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AN ABSTRACT OF THE THESIS OF Barbara Hendricks for the
Master of Science in Psychology presented May 14, 1976.

Title: Clinical Use of the Midi-Mult.

APPROVED BY MEMBERS OF THE THESIS COMMITTEE:

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The MMPI is used as a diagnostic tool in clinical settings. However, its length is a detriment. Various attempts have been made to develop shortened versions of the standard MMPI. One of the widely used short forms is Kincannon's Mini-Mult, but its validity scales are less accurate than the full MMPI.

Dean's Midi-Mult is a more recent short form of the MMPI designed to approximate more closely the scores on the validity scales and clinical scales of the standard MMPI.

The present study was conducted at the Kaiser Mental Health Clinic in Portland, Oregon during the months of June through December of 1975. This study had two objectives. The first objective was to conduct a replication of the MMPI/Midi-Mult correlations reported by Dean. This was accomplished by administering standard-form MMPIs to fifty outpatients and then extracting the Midi-Mult from the MMPI, using regression equations for each scale as derived by Dean. The scores for the MMPI and Midi-Mult were compared using Pearson correlations. The results indicate that the Midi-Mult/MMPI correlations were similar to those reported by Dean with the exception of Scales 3 and 9 which differed significantly. In both cases Dean's correlations were higher.

In the present study, comparison of Midi-Mult and MMPI mean scores (K-corrected) indicated that the scale means of the Midi-Mult and MMPI were not significantly different for nine scales, but were different for Scales F, K, and 6.

The second objective was to determine the utility of the Midi-Mult in actual clinical use. Accordingly, one new patient was selected by each therapist at the Kaiser Mental Health Clinic. The MMPIs were scored for both the MMPI and Midi-Mult. Lachar analyses were compiled for both tests. The profiles were coded and the therapists

were asked to rank-order the profiles in order of most likely to least likely to be their patient. Spearman correlations were calculated for the comparison of the MMPI rankings with the Midi-Mult rankings. There was a diverse range in the correlations, and the correlations were related to levels of training. One patient was correctly identified as being the therapist's patient for the MMPI, while three patients were correctly identified using the Midi-Mult profiles. Each patient's mean rank on the Midi-Mult and on the MMPI were compared. The result did not indicate a significant difference in the ranks of the two tests. An index of clinician's vagueness was not significantly different for the Midi-Mult and the MMPI.

CLINICAL APPLICATION OF THE MIDI-MULT

by

BARBARA HENDRICKS

A thesis submitted in partial fulfillment of the
requirements for the degree of

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TO THE OFFICE OF GRADUATE STUDIES AND RESEARCH:

The members of the Committee approve the thesis of
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CHAPTER I

INTRODUCTION

The Minnesota Multiphasic Personality Inventory (MMPI) is a widely used diagnostic tool, both in inpatient and outpatient settings. Since its publication in 1943, the MMPI has been applied to a wide variety of clinical and research problems. Although it was initially developed within the area of psychiatric practice, the MMPI was quickly seen to have potential for use in other areas of specialization. The MMPI can be used to screen for emotional disturbances. Identifying individuals who need psychiatric or psychological help has become important, especially in community psychology. The MMPI is also widely used as an aid in diagnosis and classification of patients (Dahlstrom, Welsh & Dahlstrom, 1975). It is useful in estimating an individual's emotional control and in investigation of symptomatic status.

The MMPI authors (Hathaway & McKinley, 1943) and the publisher (University of Minnesota) have permitted widespread use of the items contained in the inventory as an item bank for the formation of new scales. As a result there are at recent count 455 additional scales which have been developed for the MMPI. These scales are designated

Special Scales and may be found in Volume II of An MMPI Handbook (Dahlstrom, Welsh, & Dahlstrom, 1975).

The present study is not concerned with new scales, but with the evaluation of a set of 86 items which is used to approximate scores for 11 of the original basic scales of the standard MMPI with its 566 items.

