Personality is defined as an individual’s enduring and pervasive motivations, emotions, interpersonal styles, attitudes, and traits. Personality assessment is the systematic measurement of these personality characteristics. Personality tests measure such difficult-to-define concepts as depression, anger, and anxiety. Even more challenging personality concepts such as somatization, ability to delay gratification, or suicide potential can be quantified by the means of personality assessment. Personality assessment can be of utmost importance in the scientific study of psychology and psychiatry.

PURPOSES OF PSYCHOLOGICAL TESTING

Personality testing can be an expensive undertaking. A considerable amount of time is required to administer, score, and interpret psychological test results. Personality testing should not be routinely obtained from all psychiatric patients. Personality testing can be helpful with selective patients from both a clinical and a cost–benefit analysis perspective.

Assisting in Differential Diagnosis

Psychiatric diagnosis can be a difficult and, at times, confusing exercise. However, knowing a patient’s diagnosis is essential to treatment, as a proper diagnosis can assist in understanding the disorder. Psychological diagnosis can be a difficult and, at times, confusing exercise. However, knowing a patient’s diagnosis is essential to understanding the disorder. Psychological testing can provide baseline information at the beginning of therapy, and repeat testing can then be used to assess change that occurred during the course of therapy.

Providing Narrow-Band Assessment

Narrow-band personality tests measure a single personality characteristic or a few related characteristics. Broad-band personality tests, on the other hand, are designed to measure a wide spectrum of personality characteristics. A psychiatrist may need answers to specific questions, such as those that arise when assessing the degree of clinical depression, measuring the intensity of the state or trait anxiety, or, possibly, quantifying the amount of a patient’s anger. Such quantification can be helpful in measuring severity or in providing a baseline for future assessment.

PSYCHOMETRIC PROPERTIES OF PERSONALITY ASSESSMENT INSTRUMENTS

The quality of personality tests varies widely. On the one hand, there are well-constructed, empirically validated instruments, and, on the other hand, there are “psychological tests” that one can find in the Sunday supplement of the newspaper or on the Internet. Evaluating the usefulness of particular psychological instruments can be challenging, even to the well informed.

Aiding in Psychotherapy

Psychological tests can be useful in psychotherapy. The usefulness of these tests can be even more important for short-term, problem-centered therapy, where understanding the patient and his or her problem must be accomplished quickly. Psychological assessment can be used in pretreatment planning, assessing progress once therapy begins, and in evaluating the effectiveness of therapy. Patients need to have objective information about themselves at the time of therapy if they are to go about changing themselves productively. Personality tests, particularly objective tests, allow patients to compare themselves to objective norms and evaluate the extent and magnitude of their problem. Testing also can reveal areas of the patient’s life that may be problematic but for which the patient may not have a full appreciation. Information about patients’ willingness to reveal information about themselves can also be helpful. Psychological tests may reveal considerable information concerning the patient’s inner life, feelings, and images, which may make therapy progress faster. Psychological testing can provide baseline information at the beginning of therapy, and repeat testing can then be used to assess change that occurred during the course of therapy.

Normative Sample

To construct a personality test, a representative sample of subjects (normative sample) should be administered the test to establish expected performance. Basic issues, such as the size and representativeness of the sample used to construct the test, must be evaluated. To illustrate this point, the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), a well-constructed instrument, initially tested approximately 2,900 subjects. However, approximately 300 subjects were eliminated because of test invalidity or incompleteness of needed information.

Test Characteristics

To be useful, any psychological test must be completed, in its entirety, by the intended test taker. If the questions are offensive

A 49-year-old man had abruptly resigned his position as an accountant and decided he was going to start an oil exploration business. He had never worked in the oil business and knew nothing about the profession. The patient had received a revelation from an unknown entity through an auditory hallucination. This voice told him he would become quite wealthy in the business if he would simply follow the directions given to him. Around this time, the patient had a marked change in personality. Although his grooming was formally very neat and appropriate, he became disheveled. He began sleeping about 3 hours a night. He became somewhat agitated and talked loudly to those around him.

The differential diagnosis in this case includes schizophrenia and bipolar disorder. Psychological testing might be helpful in assisting in this differential diagnosis, as well as in formulation of a treatment plan.
or are difficult to understand, then the individual taking the test may not complete all items. These omissions can create problems, especially when normative tables are used to interpret results.

**Validity Issues**

Perhaps the most important characteristic in evaluating the scientific merit of a given personality test is the validity of the instrument. Does the test measure what it purports to measure? If a test is designed to measure depression, does it indeed measure depression? Although validity may seem like a simple issue to address, it can become complex, especially when attempting to measure such characteristics as self-esteem, assertiveness, hostility, or self-control.

**Face Validity.** *Face validity* refers to the content of the test items themselves. In other words, do the items appear to measure what they purport to measure? One problem with face validity is that professionals differ in their subjective appraisal of individual items.

**Criteria and Construct Validity.** Although face validity refers to the degree that test items appear on the surface to measure what the instrument, as a whole, purports to measure, *criterion validity* uses data outside the test itself to measure validity. For example, if a test were designed to measure hypochondria, one would expect that a patient with high scores would have more visits to the physician’s office, complain more of physical symptoms, and use prescribed and over-the-counter medications more extensively.

**Concurrent and Predictive Validity.** To determine test *concurrent validity*, external measures are obtained at the same time that the test is given to the sample of subjects. Thus, the concurrent validity of the test reveals that, at a given point of time, high scorers on a test may be more likely than low scorers on a test to manifest the behavior reflected in the criteria (e.g., more physician visits or more medication for a hypochondriac patient). Occasionally, however, a test developer is interested in predicting future events. The *discriminant validity* of a test tells whether the test is able to discriminate between known groups of patients at a given time. Is a measure of depression able to statistically discriminate among mild, moderate, and severe major depression disorder?

**Factor Validity.** *Factor validity* utilizes a multivariate statistical technique known as *factor analysis* to determine if certain major groups of items on a given test empirically cluster together. For example, on a personality test measuring depression, do items concerning vegetative symptoms tend to covary together?

**Reliability**

*Reliability* refers to the degree that a test measures what it purports to measure, consistently. The key word here is *consistently*. There are several means of checking reliability, including test–retest reliability, internal consistency reliability, and parallel form reliability.

**Test–Re-test Reliability.** *Test–retest reliability* is obtained by simply administering the same test on two occasions to a group of subjects and statistically correlating the results. To be useful, the correlation coefficient should be at least 0.80 if the two tests were administered within 2 weeks of each other and if the trait in question is stable.

