Computer MMPI Reports: A Comparison of Three Commercially Available Reports on Accuracy, Format, and Utility

Kathryn Elaine Edwards

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COMPUTER MMPI REPORTS: A COMPARISON OF THREE COMMERCIAL REPORTS ON ACCURACY, FORMAT, AND UTILITY

by

Kathryn Elaine Edwards

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
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Kathryn Elaine Edwards
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CHAPTER I

Introduction

Discussions of the merits and disadvantages of programmed interpretations of the Minnesota Multiphasic Personality Inventory (MMPI) are traditionally begun by referring to Meehl's (1956) article, "Wanted--A Good Cookbook." Although the debate over relative superiority of mechanically applied decision rules versus human judgment has continued for two decades, the outcome seems clear: The actuarial approach has been shown to be equal to, or better than, the clinical approach in a number of studies (Goldberg, 1970; Meehl, 1956; Sines, 1970).

The development of "cookbooks" containing code types by Gilberstadt and Duker (1965), Marks and Seeman (1963), and Sines (1966) were the first efforts to fulfill Meehl's request. Although such cookbooks were useful additions to MMPI literature, they were not able to classify the majority of MMPI score patterns (Manning, 1971).

However, with the introduction and continued development of computerized scoring and interpretative systems in the 1960's and 1970's, a greater number of MMPI score patterns may now be classified (Manning, 1971). In addition, computerized scoring made available numerous special scales which heretofore were often unscored and therefore unused.
Several other advantages enhanced the attractiveness of computer interpretations. First, when the same model was used in each case, improved reliability was achieved by eliminating the source of random error in human judgment (Eichman, 1972; Goldberg, 1970; Manning, 1971). Second, improved reliability resulted in increased validity, as reported by Bringman, Balance, and Giesbrecht (1972; Goldberg (1970); and Sines (1970). Third, the validity of the MMPI as a diagnostic instrument can be continually improved if MMPI research results are considered in the construction and revision of computer systems (Eichman, 1972; Manning, 1971). Finally, another advantage of computer interpretation lays in saving time for the professional (Fowler, 1967; Manning, 1971; Meehl, 1956). As professionals are released from tasks which a computer does more reliably and with greater validity, they become free to pursue other areas of treatment and research (Fowler, 1969a; Meehl, 1956). Here, time is precious in a monetary sense. The modest cost of most computer interpretive services makes inevitable their continued use and expanding popularity (Eichman, 1972; Fowler, 1972; Gynther, 1972; Lachar, 1974a; Manning, 1971; Rogers, 1972).

Currently there are at least seven commercial MMPI computer services available to mental health professionals: Automated Psychological Assessment (Lachar, 1974b); Clinical Psychological Services, Inc.; Institute of Clinical Analysis: MMPI-ICA Computer Report; OPTIMUM Psychodiagnostic
Consultation Service; Psychological Corporation MMPI Reporting Service (Mayo); Psychological Resources Support System; and Roche Psychiatric Service Institute: MMPI Computerized Interpretation (Fowler, 1972).

Although some of these services have received extensive exposure in the literature, such as the Mayo and Roche services, others have not. Eichman's (1972) review and descriptive accounts of four services (Institute of Clinical Analysis, OPTIMUM, Mayo, and Roche) are in the Seventh Mental Measurements Yearbook (Buros, 1972). In Eichman's review, the shortcomings as well as the assets of each of these four services were presented so that the readers could evaluate the appropriateness of each service to their needs. Eichman briefly described the components contained in each service's report, including its cost, the availability of manual and/or reference guides, and the promptness of service.

Manning (1971) offered a "comparative survey" of four services (Mayo, Clinical Psychological Services, OPTIMUM, and Roche). Manning submitted the same protocol to each of three services (OPTIMUM was excluded) and compared the resulting reports with the descriptive and diagnostic summary he had made prior to obtaining results from the services. He presented the returned reports in his review. Although the reader is supplied with sample reports of the same client, and with Manning's own clinical MMPI interpretation, no inter-report comparison was made by Manning. He presented
an informative, brief review of the development, kinds and scope of coverage, cost, description of procedures (where possible), and any supporting validity studies of each service. While this information is useful to prospective buyers in the programmed interpretation market, the reader is not provided with direct between-service comparisons.