CHAPTER II

DESCRIPTION OF THE MMPI

The MMPI is based on the method of empirical construction rather than factor analysis (Hilgard, Atkinson, & Atkinson, 1975). In the empirical method the direction in which an item is to be scored is established by pre-testing a large number of items on criterion groups who are known to be high or low on the trait in question (Krech, Crutchfield, & Levson, 1969). Only the questions which discriminate significantly between groups are then retained to make up the inventory. The MMPI items range widely in content. They include such areas as health, psychosomatic symptoms, neurological disorders, political and social as well as neurotic and psychotic behavior manifestations (Anastasi, 1976). An example might be the development of a scale of items which would differentiate schizophrenic from normal individuals. First the same series of items is given to a criterion group and to a control group. The criterion group might be made up of a number of patients hospitalized with a diagnosis of schizophrenia. The control group would consist of persons who have never been diagnosed as having psychiatric problems. Only the test items which discriminate significantly

between the two groups would be retained for use in a schizophrenia scale. Thus, empirical construction contrasts the responses of two distinct groups to ensure that the test items which are ultimately selected do have an empirical relationship to the personality characteristic being measured (Hilgard, Atkinson, & Atkinson, 1975).

The questions on the MMPI are true-false items made up of statements about the individual. Many of the items are based on case records or psychiatric experiences and include statements about symptoms, interests and attitudes, past experiences, and other topics. Some of the items reflect common statements that people might make about themselves, while others reflect bizarre psychiatric symptoms.

Frequently, some of the items evoke reactions of either annoyance or hesitation from the person taking the MMPI. This is probably because the person feels that the questions will be interpreted on either an intuitive or a literal basis. In actuality, single questions are not interpreted. Rather, the person's overall patterns of answers are tabulated. For example, the number of "true" responses to items that in the past have commonly been answered "true" by hospitalized schizophrenic patients would be tabulated. The similarity of a person's answers to the answers of different diagnostic groups of individuals

gives a set of scores which tells the probability that an individual with a particular profile pattern will carry out any given behavior (Dallett, 1969).

The MMPI was developed by administering a large number of initial items to the criterion groups. It is usually scored on at least 13 scales. These scales are measures of traits which, if possessed to an extreme degree, are likely to be symptoms of personality disturbances such as depression, hysteria, paranoia, etc. (Krech, Crutchfield, & Levson, 1969).

A special feature of the MMPI is the use of three validity scales. These scales represent checks on carelessness, misunderstanding, malingering, response sets, and test-taking attitudes. The L Scale (Lie Scale) is based on items which make the person appear in a favorable light, but are unlikely to be truthfully answered in the favorable direction.

The F Scale (Validity score) consists of items rarely answered in the scored direction by the standardization group. A high F score may indicate scoring errors, carelessness, gross eccentricity, or malingering. These items represent undesirable behavior, but do not cohere into any pattern of abnormality. Thus it is unlikely that a person will show all or most of these symptoms. The K Scale (Correction score) measures test-taking attitudes which are related to L and F but are more subtle. A high K score

may indicate defensiveness or an attempt to fake good. A low K score may represent excessive frankness and self-criticism or a deliberate attempt to fake bad.

L and F are used to evaluate the test record. If either one exceeds certain specified values, the MMPI is ruled invalid. The K score functions as a suppressor variable. It furnishes a correction factor which is added to the scores on scales 1, 4, 7, 8 and 9 to yield adjusted totals. Because the use of the K score is questionable, the scores on these scales are often reported with and without correction (Anastasi, 1976).

Since publication of the MMPI, about 455 new scales have been developed, most by independent investigators who did not participate in the construction of the original MMPI (Anastasi, 1976).

The use of automated interpretation for MMPI results is not a recent innovation. To the degree that test interpretation is an objective process with rules which can be specified, it is possible for an experienced test interpreter to teach these rules to others. If a given score or combination of scores is reliably associated with a given characteristic, description, or behavior potential, then such relationships may be specified.

