Manual
for Administration, Scoring, and Interpretation

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Minnesota Multiphasic Personality Inventory®-3 (MMPI®-3) Manual for Administration, Scoring, and Interpretation

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Produced in the United States of America.

Contents

Publisher's Note xi

Acknowledgments xiii

Preface xv

Chapter 1: Introduction 1

- The Original MMPI 2
- The MMPI-2 3
- The MMPI-2 RC Scales 4
- The MMPI-2-RF 6
- The MMPI-3 7

Chapter 2: Intended Uses, Diversity Considerations, User Qualifications, and Protection of Test Materials 11

- Intended Uses 11
- Diversity Considerations 12
- User Qualifications 13
- Protection of Test Materials 13

Chapter 3: The MMPI-3 Normative Sample and Derivation of Norms 17

- The MMPI-3 Normative Sample 17
  - The MMPI-2-RF-EX 17
  - Data Collection Procedures 18
  - Assembling the English-Language Normative Sample 18
  - Composition of the MMPI-3 Normative Sample 18
  - Nongendered Norms 20
- Derivation of Standard Scores 21

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Chapter 4: Procedures for Administration and Scoring . . . 23
Administration . . . 23
Assess the Testability of the Test Taker . . . 23
Use Standard MMPI-3 Administration and Response-Recording Modalities . . . 24
Supervise Testing and Maintain Test Security . . . 25
Maintain a Quiet, Comfortable Environment . . . 25
Scoring . . . 25

Chapter 5: Test Interpretation . . . 27
Structure and Sources for MMPI-3 Interpretation . . . 27
Protocol Validity . . . 29
Content Nonresponsiveness . . . 29
Cannot Say (CNS) . . . 29
Combined Response Inconsistency (CRIN) . . . 30
Variable Response Inconsistency (VRIN) . . . 30
True Response Inconsistency (TRIN) . . . 30
Over-Reporting . . . 32
Infrequent Responses (F) . . . 33
Infrequent Psychopathology Responses (Fp) . . . 33
Infrequent Somatic Responses (Fs) . . . 34
Symptom Validity Scale (FBS) . . . 34
Response Bias Scale (RBS) . . . 34
Under-Reporting . . . 37
Uncommon Virtues (L) . . . 37
Adjustment Validity (K) . . . 38
Substantive Scale Interpretation . . . 39
Higher-Order (H-O) Scales . . . 40
Emotional/Internalizing Dysfunction (EID) . . . 41
Thought Dysfunction (THD) . . . 41
Behavioral/Externalizing Dysfunction (BXD) . . . 41
Restructured Clinical (RC) Scales . . . 42
Demoralization (RCd) . . . 43
Somatic Complaints (RC1) . . . 43
Low Positive Emotions (RC2) . . . 43
Antisocial Behavior (RC4) . . . 44
Ideas of Persecution (RC6) . . . 44

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Dysfunctional Negative Emotions (RC7) . . . 44
Aberrant Experiences (RC8) . . . 44
Hypomanic Activation (RC9) . . . 45
Specific Problems (SP) Scales . . . 51
Somatic/Cognitive Scales . . . 52
Malaise (MLS) . . . 52
Neurological Complaints (NUC) . . . 52
Eating Concerns (EAT) . . . 52
Cognitive Complaints (COG) . . . 52
Internalizing Scales . . . 54
Suicidal/Death Ideation (SUI) . . . 55
Helplessness/Hopelessness (HLP) . . . 55
Self-Doubt (SFD) . . . 55
Inefficacy (NFC) . . . 55
Stress (STR) . . . 55
Worry (WRY) . . . 55
Compulsivity (CMP) . . . 55
Anxiety-Related Experiences (ARX) . . . 55
Anger Proneness (ANP) . . . 56
Behavior-Restricting Fears (BRF) . . . 56
Externalizing Scales . . . 60
Family Problems (FML) . . . 60
Juvenile Conduct Problems (JCP) . . . 60
Substance Abuse (SUB) . . . 61
Impulsivity (IMP) . . . 61
Activation (ACT) . . . 61
Aggression (AGG) . . . 61
Cynicism (CYN) . . . 61
Interpersonal Scales . . . 65
Self-Importance (SFI) . . . 65
Dominance (DOM) . . . 65
Disaffiliativeness (DSF) . . . 66
Social Avoidance (SAV) . . . 66
Shyness (SHY) . . . 66
Personality Psychopathology Five (PSY-5) Scales . . . 68
Aggressiveness (AGGR) . . . 69

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Psychoticism (PSYC) . . . 69
Disconstraint (DISC) . . . 69
Negative Emotionality/Neuroticism (NEGE) . . . 69
Introversion/Low Positive Emotionality (INTR). . . . 69
Writing an MMPI-3 Interpretive Report . . . 72
Case Illustrations . . . 73
Ms. N . . . 73
Background . . . 73
Detailed Analysis of MMPI-3 Findings . . . 74
MMPI-3 Interpretation . . . 75
Mr. S. . . . 84
Background . . . 84
MMPI-3 Interpretation . . . 84
Mr. A. . . . 92
Background . . . 92
MMPI-3 Interpretation . . . 92

