

The MMPI: Decoding Your Personality Structure

Authored by
mohammad looti

June 17, 2026

RECOMMENDED CITATION

mohammad looti (2026). *The MMPI: Decoding Your Personality Structure*.

PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=38589>

The Minnesota Multiphasic Personality Inventory (MMPI) is one of the most frequently used personality tests in mental health. The test is used by trained professionals to assist in identifying personality structure and psychopathology.

History and development

The original authors of the MMPI were Starke R. Hathaway, PhD, and J. C. McKinley, MD. The MMPI is copyrighted by the University of Minnesota. The standardized answer sheets can be hand scored with templates that fit over the answer sheets, but most tests are computer scored. Computer scoring programs for the current standardized version, the MMPI-2, are licensed by the University of Minnesota Press to Pearson Assessments and other companies located in different countries. The computer scoring programs offer a range of scoring profile choices including the extended score report, which includes data on the newest and most psychometrically advanced scales--the Restructured Clinical, & Hathaway, S. R. (1942). A multiphasic personality schedule (Minnesota): IV. Psychasthenia. *Journal of Applied Psychology*, 26, 614-624. The difference between this approach and other test development strategies used around that time was that it was atheoretical (not based on any particular theory) and thus the initial test was not aligned with the prevailing psychodynamic theories of that time. The atheoretical approach to MMPI development ostensibly enabled the test to capture aspects of human psychopathology that were recognizable and meaningful despite changes in clinical theories. However, because the MMPI scales were created based on a group with known psychopathologies, the scales themselves are not atheoretical by way of using the participants' clinical diagnoses to determine the scales' contents.

MMPI-2

The first major revision of the MMPI was the MMPI-2, which was standardized on a new national sample of adults in the United States and released in 1989. It is appropriate for use with adults 18 and over. Subsequent revisions of certain test elements have been published, and a wide variety of subscales was also introduced over many years to help clinicians interpret the results of the original clinical scales, which had been found to contain a general factor that made interpretation of scores on the clinical scales difficult. The current MMPI-2 has 567 items, all true-or-false format, and usually takes between 1 and 2 hours to complete depending on reading level. There is an infrequently used abbreviated form of the test that consists of the MMPI-2's first 370 items. The shorter version has been mainly used in circumstances that have not allowed the full version to be completed (e.g., illness or time pressure), but the scores available on the shorter version are not as extensive as those available in the 567-item version...

MMPI-A

A version of the test designed for adolescents, the MMPI-A, was released in 1992. The MMPI-A has 478 items, with a short form of 350 items.

MMPI-2 RF

A new and psychometrically improved version of the MMPI-2 has recently been developed employing rigorous statistical methods that were used to develop the RC Scales in 2003. The new MMPI-2 Restructured Form (MMPI-2-RF) has now been released by Pearson Assessments. The MMPI-2-RF produces scores on a theoretically grounded, hierarchically structured set of scales, including the RC Scales. The modern methods used to develop the MMPI-2-RF were not available at the time the MMPI was originally developed. The MMPI-2-RF builds on the foundation of the RC Scales, which have been extensively researched since their publication in 2003. Publications on the MMPI-2-RC Scales include book chapters, multiple published articles in peer-reviewed journals, and address the use of the scales in a wide range of settings. The MMPI-2-RF scales rest on an assumption that psychopathology is a homogenous condition that is additive.

Current scale composition

Clinical scales

Scale 1 (AKA the Hypochondriasis Scale) : Measures a person's perception and preoccupation with their health and health issues., Scale 2 (AKA the Depression Scale) : Measures a person's depressive symptoms level., Scale 3 (AKA the Hysteria Scale) : Measures the emotionality of a person., Scale 4 (AKA the Psychopathic Deviate Scale) : Measures a person's need for control or their rebellion against control., Scale 5 (AKA the Femininity/Masculinity Scale) : Measures a stereotype of a person and how they compare. For men it would be the Marlboro man, for women it would be June Cleaver or Donna Reed., Scale 6 (AKA the Paranoia Scale) : Measures a person's inability to trust., Scale 7 (AKA the Psychasthenia Scale) : Measures a person's anxiety levels and tendencies., Scale 8 (AKA the Schizophrenia Scale) : Measures a person's unusual/odd cognitive, perceptual, and emotional experiences, Scale 9 (AKA the Mania Scale) : Measures a person's energy., Scale 0 (AKA the Social Introversion Scale) : Measures whether people enjoy and are comfortable being around other people.

Validity scales

The validity scales in the MMPI-2 RF are minor revisions of those contained in the MMPI-2, which includes three basic types of validity measures: those that were designed to detect non-responding or inconsistent responding (CNS, VRIN, TRIN), those designed to detect when clients are over reporting or exaggerating the prevalence or severity of psychological symptoms (F, Fb, Fp, FBS),

and those designed to detect when test-takers are under-reporting or downplaying psychological symptoms (L, K)). A new addition to the validity scales for the MMPI-2 RF includes an over reporting scale of somatic symptoms scale (Fs).