The development of an automated interpretation system using a clinical approach requires an experienced MMPI

interpreter who develops interpretative statements on the basis of MMPI profiles and is required to make clear the test characteristics which evoke each statement. The clinician's interpretations become the statement library while his explanations become the rules for using any given interpretative statement. Such an assessment tool is the method presented by Lachar in his handbook for clinical assessment and automated interpretation of the MMPI (Lachar, 1974). This handbook is designed to serve as a source book for clinicians who must apply MMPI data to clinical problems. It also presents an automated interpretation system. This interpretive system was initially designed to be computer implemented but can also easily be utilized by clinicians without access to computer equipment.

CHAPTER III

SURVEY OF ABBREVIATED FORMS OF THE MMPI

The length of the MMPI has made it desirable to have a test which is equally useful while requiring less time for the patient to take. One of the first attempts to deal with this problem was Kincannon's Mini-Mult. The Mini-Mult was developed by selecting a sample of 71 items which were considered representative of the content clusters which occur in the MMPI validity and clinical scales. This item pool was examined in terms of its ability to predict the standard scale scores. It was found that the Mini-Mult showed a 9% loss in reliability and a 14% loss in correspondence, compared with the full MMPI. Studies examining the Mini-Mult have included a diverse range of subjects. They include admissions to the psychiatric service of a hospital, admissions to a local community health center, and admissions to an acute psychiatric service of a hospital (Kincannon, 1968).

Among the most serious difficulties with the Mini-Mult have been the validity, high points, and elevation of the profiles. Dean (1972) tested the applicability of the Mini-Mult to a predominantly normal population which used

a Health Evaluation Center of an urban hospital. She found that scales L, F, and Ma on the Mini-Mult had the lowest correlations with the full MMPI. The correlations are .83, .77, and .72 respectively. It has also been demonstrated that the Mini-Mult has failed to classify profiles adequately on an individual basis (Lichtenstein & Bryan, 1966).

Since the advent of the Mini-Mult, several other abbreviated MMPIs have been developed. They include the Midi-Mult, the Hugo, and the Faschingbauer. The Hugo (Newmark, Owen, & Newmark, 1975) contains 173 items and was developed by administering the full MMPI to 176 college students and then running linear analyses on the responses. The obtained scores are converted to scale scores. To date, there is no published information about the utility of the Hugo.

The Fashingbauer concurs highly with standard MMPI decisions regarding validity. The Faschingbauer has been demonstrated to be of use with a normal college sample (Newmark, Owen, & Newmark, 1975). It contains 166 items and was developed by using cluster analytic techniques similar to Kincannon's.

The Midi-Mult was developed by Dean at the USPHS Hospital in Baltimore, Maryland. This test was derived from the Mini-Mult. Dean developed new item subsets to serve as short forms for scales L, F, and Ma because these

three scales have traditionally had lower correlations with the MMPI than do the other scales. Varying combinations of items were tried until the revised short form correlated at least .80 with the MMPI. These changes in the item subsets resulted in expansion of the Mini-Mult to 86 items.

In the Midi-Mult the patient is administered the test which is in written form. The responses are scored and are converted to standard MMPI scale scores by use of weighted regression formulas. The Midi-Mult has proven to predict effectively the MMPI scales for normal subjects in a medical setting (Newmark, Owen, & Newmark, 1975).

The most recent abbreviated MMPI is the MMPI-168, developed by Overall and Gomez-Mont (1974). It has been demonstrated that most of the reliable variance in the MMPI is adequately represented in only the first 168 items of the standard Form R MMPI (Overall & Gomez-Mont, 1974). As a result, it seemed reasonable to expect that the factor structure of the first 168 items represents the factor structure of the full MMPI. Overall, Hunter, and Butcher (1973) found six independent factors in the MMPI-168. They were Somatization, Low Morale, Psychotic Distortion, Depression, Acting Out, and Feminine Preferences. The factors seem adequate to represent neuroses, anxiety reactions, depression, psychopathy, and major psychotic

disturbance. To examine the validity of the factor scoring of the MMPI-168, the investigators determined the proportions of subjects in normal and abnormal samples with T scores above 70. The findings were that the factor scoring was sufficiently specific and sensitive to justify use as a screening instrument (Overall, Hunter, & Butcher, 1973).