References . . . 101

Appendixes

A. Item Composition of Scales . . . 111
A-1. Validity Scales . . . 112
A-2. Higher-Order (H-O) Scales . . . 115
A-3. Restructured Clinical (RC) Scales . . . 116
A-4. Somatic/Cognitive Scales . . . 118
A-5. Internalizing Scales . . . 119
A-6. Externalizing Scales . . . 121
A-7. Interpersonal Scales . . . 123
A-8. Personality Psychopathology Five (PSY-5) Scales . . . 124
B. T-Score Conversion Tables . . . 125
B-1. Linear T-Score Conversions for the Validity Scales . . . 126
B-2. Uniform T-Score Conversions for the Higher-Order (H-O) and Restructured Clinical (RC) Scales. . . . 127
B-3. Uniform T-Score Conversions for the Somatic/Cognitive and Internalizing Scales . . . 128
B-4. Uniform T-Score Conversions for the Externalizing and Interpersonal Scales . . . 128
B-5. Uniform T-Score Conversions for the Personality Psychopathology Five (PSY-5) Scales . . . 129

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C. Scale Membership and Scored Direction of Items . . . 131
D. Item Content and Reading Level . . . 137
E. Item Conversion Tables . . . 147
E-1. MMPI-3 to MMPI-2-RF . . . 148
E-2. MMPI-2-RF to MMPI-3 . . . 150
F. Profile Forms . . . 153
F-1. Profile for Validity Scales . . . 154
F-2. Profile for Higher-Order (H-O) and Restructured Clinical (RC) Scales . . . 155
F-3. Profile for Somatic/Cognitive and Internalizing Scales . . . 156
F-4. Profile for Externalizing and Interpersonal Scales . . . 157
F-5. Profile for Personality Psychopathology Five (PSY-5) Scales . . . 158

Index . . . 159

Tables

1-1. The MMPI-3 Scales . . . 9
1-2. Available MMPI-3 Materials . . . 10
3-1. Ethnic Origins of Participants in the MMPI-3 Normative Sample Compared to 2020 Projected Census Data . . . 19
3-2. Age Distribution of Participants in the MMPI-3 Normative Sample Compared to 2020 Projected Census Data . . . 19
3-3. Education of Participants in the MMPI-3 Normative Sample Compared to 2020 Projected Census Data . . . 19
3-4. Sites for Data Collection of Participants in the MMPI-3 Normative Sample . . . 20
5-1. Recommended Structure and Sources of Information for MMPI-3 Interpretation . . . 28
5-2. Cannot Say (CNS) Score Interpretation . . . 31
5-3. CRIN (Combined Response Inconsistency) Interpretation . . . 31
5-4. VRIN (Variable Response Inconsistency) Interpretation . . . 31
5-5. TRIN (True Response Inconsistency) Interpretation . . . 32
5-6. F (Infrequent Responses) Interpretation . . . 35
5-7. Fp (Infrequent Psychopathology Responses) Interpretation . . . 35
5-8. Fs (Infrequent Somatic Responses) Interpretation . . . 36
5-9. FBS (Symptom Validity Scale) Interpretation . . . 36
5-10. RBS (Response Bias Scale) Interpretation . . . 36
5-11. L (Uncommon Virtues) Interpretation . . . 38
5-12. K (Adjustment Validity) Interpretation . . . 39
5-13. Emotional/Internalizing Dysfunction (EID) Interpretation . . . 41

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5-14. Thought Dysfunction (THD) Interpretation . . . 42
5-15. Behavioral/Externalizing Dysfunction (BXD) Interpretation . . . 42
5-16. Demoralization (RCd) Interpretation . . . 45
5-17. Somatic Complaints (RC1) Interpretation . . . 46
5-18. Low Positive Emotions (RC2) Interpretation . . . 47
5-19. Antisocial Behavior (RC4) Interpretation . . . 48
5-20. Ideas of Persecution (RC6) Interpretation . . . 49
5-21. Dysfunctional Negative Emotions (RC7) Interpretation . . . 49
5-22. Aberrant Experiences (RC8) Interpretation . . . 50
5-23. Hypomanic Activation (RC9) Interpretation . . . 51
5-24. Malaise (MLS) Interpretation . . . 53
5-25. Neurological Complaints (NUC) Interpretation . . . 53
5-26. Eating Concerns (EAT) Interpretation . . . 54
5-27. Cognitive Complaints (COG) Interpretation . . . 54
5-28. Suicidal/Death Ideation (SUI) Interpretation . . . 56
5-29. Helplessness/Hopelessness (HLP) Interpretation . . . 56
5-30. Self-Doubt (SFD) Interpretation . . . 57
5-31. Inefficacy (NFC) Interpretation . . . 57
5-32. Stress (STR) Interpretation . . . 58
5-33. Worry (WRY) Interpretation . . . 58
5-34. Compulsivity (CMP) Interpretation . . . 58
5-35. Anxiety-Related Experiences (ARX) Interpretation . . . 59
5-36. Anger Proneness (ANP) Interpretation . . . 59
5-37. Behavior-Restricting Fears (BRF) Interpretation . . . 60
5-38. Family Problems (FML) Interpretation . . . 62
5-39. Juvenile Conduct Problems (JCP) Interpretation . . . 62
5-40. Substance Abuse (SUB) Interpretation . . . 63
5-41. Impulsivity (IMP) Interpretation . . . 63
5-42. Activation (ACT) Interpretation . . . 64
5-43. Aggression (AGG) Interpretation . . . 64
5-44. Cynicism (CYN) Interpretation . . . 65
5-45. Self-Importance (SFI) Interpretation . . . 66
5-46. Dominance (DOM) Interpretation . . . 67
5-47. Disaffiliativeness (DSF) Interpretation . . . 67
5-48. Social Avoidance (SAV) Interpretation . . . 68
5-49. Shyness (SHY) Interpretation . . . 68