**Internal Consistency Reliability.** Another approach to determine *internal consistency reliability* is to divide a given test into two equal parts and statistically correlate the two halves for the test with each other. This technique determines the *split-half reliability* of a test. The first half of the test should be highly correlated with the second half of the test if the test is consistently measuring what it purportedly measures. Alternatively, the odd-numbered items could be correlated with the even-numbered items (odd–even consistent reliability). A reliability coefficient of 0.80 to 0.85 is needed to demonstrate usefulness in most circumstances. However, the higher the reliability as measured by the correlation coefficient, the better the test instrument.

**Parallel Form Reliability.** Sometimes, two separate forms of the same test are needed. For example, if the process of taking a test at one point in time would by itself influence a patient’s score the second time he or she took the same test, then parallel forms of the tests are needed. *Parallel forms* of a test measure the same construct but use different items to do so. To ensure that the test does, in fact, measure the same construct, the correlation coefficient between the two parallel forms of the same test is computed. Such parallel form reliability should be at least 0.90 or higher.

**Use of Standard Error of Measurement to Assess Reliability.** Another way to assess the usefulness of a given test is to examine the test’s standard error of measurement (SEM), which should be included in the test’s manual. The SEM is a single statistic that is used to estimate what the score of a given patient would be on the test if the patient took the same test again within a short period of time.

**ADULT PSYCHOLOGICAL TESTS**

**Objective Personality Tests**

*Objective personality tests* are rather straightforward in approach. Patients are usually asked specific and standard questions in a structured written or oral format. Each patient is typically asked the same question. The data obtained from a given patient are compared to similar data obtained from the normative group. The degree to which the patient deviates from the norm is noted and is used in the interpretive process. The patient’s responses are scored according to certain agreed-upon criteria. The obtained scores are then compared with normative tables and often converted to standardized scores or percentiles, or both. The MMPI-2 is an example of an objective personality test. Table 5.5-1 lists a sample of objective personality test along with a brief description and brief list of strengths and weaknesses.

**Minnesota Multiphasic Personality Inventory.**

The MMPI-2 is relatively easy to administer and score and takes approximately 1.5 hours for most patients to complete. It consists of 567 true or false questions concerning a wide variety of issues and requires only an eighth-grade reading comprehension. Scoring of the MMPI-2 involves adding up the number of responses on numerous scales and comparing the results to certain normative information. Interpretation of the MMPI-2 is more straightforward than with many other tests.

When a patient takes the MMPI-2, questions are not grouped in any particular order to aid in interpretation. Various items in the MMPI-2 can be selected, sorted, and analyzed according to various criteria. A new version of the MMPI-2 was developed in 2008, the MMPI-2 Restructured Form (MMPI-2 RF). It contains 338...
Table 5.5-1

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota Multiphasic Personality Inventory-2 (MMPI-2)</td>
<td>567 items; true–false; 20 primary scales</td>
<td>Current revision of MMPI that has updated the response booklet; revised scaling methods and new validity scores; new normative data</td>
<td>Preliminary data indicate that the MMPI-2 and the MMPI can provide discrepant results; normative sample biased toward upper socioeconomic status; no normative data for adolescents</td>
</tr>
<tr>
<td>Million Clinical Multiaxial Inventory (MCMI)</td>
<td>175 items; true–false; 20 primary scales</td>
<td>Brief administration time; corresponds well with diagnostic classifications</td>
<td>In need of more validation research; no information on disorder severity; needs revision for DSM-5</td>
</tr>
<tr>
<td>Million Clinical Multiaxial Inventory-II (MCMI-II)</td>
<td>175 items; true–false; 25 primary scales</td>
<td>Brief administration time</td>
<td>High degree of item overlap in various scales; no information on disorder or trait severity</td>
</tr>
<tr>
<td>16 Personality Factor Questionnaire (16 PF)</td>
<td>True–false; self-report format; 16 personality dimensions</td>
<td>Sophisticated psychometric instrument with considerable research conducted on nonclinical populations</td>
<td>Limited usefulness with clinical populations</td>
</tr>
<tr>
<td>Personality Assessment Inventory (PAI)</td>
<td>344 Items; Likert-type format; 22 scales</td>
<td>Includes measures of psychopathology, personality dimensions, validity scales, and specific concerns to psychotherapeutic treatment</td>
<td>The inventory is new and has not yet generated a supportive research base</td>
</tr>
<tr>
<td>California Personality Inventory (CPI)</td>
<td>True–false; self-report format; 17 scales</td>
<td>Well-accepted method of assessing patients who do not present with major psychopathology</td>
<td>Limited usefulness with clinical populations</td>
</tr>
<tr>
<td>Jackson Personality Inventory (JPI)</td>
<td>True–false; self-report format; 15 personality scales</td>
<td>Constructed in accord with sophisticated psychometric techniques; controls for response sets</td>
<td>Unproved usefulness in clinical settings</td>
</tr>
<tr>
<td>Edwards Personal Preference Schedule (EPPS)</td>
<td>Forced choice; self-report format</td>
<td>Follows Murray's theory of personality; accounts for social desirability</td>
<td>Not widely used clinically because of restricted nature of information obtained</td>
</tr>
<tr>
<td>Psychological Screening Inventory (PSI)</td>
<td>103 items; true–false; self-report format</td>
<td>Yields four scores, which can be used as screening measures on the possibility of a need for psychological help</td>
<td>The scales are short and have correspondingly low reliability</td>
</tr>
<tr>
<td>Eysenck Personality Questionnaire (EPQ)</td>
<td>True–false; self-report format</td>
<td>Useful as a screening device; test has a theoretical basis with research support</td>
<td>Scales are short, and items are transparent as to purpose; not recommended for other than a screening device</td>
</tr>
<tr>
<td>Adjective Checklist (ACL)</td>
<td>True–false; self-report or informant report</td>
<td>Can be used for self-rating or other rating</td>
<td>Scores rarely correlate highly with conventional personality inventories</td>
</tr>
<tr>
<td>Comrey Personality Scales (CPS)</td>
<td>True–false; self-report format; eight scales</td>
<td>Factor analytic techniques used with a high degree of sophistication in test constructed</td>
<td>Not widely used; factor analytic interpretation problems</td>
</tr>
<tr>
<td>Tennessee Self-Concept Scale (TSCS)</td>
<td>100 items; true–false; self-report format; 14 scales</td>
<td>Brief administration time yields considerable information</td>
<td>Brevity is also a disadvantage, lowering reliability and validity; useful as a screening device only</td>
</tr>
</tbody>
</table>

(Courtesy of Robert W. Butler, Ph.D., and Paul Satz, Ph.D.)

The MMPI-2 RF is meant to be an alternative to the MMPI-2, not a replacement.