Because the Midi-Mult contains only 86 items as contrasted to 173 items for the Hugo, 166 items for the Faschingbauer, and 168 for the MMPI-168, it was decided to investigate the Midi-Mult. There were two reasons for this decision. Time is at a premium in many clinics, and a test which is quickly administered enables the therapist to spend more time with the patient. Another important factor is the patient's tolerance for a long test. As a test becomes longer, it is increasingly difficult for some patients (for example, the anxious or the very depressed patient) to complete the test. The areas of interest were to conduct a replication of Dean's work and to determine the utility of the test in actual clinical practice.

CHAPTER IV

METHOD

Subjects

The study was conducted at the Bess Kaiser Mental Health Clinic in Portland, Oregon. The Mental Health Clinic is part of the Permanente Clinics but is a separate facility with a staff of 22 therapists. The Clinic provides mental health services for the Kaiser membership in the greater Portland area. The staff consists of psychiatrists, clinical psychologists, and social workers. The patient population at Kaiser is outpatient and is similar to the population used in Dean's study.

The subjects consisted of 50 of the new patients (25 males and 25 females) who came into the clinic during the months of June through December of 1975. The subjects ranged from 18 to 55 years of age.

Procedure

This study had two areas of interest. The first was to conduct a replication of Dean's study. The second area of interest was to investigate the utility of the Midi-Mult in an actual clinical setting. The Midi-Mult forms were extracted from the standard-form MMPIs and were scored

and converted into Midi-Mults using regression equations for each scale as derived by Dean. K-corrected scores were used in the profiles and interpretations which were presented to the Clinic staff in order to facilitate profile code interpretation.

Each of the 12 staff members at the Mental Health Clinic who sees new-patient intakes was asked to select his next new adult patient (over 18 years of age) and administer the standard MMPI to this patient. A standard MMPI and a Midi-Mult were scored from these MMPIs. The resultant profiles were used to generate a Lachar interpretation for each test. Each patient was assigned two code numbers--one for his Midi-Mult description and one for his MMPI description. The hypothesis to be tested was that a therapist would be able to pick out his patient from a group of patients with as much accuracy using the Midi-Mult-generated Lachar analyses as he would with the standard MMPI Lachar analyses of the patients. The therapist then rank-ordered the patients (using the code numbers) from most likely to least likely to be his patient. The ranking was done for the Midi-Mult Lachars and for the standard MMPI Lachars. The therapists were also asked to divide the patients into three groups. The first group combined the patients whom the therapist believed could be his patient. The next group contained

those patients about whom the therapist was not sure, and the third group contained patients whom he definitely believed could not be his patient.

CHAPTER V

RESULTS

A Pearson product-moment correlation was used to obtain correlations of the Midi-Mult/MMPI scales in the replication portion of the study. The results of the present study and those of Dean are presented in Tables I and II.

TABLE I

CORRELATIONS OF MIDI-MULT/MMPI SCALES (NOT K-CORRECTED)

L	=	.76
F	=	.84
K	=	.85
1	=	.86
2	=	.89
3	=	.73
4	=	.89
6	=	.81
7	=	.89
8	=	.90
9	=	.76

(N = 50)

TABLE II
DEAN'S CORRELATIONS OF MIDI-MULT/MMPI SCALES
(NOT K-CORRECTED)

L	=	.83
F	=	.88
K	=	.92
1	=	.91
2	=	.89
3	=	.86
4	=	.81
6	=	.81
7	=	.94
8	=	.87
9	=	.89

(N = 125)

In order to evaluate the differences in magnitude between these Pearson product-moment correlations, the Pearson correlations were changed to Fisher zs and a test for the difference between two Fisher z values was done (Bruning & Kintz, 1968). The statistical significance of this difference was determined by computing a z statistic, which is the difference between two corresponding Fisher z scores. A z statistic of less than 1.96 at the .05 level of significance indicates that the z is not significant. The results of the test for differences are presented in Table 3.