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5-50. Aggressiveness (AGGR) Interpretation . . . 70
5-51. Psychoticism (PSYC) Interpretation . . . 70
5-52. Disconstraint (DISC) Interpretation . . . 71
5-53. Negative Emotionality/Neuroticism (NEGE) Interpretation . . . 71
5-54. Introversion/Low Positive Emotionality Interpretation . . . 72

Figures

2-1. Sample Litigation-Related Demand for Disclosure of Copyright- and Trade-Secret-Protected Test Materials Distributed by Pearson . . . 15
3-1. Prototype Distribution Serving as Target in the Derivation of the Uniform T Scores . . . 22
5-1. Ms. N's Validity Scales Profile . . . 77
5-2. Ms. N's Higher-Order (H-O) and Restructured Clinical (RC) Scales Profile . . . 78
5-3. Ms. N's Somatic/Cognitive and Internalizing Scales Profile . . . 79
5-4. Ms. N's Externalizing and Interpersonal Scales Profile . . . 80
5-5. Ms. N's Personality Psychopathology Five (PSY-5) Scales Profile . . . 81
5-6. Ms. N's T Scores by Domain . . . 82
5-7. Ms. N's Item-Level Information . . . 83
5-8. Mr. S's Validity Scales Profile . . . 85
5-9. Mr. S's Higher-Order (H-O) and Restructured Clinical (RC) Scales Profile . . . 86
5-10. Mr. S's Somatic/Cognitive and Internalizing Scales Profile . . . 87
5-11. Mr. S's Externalizing and Interpersonal Scales Profile . . . 88
5-12. Mr. S's Personality Psychopathology Five (PSY-5) Scales Profile . . . 89
5-13. Mr. S's T Scores by Domain . . . 90
5-14. Mr. S's Item-Level Information . . . 91
5-15. Mr. A's Validity Scales Profile . . . 94
5-16. Mr. A's Higher-Order (H-O) and Restructured Clinical (RC) Scales Profile . . . 95
5-17. Mr. A's Somatic/Cognitive and Internalizing Scales Profile . . . 96
5-18. Mr. A's Externalizing and Interpersonal Scales Profile . . . 97
5-19. Mr. A's Personality Psychopathology Five (PSY-5) Scales Profile . . . 98
5-20. Mr. A's T Scores by Domain . . . 99
5-21. Mr. A's Item-Level Information . . . 100

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1

Introduction

The MMPI-3 (Minnesota Multiphasic Personality Inventory-3) is a 335-item version of the MMPI® instruments designed to provide a comprehensive and efficient assessment of clinically relevant variables with updated items, scales, and norms. It is a broadband instrument intended for use with individuals ages 18 years and older in a variety of settings in which the MMPI instruments have traditionally been applied. The procedures and guidelines described in this manual are designed to maximize the usefulness of the findings generated by the test.

Information on the validity and other psychometric features of the instrument is reported in detail in the accompanying *MMPI-3 Technical Manual* (Ben-Porath & Tellegen, 2020a), which also provides the rationale for developing the test, the procedures used to fashion the scales, descriptive findings on the scales, and a discussion of the extensive external correlate data reported in the appendixes. The *MMPI-3 Technical Manual* Appendixes D and E document the validity of the MMPI-3 scale scores in the broad range of settings in which the test is recommended for use and serve as the basis for generating the empirically grounded interpretive recommendations provided in Chapter 5 of this manual. Appendix E of the *Technical Manual* also includes extensive analyses that establish the comparability of MMPI-2-RF (Ben-Porath & Tellegen, 2008/2011) and MMPI-3 empirical correlates. These analyses demonstrate that the extensive literature available to guide MMPI-2-RF interpretation can also be applied with confidence to the MMPI-3.

The MMPI-3 test manuals fulfill the requirements for supporting documentation of tests outlined in the *Standards for Educational and Psychological Testing* (American Educational Research Association et al., 2014). Additional resources available to MMPI-3 users include web pages maintained by the test publisher, the University of Minnesota Press (www.upress.umn.edu/test-division), and the distributor, Pearson (www.PearsonAssessments.com/mmpi-3), that provide updates on test developments as well as information about obtaining MMPI-3 materials and about training resources and opportunities.

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Of the 335 MMPI-3 items, 263 are drawn from the 338-item MMPI-2-RF, from which 75 items were dropped in the course of developing the MMPI-3. (See Appendix E for MMPI-3/MMPI-2-RF item conversion tables.) The items for each of the 52 scales that make up the MMPI-3 have been ordered so that they are distributed throughout the inventory. Chapter 4 details the options available for scoring the test. It can be hand scored using scoring keys, answer sheets, and profile forms, or it can be computer scored either on-site via Pearson's scoring and reporting systems or by mail-in to Pearson. Several computer-generated reports are available. The MMPI-3 Score Report provides raw and standard (T) scores for the scales as well as item-level information—including unscorable responses and responses to critical items—to be taken into consideration when interpreting MMPI-3 test results. Score Report users have the option to plot comparison group data along with the profile of the test taker. For example, for an individual tested in an outpatient community mental health setting, mean scores plus and minus one standard deviation for a sample of individuals tested in such a setting can be plotted along with the test taker's profile. When these optional comparison group data are used, the Score Report also indicates, for each scale, the percentage of comparison group members with

scores at or below those of the test taker. The MMPI-3 Interpretive Report for Clinical Settings includes all the elements of the Score Report, augmented by a narrative interpretation of the test results. The statements generated in the Interpretive Report are based on the item content of the scales and empirical correlates of the MMPI-3. The report is annotated, providing information about which MMPI-3 scale scores trigger a given statement and on what basis, and about relevant sources for correlate-based statements. The *MMPI-3 User's Guide for the Score and Clinical Interpretive Reports* (Ben-Porath & Tellegen, 2020b) discusses in detail the features and use of the MMPI-3 Interpretive Report for Clinical Settings. The MMPI-3 Police Candidate Interpretive Report (PCIR), designed for use in preemployment assessments of law enforcement candidates, is described in a separate user's guide (Corey & Ben-Porath, 2020a).