**Personality Assessment Inventory (PAI).** Another increasingly popular objective personality test is the Personality Assessment Inventory (PAI). This test consists of 344 items that are written at a fourth-grade reading level. This reading level ensures that most patients can complete it without experiencing any reading problems. The PAI takes about 45 to 50 minutes to complete for most patients. The PAI was normed on 1,000 community-dwelling individuals stratified according to sex, race, and age. There are no separate norms for male and female as there are in the MMPI. In addition, data were gathered on 1,246 clinical subjects and 1,051 college students in the normative process. The clinical subjects were drawn from a variety of different clinical settings, including inpatient psychiatric facilities (25 percent), outpatient psychiatric facilities (35 percent), correctional institutions (12 percent), medical settings (2 percent), and substance abuse treatment programs (15 percent).

The PAI has 11 clinical scales. These main clinical scales are similar to the MMPI-2 clinical scales and measure such personality issues as somatic concerns, depression, paranoia, borderline...
Projective Personality Test

Projective personality tests, in contrast to objective personality instruments, are more indirect and unstructured. Unlike objective tests in which the patient may simply mark true or false to given questions, the variety of responses to projective personality tests are almost unlimited. Instructions are usually very general in nature, allowing the patient’s fantasies to be expressed. The patient generally does not know how his or her responses will be scored or analyzed. Consequently, trying to feign the test becomes difficult. Projective tests typically do not measure one particular personality characteristic such as “type A personality” (e.g., narrow-band measurement) but instead are designed to assess one’s personality as a whole (e.g., broad-band measurement).

Projective tests often focus on “latent” or unconscious aspects of personality. Obviously, psychologists and others differ in the degree to which they rely on “unconscious” information. In many projective techniques, the patient is simply shown a picture of something and asked to tell what the picture reminds him or her of. An underlying assumption of projective techniques (projective hypothesis) is that, when presented with an ambiguous stimulus, such as an inkblot, for which there are an almost unlimited number of responses, the patient’s responses will reflect fundamental aspects of his or her personality. The ambiguous stimulus is a sort of screen on which the individual projects his or her own needs, thoughts, or conflicts. Different persons have different thoughts, needs, and conflicts and, hence, have widely different responses. A schizophrenic’s responses often reflect a rather bizarre, idiosyncratic view of the world.

**Table 5.5-2**

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rorschach test</td>
<td>Ten stimulus cards of inkblots, some colored, others achromatic</td>
<td>Most widely used projective device and certainly the best researched; considerable interpretative data available</td>
<td>Some Rorschach interpretive systems have unimproved validity</td>
</tr>
<tr>
<td>Thematic Apperception Test (TAT)</td>
<td>20 Stimulus cards depicting a number of scenes of varying ambiguity</td>
<td>A widely used method that, in the hands of a well-trained person, provides valuable information</td>
<td>No generally accepted scoring system results in poor consistency in interpretation; time-consuming administration</td>
</tr>
<tr>
<td>Sentence completion test</td>
<td>A number of different devices available, all sharing the same format with more similarities than differences</td>
<td>Brief administration time; can be a useful adjunct to clinical interviews if supplied beforehand</td>
<td>Stimuli are obvious as to intent and subject to easy falsification</td>
</tr>
<tr>
<td>Holtzman Inkblot Technique (HIT)</td>
<td>Two parallel forms of inkblot cards with 45 cards per form</td>
<td>Only one response is allowed per card, making research less troublesome</td>
<td>Not widely accepted and rarely used; not directly comparable to Rorschach interpretive strategies</td>
</tr>
<tr>
<td>Figure drawing</td>
<td>Typically human forms but can involve houses or other forms</td>
<td>Quick administration</td>
<td>Interpretive strategies have typically been unsupported by research</td>
</tr>
<tr>
<td>Make-a-Picture Story (MAPS)</td>
<td>Similar to TAT; however, stimuli can be manipulated by the patient</td>
<td>Provides idiographic personality information through thematic analysis</td>
<td>Minimal research support; not widely used</td>
</tr>
</tbody>
</table>

(Courtesy of Robert W. Butler, Ph.D., and Paul Satz, Ph.D.)

features, or alcohol or drug problems. The PAI also has five treatment-related scales that are designed to address such issues as treatment rejection, suicide ideation, or aggression.

**Rorschach Test**. Herman Rorschach, a Swiss psychiatrist, developed the first major use of projective techniques around 1910. The Rorschach test is the most frequently used projective personality instrument (Fig. 5.5-1). The test consists of ten ambiguous symmetrical inkblots. The inkblot card appears as if a blot of ink were poured onto a piece of paper and folded over—hence, the symmetrical appearance.

Minimal interaction between the examiner and the patient occurs while the Rorschach is administered, which ensures standardization procedures are upheld. The examiner writes down verbatim what the patient says during the above-described “free association” or “response proper” phase. If the patient rotates the card during his or her response, then the examiner makes the appropriate notation on the test protocol. After the patient has given responses to all ten cards, an inquiry phase

**FIGURE 5.5-1**

Card 1 of the Rorschach test. (From Hermann Rorschach, *Rorschach®-Test. Copyright © Verlag Hans Hubar AG, Bern, Switzerland, 1921, 1948, 1994, with permission.*)
of administration begins. The examiner asks the patient to go through the cards again and help the examiner see the responses he or she gave. The examiner reads the patient’s initial response and asks the patient to point out what he or she saw and explain what made it look like that to him or her. An almost unlimited range of responses is possible with the Rorschach test and most projective tests.

**Thematic Apperception Test.** Although the Rorschach test is clearly the most frequently used projective personality test, the Thematic Apperception Test (TAT) is probably in second place. Many clinicians will include both the TAT and the Rorschach test in a battery of tests for personality assessment. The TAT consists of a series of ten black-and-white pictures that depict individuals of both sexes and of different age groups, who are involved in a variety of different activities. An example of a TAT card is presented in Figure 5.5-2.

Henry Murray developed the TAT in 1943 at the Harvard Psychological Clinic. The stories that the patient makes up concerning the pictures, according to the projective hypothesis, reflect the patient’s own needs, thoughts, feelings, stresses, wishes, desires, and view of the future. According to the theory underlying the test, a patient identifies with a particular individual in the picture. This individual is called the hero. The hero is usually close to the age of the patient and frequently of the same sex, although not necessarily so. Theoretically, the patient would attribute his or her own needs, thoughts, and feelings to this hero. The forces present in the hero’s environment represent the press of the story, and the outcome is the resolution of the interaction between the hero’s needs and desires and the press of the environment.

**Sentence Completion Test.** Although a projective instrument, the sentence completion test is much more direct in soliciting responses from the patient. He or she is simply presented with a series of incomplete sentences and is asked to complete the sentence with the first response that comes to mind. The following are examples of possible incomplete sentences:

- My father seldom . . .
- Most people don’t know that I’m afraid of . . .
- When I was a child, I . . .
- When encountering frustration, I usually . . .

