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# Personality Assessment in Forensic Clinical Practice

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## Background

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Personality Disorder is a challenge to define as it describes a wide range of disparate behaviours. A good comprehensive definition comes from Blackburn (1998).

*'Personality disorders are currently defined as enduring patterns of cognition affectivity, interpersonal behaviour and impulse control, that are culturally deviant, pervasive and inflexible and lead to distress or social impairment.'* Blackburn (1998)

A less specific diagnostic definition is provided by the *International Classification of Diseases (ICD)* of the World Health Organisation:

*'Ingrained, maladaptive patterns of cognition and behaviour, recognisable in adolescence or earlier continuing throughout most of adult life, although becoming less obvious in middle or old age.'* World Health Organisation (1992)

The relationship between personality disorder and dangerous behaviour is complex and often indirect. It should be stressed that personality disorder is not a direct cause of anti-social behaviour (or other problems) in any straightforward sense but, rather, may contribute to inappropriate or anti-social activity. A diagnosis of personality disorder is, therefore, rarely sufficient to explain a serious offence (O'Rourke & Hammond, 2001).

In a position paper for the Forensic Clinical Psychology Special Interest Group (Cousins & Bailes, 2000) a review of assessment, treatment and management of personality disorder was presented. This review was almost a decade ago and, in the spirit of reflective practice, it was considered timely for there to be a revisit to the substance of this document. There have been various developments since that time, not least in the change of name from Special Interest Group to Faculty. However, whereas the original document dealt ambitiously with 'assessment, treatment and management', this document focuses upon assessment and more specifically examines psychometric issues. For up-to-date, relevant and applicable guidance on the aetiology, prevalence and psychological interventions relevant to personality disorder, the reader is referred to Alwin et al. (2006).

Safety is at the heart of all good health care. This is particularly important in forensic mental health where issues of risk as well as suitability and amenability to treatment are at their most sensitive and challenging. This framework document is intended to guide psychologists who work in Forensic settings. It sets out a framework of principles that should underpin best practice across all forensic settings. It further provides a list, prepared by Paul Devonshire, of psychometric and other tools that may be used to assist psychologists in assessment and clinical decision making.

In producing this Best Clinical Practice document, we aim to encourage clinical and forensic clinical psychologists to adopt a considered, systematic and evidence-based approach to assessment, measurement and management of people with Personality Disorder.

The focus on psychometrics in this document should not be read as a disavowal of the importance of other aspects of, and strategies in, the assessment process. These are described in greater detail elsewhere (Cohen-Cole & Bird, 2000; Houston, 1998; Vrij, 2000; Morrison, 1995; Hammond & O'Rourke, 2007). We choose merely to concentrate upon a set of procedures that are widely used but increasingly problematic due to an apparent

reluctance to integrate psychometric advances into psychological practice (Borsboom, 2006; Clark, 2006).

As its name suggests, the focus of psychometrics is upon measurement. This is a broad focus and is not, as some psychologists appear to believe, limited to self-report questionnaires or cognitive performance tests. Rather, psychometrics should include any data collection and collation procedure that leads to some form of measure being derived. There are many different strategies for data gathering and the type of test used is often dictated by the theoretical orientation and the imagination of the clinician as much as the nature of the questions being asked. Essentially, most tests can be broadly described under one or more of the following headings:

- Self-report inventories (Millon, 1997);
- Rating Measures (Blackburn & Renwick, 1996);
- Objective Performance tests (Duncan & Ausborn, 2002);
- Idiographic measures (Houston, 1998);
- Biosignal measures (Grubin & Madsen, 2005);
- Implicit Latency measures (Abel et al., 1998);
- Projective tests (Gacono, Evans & Viglione, 2002).

Each of these types of test has a potential place in psychological measurement although it must be recognised that each has its own advantages, limitations and application in forensic clinical practice. The main point to note here is that the underlying psychometric issues are similar, irrespective of the test chosen for clinical practice or research.

It should also be recognised that in the assessment of personality the emphasis has always been upon either self-report or rater judgements. Cousins and Bailes (2000), in drawing up a list of structured assessments currently used in the assessment of personality disorder, cite the Millon Clinical Multi-axial Inventory (MCMI), Millon Adolescent Clinical Inventory (MACI), Minnesota Multiphasic Personality Inventory (MMPI), Special Hospitals Assessment of Personality and Socialisation (SHAPS), the Anti-Social Personality Questionnaire (APQ) and the Psychopathy Checklist – Revised (PCL-R). They also refer to structured interviews such as the Personality Assessment Schedule (PAS) and Structured Clinical Interview for DSM Personality Disorder (SCID). Since that time, personality disorder has also been conceptualised within general personality theory, notably the Big-5 model (Costa & Widiger, 2002) and this relies almost exclusively upon self-report.