The section that follows describes important developments in the history of the MMPI instruments that establish the foundations for the MMPI-3. Chapter 1 of the *MMPI-3 Technical Manual* provides a more detailed review of these developments.

The Original MMPI

The MMPI was developed by Starke Hathaway, a clinical psychologist at the University of Minnesota Hospitals, and J. C. McKinley, head of the Department of Psychiatry and Neurology at the university, to facilitate more accurate diagnosis of patients being treated at the hospital. In constructing items for the test, Hathaway and McKinley were guided by the Kraepelinian descriptive diagnostic classification system of the 1930s. They developed a large pool of candidate items and employed empirical keying to construct the eight original MMPI Clinical Scales by contrasting the responses of differentially diagnosed patient groups with those of nonpatients. Statistical analyses were conducted to identify eight sets of items that differentiated patients who were members of eight groups given the diagnosis, respectively, of hypochondriasis, depression, hysteria, psychopathic deviance, paranoia, psychasthenia (anxiety-related disorder), schizophrenia, and hypomania from nonpatients. Several additional analyses resulted in eight final item sets, which were converted into eight diagnostic scales. Scales measuring masculinity/femininity and social introversion were added later to the set of basic scales. Hathaway and McKinley documented the development of the MMPI Clinical Scales in a series of articles (Hathaway & McKinley, 1940, 1942a; McKinley & Hathaway, 1940, 1942, 1944).

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The Clinical Scales did not perform as intended. Attempts to replicate the validity of the scales as predictors of diagnostic group membership were only marginally successful for some scales and mostly unsuccessful for others (Hathaway, 1960). However, early users of the MMPI did observe that patterns of Clinical Scale scores were associated with certain psychological characteristics. Researchers began to shift their focus from individual scale correlates to the identification of replicable empirical correlates of patterns of scale scores. The term *profile* was adopted to refer to the complete set of scores on the Clinical Scales; *profile types* or *code types* identified certain patterns or combinations of scores.

By the 1960s, use of the MMPI had undergone still further, and dramatic, changes. The diagnostic model was dropped in favor of the considerably broader goal of assessing normal and abnormal personality characteristics, symptoms of psychopathology, and behavioral propensities. Code types, rather than individual scales, were viewed as the primary information vehicles. Comprehensive studies of the empirical correlates of the code types (e.g., Gilberstadt & Duker, 1965; Marks & Seeman, 1963; Marks, Seeman, & Haller, 1974) served as major sources of interpretive inferences for the test. Also beginning in the 1960s, efforts to construct MMPI scales on the basis of item content rather than external correlates resulted in new scales and interpretive approaches (e.g., Wiggins, 1966). Content-based scales complemented the

original, empirically derived scales by providing more direct means of communication between test taker and interpreter.

The original MMPI was without precedent or peer in the volume and variety of the research that guided its application in a broad range of assessment tasks. By the 1980s, it had become the most widely used measure of personality and psychopathology in the world. Nevertheless, over the years researchers and practitioners became aware of some significant shortcomings in the test that needed to be addressed. In 1982, the University of Minnesota Press instituted the Restandardization Project, the mission of which was to develop a revised version of the original MMPI. The MMPI-2 was published in 1989; the original MMPI was discontinued in 1999.

The MMPI-2

The need to update the MMPI had been recognized and expressed for some time before the Restandardization Project began its work (see Butcher, 1972). The collection of new norms was perceived to be the most pressing need. The original MMPI normative sample was collected in the 1930s and consisted almost exclusively of White, working-class rural Minnesotans with an average of 8 years of education. This sample, although acceptable for its intended use when the test was released, was no longer adequate as the MMPI came to be used in a wide variety of settings in the United States and throughout the world. A second goal of the revision was to update the test items. Items not scored on any of the more widely used scales or items deemed offensive because they concerned religious beliefs or contained sexist wording or references to bowel and bladder functioning (Butcher & Tellegen, 1966) were eliminated. Items containing outdated language or cultural references were revised. These two goals, however, were pursued in the context of a commitment by the Restandardization Committee to maintain continuity between the original MMPI and the revised instrument. Consequently, the Clinical Scales were left essentially intact—a small number of items were revised and an even smaller number deemed offensive were dropped from the scales.

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The MMPI-2 normative sample was collected during the mid-1980s in several areas of the United States, matching insofar as possible the then-current census and producing an adequate general population sample. Over 2,900 individuals completed the test battery composed of (a) an experimental version of the test booklet, the MMPI-AX, made up of the 550 original test items and 154 new items added as candidates for replacing some of the older, nonworking items; (b) a Biographical Information Form providing extensive demographic data; and (c) a Life Events Form (a checklist of recent stressful life events).

The final version of the MMPI-2 consisted of 567 items. Of the 383 items scored on the basic Validity and Clinical Scales of the original MMPI, 372 were retained in the MMPI-2. Eleven were deleted because of objectionable content. No Clinical Scale lost more than four items, and no items were added. Of the MMPI-2 items, 64 were slight revisions of original MMPI items. Ben-Porath and Butcher (1989) found these changes to have a negligible impact on the psychometric functioning of the scales that included any of these items. Consistent with the goal of maintaining continuity with the original MMPI, the basic validity scales (L, F, and K) were also left unchanged except for deleting four objectionable items from the F scale. The MMPI-2 Clinical Scales were nearly identical to those of the MMPI.