While rigorous cross-validation studies are needed for virtually every computer service available, it is also important to be able to select a program which will best meet the needs of individual professionals and their treatment populations. Among the important factors to be considered when selecting a service are: report cost, readability of reports, accuracy of report content, and report utility (Fowler, 1967; Webb, 1970; Webb, Miller, & Fowler, 1969). It is beyond the scope of this study to consider the more expensive services (Clinical Psychological Services, OPTIMUM, Psychological Resources Support System), which range in price from $20 to $30 for each MMPI report. Large-quantity users and those with limited funds will most likely be interested in those services which offer more modest rates, such as the Automated Psychological Assessment, Institute of Clinical Analysis, Mayo, and Roche Psychiatric Service Institute services.

The Automated Psychological Assessment (APA), Institute of Clinical Analysis (ICA), and Roche Psychiatric Service Institute (RPSI) services were selected for this study. There were aspects of each of these services that merited
investigation, as indicated below. Although the Mayo is the least expensive service, it is not included in this study, since it is considered a screening report and it is not designed to provide as comprehensive an interpretation as the other services.

**Automated Psychological Assessment**

The APA service became available in 1974 and was developed by Lachar. The APA service is available "to mental health and substance abuse facilities, psychologists, psychiatrists, and psychiatric social workers (Lachar, 1976, p. 1). The APA report contains a narrative report, scores on 4 validity scales, 10 clinical scales, obvious-subtle subtests, 21 special scales, critical items, and profile of the validity and clinical scales. The report is a 4- to 5-page computer printout containing an interpretation of the validity configuration, descriptive and interpretative statements based on clinical scales, temporal stability of syndromes, probable diagnosis, defense mechanisms, recommendations for preferred treatment, and prognosis.

The APA begins its report with a reminder to the user that the report serves "as a series of hypotheses which may require further investigation" (Lachar, 1976, p. 17). The critical-item section is headed by a statement reminding the reader to avoid placing too much significance on individual test responses.
The APA provides a manual, one test booklet and two score sheets as an introductory offer at a cost of $4.00. The cost of scoring and interpretation is $7.50 per report for orders of less than 50; prices decrease for quantity orders over 50. IBM 805 answer sheets are used. Reports are mailed within 24 hours upon receipt of answer sheets.

This service is the only one of the three described in this study that has published an account of its entire procedure. In *The MMPI: Clinical Assessment and Automated Interpretation*, Lachar (1974b) described the program in detail. Included in this monograph are decision rules, statements, relative frequency, and judged accuracy of each interpretation. This monograph is available from Western Psychological Services for $10.00.

**Institute of Clinical Analysis**

The ICA became available for commercial use in 1966 and was developed by Dunlop. This service is available to physicians, psychologists, and psychiatrists. The report is a 4- to 5-page computer printout containing the following: an emotional disturbance score (Multiphasic Index); probabilities of disturbance; descriptive and interpretive statements regarding ability to cope; suggestions for improving coping; special coping problems; most frequent diagnosis; critical items; salient clinical features; scores on 4 validity scales, 10 clinical scales, 17 special scales; and
a profile of the validity and clinical scales. This service provides a manual (free on request) and a reference guide abstract. Special IBM answer sheets are used. The cost of scoring and interpretation is $10.00 per test, postpaid. Reports are mailed within 2 days after receipt of completed answer sheets. The ICA has not published an account of its procedure.