While Warren et al. (2003) found a wide variety of assessments used in treatment studies of personality disorder, Milton (2000) in a survey of UK forensic services relating to their admission of personality-disordered offenders, found less than half conducted a formal personality assessment. However, of those that did, ‘the instruments used in the assessment varied widely, addressing personality structure, general health and specific psychological problems such as anger and self-esteem’ (Milton, 2000).

Documents addressing the issue of personality disorder assessment in the UK (Dolan & Coid, 1993; Milton, 2000; McMurrin, 2002; Warren et al., 2003) serve to highlight lack of coherence and consistency within the profession (and between the professions) as to best practice. Nothing obvious changed in the decade between Dolan and Coid (1993) and Warren et al. (2003), and it is difficult to see any radical progress towards the end of another decade.

However, one major development has been the dangerous and severe personality disorder (DSPD) services at sites such as HMP Whitemoor, HMP Frankland, Rampton and Broadmoor. Each DSPD unit produces an Annual Report which details progress made. All tools used in the Assessment for the DSPD treatment have been agreed by the Central DSPD Programme (2008) and are common to all four high secure sites leading to a consistent core for PD assessment. Many of the assessments used at the DSPD sites have already been cited above. However, there have been some concerns raised about the DSPD assessment process (Tyrer et al., 2007).

One potential limitation here is the risk that such a list becomes reified and inflexible in the face of newer and more effective alternatives. The motivation to improve and refine assessments using new and more effective psychometric methods or to update existing devices may be inhibited by the existence of a rigorously imposed list of 'acceptable' assessments. In addition the idea that 'one test battery suits all' may be sub-optimal in some cases where the idiosyncratic needs of a particular patient may counter-indicate some devices within such a battery. So while, the benefits of a consistent core assessment protocol are unquestionable, it behoves the psychologist working with people with personality disorder to be particularly aware of the specific and individual assessment needs of his/her patients.

# The Psychometric Method

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## Assessor competencies

There has been some concern expressed in psychometric circles (Borsboom, 2006; Clark, 2006) that psychological practitioners are reluctant to learn and understand the requisite issues in modern psychometrics and thus optimise their measurement procedures.

However, it is also acknowledged that psychometricians and test developers need to be more responsive to the needs of practitioners in terms of providing clear and accessible guidance for the methods they espouse. What it all boils down to is that practitioners must be able to justify thoughtfully and with actuarial support, their choices when it comes to assessment and this is best done with a good grasp of psychometric technicalities. Such sophistication is all the more vital in a forensic setting where decisions made about the patients can have immediate, dire and lasting consequences.

Basic competencies for testing include the administration, scoring and interpretation of measurement devices. These are fairly mechanical competencies that mostly involve following specific instructions provided by the test publisher. Report writing and feedback of assessments is a further, less mechanical, skill that needs to be taught during training and honed by practice.

However, the decision making that is required in the selection of an assessment protocol requires a reasonably sophisticated understanding of the utility, value and appropriateness of a wide range of devices and methods (Rudner, 1994). This means that the competencies for forensic clinical psychologists need to be quite generalised and should include a willingness to keep up to date with psychometric developments.

Devices such as the PCL-R require specialist training but for many tools there is no necessity for such training provided that the practitioner has a good grasp of psychometric principles (of course, test publishers driven by economic motives may see things slightly differently). A concern may be that an inspection of pre-qualification training might reveal that future forensic clinical psychologists have little formal training in psychometric methodology beyond a few 'rules of thumb' and a very basic grasp of Classical Test Theory. This could leave practitioners vulnerable if ever challenged to demonstrate the basis of their claimed competence.

## Psychometric issues

Although Cousins and Bailes (2000) encouraged consideration of the psychometric properties of tests, there is no guidance of what criteria should be adopted. This is understandable as psychometric properties should be utilised in conjunction with the purpose and context of the assessment. For example, if the assessment requires norm referencing then representative norms are essential, if the assessment is being carried out to evaluate change then some estimate of the test-retest reliability estimate (stability) of the tests being used is needed. While this equivocal position may muddy the water for those wishing clear and precise guidelines, it reflects the reality of multipurpose and multifaceted assessment and it places a burden of self-education and peer supervision

upon the clinician. What is needed is not so much a short checklist of ‘what to look for’ in a test but a clear understanding on the part of the clinician of the measurement issues applying to the case in question.