The purpose of the test is to elicit, in a somewhat indirect manner, information about the patient that cannot be elicited from other measures. Because the patient responds in writing, the examiner’s time is limited. The length of time it takes to complete the sentence completion varies greatly depending on the number of incomplete sentences. Tests can range from less than ten sentences to greater than 75.

**Behavioral Assessment**

Behavioral assessment involves the direct measurement of a given behavior. Rather than focus primarily on human characteristics, such as repression, ego strength, or self-esteem (vague terms to a behaviorist), strict behavioral measurement concentrates on the direct measurement that can be observed, such as a number of temper tantrums per unit of time, duration and intensity and number of hyperventilation episodes, or the number of cigarettes smoked per 24-hour period.

Although early strict behaviorists would count only behaviors that were observable, a broader definition of behavior has emerged, under which just about anything people do—whether it is overt such as crying, swearing, or hand-washing or covert such as feeling and thinking—is considered behavior.

**Direct Counting of Behavior.** Measuring overt behavior is direct and can be done by the patient himself or herself, a family member, or an impartial observer.

Cognitive behavior therapists use these measurements to establish baselines of a given undesirable behavior (i.e., violent thoughts that the patient may wish to reduce). Similarly, therapists can measure behavior that the patient wants to increase (time studying, time out of bed, or distance walked on a treadmill). Follow-up measures of the same behavior monitor progress and quantify improvement.

**ASSESSMENT OF PERSONALITY IN CHILDREN AND ADOLESCENTS**

Assessment of emotional and interpersonal characteristics in children presents many challenges to the clinician because of the discontinuities in development that exist throughout childhood, adolescence, and adulthood. Many clinicians are reluctant to assign the diagnosis of a personality disorder before the ages of 16 to 18 years due to rapid changes that occur during childhood. However, assessment of children and adolescents can often reveal antecedent symptoms, behaviors, or traits associated with emotional disorders at an age when these problems are very amenable to intervention. For this reason, facility in assessment of emotional disorders in children and adolescents is important for mental health professionals.
Special Considerations in Assessment of Children

Assessment of children with symptoms of emotional or behavioral disorders is best accomplished within developmental and ecological contexts—both of which help one interpret the child’s symptoms from the perspective of developmental influences on behavior and also with consideration of the risk and protective factors in the child’s social environment. Indeed, the balance of risk and protective factors may often provide important clues as to the etiology of the child’s current problems and the prognosis for effective intervention.

The Developmental Context. Knowledge about the normal sequence and transitions of development forms a fundamental backdrop from which to view children’s suspected psychopathology. The major developmental transition of infancy related to formation of a secure attachment relationship with significant caregivers gives way to the movement from dependence to greater self-reliance in the toddler years. The developmental tasks most salient during the preschool years involve development of a growing capacity for empathy and self-control, while showing a desire for mastery of developmental tasks. Within the early to middle elementary years, youngsters strive for greater mastery of knowledge and intellectual and academic skills, leading to feelings of productivity and competence. The developmental tasks of adolescence center around separation-individuation, resolving conflicts with authority figures, peer group identification, and realistic appraisal and evaluation of self-qualities. Although development does not occur in a linear stage, familiarity with the primary developmental themes and transitions of each age period provides an important context from which to view current symptoms.

Decisions about appropriate assessment methods are also based on developmental factors. Before children participate in projective testing procedures, such as storytelling tasks, clinicians must have developmental information about their expressive language, receptive language, and conceptualization ability. Knowledge of a child’s reading proficiency is critical when presenting self-report measures. If children are asked to complete projective drawings, information about their level of visual–motor development is important for interpretation. Young children often do not have the motor or language abilities to provide meaningful responses to projective testing procedures, but they may reveal much about their socialization abilities, fears, anxieties, and significant relationships through play. Therefore, play observation techniques can be a useful alternative to more formal projective measures. Likewise, some adolescents may resist providing responses on projective measures that require verbal disclosure to a clinician but may willingly complete objective paper-and-pencil personality measures that require a less direct response. Choosing an approach to assessment with the developmental context in mind will enhance the validity of the information obtained.

Ecological Context. The broad social–ecological context of children’s family, peer group and social relationships, and the culture in which they live can influence the interpretation of assessment information. From a developmental psychopathology perspective, most psychopathology is expressed as an interaction among various factors that are operating at the levels of the individual (including developmental and personality attributes), the family (e.g., parenting skill, the security of primary attachment relationships, marital stability, and extended family support), the community (e.g., including the influences of work, school, informal social networks, socioeconomic factors, and degree of family social isolation), and the larger cultural context of society (e.g., cultural values and beliefs that govern behavior).

Two 4-year-olds were referred by their Head Start teacher due to concerns about a recent onset of regressive behavior (e.g., enuresis during the school day and immature speech patterns). Both girls were interviewed separately but were reluctant to talk with the clinician. A play interview was set up with each girl, using dolls and a dollhouse with a variety of furniture. The first girl assumed the role of “mother” and played out the scenario of feeding and diapering the baby doll in a nurturing manner. The second girl was aggressive in her play, with enactment of the “adult” dolls hitting the “child” dolls and making them “die.” The child dolls were described as having blood on them. The family context for the first girl revealed that a new baby sibling had been born just prior to the onset of regressive symptoms; the infant was born prematurely and the mother spent much time with the infant in the hospital. Both the arrival of the new sibling and the mother’s separation from her 4-year-old daughter created the social context for the emergence of the child’s regressive behavior. In the second case, the girl’s mother was interviewed. After the clinician provided a description of the girl’s play, the mother revealed that she had a new boyfriend who just moved into the house. She said she had noted her daughter’s fear of the boyfriend and her frequent tearfulness at home. She reported suspicion that her boyfriend might be sexually molesting her daughter and agreed to call Protective Services in the presence of the clinician to make a report.

There can be vastly different explanations for similar presenting symptoms, and often, the projective assessment procedures only suggest concerns without providing enough specific information about the nature and etiology of the problems. The social context can reveal both risk and protective factors that are important in conceptualizing the child’s problems. The ecological approach allows one to examine the possible multiple determinants of emotional psychopathology in children and to better understand the interaction between risk and protective factors that are present in the child’s life.

Use of Informant Information. Children and adolescents usually are referred for assessment due to concerns of their parents or caregivers. Teachers also may be the source of specific concerns. For this reason, information relevant to the diagnosis is typically obtained from these significant adults who can provide important information regarding the child’s behavior in various settings. Reliance on persons other than the client as reporters of the primary symptoms represents a fundamental difference in the process of diagnosis compared with adult assessment.