Eichman (1972) pointed out several positive attributes of the ICA service. He described the report as well written, well grounded in MMPI literature, and reflective of careful workmanship. Eichman considered the manuals and literature provided to the user as comparatively better than those offered by competing services. It would appear, then, that the combination of a skillfully written, concise, and informative report has been achieved by the ICA service. However, there are other attributes pointed out by Eichman that may weaken the overall effectiveness of the ICA report. He noted that although the service is offered to physicians, psychologists, and psychiatrists, the orientation of the language of the manual and the use of measures of general disturbance (Multiphasic Index and Probability of Disturbance) seem more directed at the general practitioner. Eichman also pointed out a lack of conservatism in several areas of the report. The symptom review relies on single items. The scoring of highly elevated F scores is not accompanied by any statement concerning doubtful validity or tendency toward exaggeration.
(this is routine procedure for other services). In some printouts, the diagnosis is stated in a very positive manner without the usual checks and balances designed to promote clinical confirmation, alteration, or rejection of the MMPI diagnosis.

Eichman (1972) stated, "It can be extremely useful to the clinician who has skill in the use of psychometric-personality data; it can be misused badly by the naive recipient, especially if he does not have an optimum set of values regarding emotional problems" (p. 255).

Roche Psychiatric Service Institute

The RPSI program is commercially available to clinical psychologists, psychiatrists, qualified general practitioners, and psychiatric institutions. The RPSI system is one of the most widely used programs available. Webb (1970) indicated that one third of all private practice psychiatrists and several hundred psychologists used the system as of 1969.

The RPSI report (Eichman, 1972) is a computer printout of 3 to 4 pages. It contains a narrative report; scores on 4 validity scales, 10 clinical scales, and 14 special scales; critical items; and a profile of the validity and clinical scores. Subscribers are provided with a manual, test booklet, 20 answer sheets, and a record of patient identification numbers. The initial cost for this is $5.00. The cost of scoring and interpretation is $10.00 per test, postpaid. Reports are mailed within 1 day upon receipt of answer sheets.
The narrative portion of the RPSI report contains inferences regarding temporal stability of a syndrome, the preferred treatment approach to description of the client, and tentative diagnosis. Eichman also pointed out that the word "psychosis" is not used even in cases where the clinician might be inclined to do so. The end of each report includes a caution against the use of the MMPI as a substitute for clinical judgment and skill. A similar statement precedes the listing of critical items, and caution against over-interpretation of single responses.

Overall, the RPSI system offers an inexpensive and appropriately conservative interpretation to a large number of users. The developers of this system have endeavored to evaluate and revise their system through various studies (Webb, 1970; Webb et al., 1969; Webb, Miller, & Fowler, 1970) and, thus, reflect an effort to contribute to the MMPI literature as well as improve the RPSI system.

However, the positive findings of the Webb et al. (1969) study were based on data derived from regular users of the RPSI system. In addition, both the 1969 and 1970 studies were not comparative evaluations of the RPSI system against other services.

Purpose of the Study

The APA, ICA, and RPSI services all offer reports that are designed to assist the clinician in the diagnosis,
understanding, and treatment of recipients of mental health services. The user or prospective user of programmed interpretation systems is, in effect, a consumer in a competitive market. How is the clinician to make the best choice among the services offered?

The purpose of this study is to evaluate and compare the reports of the APA, ICA, and RPSI services for accuracy, utility, and format within outpatient mental health facilities. The measure of format encompasses the aspects of report readability and clarity, since a report must be readable and clear in its presentation of content for clinicians to determine report usefulness. The null hypothesis is that there is no difference among the APA, ICA, and RPSI reports in mean scores for accuracy, utility, or format. In addition, an overall measure of preference of service was obtained and the null hypothesis is that no one service would be chosen significantly more frequently than any other service.

The APA, ICA, and RPSI services were selected for this study for several reasons. The APA system was chosen because (1) it is inexpensive ($7.50 per test); (2) it is a relatively new service and perhaps not well known by MMPI users; (3) Lachar's (1974a) validation study was conducted with clinicians who had 1 hour of patient contact, which may not have been enough contact time to allow judges to know their patients well; and (4) it was the only service (besides the Mayo) which had published a full account of its procedure.
Lachar (1976) stated that the publication of the APA's procedure would allow clinicians to "critically evaluate the appropriateness of this system for various clinical facilities and evaluative purposes" (p. 1). It was hoped that this study would further assist MMPI users in their judgments about this service in regard to their clinical needs.

