37	VT	80	VT	123	VT	166	VT	209	F	252	VT	295	F	338	VT
38	VT	81	VT	124	VT	167	ST	210	F	253	VT	296	MT	339	VT
39	VT	82	VT	125	VT	168	ST	211	VT	254	F	297	VT	340	F
40	F	83	VT	126	F	169	MT	212	F	255	VT	298	F	341	VT
41	VT	84	VT	127	VT	170	F	213	MT	256	VT	299	VT	342	F
42	VT	85	VT	128	VT	171	VT	214	VT	257	MT	300	F	343	ST
43	F	86	ST	129	ST	172	MT	215	VT	258	VT	301	VT	344	F



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Missing Items

The following items were not answered by the respondent:

Item	Text
209.	[Item text was removed from this report for sample purposes.]

***** End of Report *****

PAI Strengths

- The PAI is often used in forensics and corrections, where moderate support for its validity has been noted. The PAI has a number of strengths for applied psychological assessment.
  - First, respondents are asked to rate their responses on a 4-point graduated scale, (false, somewhat true, mainly true, very true,) rather than a true/false scale. This contributes to greater scale reliability and validity, as it provides respondents with the opportunity to give nuanced ratings of themselves.

PAI Strengths

- Second, it is relatively economical, assessing most of the constructs that are widely considered important in clinical personality assessment with only 344 items.
- Third, nearly all of the PAI items are readable at the 4th grade level. Brevity and straightforward item wording reduce the administrative burden on respondents.

PAI Strengths

- All of the constructs measured by the PAI are commonly used by psychologists and are named in such a way that they can be readily understood.
- Unlimited-use interpretive software that was written by the test author is available from the publisher.
- As well as an adolescent version of the test, the Personality Assessment Inventory-Adolescent (PAI-A), developed for use with adolescents 12 to 18 years of age. This measure requires only fourth-grade reading level and takes only 45 minutes to complete

PAI Strengths

- The PAI-A also has the advantage of assessing borderline features, which most other instruments used with adolescents do not include.

PAI Strengths

- (statistical) strengths of the PAI, importantly including content validity and discriminant validity.

PAI Limitations

- PAI-A scales do not correspond directly with DSM categories.

FMHE DATA Interpretation

- Identify Hypotheses
- The individual does not have a genuine clincial condition
- The individual has a Clinical Condition but there is no Functional Limitation/Impairment that interfere with Work Capacity
- Individual has CC w/Functional Limitation that interferes with Work Capacity
- Individual is unable to perform their substantial occupational duties for reason(s)
  - Not Related to an injury

Functional Ability – Job Demands

- Do the Functional abilities pre and post affects on Job Demands
- How is the Work Capacity limited
- RULE OUT other Causes of Work Impairment

Depression

- Depression
  - Fatigue
  - Decreased work output
  - Mild Impaired executive functioning
  - Impaired Working Memory
  - Impaired Verbal Fluency

Many individuals work while suffering Depression

Bipolar

Bipolar
- Mood Cycling
- Impaired decision making
- Interpersonal Conflicts
- Impaired Verbal memory
- Impaired executive functions

Bipolar symptoms have greater affect on Work Capacity

Anxiety

Anxiety
- Panic Disorder – Missing Work, Avoidance
- Issues with Attention
  - OCD – Selective Attention
- Impaired verbal Memory
- Preoccupation with trauma or threats