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5.5 Personality Assessment: Adults and Children

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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 etiology of the presenting psychiatric problem and the prognosis of the disorder. 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. 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. Providing Narrow-Band Assessment Narrow-band personality tests measure a single personality characteristic or a few related characteristics. Broad-bank 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 wellconstructed, 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. 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 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 of more 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–Retest 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 splithalf 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. Table 5.5-1 Objective Measures of Personality

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 questions and allows less time to administer. 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 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. 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 lists the common projective tests together with a description and strengths

and weaknesses for each test. Table 5.5-2 Projective Measures of Personality 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. FIGURE 5.5-1 Card I of the Rorschach test. (From Hermann Rorschach, Rorschach®-Test. Copyright © Verlag Hans Hubar AG, Bern, Switzerland, 1921, 1948, 1994, with permission.)

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 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. FIGURE 5.5-2 Card 12F of the Thematic Apperception Test. (Reprinted from Henry A. Murray, Thematic Apperception Test, Harvard University Press, Cambridge, MA. Copyright © 1943 President and Fellows of Harvard College, © 1971 Henry A. Murray, with

permission.) 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). Table 5.5-3 Projective Assessment Procedures for Children

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 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. Table 5.5-4 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. Table 5.5-5 Personality Measures for Specific Disorders in Children

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 type of personality inventory is used to confirm a diagnosis, but both provide valuable information about the nature and severity of symptoms that can be combined with other approaches to arrive at a diagnosis. Advantages of the specific personality inventories include their brevity, low cost in terms of time to administer, and ease in scoring and interpreting. However, as with similar adult measures, caution should be taken in reviewing the psychometric qualities of these personality measures, particularly with regard to discriminant validity for the disorder under study versus other disorders versus children without disorders.

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 costeffectiveness, and their utility in multitrait–multimethod diagnostic procedures (Table 5.5-6 presents examples of these measures). Table 5.5-6 Behavioral Assessment Procedures for Children

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). 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 selfreport (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.

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