The ICA report was included because (1) it is relatively inexpensive ($10.00 per test); (2) it was considered to be a well-written and comprehensive report by Eichman (1972); and (3) it was interesting to determine if Eichman's criticisms of the ICA report, concerning over-interpretation and lack of caution, would be confirmed or not confirmed by psychologists, psychiatrists, and social workers in an outpatient clinical setting.

The RPSI system was selected because (1) it is moderately priced ($10.00 per report); (2) it was one of the most widely used services; (3) it was well regarded in the literature by those who have examined commercially available services; and (4) although the RPSI system had been evaluated for utility, accuracy, and clarity (Webb et al., 1969), and favorable results were obtained, this study was conducted among regular users of the RPSI system. It would seem that this population of users would have a bias in favor of the RPSI system. The present study allowed outpatient therapists to directly compare the RPSI system against other services.
CHAPTER II

Methods

Raters

Twenty mental health professionals (seven M.A. psychologists, five Ph.D. psychologists, two Ed.D. psychologists, five M.S.W. social workers, and one psychiatrist) working as therapists in outpatient, community mental health clinics were selected to rate the reports of the Automated Psychological Assessment (APA), Institute of Clinical Analysis (ICA), and Roche Psychiatric Service Institute (RPSI) services. Of the raters, 7 were female and 13 were male. The mean years of experience as outpatient therapists was 7.1, with a range of 1 to 21 years. These raters were unpaid and therefore were selected on the basis of their willingness to participate in the study. The identity of each rater was coded by number to ensure personal anonymity. Each rater was offered a copy of the study upon its completion.

Examinees

The 20 professionals who participated in the study were asked to select 1 client each from their caseloads, whom they knew well and had seen a minimum of 6 hours in therapy. Raters were reminded that the purpose of this study was to assist outpatient therapists in selecting the best programmed
MMPI interpretation system for their setting, and was not
designed to provide additional information on clients which
were the most atypical or the least understood in their case­
load. Thus, to maximize the validity and usefulness of this
study, it was necessary for the raters to select clients who
would be cooperative in taking the MMPI and for whom the
raters could best compare the MMPI interpretive reports (see
Appendix A, Instructions to Raters).

Because computer reports generated for nonwhite clients
have been reported to be of doubtful validity (Lachar, 1974a),
rater-therapists were asked to select white clients. There
were 10 male and 10 female clients selected, with an age
range of 24 to 51 years. The mean number of hours in therapy
was 25, with a range of 7 to 102. Two clients were diagnosed
as psychotic, 10 as neurotic, and 6 as having personality
disorders; for 2 clients, diagnoses were not given.

Rating Scale

The rating scale used in this study (see Appendix B) was
adapted from the one used by Webb, Miller, and Fowler (1969)
and again by Webb (1970) in evaluations of the RPSI system.
The Roche Laboratories originally used this scale in 1969 to
assess the usefulness of the RPSI system and to identify
areas of their report which needed revision. Pilot studies
were conducted by Webb et al. (1969) to assess the clarity,
relevance, and sensitivity of each item of the scale. The
scale was again used in 1970 by Webb to replicate the Webb et al. (1969) study.