MMPI-2 innovations included (a) new norms more representative of the population of the United States, (b) a new method of calculating MMPI-2 standard uniform T scores (Tellegen & Ben-Porath, 1992) for the Substantive Scales of the inventory, (c) two new response inconsistency scales, VRIN and TRIN, to assist in identifying protocols marked by random or fixed responding, fashioned after similar indicators developed

by Tellegen (1988), (d) a new scale, F_B, designed to identify infrequent responding to items that appear in the latter part of the MMPI-2, and (e) the MMPI-2 Content Scales (Butcher et al., 1990), which replaced the original MMPI Content Scales (Wiggins, 1966) and offered, as did the Wiggins scales, a more focused assessment of some of the same attributes targeted by the Clinical Scales (e.g., anxiety, depression, bizarre mentation) and assessment of some areas that were not covered directly by the Clinical Scales (e.g., fears, anger, family problems).

The development and validation of the MMPI-2 were documented in the first edition of the test manual (Butcher et al., 1989). Although some doubts were expressed initially about whether continuity had been preserved (see Dahlstrom, 1992), research on the congruence of code types generated by the two sets of norms indicated that in the vast majority of cases the same findings were obtained when taking measurement error into account (Ben-Porath & Tellegen, 1995; Graham et al., 1991).

Consistent with the history of the original MMPI, research and development continued after publication of the MMPI-2. A revised edition of the test manual (Butcher et al., 2001) documented new MMPI-2 scales: two validity scales, Fp (Arbisi & Ben-Porath, 1995), a measure of infrequent responding less likely than the F scale to reflect genuine psychopathology, and S, assessing superlative self-presentation (Butcher & Han, 1995); component scales for the Content Scales (Ben-Porath & Sherwood, 1993); a set of scales designed to measure major dimensions of personality pathology, the Personality Psychopathology Five (PSY-5; Harkness et al., 1995; Harkness et al., 2002); and a revised version of the Ho (Hostility) scale (Cook & Medley, 1954). Subsequent developments included the introduction of nongendered norms for the instrument (Ben-Porath & Forbey, 2003) and the addition of the Symptom Validity Scale (FBS; Lees-Haley et al., 1991) to the standard Validity Scales of the test.

None of these improvements had a direct impact on the core information source of the MMPI-2, the Clinical Scales. It is worth noting that in the preface to Dahlstrom and Welsh's (1960) *MMPI Handbook,* Starke Hathaway, developer of the Clinical Scales, wondered why no improvements had been proposed to the scales that had been published nearly two decades earlier. It would be three more decades before Auke Tellegen would initiate such improvements shortly after the MMPI-2 was published in 1989, which culminated in the development of the MMPI-2 Restructured Clinical (RC) Scales, documented in a test monograph (Tellegen et al., 2003).

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The MMPI-2 RC Scales

Two major and jointly compelling factors motivated the RC scale development project. One was the well-recognized major strength of the Clinical Scales, namely, the largely empirical method of selecting items on the basis of important diagnostic correlates, ensuring that embedded in the Clinical Scale item pools were clinically significant dimensions. The second factor was the equally well-known fact that the Clinical Scales were not psychometrically optimal. The basic problem, one that compromised convergent and discriminant validities of most of the scales, was excessive structural heterogeneity (i.e., overextended multidimensionality, conflicting directionality, and some noise), which was reflected in overly wide-ranging item content, concomitant item overlap between scales, and some unacceptably high scale intercorrelations among the Clinical Scales, stemming from their inadvertent saturation with Demoralization variance (discussed shortly). Together, these factors highlighted the need for and potential benefit of updating the Clinical Scales.

To a significant extent, excessive correlations among the Clinical Scales stemmed from Hathaway and McKinley's (1942b) use of a nonpatient sample as the reference group when following the method used

by Strong (1938) for developing his Vocational Interest Blank. A key difference between the two scale-development efforts was that Strong had used for constructing each of the vocational interest scales a contrast group representing the same general group of occupations other than the targeted one. Had Hathaway and McKinley followed Strong's approach fully and used a contrast group made up of patients with other (than the targeted disorder) diagnoses, they likely would not have included items on the Clinical Scales that were linked generally to "patienthood" and that gave rise to the excessive correlations stemming from oversaturation with Demoralization. Tellegen et al. (2003) discuss this issue in detail.

The RC Scales were designed to address the heterogeneity problem and to make clinically significant information more accessible. Each scale measures separately one of the dimensions that had been identified as a major component of one or more of the Clinical Scales. Construction of the RC Scales (Tellegen et al., 2003) occurred in four steps. Throughout the process, analyses were conducted and replicated with large clinical samples to reduce the likelihood that chance findings would affect the restructuring effort.

The first step was to develop a measure of Demoralization, the common nonspecific factor that contributed substantial shared variance to all of the Clinical Scales and was one of the dimensions contributing to the heterogeneity of the scales. Tellegen (1985) had described Demoralization as a general factor that inflates correlations between measures of attributes that would be expected to be relatively independent in clinical inventories like the MMPI. Tellegen's observations regarding Demoralization were based on his study of the structure of mood, in which a broad, overarching dimension of Pleasant versus Unpleasant affect (analogous to Demoralization) had been identified (Watson & Tellegen, 1985). Within this framework, Demoralization was conceptualized as combining high negative and low positive activation, conditions Tellegen (1985) had identified respectively as risk factors for pathological anxiety and depression. Guided by this conceptualization, a measure of Demoralization was constructed by identifying a set of items that had relevant variance in common with both Clinical Scales 7 and 2 (respectively measures of anxiety-related psychopathology and depression). The content of these items was found to be congruent with that of the Pleasant vs. Unpleasant dimension.