Therefore, the validity of the information presented about children’s symptoms is often a concern for clinicians. During intake, parents often express feelings of anxiety or frustration regarding their child’s problems, and their descriptions of the child may be exaggerated or vague (e.g., “She never minds” or “He always acts like a monster”). It is not uncommon for depressed parents to report an increased number and severity
level of symptoms in their children. In cases where one suspects that the informant’s perceptions may be distorted, it is critical to obtain collateral information from teachers or others who are familiar with the child’s current problems. A primary task is to help informants translate imprecise complaints to specific descriptions of behaviors of concern, using methods that help the clinician ascertain the nature, frequency, and severity of symptoms. The behavioral assessment procedures described later are very useful in providing age- and gender-referenced ratings of symptom characteristics.

Specialized Training. Clinicians who conduct personality assessment of children need training not only in clinical assessment methods but also in developmental psychology and child psychopathology. Presentation of many emotional disorders in prelatency years differs from postlatency presentation. Training and experience in how to assist the child with the demands of the testing situation are also critical. Children’s ability to participate in testing depends on their attention and concentration ability, anxiety regarding separation from significant others during the testing, fatigue or hunger states, motivation and persistence, and the relatively greater influence of familial, cultural, and environmental variables on their ability to participate effectively in the testing. A clinician with specialized training to work with children will have both the understanding of these influences on child test-taking behavior and the skills to work with the challenges of testing children so as to achieve more valid results.

ASSESSMENT FOR CHILDREN AND ADOLESCENTS

Like assessment of adults, personality assessment of children can be accomplished via three primary methods: projective, objective, and behavioral tests and procedures. The projective methods involve direct interaction with the child and adolescent, whereas the objective and behavioral methods often involve obtaining information from significant adults in the child’s life as well as direct interaction with the child. With the evolution of more sophisticated statistical methodology and psychometric science in recent years has come the development of new objective and behavioral measures of personality. Improved validity indices and psychometric procedures that take into account informant reporting are now routinely included. Many of the projective procedures have changed less, although improvements in developmental norms for interpretation have increased the diagnostic validity of measures such as the Rorschach.

Projective Assessment Procedures

As stated in the adult subsection, objective tests of personality present the patient with a structured set of questions and a finite range of answers. Projective tests, on the other hand, present more ambiguous stimuli and ask the adult or child to make up something (i.e., story, percept, or drawing) related to the stimulus. The most common projective assessment procedures for children and adolescents are the Rorschach test, various projective storytelling measures (i.e., Roberts Apperception Test for Children—2nd edition, or Children’s Apperception Test), projective drawings (such as human figure and kinetic family drawings), and incomplete sentence procedures (Table 5.5-3).

Rorschach Test. Projective instruments such as the Rorschach test allow the clinician to explore dynamics of the child’s personality by gathering information on both the child’s perceptual–cognitive world and inner fantasy world. The Rorschach test ideally is used as part of a more comprehensive battery that includes an interview with the child and significant adults, expressive (play) techniques, and perhaps storytelling techniques to allow the child the maximum freedom and spontaneity of expression.

The Rorschach test with children has a long research and clinical history of examining developmental norms and symbolic interpretations. Clinicians using the Rorschach test for the evaluation of children and adolescents must take care to analyze the structural summary within the context of appropriate age norms, as a given result may be interpreted as normal for a young child but could be of concern in an adolescent. Children’s Rorschach responses have been examined as a function of their cognitive functioning, academic performance, and behavioral problems within the school setting. The underlying conceptual framework for this work hypothesizes that there is a direct relationship between the degree of secondary process development and school achievement.

As with adults, there are numerous systems for administering and scoring the Rorschach with children, but all ask children to say what they see on the inkblot (i.e., the percept), followed by an inquiry referring back to each response. Whether the inquiry should be done following the child’s free association responses to all ten inkblots or best accomplished after each individual blot is controversial. Proponents of the latter approach suggest that young children may have difficulty remembering the reasoning behind the original free associations or may become fatigued by the end of the test, thus limiting their cooperation and responsiveness to the inquiry. Clinicians must also be aware of state anxiety as a potential confounding variable in children’s responses to the Rorschach test. Care in building rapport and an explanation of the purpose and process of testing can ease the situational anxiety.

As with adults, scoring is done on the basis of response characteristics, or determinants, such as form, color, shading, texture, and dimensionality. The content and form quality of the child’s responses are also used in scoring and interpretation.

Projective Storytelling Procedures. In projective storytelling approaches, the child is presented with a picture stimulus of human or animal figures in rather ambiguous situations. The child is asked to make up a story about the figures—a story that has a beginning and end and includes the thinking and feeling of the persons represented in the pictures. A fantasy response is evoked, and the resulting projective information is a combination of the perceptual and the imaginative. Stories are typically analyzed for repetitive, unique, intense, or problematic themes, beliefs, or affects. This procedure is very similar to the TAT approach used with adults.

Children’s Apperception Test. The initial Children’s Apperception Test (CAT), developed in 1949, used animal figures and was developed for children ages 3 to 10 years. Animal figures were thought to be more culture-free than human characters. In 1965, the human figures version (CAT-H) was produced, showing human figures in situations as analogous as possible.
5.5 Personality Assessment: Adults and Children

<table>
<thead>
<tr>
<th>Name</th>
<th>Age Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rorschach Inkblot Test</td>
<td>5 years–Adulthood</td>
<td>Consists of ten inkblots, some colored and others achromatic, used as basis for eliciting associations that are revealing of disrupted personality development.</td>
</tr>
<tr>
<td>Children's Apperception Test (CAT)</td>
<td>3–10 years</td>
<td>Two versions of the CAT—animal and human—depict characters in various social situations and are used to elicit stories from children. Younger children are felt to identify more readily with the animal figures, while older children are usually presented the human figures. Scoring and interpretation is based on psychodynamic theory.</td>
</tr>
<tr>
<td>Adolescent Apperception Cards</td>
<td>12–19 years</td>
<td>11 picture cards focus on parent-, peer-, and sibling-adolescent interaction, pulling for themes of physical and sexual abuse, neglect, peer acceptance, loneliness, depression, drug use, and domestic violence. Two versions are available—one depicting white teenagers and the other black teenagers.</td>
</tr>
<tr>
<td>Roberts Apperception Test for Children—2nd edition (RATC-2)</td>
<td>6–18 years</td>
<td>16 picture cards—with parallel male and female versions depicting Caucasian, black, or Hispanic characters—are designed to elicit information about two independent dimensions: adaptive social perception (which is a developmental measure) and the presence of mal-adaptive or atypical social perception (which is a clinical measure). The responses indicate where a child is on a continuum of social understanding. The revision has an expanded age range (from 6 to 18 years) and a standardized scoring system based on updated, stratified normative data to aid interpretation.</td>
</tr>
<tr>
<td>Tell-Me-A-Story (TEMAS)</td>
<td>5–18 years</td>
<td>Multicultural apperception test with 23 color picture cards (11 of which are sex specific) depicting minority (Hispanic or black) or nonminority characters. Measures ten personality functions (e.g., aggression, interpersonal relations, and self-concept), 18 cognitive functions (e.g., reaction time, fluency, sequencing, and imagination), and seven affective functions (e.g., happy, sad, angry, and fearful). Has an objective scoring system and normative data based on a diverse cultural and ethnic sample.</td>
</tr>
<tr>
<td>Projective Drawings</td>
<td>3 or 4 years through adolescence</td>
<td>Various versions exist, from individual drawings of human figures, a house, and tree to kinetic drawings of family. These are simple, cost-effective measures that provide information on children's perceptions of self and relationships with others. Especially useful with children who have difficulty with verbal expression. Objective scoring available for some drawings (e.g., human figures), but interpretation of other types of projective drawings is often subjective.</td>
</tr>
<tr>
<td>Sentence and Story Completion Tasks</td>
<td>4 or 5 years through adolescence</td>
<td>A number of different formats available, each providing a sentence stem or initiating a story, after which the child is asked to complete the sentence or story. Provides information on such factors as interpersonal relationships and dynamics, self perception, wishes, and worries.</td>
</tr>
</tbody>
</table>