The term ‘psychometric properties’ covers a wide variety of parameters including the norms and standards, reliability estimates, estimates of measurement error, validity coefficients, model fitting parameters and sensitivity and specificity parameters. This variety of ‘properties’ can be disconcerting and bewildering to the practitioner but, nevertheless, it is important that the accuracy and viability of any assessment tool is clearly understood and is taken into consideration when forming a judgment of an individual assessee.

The salience of some psychometric properties over others will depend upon the use to which a test is being put. For example, if a device is being used to evaluate change it is important to ascertain that it manifests a strong degree of stability or test-retest reliability, otherwise observed changes in a person’s score may be as much a result of random measurement error as the effect of any intervention. On the other hand, if the clinician is seeking a measure of current state or mood the long-term stability of the measure is not important and one might be more interested in examining the internal consistency in order to estimate the reliability of the test score.

Clinicians carrying out assessments on individuals need to be acutely aware of the psychometric properties of the tests they are using in order to:

- locate the individual along the continuum being measured, usually requiring access to test norms and standards;
- determine the error in their allocation of a person’s score, requiring knowledge of the relevant aspects of test reliability; and
- judge whether the test is ‘fit for purpose’, requiring a clear understanding of the validity of the test and its limits.

## ‘Positioning’ the Assessee

Nearly all psychometric tests seek to provide scores that locate an individual upon one or more continua. In order to evaluate whether the person being assessed is ‘low’ or ‘high’ on the continuum in question, it is necessary to compare their score with some form of comparative criteria. Typically, these criteria are in the form of test norms (means and standard deviations drawn from a large representative sample). Occasionally they may take the form of *a priori* ‘cut-off’ scores that discriminate, for example, pathological from non-pathological people. The former approach is known as norm referencing and the latter is often called criterion referencing. The point is that knowledge of a score itself tells us nothing about the individual assessed without some kind of reference point to enable us to make comparative judgement of the individual’s relative position along the continuum in question. Standardised tests provide the means by which individuals can be compared to norms and standards derived from a large representative sample.

The applicability of these norm referenced tests is heavily influenced by the appropriateness of the normative sample used. It is a matter of concern that many tests used in the UK have been normed on US samples because, to use these norms, we have to

assume that our assessee is drawn from the normative population. It is incumbent on the assessor to ascertain that the norms are appropriate for the use to which they will be put. Clearly, a situation in which the assessments may inform decisions regarding disposal or the provision of treatment, places a high burden upon the assessor to justify their interpretation of the scores. This means being au-fait with the normative sample being utilised.

### Measurement error

As well as identifying the extent of the construct being measured the assessor also needs to be aware of the degree of measurement error that applies. All psychological measures are prone to error, some more than others. An immediate indication of the degree of error one can expect in a test is given by the reliability coefficient. There are a number of ways that a reliability coefficient can be estimated but they all essentially summarise some aspect of consistency observed from the interaction of the test with a given sample. For example, the stability or test-retest reliability of a test can be evaluated by assessing the consistency of test scores taken at two time points, the correlation between a sample of scores taken at time one and time two informs the coefficient of reliability or stability. Alternatively, the tester may be interested in the consistency between different parts of the test, also known as internal consistency. In the early days of testing this was evaluated by splitting the test into two halves and correlating the scores from each half. This 'split-half' method has been superseded by a more robust method espoused by Kuder and Richardson (1937) and generalised by Cronbach (1951) which gives the mean of all possible split-halves for a given test. This latter coefficient is often referred to as a KR20 or Cronbach Alpha coefficient.

Other possible ways of estimating reliability depending on the nature of the test and the kind of consistency one is looking for include model fitting techniques (for multifactorial tests) and inter-judge consistency (for tests designed to provide qualitative judgments).

Most forms of the reliability coefficient may be viewed as the squared correlation between the test score and the underlying hypothetical 'true' score. Thus, a reliability coefficient of 0.70 tells us that 30 per cent of the test score variance is unrelated to the hypothetical true score. One might put it that such a test has a 30 per cent potential error, and clearly one would need to interpret a score from this test with a degree of caution. In fact, this is a rather simplistic interpretation because the error of measurement is also a function of the expected spread of the scores as measured by the standard deviation. When evaluating the error in a test score it is conventional to estimate the standard error of measurement (SEM) with the following formula.

$$SEM = \sigma\sqrt{(1-r_{tt})}$$

$\sigma$  = Standard Deviation  $r_{tt}$  = Reliability Coefficient

Thus when reporting a test score it is important to take on board the fact that tests with low reliabilities only give a vague indication of the assessee's position along the continuum. The greater the SEM the less accurate the test score so the lower the confidence we should have in their position on the score continuum.