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The second major step in constructing the RC Scales was to conduct separate principal component analyses of each of the original Clinical Scales items combined with the Demoralization items. In each of these analyses, the first rotated factor was marked by the original Demoralization items as well as by those Clinical Scale items that were also Demoralization markers. For most Clinical Scales, a two-factor solution also led to the identification of a meaningful and distinctive non-Demoralization component. For some Clinical Scales, a three-factor solution was needed to recover a meaningful dimension that was not more properly designated as the major distinctive component of a different Clinical Scale. In the case of the original Scale 5, a four-factor solution was required, which produced two distinctive components. Step 2 thus yielded 12 sets of items representing Demoralization and 11 major distinctive Clinical Scale components.

The third step was the construction of a set of seed scales representing the 12 identified Clinical Scale components. A series of analyses was conducted to maximize both the representativeness and the mutual distinctiveness of these 12 core scales.

The fourth step of scale construction focused on developing the nine final RC Scales representing Demoralization and the eight Clinical Scales that represented or were related to major recognized psychopathologies.[2] Correlations were computed for each seed scale with each of the 567 MMPI-2 items. Items were added to each of the nine targeted scales if they were sufficiently correlated with it and minimally with the 11 other seed scales. Subsequently, a small number of items were reassigned to different scales

[2] Seed scales developed on the basis of the original MMPI Clinical Scales 5 and 0 were used in the subsequent construction of the MMPI-2-RF.

based on correlations between RC scale items and external criteria. Additional procedural details, including the criteria used for determining what constituted sufficient and minimal correlations for the various scales, are reported by Tellegen et al. (2003).

Following extensive validation studies, the nine RC Scales were added to the MMPI-2. Tellegen et al. (2003) recommended that the scales be used to aid in the interpretation of the Clinical Scales profile by taking advantage of the substantially improved discriminant validity and content delineation of the RC Scales. Subsequent studies provided further empirical evidence of the validity and utility of the RC Scales in a variety of settings in which the MMPI-2 was frequently used. This literature, and additional correlates reported in the *MMPI-2-RF Technical Manual,* formed the basis for the empirically grounded interpretive recommendations in the *MMPI-2-RF Manual for Administration, Scoring, and Interpretation.*

Although of considerable value as measures of the major distinctive core components of the Clinical Scales, the RC Scales were never thought to be sufficient for a comprehensive MMPI-2-based assessment of clinically relevant attributes. Needed in addition were scales measuring facets of the original Clinical Scales that warranted separate assessments (e.g., shyness, anxiety, aggression, substance abuse) and other significant attributes not assessed, or not directly assessed, by the RC Scales (e.g., interests, suicidal ideation, fears), and a set of higher-order dimensions was still to be identified. These and other objectives were accomplished through development of the MMPI-2-RF (Ben-Porath & Tellegen, 2008/2011).

The MMPI-2-RF

The goal for the MMPI-2-RF was to develop a comprehensive set of scales yielding an efficient and exhaustive assessment of the salient, clinically relevant variables measurable with the MMPI-2 item pool. The methods for developing many of these additional scales were similar to those used to construct the RC Scales: factor analyzing relevant substantive item domains; assembling seed scales; recruiting items from the entire MMPI-2 pool; optimizing scale reliability, distinctiveness, and meaningfulness; and taking external correlates into consideration. However, the RC scale construction project was relatively circumscribed compared to the series of wide-ranging analyses conducted to achieve a comprehensive set of Substantive Scales. The Validity Scales for the MMPI-2-RF were also updated.

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Chapter 1 of the *MMPI-3 Technical Manual* provides an account of the restructuring effort that resulted in the 9 Validity Scales and 28 additional Substantive Scales (3 Higher-Order Scales, 23 Specific Problems Scales, and 2 Interest Scales) that made up the MMPI-2-RF. A revised set of PSY-5 Scales was constructed independently by authors Harkness and McNulty. The PSY-5 model was originally developed by Allan Harkness and John McNulty (1994) to represent major dimensions of personality pathology. The clinical and personological importance of the PSY-5 Scales has been corroborated by a significant body of empirical research and the inclusion in *DSM-5®* (American Psychiatric Association, 2013, pp. 761–781) of an alternative model of personality disorders that closely resembles the PSY-5 model.

Released for use in 2008, the MMPI-2-RF provided a more efficient and psychometrically up-to-date version of the test, composed of a reduced set of MMPI-2 items, with scales standardized on a subset of the MMPI-2 normative sample. Exclusive reliance on MMPI-2 items and norms made it possible to incorporate into the *MMPI-2-RF Technical Manual* descriptive and empirical correlate data derived from over 70,000 MMPI-2 protocols, including roughly 100,000 internal and external MMPI-2-RF test score correlates. Moreover, many peer-reviewed MMPI-2-RF studies, particularly those that appeared shortly after the test was published, were based on MMPI-2 data sets from which the MMPI-2-RF was scored.