Table 5.5-3: Projective Assessment Procedures for Children

To those pictured in the animal version. During administration, the cards are presented individually in the numbered order of the card (because certain cards were designed for sequential impact). The child is asked to tell a story about each picture (e.g., what is going on, what happened before, and what will happen next). There is some debate about the use of prompts with young children and whether such prompts (e.g., “How did the story end?”) may contaminate important projective information. Generally, prompts are often necessary to help the young child understand what is expected. Young children have a tendency to merely label or describe portions of the picture and may not understand the concept of telling a story with a beginning, middle, and conclusion. However, the clinician must always guard against overly intrusive or helpful prompts that guide the child’s responses in a particular direction or suggest a specific format for the story. The various scoring protocols for the CAT have focused on the analysis of ego functions and evaluation of the relative use of various defense mechanisms. However, qualitative interpretation is also made based on recurrent or sequential themes and determination of identification figures, while taking into consideration the child’s family and case history information.

**Roberts Apperception Test for Children—2nd Edition.** The original Roberts Apperception Test for Children (RATC) was developed specifically for children and provided a standardized system for scoring the thematic content and structural characteristics of the child’s responses. The 2nd edition of the RATC is now available, and it provides normative data (stratified by geographic region, sex, ethnicity, and parental education) on a sample of 1,000 children and adolescents, ages 6 to 18 years, to aid in clinical interpretation. The RATC-2 asks the child or adolescent to tell a story in response to each of 16 test pictures that represent important interpersonal themes. The RATC-2 assesses two independent dimensions: adaptive social perception (which is a developmental measure) and the presence of maladaptive or atypical social perception (which is a clinical measure). The responses indicate where a child is on a continuum of social understanding. Interpretation of the RATC-2, like that of other projective measures, is based on the assumption that children presented with ambiguous drawings of children and adults in everyday interaction will project their typical thoughts, concerns, conflicts, and coping styles into the stories that they create.

The RATC-2 has three parallel versions of the test pictures—one for Caucasian children, one featuring African American children, and the other depicting Hispanic children.

**Objective Personality Measures**

Objective approaches to child personality assessment typically have straightforward test stimuli and clear instructions regarding completion of the tests, as opposed to projective approaches, which typically use more unstructured, ambiguous test stimuli.
Objective tests typically have good standardization, reliability, and validity, and they often are norm referenced so as to provide comparisons with a particular criterion group.

The advantages of using objective measures with children are similar to those previously discussed with adults. Disadvantages include the length of the measures (some have several hundred questions to which the informant must respond), the reading level required for completion (which could place children and adolescents at a disadvantage), and the initial outlay of expense to purchase either computer administration or computer scoring software. Despite the disadvantages, objective personality measures remain an important part of a comprehensive personality assessment by providing a broad survey of major areas of psychopathology at the initial stages of the evaluation. Table 5.5-4 list some of the major objective personality measures for children.

**Personality Measures for Specific Disorders in Children.** In contrast to the multidimensional personality measures already discussed, several measures address more specific disorders in children, such as depressive and anxiety disorders. Examples of several of these measures are found in Table 5.5-5.

Often, clinicians will use the multidimensional personality measures to obtain a broad overview of risk for psychopathology and then use the more narrow-band, specific measures to explore a particular set of symptoms in greater detail. Neither

### Table 5.5-4
**Objective Personality Measures for Children**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Personality Questionnaire (CPQ)</td>
<td>8–13 years</td>
<td>140-item questionnaire that measures 14 basic personality traits useful in predicting school achievement, delinquency, leadership, and potential emotional problems. Can be individually or group administered.</td>
</tr>
<tr>
<td>High School Personality Questionnaire (HSPQ)</td>
<td>13–18 years</td>
<td>An upward extension of CPQ, this scale can be individually or group administered to junior and senior high school students. Has 142 items measuring 14 personality traits. Useful in predicting school achievement, vocational fitness, delinquency, and leadership, as well as those who need clinical assistance.</td>
</tr>
<tr>
<td>Millon Adolescent Personality Inventory (MAPI)</td>
<td>Adolescents (13–18 years)</td>
<td>An objective, 150-item, true–false, self-report inventory that identifies eight personality styles (introversion, inhibited, cooperative, sociable, confident, forceful, respectful, and sensitive); eight concerns frequently expressed by adolescents (self-concept, personal esteem, body comfort, sexual acceptance, peer security, social tolerance, family rapport, and academic confidence); and four scales that are typically of interest to clinicians (impulse control, social conformity, scholastic achievement, and attendance consistency). Reliability and validity indices help identify poor test-taking attitudes and confused or random responding.</td>
</tr>
<tr>
<td>Millon Adolescent Clinical Inventory (MACI)</td>
<td>Adolescents (13–19 years)</td>
<td>Designed to expand the clinical utility of the MAPI, the MACI stresses maladaptive levels of the original eight personality styles on the MAPI. The MACI also uses DSM-IV disorders. Includes Clinical Indices Scales that tap eating dysfunctions, substance abuse proneness, delinquent predisposition, impulsive propensity, anxious feelings, depression affect, and suicidal tendency. It is helpful in confirming diagnostic hypotheses, developing individual treatment plans, and measuring progress before, during, and after treatment.</td>
</tr>
<tr>
<td>Millon Pre-Adolescent Clinical Inventory (M-PACI)</td>
<td>9–12 years</td>
<td>Written at a third-grade reading level, the M-PACI is designed to provide an integrated view of the child's emerging personality patterns and current clinical signs, which may help to detect early signs of Axis I and II disorders. The scales tap into emerging personality patterns (i.e., confident, outgoing, conforming, submissive, inhibited, unruly, and unstable) and current clinical signs (i.e., anxiety/fears, attention deficits, obsessions/compulsions, conduct disorder, disruptive behaviors, depressive moods, and reality distortions). Paper-and-pencil, CD, and computer administration formats are available. The Interpretive Report provides an integrated analysis of results with regard to the child's personality patterns and clinical signs.</td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory–Adolescent (MMPI-A)</td>
<td>14–18 years</td>
<td>This 478-item, true–false objective measure of psychopathology is specifically designed for use with adolescents. It contains the basic clinical scales of the original MMPI along with four new validity scales, 15 content scales and six supplementary scales, and 28 Harris and Linges and three Si subscales. Both hand-scoring and computer-scoring programs are available, as well as an MMPI-A Interpretive System.</td>
</tr>
<tr>
<td>Personality Inventory for Children–2nd edition (PIC-2)</td>
<td>Preschool-Adolescence (5–19 years)</td>
<td>An objective, multidimensional parent-report measure of the emotional, behavioral, cognitive, and interpersonal adjustment of children and adolescents. The total scale has 275 items (reduced from 420 in the 1st edition) that provide scores on several key areas: cognitive impairment, family dysfunction, psychological discomfort, social withdrawal, impulsivity and distractibility, delinquency, reality distortion, somatic concern, and social skills deficit. Two normative groups are available for the PIC-2. One includes boys and girls in kindergarten through 12th grade and is representative of the U.S. population in regard to socioeconomic levels and ethnicity. The second sample includes parents of children that had been referred for educational or clinical intervention.</td>
</tr>
</tbody>
</table>