While most of the items from Webb's 1970 scale are retained in the present study, there are several exceptions. Item 1 of the original survey was: "The report is well organized and its descriptions are clear." This item has been split in the present study to form Item 1, report organization, and Item 2, clarity of description. It was determined that report organization was not necessarily the same concept as clarity of description. Items 10 and 11 of the present study were added to assess readability of the reports. If a report is too long, it may not be read by many therapists who are pressed for time. If a report is too short, it may not be adequately informative. Item 15 in the original survey was omitted in the present study: "This report, compared to most non-computerized psychological reports I have seen, is . . . ." It is not the purpose of this study to compare any of the services with non-computerized reports. Item 18 ("This report provides adequate cautions about proper use of MMPI data") was included in the present study, in part because of Eichman's (1972) criticism of the ICA for omitting such cautions to report users, and also because the author considers the inclusion of this reminder to be appropriate. The wording of Item 19 (Item 16 in the Webb et al., 1969, study) was changed to allow raters to use the 5-point scale. Item 20 has been added as a measure of overall assessment of
the three services by the raters. Raters were asked to rank-order their preferences of first, second, and third choice of report: "Assuming equal cost and speed of service, which report would you choose first, second, and third?"

The measures of accuracy, format, and utility used by Webb et al. (1969) were derived from clustering items into three groups. A measure of accuracy of report content was derived from clustering Items 3, 4, 5, 6, 7, 8, 10, 15, and 17. A measure of format was derived from clustering Items 1, 2, 11, 12, and 13. A measure of utility was derived from clustering Items 9, 14, 16, 18, and 19.

Items 1-19 were designed as Likert scale items with five choices, from "strongly disagree" to "strongly agree" (see Appendix B). Values of 1 through 5 were assigned to each, with "strongly disagree" weighted as 1 and "strongly agree" as 5. Values for Items 5, 6, 8, 11, 12, 13, 14, 15, and 16 were reversed prior to scoring.

Procedure

Each client was asked to complete the MMPI with the usual instructions given by the therapists in their settings. All clients used the group form and IBM 805 answer sheets. The resulting 20 protocols were transcribed by the investigator so that three sets of the original 20 were produced. The protocols that were sent to ICA were transformed to the 1230 IBM answer sheets used by that company. The protocols
that were sent to RPSI were transformed to the RPSI form, which uses a different item order. These 60 protocols were checked for accuracy of transcription by the examiner and an assistant.

The three sets of 20 protocols were submitted to the APA, ICA, and RPSI services for scoring and interpretation. When all 60 reports were returned by the three services, each rater was given 3 reports (1 from each service) on his/her client, the rating instrument, and a cover letter with instructions from the researcher.

To minimize bias from exposure to any previous MMPI reports of the selected client, each rater was requested to refrain from reviewing that material if present in the client's case file. To prevent order effect, each judge was requested to read completely each report in the order presented to them. The reports were arranged so that each service report was read first, second, and third approximately an equal number of times across all raters.
CHAPTER III

Results

Three one-way analyses of variance were applied to the mean scores of clustered items relating to accuracy, format, and utility (see Table 1).

Table 1

<table>
<thead>
<tr>
<th>Service</th>
<th>Cluster</th>
<th>Accuracy</th>
<th>Format</th>
<th>Utility</th>
</tr>
</thead>
<tbody>
<tr>
<td>APA</td>
<td></td>
<td>33.30</td>
<td>17.90</td>
<td>17.85</td>
</tr>
<tr>
<td>ICA</td>
<td></td>
<td>33.50</td>
<td>17.60</td>
<td>18.10</td>
</tr>
<tr>
<td>RPSI</td>
<td></td>
<td>38.25</td>
<td>19.45</td>
<td>20.50</td>
</tr>
</tbody>
</table>

A significant difference among means was obtained from the analysis applied to accuracy, \( F(2, 57) = 3.28, p < .05 \). Multiple comparisons, using Fisher's least significant difference procedure, indicate that the RPSI report was judged more accurate than the APA report, \( t(57) = 2.56, p < .05 \); and the ICA report, \( t(57) = 2.56, p < .05 \).

The analysis of variance results on the measure of utility indicate no significant difference in ratings on the
items measuring utility, $F(2, 57) = 2.3$, $p > .05$; however, the Tukéy procedure for multiple comparisons does show the RPSI report to receive higher ratings on utility than the APA, $t(57) = 2.49$, $p < .05$; and the ICA, $t(57) = 2.75$, $p < .05$. The analysis of variance results indicate no significant difference among the mean scores measuring format, $F(2, 57) = 1.29$, $p > .05$.