TABLE III

Z STATISTICS SHOWING THE DIFFERENCE IN THE CORRELATIONS
BETWEEN THE PRESENT STUDY AND DEAN'S STUDY

Scale	Present Study Fisher Z	Dean's Study Fisher Z	Z Statistic
L	.996	1.188	-1.12
F	1.221	1.376	- .90
K	1.256	1.589	-1.94
1	1.293	1.528	-1.37
2	1.422	1.422	0
3	.929	1.293	-2.12*
4	1.422	1.127	+1.72
6	1.127	1.127	0
7	1.422	1.738	-1.84
8	1.472	1.333	+ .81
9	.996	1.422	-2.48*

* $p < .05$

Differences in Scales D, F, K, 1, 2, 4, 6, 7 and 8 are not significant at the .05 level, indicating that the correlational values are not proven to be dissimilar. Scales 3 and 9 are significant indicating that these two scales are very likely different for the two studies.

Also of interest was a comparison of the mean scores for the scales with the mean scores for the standard MMPI. The results appear in Table IV. Mean profiles for males and females on MMPI and Midi-Mult appear in Figures 1 and 2.

TABLE IV
COMPARISON OF MIDI-MULT AND MMPI MEAN SCORES
(K-CORRECTED)

N = 48

Midi-Mult $\bar{Y}$	MMPI $\bar{Y}$	<u>t</u>
L = 4.39	L = 4.04	1.59
F = 8.21	F = 10.23	-3.77**
K = 14.71	K = 13.27	3.80**
1 = 18.35	1 = 18.47	-.26
2 = 29.30	2 = 28.71	.40
3 = 26.90	3 = 27.65	-1.24
4 = 27.08	4 = 27.23	-.38
6 = 12.54	6 = 13.54	-2.45*
7 = 36.35	7 = 35.35	1.89
8 = 36.75	8 = 35.73	1.35
9 = 20.12	9 = 20.71	-1.20

*p<.05

**p<.01

A t test for correlated means was performed (Bruning & Kintz, 1968) to determine the significance of the difference between the means of each scale for the two tests. The results are presented in Table IV. Only scales F, K, and 6 showed a significant difference. For this group of patients, the Midi-Mult underestimated F and overestimated K.

The rank ordering done by the therapists was correlated using a Spearman correlation (Hays, 1973) in order to see how closely the Midi-Mult patient rankings corresponded with the MMPI patient rankings. The resultant correlations appear in Table V.

The Minnesota Multiphasic Personality Inventory

Starke R. Hathaway and J. Charnley McKinley

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Scorer's Initials _____

Broken line indicates Midi-Mult
Solid line indicates MMPI

Figure 1

Average MMPI and Midi-Mult Profiles (Males)

The Minnesota Multiphasic Personality Inventory

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Starke R. Hathaway and J. Charnley McKinley

Scorer's Initials _____

Broken line indicates Midi-Mult
Solid line indicates MMPI

Figure 2

Average MMPI and Midi-Mult Profiles (Females)

The correlations are presented in groups indicating the level of education of the therapists. For the therapists in this study there were four different levels. The first level was MD (Psychiatrist), the second level was PhD (Psychologist), the third level was MS, and the fourth level was Mental Health Assistant.