A primary disadvantage of limiting the MMPI-2-RF to the MMPI-2 item pool was that this did not allow the authors to address known shortcomings of these items. For example, although many original MMPI items were rewritten for the MMPI-2, some items (old and new) remained awkwardly worded and included overcomplicated content that could have been simplified. The authors were also unable to address concerns from MMPI-2 researchers and users about limited coverage in the MMPI-2 item pool of important clinical phenomena such as disordered eating. Moreover, the MMPI-2 norms used to standardize MMPI-2-RF scales are 35 years old as of this writing. The population they were intended to represent (U.S. adults) has changed substantially, both demographically (e.g., ethnic diversity, education, and age) and experientially (for example, no member of the MMPI-2/MMPI-2-RF normative sample was likely to have heard of, let alone used, the internet). The MMPI-3 addresses these disadvantages.

The MMPI-3

The primary goals for the MMPI-3 were to expand the item pool and update the test norms. Chapter 2 of the *MMPI-3 Technical Manual* describes in detail the procedures followed to accomplish these objectives. Data used to construct the MMPI-3 were collected with an expanded version of the MMPI-2-RF, which included the 338 MMPI-2-RF items followed by 95 trial items that were candidates for inclusion in the revised inventory. Of the 338 MMPI-2-RF items, 39 were rewritten to correct awkward language or simplify content. Research described in the *MMPI-3 Technical Manual* had established the psychometric comparability of these items and their MMPI-2-RF counterparts. Placing the 338 MMPI-2-RF items first in the 433-item MMPI-2-RF-EX booklet made it possible to administer the expanded booklet in applied settings, score the MMPI-2-RF, and use the obtained results in actual assessments. Pearson developed a version of its scoring and reporting system, Q Local EX, which the MMPI-3 research team made available to field data collection sites.

Field data were obtained with these materials from over 14,000 individuals who were administered the MMPI-2-RF-EX as part of assessments representing the broad range of settings and populations within which the test is used. These included evaluations conducted in various mental health, medical, forensic, and public safety agencies and practices. As detailed in the *MMPI-3 Technical Manual,* field data were used for three purposes: scale development, scale score validation (using data not used for scale development), and assembling MMPI-3 comparison groups. Validation data, available for subsets of field data participants, included: clinician ratings and extensive record reviews in mental health settings; clinical ratings and postsurgical outcome data in medical settings; standardized test scores and available outcomes in forensic settings; and job performance outcomes, psychosocial history data, and standardized test results in public safety settings.

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The MMPI-2-RF-EX was also administered by several researchers to over 8,000 students at colleges[3] and universities throughout the United States and in New Zealand. These data were collected for research purposes. Students were administered a broad range of collateral measures selected to examine in detail the empirical correlates of revised and new MMPI-3 scale scores. Limitations imposed by the relatively restricted range of psychopathology among college students were offset by the opportunity to administer comprehensive test batteries that facilitated detailed, fine-grained validity analyses of MMPI-3 scores and by the broad range of field data just described.

In addition to the validation analyses, MMPI-3 field and college student data were used to examine the comparability of scores on MMPI-3 versions of MMPI-2-RF scales. Although, for the most part, scale revisions were modest, users may question whether MMPI-2-RF research findings can be applied when interpreting scores on the updated MMPI-3 scales. The *MMPI-2-RF Technical Manual* includes extensive

[3] The terms *college* and *college students* as used in this manual refer to those attending postsecondary educational institutions in the United States.

empirical correlate data for substantive scale scores that served as the foundation for statements in the interpretive guidelines for the test. These data were augmented by findings reported in over 400 peer-reviewed MMPI-2-RF studies. Appendix E of the *MMPI-3 Technical Manual* includes the results of extensive analyses that document the comparability of correlates obtained with the two versions of the inventory in the various settings in which it has been used. These findings support integration of the MMPI-2-RF literature, including correlates reported in the test's *Technical Manual* and in peer-reviewed research literature, in the body of MMPI-3 research. The interpretive guidelines provided in Chapter 5 of this manual are supported by the existing MMPI-2-RF literature and by the broad range of additional validity data reported in the *MMPI-3 Technical Manual.*

The MMPI-2-RF-EX was also used to collect data for the development of two new MMPI-3 normative samples. The University of Minnesota Press hired EurekaFacts, a social science and market research firm experienced in nationwide data collection and with expertise in recruiting members of difficult-to-reach populations, including collecting data with Hispanic and Spanish-speaking populations, to collect the data used to develop English- and Spanish-language norms for the MMPI-3. Data were collected between September 2017 and December 2018 from 3,400 individuals throughout the United States. Chapter 3 of this manual describes the MMPI-3 English-language normative sample, made up of 810 men and 810 women. Chapter 2 of the *MMPI-3 Technical Manual* includes a detailed description of the normative data collection process. The *MMPI-3 Manual Supplement for the U.S. Spanish Translation* (Ben-Porath et al., 2020) describes the Spanish-language MMPI-3 normative sample, composed of 275 men and 275 women.

Table 1-1 of this manual provides a brief description of the 52 MMPI-3 scales. Table 1-2 includes a list and description of available MMPI-3 materials. Appendix A lists the item composition of the scales and the scored direction of the items; Appendix B provides raw- to T-score conversion tables for the MMPI-3 scales based on the normative sample of 1,620 men and women; Appendix C lists the 335 MMPI-3 items and the scale membership and scored direction of the items; Appendix D includes item content and reading level for each item; Appendix E provides item conversion tables for the MMPI-3 and MMPI-2-RF; and Appendix F includes the MMPI-3 profiles.