Figure 1 presents the mean scores of the first 19 items of the questionnaire. This item-by-item display of mean results illustrates the consistently similar ratings of the APA and ICA reports and the generally higher ratings of the RPSI report.

Item 20 of the questionnaire requested that therapists rank their overall preference order of the three reports. Application of Friedman's two-way analysis of variance by ranks revealed that the RPSI report was ranked as the first choice, $X^2_r(2) = 6.1$, $p < .05$. 

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*Scale values are reversed for Items 5, 6, 8, 11, 12, 13, 14, 15, and 16.

Figure 1. Mean scores on Items 1-19 for the Automated Psychological Assessment (APA), Institute of Clinical Analysis (ICA), and Roche Psychiatric Service Institute (RPSI) reports in clustered groups measuring accuracy, format, and utility.
CHAPTER IV

Discussion

The results of this study indicate that the Roche Psychiatric Service Institute (RPSI) report was preferred over the Automated Psychological Assessment (APA) and Institute of Clinical Analysis (ICA) reports by a group of outpatient therapists of varied disciplines. The RPSI report was judged as most accurate in report content for clients having a wide range of diagnoses.

However, no report was judged to be significantly superior on format, a measure of report style of presentation. An examination of responses to Items 11 and 12, included in the measure of format, reveals that the therapists did not view any of the three reports as too long or too short. Ratings on Item 13, also included in the measure of format, support Webb's (1970) conclusions that contradictions in computer-generated reports are inherent when paragraphs are independently chosen. Another possible explanation may be that apparent report contradiction may actually represent clients in conflict rather than weaknesses in report construction (Webb, 1970).

Although no significant difference between reports was identified on the measure of utility, using the $F$ test, the Tukey procedure with an experiment-wise error term yields
results that indicate higher ratings for the RPSI report. The results of Item 18, included in the measure of utility, produce one interesting outcome of the study. The responses to this item indicate that Eichman's (1972) opinion, that the ICA report is noticeably lacking in adequate cautions about proper use of MMPI data, is not confirmed. Although the ICA report received the lowest ratings on Item 18, the difference among reports is not significant. Does this mean that the ICA report was viewed as being as equally cautious as the APA and RPSI reports? Does it mean that practicing clinicians view such cautions as unnecessary, or have they developed internal rules for proper use of test data? These questions may represent interesting areas for future study.

The specific intention of the study was to allow practicing clinicians to compare these three companies' reports by using a scale of items which have been tested and reported in the literature. Yet, these 20 items do not represent the universe of relevant factors that clinicians could, or do, use to rate and rank MMPI reports. One property of these reports that was not considered in the structuring of the questionnaire was the physical aspect of the reports. It was discovered that two physical properties which were not addressed in the questionnaire had some unknown effect on two clinicians' preferences. One rater volunteered that the odor of Report A (APA) was offensive and caused his eyes to burn. Another rater remarked that Report A was awkward to handle.
and frustrating to review, because the pages of the report were still attached in computer paper fashion, making one long piece which had to be separated. Reports B and C (RPSI and ICA, respectively) were already collated and stapled.

It is likely that other unidentified variables influenced the outcome of this study. The presentation of a scale of items that sample all relevant aspects of computer-generated report choice could make a questionnaire too lengthy and discourage its use in work settings. However, further refinement and specificity of item content is necessary if further investigation into the computer-generated MMPI report market is to take place.