TABLE V
SPEARMAN CORRELATIONS FOR MIDI-MULT/MMPI RANKINGS
BY THERAPISTS

N = 12

<u>r</u>	<u>MD</u>	<u>Median</u>
=	.96	
	.68	= .82
<u>r</u>	<u>PhD</u>	
=	.90	
	.86	
	.83	
	.55	
	.54	= .83
<u>r</u>	<u>MS</u>	
=	.64	
	.45	= .55
<u>r</u>	<u>Mental Health Assistant</u>	
=	.59	
	.47	
	.22	= .47

The correlation for the therapists as a whole is .70 which is significant at the .01 level. For this particular sample of therapists, the correlations of Midi-Mult/MMPI rankings appear to increase with amount of education. A correlation of .57 or greater is significant at the .05 level using a two-tailed test. Seven of the correlations (58%) were significant at this level. Seven of the correlations (42%) were less than $r = .57$ and were not significant. One patient was correctly identified as being the therapist's patient (appearing as #1 on the list) for the MMPI Lachars. Three patients were correctly identified for the Midi-Mult Lachar profiles. The inference is that within this clinic the Lachar interpretation of the Midi-Mult seems to do as well as the Lachar interpretation of the MMPI. The probability of correctly selecting one's patient by chance is .08. Five therapists included their patient in group #1 (could be my patient) for the Midi-Mult while four therapists included their patient in Group #1 for the full MMPI. Patients' ranks on Midi-Mult and MMPI (those ranks assigned by patients' clinicians) were summed, averaged, and compared by use of a t test. The result was a $t = 1.69$, which does not indicate a significant difference in the ranks of patients on the two tests at the .05 level of significance.

The middle group which the therapists indicated as being those profiles which might or might not be their patient was termed the vague region. The size of the vague region varied from 0 to 3 patients for the Midi-Mult and from 0 to 5 patients for the standard MMPI.

The index of vagueness (Paulson, 1976) was defined as the number of cases which the therapist felt could be his patient (Group 1) + the number of cases about which he was not sure (Group 2). The results are listed for both Midi-Mult and MMPI in Table VI. The numbers represent actual numbers of patients placed in Groups 1 and 2.

TABLE VI

SCOPE OF THE INDEX OF VAGUENESS FOR MIDI-MULT AND MMPI

Midi-Mult		MMPI	
Therapist		Therapist	
A	<u>2</u>	A	<u>2</u>
B	<u>6</u>	B	<u>7</u>
C	<u>4</u>	C	<u>7</u>
D	<u>3</u>	D	<u>7</u>
E	<u>5</u>	E	<u>4</u>
F	<u>5</u>	F	<u>4</u>
G	<u>7</u>	G	<u>8</u>
H	<u>6</u>	H	<u>6</u>
I	<u>4</u>	I	<u>4</u>
J	<u>4</u>	J	<u>6</u>
K	<u>4</u>	K	<u>4</u>
L	<u>8</u>	L	<u>8</u>
$\bar{X} = 4.83$		$\bar{X} = 5.58$	

A t test for correlated means (one tailed) was done. The t statistic was t = 1.68. This indicates that the size of the index was not significantly different for the Midi-Mult than for the MMPI at .05 level of significance.

Inclusion in Group 3 (those patients whom the therapist felt were not his patient) was considered the criterion for failure. In three instances the patient was mistakenly placed in Group 3 using the MMPI Lachars. In three instances the patient was placed in Group 3 using the Midi-Mult Lachars.

CHAPTER VI

DISCUSSION

The present study did find agreement between the correlations for this replication of Dean's study and Dean's correlations for the Midi-Mult/MMPI scales. Exceptions were Scales 3 and 9, which did not agree with Dean's findings and which were significantly lower. Also, in the replication, statistically significant differences were found between Midi-Mult/MMPI means for scales F, K, and 6. Otherwise, the average profile generated by the Midi-Mult was similar to the average MMPI profile. The size of the vague region was slightly larger for the MMPI Lachars than for the Midi/Mult Lachars. Only one therapist identified his patient using the MMPI profiles and Lachar analyses, while three therapists were able to identify their patients using the Midi-Mult profiles and Lachar analyses. This difference in favor of the Midi-Mult is not statistically significant, but does suggest that in this clinical setting in the case of this present study the Midi-Mult profiles and analyses are not inferior to the profiles and analyses based on the standard MMPI.

It is possible that problems in regard to the empirical validity of the MMPI may be compounded by the use of the

Lachar analyses in terms of adding to the invalidity. It should also be noted that the Midi-Mult does not include Scales 5 or 0.