The SEM must be seen as a function of the test and not the individual and this itself poses problems. Thus, a more refined approach to measurement error would be to try to obtain error terms for each individual independently (Lord & Novick, 1968). This cannot be easily

done when we use tests developed in the traditional manner using Classical Test Theory. Currently, most tests in use in personality assessment are developed this way, however there is a growing awareness of the limitation of this approach and the diligent clinician needs to be increasingly aware of new paradigms in psychometrics such as those built around Item Response Theory (IRT) (Embretson & Hershberge, 1999; van der Linden & Hambleton, 1996). Briefly, this approach is concerned less with the resulting test score as with the item response profile that each individual generates. In this way finer discrimination between people can be made and individual SEM parameters can be identified.

Of course, it should be recognised that forensic clinical psychologists do not generally base their judgements upon one test score and there is typically a pattern of scores to take into account as well as a great deal of collateral information. While this may reduce distorted decision making brought about by one or two unreliable tests, it is important to realise that poor reliability does make assessments sub-optimal. Accurate measurement is a prerequisite for evidence-based practice and is essential to NSF standards, Human Rights and, of course, our Code of Ethics.

The take home message here is that the test user has a responsibility to develop the sophistication and skills required to apply modern psychometric methods to the assessment context. These skills need to be sufficiently well rooted to enable the clinician to make flexible, defensible and informed choices on the utility of the methods and devices they choose to carry out an assessment. There is a burden of responsibility on trainers and accreditation boards to emphasise the need for rigorous basic training in psychometric theory and procedures.

## **Fit for Purpose?**

Psychometric tests are used for a wide range of reasons and while some are particularly good for one purpose they may be inadequate for another. There is really no blanket test for all purposes although it is clear that clinicians will have 'favourites' that they use a lot based upon their experience and training. However, the clinician involved in psychometric assessment in a forensic clinical context needs to maintain a breadth and generality of expertise in order to tailor their assessment to the individual's needs.

This means that they must be able to critically evaluate whether a particular test is fit for purpose. A simple example, as mentioned above, is the case where a test is required to evaluate change following an intervention. Here, it is necessary to identify one that has a well established stability or test-retest reliability. In this way any changes that are observed are likely to be the result of real change and not just fluctuations due to error in the measurement.

Some tests are designed to position the respondent within a particular model of personality or interpersonal functioning. An example of the latter is the CIRCLE of Blackburn and Renwick (1996) that seeks to place an individual within the interpersonal circumplex space. While it may not be necessary to buy into the underlying model completely to gain useful insights from this test, it is implicit that the model has explanatory meaning in the assessment. This is also true of some multifactoral tests such as the Millon Multiaxial measures (Millon, 1997) or the SCID (Steinberg, 1994).

Another consideration that is important to bear in mind is the fact that many psychometric tests are based upon self-report. McMurran (2002) questions the accuracy of self report measures claiming that they are inaccurate primarily because of symptom over-reporting. However, there may also be cases in forensic settings where the inaccuracy moves the other way where assesses attempt to 'fake good'. It should be clear that interviews are also predicated upon self-report and the same limitations apply to structured interviews as to questionnaires. Clearly, in the assessment of non-compliant and unwilling people this poses severe problems. Many self-report tests will include so called 'validity' scales to tap fallacious responding but these scales are often easily foiled or context specific (Piedmont et al., 2000; Edens & Ruiz, 2006).

Another option is to utilise measures that do not rely entirely on self report. These may be in the form of a mixture of interview and patient history (Hare, 1989), rating scales in which others rate the behaviour of the person being assessed examples here may be the CIRCLE (Blackburn & Renwick, 1996) or the LAPS (Leahy, 2007) among others. Alternatively, it may be possible to use performance tasks (Gray et al., 2003; McLoughlin, 2003), implicit latency measures (Abel et al., 1998; Kalmus & Beech, 2005) or biosignal responding (Staunton, Hammond & Lambert, 2008) for particular characteristics. Irrespective of the means of data collection the same psychometric requirements relating to measurement error still hold.