Content scales

To supplement these multidimensional scales and to assist in interpreting the frequently seen diffuse elevations due to the general factor (removed in the RC scales) were also developed, with the more frequently used being the substance abuse scales (MAC-R, APS, AAS), designed to assess the extent to which a client admits to or is prone to abusing substances, and the A (anxiety) and R (repression) scales, developed by Welsh after conducting a factor analysis of the original MMPI item pool.

PSY-5 scales

Unlike the Content and Supplementary scales, the PSY-5 scales were not developed as a reaction to some actual or perceived shortcoming in the MMPI-2 itself, but rather as an attempt to connect the instrument with more general trend in personality psychology. The five factor model of human personality has gained great acceptance in non-pathological populations, and the PSY-5 scales differ from the 5 factors identified in non-pathological populations in that they were meant to determine the extent to which personality disorders might manifest and be recognizable in clinical populations. The five components were labeled Negative Emotionality (NEGE), Psychoticism (PSYC), Introversion (INTR), Disconstraint (DISC) and Aggressiveness (AGGR).

Scoring and interpretation

Like many standardized tests, scores on the various scales of the MMPI-2 and the MMPI-2-RF are not representative of either percentile rank or how "well" or "poorly" someone has done on the test. Rather, analysis looks at relative elevation of factors compared to the various norm groups studied. Raw scores on the scales are transformed into a standardized metric known as T-scores (Mean or Average equals 50, Standard Deviation equals 10), making interpretation easier for clinicians. Test manufacturers and publishers ask test purchasers to prove they are qualified to purchase the MMPI/MMPI-2/MMPI-2-RF and other tests.

Recent Advancements in the MMPI-2

RC and Clinical Scales

The Restructured Clinical Scales are psychometrically improved versions of the original Clinical

Scales, which were known to contain a high level of interscale correlation, overlapping items, and were confounded by the presence of an overarching factor that has since been extracted and placed in a separate scale (demoralization). The RC scales measure the core constructs of the original clinical scales. Critics of the RC scales assert they have deviated too far from the original clinical scales, the implication being that previous research done on the clinical scales will not be relevant to the interpretation of the RC scales. However, research on the RC scales assert that the RC scales predict pathology in their designated areas better than their concordant original clinical scales while using significantly fewer items and maintaining equal to higher internal consistency reliability and validity; further, unlike the original clinical scales, the RC scales are not saturated with the primary factor (demoralization, now captured in RCdem) which frequently produced diffuse elevations and made interpretation of results difficult; finally, the RC scales have lower interscale correlations and, in contrast to the original clinical scales, contain no interscale item overlap. The effects of removal of the common variance spread across the older clinical scales due to a general factor common to psychopathology, through use of sophisticated psychometric methods were described as a paradigm shift in personality assessment. Critics of the new scales argue that the removal of this common variance makes the RC scales less ecologically valid (less like real life) because real patients tend to present complex patterns of symptoms. However, this issue is addressed by being able to view elevations on other RC scales that are less saturated with the general factor and, therefore, are also more transparent and much easier to interpret.

Addition of the Lees-Haley FBS (Symptom Validity)

The following discussion concerns the Lees-Haley validity scale, FBS. After its addition to MMPI-2 the FBS was renamed "Symptom Validity" to address the concerns that its full name appears prejudicial, although the FBS acronym continues to be used in academic publications to refer to Lees-Haley's scale.

The FBS was developed by psychologist Paul Lees-Haley, who works mainly for defendants (insurance companies etc.) in personal injury cases. The scale was introduced in MMPI after a review of the literature.

One of the critics of the Lees-Haley FBS is retired psychologist James Butcher, who reported that more than 45% of psychiatric patients he studied had FBS scores of 20 or more. These are relatively high scores that suggest symptom exaggeration. While Butcher contends that it is unlikely that so many psychiatric patients intentionally misled their physicians, his study has been criticized by numerous clinical neuropsychologists on methodological and conceptual grounds, including the likelihood that his subject pool included patients who may have had secondary gain motive to feign symptoms, that he ignored recommended gender-related cut-offs, and used a less sensitive or specific MMPI-2 scale as his 'gold-standard.'

An independent professional panel recommended that the Lees-Haley FBS be included in the standard Pearson scoring system.

Several studies by independent Neuropsychologists have since been published in respected peer-reviewed journals supporting the Lees-Haley FBS scale as highly sensitive and specific (when proper cut-offs are used) in identifying individuals who are exaggerating somatic symptoms (as opposed to psychiatric, mood, or neurological symptoms) in settings where the base-rate of malingering is typically high (litigation, pain clinics, etc.), as it was designed to do. The FBS is one of the validity scales that is frequently considered when examining populations with secondary gain motive, particularly disability seeking patients.

In 2008 Butcher and colleagues published a review of the available evidence in Psychological Injury and Law. Ben-Porath and colleagues rebutted the review. Butcher and colleagues have continued to debate the utility of the FBS.