One suggestion for further research would be to do a rank-ordering such as the one in the present study but to control for the number of times which the therapist sees the patient prior to the ranking procedure. Also of interest would be a study in which the Midi-Mult and MMPI profiles were paired and evaluated by clinicians in terms of which profile the clinician felt most closely resembled his patient. Such a study would require that the therapist have a good degree of familiarity with his patients.

Since the results of this study are based on Midi-Mults which were extracted from full MMPIs, this study should be replicated with externally administered Midi-Mults and compared with standard MMPI results for the same patients.

On the basis of the results of this study it would appear that the Midi-Mult provides a close enough approximation to full MMPI results to justify its use as a rough screening instrument in those situations in which the MMPI would customarily be used except for its length.

A SELECTED BIBLIOGRAPHY

- Anastasi, A. Psychological Testing. New York: MacMillan Publishing Company, 1976.
- Bruning, J. and B. Kintz. Computational Handbook of Statistics. Glenview, Illinois: Scott, Foreman and Co., 1968.
- Dahlstrom, W., G. Welsh, and L. Dahlstrom. An MMPI Handbook. Vol. II: Research Applications. Minneapolis: University of Minnesota Press, 1975.
- Dallett, K. Problems of Psychology. New York: John Wiley and Sons, 1969.
- Dean, E. "A Lengthened Mini: The Midi-Mult." Journal of Clinical Psychology, 28, 1972, 68-71.
- Gayton, W., J. Bishop, M. Citrin, and J. Bassett. "An Investigation of the Mini-Mult Validity Scales." Journal of Personality Assessment, Vol. 39, No. 5, October 1975, 511-513.
- Hathaway, S. K. and M. D. McKinley. Booklet for the Minnesota Multiphasic Personality Inventory. New York: The Psychological Corporation, 1943.
- Hays, W. Statistics for the Social Sciences. New York: Holt, Rinehart and Winston, 1973.
- Hilgard, E., R. Atkinson, and K. Atkinson. Introduction to Psychology. New York: Harcourt Brace and Jovanovich, 1975.
- Kincannon, J. "Prediction of the Standard MMPI Scale Scores from 71 Items: The Mini-Mult." Journal of Consulting and Clinical Psychology, 1968, 32, 319-325.
- Krech, D., R. Crutchfield, and N. Levson. Elements of Psychology. New York: Knopf, 1969.
- Lachar, D. The MMPI: Clinical Assessment and Automated Interpretation. Los Angeles: Western Psychological Services, 1974.

- Lichtenstein, E. and J. Bryan. "Short-Term Stability of MMPI Profiles." Journal of Clinical and Consulting Psychology, 1966, 30, 172-174.
- Newmark, C., L. Cook, and W. Greer. "Application of the Midi-Mult to Psychiatric Inpatients." Journal of Clinical Psychology, 4, No. 29, 1973, 481-484.
- Newmark, C., L. Newmark and T. Faschingbauer. "Utility of Three Abbreviated MMPIs With Psychiatric Outpatients." Journal of Nervous and Mental Diseases, Vol. 159, (6) Dec. 1974, 433-438.
- Newmark, C., M. Owen, and L. Newmark. "Comparison of Three Abbreviated MMPIs for Psychiatric Patients and Normals." Journal of Personality Assessment, 39, 3, 1975, 261-270.
- Newmark, C. and A. Finch. "Comparing the Diagnostic Validity of an Abbreviated and Standard MMPI." Journal of Personality Assessment, 40, No. 1, Feb. 1976, 10-12.
- Overall, J., S. Hunter, and J. Butcher. "Factor Structure of the MMPI-168 in a Psychiatric Population." Journal of Consulting and Clinical Psychology, Vol. 41, No. 2, 1973, 284-286.
- Overall, J. and F. Gomez-Mont. "The MMPI for Psychiatric Screening." Educational and Psychological Measurement, Vol. 34, 1974, 315-319.
- Paulson, J. Personal conversation, April, 1976.