DSM, Diagnostic and Statistical Manual of Mental Disorders.
Revised Children's Manifest Anxiety Scale–2nd edition (RCMAS-2)

6–19 years

Brief self-report measure that assesses the presence of anxiety disorders in youth. The RCMAS-2 contains 49 items at a second-grade reading level, answered in a yes–no format. It assesses four key areas: physiological anxiety, social anxiety, worry, and defensive pessimism. The RCMAS-2 also assesses for the presence of academic stress, test anxiety, peer and family conflicts, and drug problems. A Spanish translation is available, as is an audio CD recording of the test items, designed for poor readers.

Multidimensional Anxiety Scale for Children (MASC)

8–19 years

Brief self-report measure that assesses the presence of anxiety disorders in youth. The 39-item long version taps seven key areas: harm avoidance, social anxiety, physical symptoms, anxiety disorders, separation/panic, Total Anxiety Index, Inconsistency Index (validity). The short version (MASC-10) combines the basic anxiety scales from the long version to produce one score that indicates the severity of anxiety problems. Written at a fourth-grade reading level, it is useful in planning focused treatment and monitoring progress.

Social Phobia and Anxiety Inventory for Children (SPAI-C)

8–14 years

Self-report inventory with 26 items written at a third-grade reading level. The SPAI-C evaluates the somatic, cognitive, and behavior aspects of social phobia in children and helps determine the most appropriate treatment plan. Written at a fourth-grade reading level, it is useful in planning focused treatment and monitoring progress.

State-Trait Anxiety Inventory for Children (STAIC)

8–14 years

Developed to assess both enduring tendencies to experience anxiety and also temporal and situational variations in levels of perceived anxiety. The STAIC consists of two 20-item scales that measure state and trait anxiety in children and determines which type of anxiety is dominant. Reliability studies for internal consistency are strong, but validity studies have not strongly supported the state-trait distinction in children.

Fear Survey Schedule for Children (FSSC) and Fear Survey Schedule for Children–Revised (FSSC-R)

7–12 years

The FSSC is an 80-item scale developed to assess specific fears in children. Categories of items include school, home, social, physical, animal, travel, classical phobia, and miscellaneous. Few data are available regarding psychometric properties of the FSSC. A revised version of the scale (FSSC-R) has shown good internal consistency, and total scores have discriminated between normal and school-phobic children.

Behavioral Assessment Procedures

Behavioral assessment procedures offer a highly structured method of obtaining information about behavioral or emotional functioning and social competencies of children and adolescents. These procedures include direct observations and informant ratings on normed age and sex scales. The popularity of these measures has grown in recent years, in part due to their improved psychometric properties, their cost-effectiveness, and their utility in multitrait–multimethod diagnostic procedures (Table 5.5-5 presents examples of these measures).

Validity of Informant Reports.

Use of behavioral rating scales raises questions about the validity of informant information. The research regarding agreement among various raters of child behaviors is consistent in showing greater agreement between raters who interact with a child in similar situations (e.g., between mothers and fathers) than between raters who interact with the child in different situations (e.g., between parents and teachers or parents and children).
Table 5.5-6
Behavioral Assessment Procedures for Children