## **Categorical vs. Dimensional Measurements**

Although it is widely accepted that personality attributes are dimensional rather than categorical, demand for unequivocal decisions in the forensic context feed a need to provide categorical judgements (Widiger et al., 2007; Krueger et al., 2007). Given that almost all psychological measures result in continuous scores, it is either necessary to set some thresholds that act as criteria for categorisation, or to refute the use of categorical judgments robustly. Unfortunately, the latter course is unlikely to take precedence over practical requirements of the forensic services. Thus, in specialist services for personality disorder, it may be necessary to establish categorising criteria that have some real and practical meaning (Westen, 1997).

The categorisation of continuous scores is a common strategy in clinical assessment. For example, an individual may be classified as a psychopath if s/he has a PCL-R score greater than 30 (Hare, 1991) or 25 (Rice & Harris, 1995), or 23 if you are in Brazil (Morana, Arboleda-Flórez & Câmara, 2003). However, it should be recognised that this categorising technique has grave limits because it is based on a number of implicit assumptions.

First is the assumption that the use of a particular criterion score differentiates individuals into qualitatively different classes of people. Second, the assumption is made that those individuals above and below the criterion score are sufficiently homogenous to justify the use of a shared descriptive label (e.g. Psychopath and Non-Psychopath). Finally, following on from the first two assumptions is the assumption that the scores are arrived at by a cumulative function (Hammond, Hare & O'Rourke, 2005). This carries the 'knock-on' expectation that a person's score should enable the assessor to reliably predict the profile of item responses or symptom endorsements that the person in question has made (Hammond & O'Rourke, 2004). This leads to the suggestion (Hammond, 1998) that in order to use categorising 'cut-off' scores, tests should conform to strong cumulative

psychometric models such as the Mokken's Double Monotonicity Model (Molenaar, 1996) or Rasch's probabilistic model (Bond & Fox, 2001).

The fact that a test may have excellent psychometric properties in terms of measurement error, internal consistency and stability does not mean that it is safe to assume it may be used for categorising respondents. One possible strategy is to make use of the test information function which is the point of maximum discrimination for a test score but this is not generally made available unless an IRT analysis has been carried out on the test (Embretson & Reise, 2000; Cooke & Michie, 1997). Typically, this kind of sophisticated modelling of personality measures is not carried out and the practitioner is often working with measures that rely at best on sample-dependent criteria or, at worst, on arbitrary criteria developed using the test developer's best judgement. It should be clear that the use of categorisation criteria is a fairly technical issue and there is a pressing need to look at it closely in order to identify a defensible best practice for each device in which it is used.

## Choosing a Test

All this leads us to the question of how are we to make choices between the wide variety of tests on offer. Cousins and Bailes (2000) state that *'instruments designed for the structured assessment of personality traits and disorders should be carefully selected for their relevance to the treatment and management needs of individual clients. Only instruments that have a good history of application in clinical settings and with established and well-documented psychometric properties should be considered for use.'* This is good advice but as we have seen this is a more complex issue than it first appears. In the Appendix of this paper, Paul Devonshire has collated a list of available assessment devices useful in the assessment of Personality Disorder. However, it remains up to each individual clinician to make the most informed choice they can regarding the test's suitability for the purpose intended. Nevertheless, there are a number of steps that may help make the choice of test defensible.

**Step 1:** Check the test manual. It should contain details of the size and make-up of the normative sample as well as estimates of reliability, both internal consistency and stability. Tools with sparse manuals that do not provide this basic information should be immediately considered suspect. In addition, details of any validation studies should be reported to allow you to check that the construct in question dovetails with your own understanding of its meaning. These studies may involve concurrent validation evidence revealing the correlates of the test. They may address construct validation often by use of factor analysis or structured equation modeling. For tools that purport to be predictive of some specific outcome (i.e. re-offending) you would reasonably expect predictive validity data to be presented. Use of a psychometric device for decision support purposes that does not have a good evidence base should be considered professionally indefensible.

**Step 2:** Ascertain that the normative sample may be applicable to the case you are assessing. If a widely used test only has norms based upon US samples it may be tempting to still use it. There may be very little wrong with such norms in research where aggregated scores are used but we must take great care when applying such norms to an individual patient. The clinician should be able to justify the use of a particular set of norms in locating an individual along the continuum in question because the implications of any interpretation of the scores obtained may be life altering.

**Step 3:** Read the test carefully and ascertain that the meaning of the items is clear and unequivocal. It is often said that the UK and US are divided by a common language. Terms and phrases do have different connotations across countries and across time. For example, one of the extraversion items in the early Eysenck Personality Inventory asked respondents whether they enjoyed gay parties, today such a question might be used to help gauge sexual orientation rather than extraversion.