Users transitioning from the MMPI-2-RF to the MMPI-3 will notice changes in the location and scoring of some scales. Specifically, the MMPI-2-RF Cynicism scale, originally a Restructured Clinical scale (RC3), is now included among the Externalizing Specific Problems Scales. Family Problems (FML), included among the Interpersonal Scales on the MMPI-2-RF, has also been relocated to the MMPI-3 Externalizing Scales. The MMPI-2-RF scale Interpersonal Passivity (IPP) remains in the Interpersonal Scales group. However, the scale is now labeled Dominance (DOM), and the scoring key for this scale was reversed. These changes are discussed in detail in Appendix B of the *MMPI-3 Technical Manual.*

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Table 1-1. The MMPI-3 Scales

Validity Scales	
CRIN	Combined Response Inconsistency – Combination of random and fixed inconsistent responding
VRIN	Variable Response Inconsistency – Random responding
TRIN	True Response Inconsistency – Fixed responding
F	Infrequent Responses – Responses infrequent in the general population
Fp	Infrequent Psychopathology Responses – Responses infrequent in psychiatric populations
Fs	Infrequent Somatic Responses – Somatic complaints infrequent in medical patient populations
FBS	Symptom Validity Scale – Noncredible somatic and cognitive complaints
RBS	Response Bias Scale – Exaggerated memory complaints
L	Uncommon Virtues – Rarely claimed moral attributes or activities
K	Adjustment Validity – Claims of uncommonly high level of psychological adjustment
Higher-Order (H-O) 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
Restructured Clinical (RC) Scales	
RCd	Demoralization (DEM) – General unhappiness and dissatisfaction
RC1	Somatic Complaints (SOM) – Diffuse physical health complaints
RC2	Low Positive Emotions (LPE) – Lack of positive emotional responsiveness
RC4	Antisocial Behavior (ASB) – Rule breaking and irresponsible behavior
RC6	Ideas of Persecution (PER) – Self-referential beliefs that others pose a threat
RC7	Dysfunctional Negative Emotions (DNE) – Maladaptive anxiety, anger, irritability
RC8	Aberrant Experiences (ABX) – Unusual perceptions or thoughts associated with thought dysfunction
RC9	Hypomanic Activation (HPM) – Overactivation, aggression, impulsivity, and grandiosity
Specific Problems (SP) Scales	
Somatic/Cognitive Scales	
MLS	Malaise – Overall sense of physical debilitation, poor health
NUC	Neurological Complaints – Dizziness, weakness, paralysis, loss of balance, etc.
EAT	Eating Concerns – Problematic eating behaviors
COG	Cognitive Complaints – Memory problems, difficulties concentrating
Internalizing Scales	
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
STR	Stress – Problems involving stress and nervousness
WRY	Worry – Excessive worry and preoccupation
CMP	Compulsivity – Engaging in compulsive behaviors
ARX	Anxiety-Related Experiences – Multiple anxiety-related experiences such as catastrophizing, panic, dread, and intrusive ideation
ANP	Anger Proneness – Becoming easily angered, impatient with others
BRF	Behavior-Restricting Fears – Fears that significantly inhibit normal behavior

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Table 1-1. The MMPI-3 Scales *(continued)*

Externalizing Scales	
FML	Family Problems – Conflictual family relationships
JCP	Juvenile Conduct Problems – Difficulties at school and at home, stealing
SUB	Substance Abuse – Current and past misuse of alcohol and drugs
IMP	Impulsivity – Poor impulse control and nonplanful behavior
ACT	Activation – Heightened excitation and energy level
AGG	Aggression – Physically aggressive, violent behavior
CYN	Cynicism – Non-self-referential beliefs that others are bad and not to be trusted
Interpersonal Scales	
SFI	Self-Importance – Beliefs related to having special talents and abilities
DOM	Dominance – Being domineering in relationships with others
DSF	Disaffiliativeness – Disliking people and being around them
SAV	Social Avoidance – Not enjoying and avoiding social events
SHY	Shyness – Feeling uncomfortable and anxious in the presence of others
Personality Psychopathology Five (PSY-5) Scales	
AGGR	Aggressiveness – Instrumental, goal-directed aggression
PSYC	Psychoticism – Disconnection from reality
DISC	Disconstraint – Under-controlled behavior
NEGE	Negative Emotionality/Neuroticism – Anxiety, insecurity, worry, and fear
INTR	Introversion/Low Positive Emotionality – Social disengagement and anhedonia

Table 1-2. Available MMPI-3 Materials

Test administration and scoring

- MMPI-3 test booklets – Used for paper-and-pencil administration (available in English, Spanish, and French for Canada)
- MMPI-3 audio USB – Used for audio administration (available in English and Spanish)
- MMPI-3 answer sheets – Used to record responses to paper-and-pencil or audio administration (available in English, Spanish, and French for Canada)
- Pearson's scoring and reporting systems – Used for onscreen administration, scoring, and reporting (available in English and Spanish)
- MMPI-3 hand-scoring kit – Used to hand score the MMPI-3 scales

Manuals

- *MMPI-3 Manual for Administration, Scoring, and Interpretation* – Describes standard procedures for using the test
- *MMPI-3 Technical Manual* – Describes the historical foundations and development of the MMPI-3 and provides psychometric findings for the MMPI-3 scales
- *MMPI-3 Manual Supplement for the U.S. Spanish Translation* – Describes the Spanish-language materials and test norms

User's guides

- *MMPI-3 User's Guide for the Score and Clinical Interpretive Reports* – Describes the MMPI-3 Score Report and MMPI-3 Interpretive Report for Clinical Settings and how to interface with Pearson's scoring and reporting systems to generate and customize these reports
- *MMPI-3 User's Guide for the Police Candidate Interpretive Report* (PCIR) – Describes a specialized interpretive report for use in preemployment assessments of police officer candidates

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