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Age Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Youth Inventories--2nd edition (BYI-II)</td>
<td>7–18 years</td>
<td>The BYI consists of five inventories of 20 questions each: depression, anxiety, anger, disruptive behavior, and self-concept. The five self-report inventories can be administered separately or in combination, with administration time only 5 minutes per inventory. The normative group is well stratified for age, sex, ethnicity, and socioeconomic status. Results provide clinical ranges for symptom severity, profile analysis for general understanding, and items or item clusters as probes for deeper understanding.</td>
</tr>
<tr>
<td>Behavior Assessment System for Children--2nd edition (BASC-2)</td>
<td>Preschool: 2–5 years School age: 6–11 years Adolescent: 12–21 years</td>
<td>Multidimensional scale, normed by age and sex, which measures behavior, emotions, and self-perceptions. Includes parent and teacher rating scales, a self-report of personality scale, a student observation system, and a structured developmental history. It is available in Spanish as well as English, and it provides an audio CD recording for individuals with reading problems. Assesses internalizing, externalizing, and school problems, atypical behavior, and adaptive skills. Both computer- and hand-scored versions are available.</td>
</tr>
<tr>
<td>Child Behavior Checklist (CBCL), Teacher's Report Form (TRF), and Youth Self Report (YSR)</td>
<td>CBCL 1.5–5 years TRF 1.5–5 years CBCL 6–18 years TRF 6–18 years YSR 11–18 years</td>
<td>Multiaxial, empirically based scales, normed by age and sex that assess social competencies as well as behavioral/emotional problems. The CBCL 6–18, TRF 6–18, and YSR 11–18 were designed to obtain similar types of data in a similar format from parents, teachers, and youth. The behavior problem items on these scales cluster into eight subscales: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior. The analogous CBCL 1.5–5 extends the empirically based assessment to younger children. It includes an Emotionally Reactive subscale, but excludes the Social, Thought, and Rule-Breaking subscales. On the YSR, youths rate themselves for how true each item is within the past 6 months. A new scoring module (2007) displays problem-scale profiles and cross-informant bar graphs in relation to multicultural norms.</td>
</tr>
<tr>
<td>Semistructured Clinical Interview for Children (SCIC)</td>
<td>6–11 years</td>
<td>Developed to accompany the CBCL 4–18 and TRF, this interview format was adapted to the cognitive levels and interactive style of 6- to 11-year-old children. It provides open-ended questions designed to elicit children's reports on various important areas of their lives, including family, friends, school, activities, concerns, and fantasies. Also includes a kinetic family drawing, brief achievement tests, a screen for fine and gross motor abnormalities, and probe questions about problems attributed to the child by others.</td>
</tr>
<tr>
<td>Symptom Checklist-90 Revised (SCL-90-R)</td>
<td>Parent Rating Scales: 3–17 years Teacher Rating Scales: 5–17 years Adolescent Self-Report: 13–17 years</td>
<td>A 90-item self-report scale that asks respondents to rate the subjective severity of psychological symptoms in nine areas: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychotism. It yields three general indices: a Global Severity Index of overall psychological distress; a Positive Symptom Distress Index (designed to measure intensity of symptoms), and a Positive Symptom Total Index, which reports the number of self-reported symptoms.</td>
</tr>
<tr>
<td>Piers-Harris Children's Self Concept Scale–2nd edition (PHCSCS-2)</td>
<td>7–18 years</td>
<td>An 80-item self-report scale of self-concept and self-esteem in children. It yields a Total Self-Concept Score, along with subscale scores (Behavioral Adjustment, Freedom from Anxiety, Happiness and Satisfaction, Intellectual and School Status, Physical Appearance and Attributes, and Popularity) that permit more detailed interpretation. It is used in clinical settings to determine specific areas of conflict, typical coping and defense mechanisms, and appropriate intervention techniques.</td>
</tr>
</tbody>
</table>

Advantages and Disadvantages of Behavioral Approaches. There are several advantages of the behavioral approaches to assessment of behavior and emotional functioning in children and youth. These procedures are cost-effective in that they maximize the amount of information obtained with little clinician time. They often have convenient hand-score or computer scoring methodology, another cost-effective aspect. Use of behavioral assessment increases the likelihood of obtaining information from multiple sources (e.g., teachers and parents) across multiple settings (e.g., school, home, and day care). These sources of information are necessary for some diagnoses, such as attention-deficit/hyperactivity disorder (ADHD), and likely increase the validity of other diagnoses. Many of the scales are empirically derived, factor-analytic
scales that are normed for age and sex and generally possess good psychometric properties.

Disadvantages of behavioral rating methods in children include questions about the validity of informants’ reports and concerns about informant reading level. The behavioral ratings are filtered through the perceptions of the informant, and the degree of frustration, emotional pathology (e.g., depression), and intellectual and academic skills of the informant are critical to understanding the report. There is much debate about how to handle discrepant ratings across informants. Although perfect correlation is not expected, the issue of how to weigh one person’s observations against those of another is an important issue that is as yet unresolved.

Achenbach Child Behavior Checklists. The checklists developed by Thomas Achenbach have been perhaps the most widely used behavioral rating scales in child and adolescent clinics in recent years. Similar to the Behavior Assessment System for Children, 2nd edition (BASC-2), the Achenbach scales include a parent rating (the Child Behavior Checklist [CBCL]), a teacher rating (Teacher Report Form [TRF]), and a self-report (Youth Self-Report [YSR]). The CBCL is appropriate for children from the ages of 6 to 18 years, the TRF is used for children from the ages of 6 to 18 years, and the YSR is appropriate for those from the ages of 11 to 18 years. Each scale is interpreted in comparison to a large normative sample stratified by age and sex. A cross-informant computerized scoring paradigm is provided to assist with comparisons of the CBCL, TRF, and YSR measures regarding a given client.

A version of the CBCL and TRF for toddlers (CBCL 1.5–5 and Caregiver–Teacher Report Form for Ages 1.5–5) is also available. The Internalizing, Externalizing, and Total Problems scales are scored from both forms. The CBCL 1.5–5 also includes the Language Development Survey and a Sleep Problems syndrome scale. The C-TRF asks teachers and caregivers to provide descriptions of problems, disabilities, issues that concern the respondent most about the child, and things that the respondent views to be best about the child. A separate computerized scoring system is available for the toddler versions of the CBCL.

Other Behavioral Personality Approaches. Many other behavioral approaches to assessment are available in addition to behavior rating scales, as discussed in the earlier part of this section. Direct observations of child and adolescent behavior can be a useful adjunct to other assessment procedures, whether the observation is unstructured or structured according to a specific format.

References


Bram AD. The relevance of the Rorschach and patient-examiner relationship in other assessment procedures, whether the observation is unstructured or structured according to a specific format.

Although cognitive and neuropsychological assessments might overlap, these approaches analyze behavior according to two different paradigms. Cognitive assessment is undertaken without reference to the possible neurobiological underpinnings of overt behavior, and it describes the patient very much as others might observe him or her in the world. Neuropsychological assessment is undertaken in the context of growing knowledge about brain–behavior relationships, and it has the additional possibility of describing the child in terms of unseen neural pathways. These approaches provide ways of conceptualizing how children integrate information (and their thinking, learning, and responding) at different levels. General cognitive assessment focuses on understanding behavior at a cognitive level and in descriptive terms. Focused neuropsychological assessment introduces the additional possibility of understanding behavior at neural levels and in neurological terms. However, regardless of the theoretical differences among the psychologists undertaking these evaluations, in a practical way it is the patient’s referral issues that shape the assessment process and focus the interpretation of results.

Basics of Psychological Assessment

Psychological assessment involves more than testing. Although measurements are useful, testing involves more than scores.

The Testing Process

In addition to testing, assessment procedures include examining past records (medical examinations, prior testing, report cards), interviewing the client and his or her family (in structured and unstructured formats), obtaining information from home and school (and, sometimes, onsite observations), and obtaining rating scales that have been filled out by the child’s parents and teachers (regarding developmental, behavioral, emotional, and diagnostic issues). The diagnostic aspect of the process involves an attempt to determine the psychiatric and educational categories for which the client meets the criteria. Cognitive and neuropsychological tests are only two aspects of an attempt to get a broad view of the way a child solves problems in the world, to understand his or her unique interaction with any diagnostic category, and to provide recommendations for interventions.

Measurements in Testing

Although many techniques might be used to help understand a child client and his or her referral question, the emphasis here is on standardized testing (based on regularized procedures as well as