**Step 4:** It is a good practice is to submit yourself to the test before choosing it. In this way you will be able to detect any anomalies in the wording and instructions of the test. This will also enable you to judge the amount of effort and time you are asking of your respondent.

**Step 5:** Match the psychometric information in the test manual to your specific assessment needs. You will need a clear idea of the purpose of your assessment (e.g. admission screening, treatability assessment, assessing change, informing custody decisions, supporting diagnosis, etc.). Each of these may place a different weight on the psychometric parameters reported by the test developers.

Choice of a psychometric test should be a complex and multi-faceted decision, it is no longer enough to grab a test from the test library shelf on the basis that it purports to measure something approximating to the construct you have in mind. It is now vital that considered and educated choices are made, This is not only because there are a great many tests in existence that have marginal value at best, but also because decisions supported by psychometric tests can have life changing repercussions for our patients.

Of course, Clinicians and Practitioners should never rely solely on psychometric tests for clinical decision making in any context. Best practice dictates that we must utilise a number of assessment strategies in Forensic Practice. The next section provides some guidance on ‘widening the lens’ when assessing people with personality disorder.

# Best Clinical Practice: Widening the Lens

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Reviews of the literature highlight the essential characteristics of good assessment (Melton et al., 1997; Doyle & Dolan, 2002; McMurrin 2002; McDermut & Zimmerman, 2005; Archer, 2006) provide a reasonably consistent view of the characteristics of good assessment. Here we summarise briefly in five areas the main features of good assessment practice for forensic clinical psychology.

## 1. Utilise multiple sources of information

Good assessments are comprehensive and use multiple sources for information. A combination of self-report instruments and semi-structured interview and third-party reports is recommended as good practice in Personality Disorder assessment (Alwin et al., 2006). Sources of information may include:

- Comprehensive Histories, Chronologies and Case notes;
- Comprehensive clinical interview (Holistic, BioPsychosocial assessment);
- Third-party reports (Hospital Records, GP Records, Psychiatric Reports, Case Notes, Criminal Records, Police Reports, Victim Statements, Family Inputs);
- Direct behavioural observation;
- Self- and Family-Reports;
- Psychometric testing.

Information sources are evaluated in themselves and can be explored through clinical interview.

## 2. Informed by a defensible model

Secondly, good assessment should be informed by a defensible explanatory model. One such is the biopsychosocial model (Frankel & Dalenberg, 2006; Borrell-Carrió, Suchman & Epstein, 2004; Bloom, 2007). In this framework patients are assessed in terms of Biological (neurological and physiological), Psychological (cognitive and emotional), Social (interpersonal, family, friends) and Clinical factors in addition to any relevant contextual factors (Finances, housing, etc.) (O'Rourke et al., 2003). Patients also need to be assessed for their specific risk and need features as well as for responsivity (their response learning style to service inputs, treatment, management, etc.) and previous response to treatment and/or care (O'Rourke & Hammond, 2004).

## 3. Collaboration with subject

Thirdly, effective assessment recognises that the quality of self-report varies with internal motivation(s) with mood state, and with anticipated consequences of disclosure (Boccaccini, 2007; Heilbrun, 1992; Melton et al, 1997). Building positive, collaborative and reassuring relationships is an essential part of any assessment formulation process.

## 4. Recognise the dynamic and ongoing nature of assessment

Assessment should be ongoing and it should be appreciated that its quality improves over time. People with Personality Disorder invariably have multiple needs and vulnerabilities, and have difficulties with trust and thus reveal things only when rapport has been well established. It will be noted that there may be a tension between the forensic and clinical

role here in that assessments for the court are essentially time limited and are not subject to modification and development after the assessment report has been submitted. Where the assessment focus has been for therapeutic purposes a longer term and more flexible strategy may be adopted (Melton et al., 1997; Archer, 2006).

## **5. Communication**

Finally, good quality assessment is achieved through accurate, complete and communicated records, which are regularly, updated and reviewed. Good assessment (tools, records, systems) is the bridge to close the gap between problem identification, solution finding and effective outcomes (O'Rourke et al., 2003).

## **Service Users input**

There is an ongoing need for research to increase understanding of Personality Disorders. Good quality assessment is essential to inform such research as well as the provision of effective treatment based on client needs. Personality Disorder is a problem that affects individuals across the lifecycle; to identify problems accurately and early, good communication with service users and between agencies is essential (Rigby & Longford, 2004; Alwin et al., 2006; Huband & Duggan, 2007).