It was suggested to the author that each report be transcribed onto identical paper to eliminate such variables as type of paper, print, and visual layout. If done, this would have approached a validity study, which was not the intent of the investigation. This also would have eliminated factors that do apparently have a bearing on report choice. This study suggests that when professionals are asked to carefully examine a clinical tool, which also happens to be a product on the commercial market, it appears that being both clinician and consumer influences choices—choices that may best be made from a professional perspective.
APPENDIX A

Introductory Letter and Instructions for Raters
I am a graduate student in the clinical psychology program at Western Michigan University, currently beginning work on my thesis. The purpose of my study is to provide a comparative evaluation of three MMPI computer interpretation services. I hope that such an evaluation will aid outpatient mental health workers, such as yourself, in an objective selection of a computer service.

Although you may be familiar with one or more of the seven MMPI services now available, this study will hopefully provide you with the means to directly compare three of these services within your work setting. Your agency may wish to base its selection of a computer service on your findings.

To maximize the usefulness of your evaluation and to aid you in making the comparisons, it will be necessary for you to select a client who you know quite well. While "knowing well" is always a subjective and arbitrary judgment, for the purpose of this study we will define this as "a client in treatment for a minimum of 6 hours on a one-to-one basis." Please select a client who is a white adult. In addition, please do not choose a client that is your most difficult case. Computer reports by definition are blind interpretations, and the selection of clients which are most atypical or least understood will likely compound this problem. Please refrain from reviewing any previous testing results on your client before completing this scale. Of course, you may certainly keep the reports and compare them with previous testing after I have received your completed scale.

After you have selected a client which you judge to fit the criteria outlined, please administer the MMPI test to him/her with the usual instructions given at your clinic. If the MMPI is not administered at your clinic, I can arrange to administer the test for you.

I will gather the completed protocols on _________ as agreed. I will triplicate your client's protocol and then submit these three protocols to the MMPI services selected for this study. When the reports are sent back to me from these services, I will deliver them to you along with the rating instrument and instructions. On _________, I will collect the completed scale from you.
Thank you for taking the time from your busy schedule to rate these reports. Without your assistance, I would not be able to complete this thesis topic. If you would like a finished copy of the study, I will gladly make this available to you.

Following is a summary of this process and some reminders about instructions to which you may want to refer:

1. Select a well-known (minimum of 6 hours in treatment) white, adult client who is not the most difficult or atypical client in your caseload.

2. Administer the MMPI as you generally do in your setting.

3. Please do not review any previous testing results on your client.

4. I will pick up the completed test answer sheet on _____.

5. I will triplicate the answer sheets and send these to the three services.

6. I will distribute the three resulting reports on your client, instructions, and a rating instrument to you on _____.

7. I will collect the completed scale from you on _____.

8. You may keep all three reports on your client.

9. Confidentiality of all clients will be protected; each client will be designated by number only.

10. All raters participating in this study will be designated by numbers; this coding will ensure that your identity will be protected as well as your client's.

It is very important that numbers 1, 2, and 3 are followed carefully. Otherwise, confounding variables will enter and certainly minimize what can be concluded from the data.

If you have any questions at all, please feel free to call me (collect) at any time after 6:00 at my home, 349-1210, or from 8:00 to 5:00, Monday-Friday, at the Albion Family Clinic (1-517-629-5531).

Again, I thank you for your time and assistance!

Sincerely,

Kathryn E. Edwards
The following information will assist me in analyzing the results.

Please indicate your:

Degree ___________________

Sex _____ M _____ F

Post-graduate clinical experience time in years _____
or months ____

Please indicate your client's diagnostic code per DSM II
______________.

Sex _____ M _____ F

Age ____

Hours in therapy ____
APPENDIX B

Rating Scale
INSTRUCTIONS

*Do not review any previous test results on your client before completing this scale.

*Please read each report completely in the order given to you.

*Rate the three reports on each item before moving on to the next item.

*The reports are lettered A, B, and C in colors at the top of each page of each report. Place the letter designating each report on one of the five lines for each item.

NOTE THAT THERE IS ENOUGH SPACE PROVIDED ON EACH LINE SO THAT MORE THAN ONE REPORT CAN BE GIVEN THE SAME RATING ON ANY ITEM.