Our approach to comprehensive evidence-based assessment and formulation of personality disorder is founded on the principle that people with personality disorders (whatever the nature) should be treated in the same way as people with any other illness or medical conditions. This view is supported by the Department of Health, the Royal Colleges and Mental Health charities.

There is every reason to view personality disorder primarily as cognitions and behaviour(s) that respond to the same psychological principles that govern behaviour problems more generally. For example, outcome after specialist treatment for anger, depression or substance use problems is strongly driven by post adjustment factors such as social support, housing and environment factors.

Care and treatment needs should be properly assessed and wherever possible provided with the full co-operation and agreement of the service user and his/her significant others (family and carers). The next section provides a description of personality assessment of offenders with intellectual disabilities where fully informed compliance may be less easy to obtain.

# Assessment of personality disorder in offenders with intellectual disabilities

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The reported prevalence of personality disorder in offenders with intellectual disabilities has varied widely depending on the study samples and procedures used (e.g. Alexander & Cooray, 2003; Cooper et al., 2007). Lindsay (2007) made several recommendations in considering the nature of personality disorder in this client group, including: (a) greater use of behavioural observation and informant information to make diagnostic classifications; and (b) greater awareness of a number of cultural factors affecting the diagnosis of personality disorder in these clients. For example, people with intellectual disabilities have often lived more restricted lives than those in the mainstream population and consequently have less opportunity to experience a range of social and sexual relationships which, in turn, may have hindered personality development. This is likely to be true for a large section of this population and, therefore, one must take into account cultural norms in making a diagnosis of personality disorder.

Similarly, Lindsay (2007) notes that other contextual factors such as higher levels of suggestibility, lower levels of occupational activity, and higher levels of required dependency need to be considered when making a personality disorder diagnosis in people with intellectual disabilities.

Personality disorder has relevance for offenders with intellectual disabilities as it is associated with their risk for violence and recurrent offending behaviour (e.g. Alexander et al., 2006; Lidher et al., 2005). In a large multi-centre study, Lindsay et al. (2006) compared rates of personality disorder in offenders with intellectual disabilities in community, low/medium secure and high secure settings using *DSM-IV* criteria (American Psychiatric Association, 1994). The reliability between independent raters was generally over 80 per cent. *DSM-IV* diagnoses were made on the basis of four information sources: file review, interview with clinician, observations by care staff and Structured Assessment of Personality interview (SAP; Pilgrim & Mann 1990). The prevalence of personality disorder across the study population was 39 per cent. Perhaps unsurprisingly, anti-social personality disorder (APD) was the most frequently diagnosed personality disorder (22.1 per cent) and significantly more individuals were diagnosed with APD in the high secure setting than in the other two settings. These authors also found that when data for the three groups was combined, the occurrence of personality disorder was positively associated with the assessed risk for violence using the Violence Risk Appraisal Guide (VRAG; Quinsey et al., 1998). Lindsay et al. (2006) concluded that the assessment and diagnosis of personality disorder in this client group was reliable and valid. The assessment data followed similar patterns to those seen in mainstream offender populations, and the presence of personality disorder was not associated with measured IQ. Furthermore, there were no diagnoses of Dependent personality disorder reported which might have been anticipated given the study group's developmental delay.

Evaluating data from the same study groups, Hogue et al. (2006) reported that *ICD-10* personality disorder classifications (World Health Organisation, 1992) presented in a manner consistent with that reported by Lindsay et al. (2006), with participants from high

security settings having a higher rate of diagnosis than participants from the other two settings. In addition, having an *ICD-10* Dissocial personality diagnosis was a significant predictor of level of security. These findings support the proposal that assessment and identification of personality disorder in this client group can be helpful in predicting and managing risk.

As discussed elsewhere, it could be argued that the Psychopathy Checklist – Revised (PCL-R; Hare, 1991) does not assess a discrete personality disorder – rather a construct relating to severe personality dysfunction characterised by a constellation of affective, interpersonal and behavioural features associated with forensic risk in adult male offenders (Cooke & Michie, 2001). Recently, Morrissey and colleagues (Morrissey et al., 2005, 2007a, 2007b) have investigated the utility, discriminant and predictive validity of the PCL-R in male adult offenders with intellectual disabilities and found that it predicts both response to treatment and transition from high to medium secure conditions, both within two years of assessment. However, it did not reliably predict institutional violence.