Example: If you think that all three reports are completely full of big holes, you would mark Item 0 as follows:

0. The report is full of big holes.

__________________Strongly disagree
__________________Mildly disagree
__________________Neutral
__________________Mildly agree
C B A Strongly agree

* * * * * * * * * * * * * * * * * * * * * * * * * * * *

Please rate the three reports on the 20 items below; place the letters A, B, C on the appropriate lines.

1. The report is well organized.

__________________Strongly disagree
__________________Mildly disagree
__________________Neutral
__________________Mildly agree
__________________Strongly agree
2. Descriptions in this report are clear.

_____________Strongly disagree
_____________Mildly disagree
___________Neutral
___________Mildly agree
_____________Strongly agree

3. The report gives a valid overall description of this client.

_____________Strongly disagree
_____________Mildly disagree
___________Neutral
___________Mildly agree
_____________Strongly agree

4. The behaviors described are characteristic of this person.

_____________Strongly disagree
_____________Mildly disagree
___________Neutral
___________Mildly agree
_____________Strongly agree

5. Major symptoms of this person are omitted.

_____________Strongly disagree
_____________Mildly disagree
___________Neutral
___________Mildly agree
_____________Strongly agree

6. The reports overemphasized this person's psychosomatic complaints.

_____________Strongly disagree
_____________Mildly disagree
___________Neutral
___________Mildly agree
_____________Strongly agree
7. This person's mood and feelings are accurately described.

____________Strongly disagree
____________Mildly disagree
____________Neutral
____________Mildly agree
____________Strongly agree

8. The report misrepresents this person's interpersonal relations.

____________Strongly disagree
____________Mildly disagree
____________Neutral
____________Mildly agree
____________Strongly agree

9. The report is helpful in planning this client's treatment.

____________Strongly disagree
____________Mildly disagree
____________Neutral
____________Mildly agree
____________Strongly agree

10. The symptoms that are reported are accurate.

____________Strongly disagree
____________Mildly disagree
____________Neutral
____________Mildly agree
____________Strongly agree

11. The report is too long.

____________Strongly disagree
____________Mildly disagree
____________Neutral
____________Mildly agree
____________Strongly agree
12. The report is too short.

_____________ Strongly disagree
_____________ Mildly disagree
_____________ Neutral
_____________ Mildly agree
_____________ Strongly agree

13. Parts of the report contradicted each other.

_____________ Strongly disagree
_____________ Mildly disagree
_____________ Neutral
_____________ Mildly agree
_____________ Strongly agree

14. I could find little useful in this report.

_____________ Strongly disagree
_____________ Mildly disagree
_____________ Neutral
_____________ Mildly agree
_____________ Strongly agree

15. The severity of personality disorder was overemphasized.

_____________ Strongly disagree
_____________ Mildly disagree
_____________ Neutral
_____________ Mildly agree
_____________ Strongly agree

16. Unimportant and trivial information was included.

_____________ Strongly disagree
_____________ Mildly disagree
_____________ Neutral
_____________ Mildly agree
_____________ Strongly agree
17. The report's prediction of response to therapy was accurate.

_________ Strongly disagree
_________ Mildly disagree
_________ Neutral
_________ Mildly agree
_________ Strongly agree

18. This report provides adequate cautions about proper use of MMPI data.

_________ Strongly disagree
_________ Mildly disagree
_________ Neutral
_________ Mildly agree
_________ Strongly agree

19. This report would help me make more efficient use of my time with this client.

_________ Strongly disagree
_________ Mildly disagree
_________ Neutral
_________ Mildly agree
_________ Strongly agree

Item 20 is different from the other items. Please indicate which report you choose first, second, and third by writing 1, 2, 3 on the lines provided.

20. Assuming equal cost and speed of service, which report would you choose for your setting first, second, and third?

Report A _____ Report B _____ Report C _____
REFERENCES


Fowler, R. D., Jr. Computer interpretation of the MMPI. Archives of General Psychiatry, 1969, 21, 502-508. (b)