In summary, there are now a number of studies, using a range of assessment measures, some of which have been developed or modified for use with this client group, which are promising in terms of their utility and validity in the assessment of personality disorder and psychopathy in offenders with intellectual disabilities.

# A short guide to writing reports

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Report writing tends to be a matter of personal style. But in the interests of clarity and professionalism we suggest that any report should contain at a minimum, the following four sections: (These have been adapted from Zucherman, 1995.)

1. Introduction to the report.
2. The person in the evaluation.
3. The person in his/her environment.
4. Summary, Diagnostic statements, closing remarks.

## **Introduction to the report**

This section should cover: Basic information, demographics, relevant background history and details, source and reason for referral and report. Some statements regarding sources of information used.

## **The person in the evaluation**

This section should describe the person's response to all aspects of the evaluation for example interview, questions and testing. His/her presentation of self physically, behaviourally, emotionally. Mental state at interview. Abnormal symptoms and personality presentation.

## **The person in his/her environment**

Activities, daily living, work, leisure, social networks, interpersonal functioning, family relationships, academic training and employment history, offending history and Index offence, current functioning, skills and deficits, resources.

## **Summary, Diagnostic statements, closing remarks**

Formulation/Diagnostic statements, summary, cardinal features, prognosis, recommendations, action points, any referral onwards, review arrangements.

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## Appendix: Personality Assessment Tools currently available

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The assessment tools presented below are in an alphabetical order based upon the full title rather than the initials, meaning that the *SNAP* appears before the *SHAPS*. It is hoped that this will not lead to confusion or irritation.

### Anti-social Personality Questionnaire (APQ)

Blackburn, R. & Fawcett, D. (1999). The Anti-social Personality Questionnaire: An inventory for assessment of personality deviation in offender populations. *European Journal of Psychological Assessment*, 15, 14–24.

This self-report measure is an updated version of the Special Hospitals Assessment of Personality and Socialisation (SHAPS), which in turn was derived from the MMPI. There are 125 items requiring 'Yes/No' responses, 'to facilitate administration to patients of low intelligence'. If 12 items are omitted, the result is considered invalid. The standardisation sample comprised Total  $N = 737$ , Patients = 499 (Mentally ill = 90, Personality disorder = 38), Normals = 238. There are eight basic dimensions and two higher order factors.

Scale Title	No. of items	Cronbach's $\alpha$
Self-control (SC)	20	0.81
Self-esteem (SE)	18	0.87
Avoidance (A)	16	0.86
Paranoid suspicion (PS)	17	0.86
Resentment (R)	19	0.81
Aggresssion (AG)	20	0.77
Deviance (DE)	20	0.79
Extraversion (EX)	20	0.79

Higher order factors

*Factor 1* – Impulsivity and Hostile beliefs vs. Control and Conformity.

*Factor 2* – Avoidance, Poor self-esteem (+) vs Extraversion (-).

The authors claim that the APQ Scales 'may aid the formulation or functional analysis of an individual's problems, identify targets for intervention, such as social anxiety or hostile attributions, provide a baseline against which to evaluate change, and contribute to the prediction of future behaviour.'

### California Personality Inventory (CPI)

This inventory has 462 items with a True/False format. This produces 20 scales and four vectors. The content is based upon self-confessed 'folk concepts' and the inventory is for diagnosing and understanding interpersonal behaviour with a normal population.

According to Bolton (1992) in the *11th Mental Measurements Yearbook*, 'CPI is an excellent normal personality assessment device, more reliable than the manual advertises, with good normative data and outstanding interpretative information.' The validity checks are supplied by the following scales: 'Well-Being' (faking bad), 'Good Impression' (faking bad), and 'Communality' (Highly popular answers).

Scale	Title	Factor	
1	Dominance (Do)	1	Interpersonal effectiveness, style and adequacy
2	Capacity for status	1	
3	Sociability (Sy)	1	
4	Social Presence (Sp)	1	
5	Self Acceptance (Sa)	1	
6	Independence (In)	1	
7	Empathy (Em)	1	
8	Responsibility (Re)	2	Interpersonal controls, values styles and beliefs
9	Socialisation (So)	2	
10	Self-Control (Sc)	2	
11	Good Impression (Gi)	2	
12	Communality (Cm)	2	
13	Sense of Well-Being (Wb)	2	
14	Tolerance (To)	2	
15	Achievement via Conformance (Ac)	3	Intellectual stance, achievement and academic ability
16	Achievement via Independence (Ai)	3	
17	Intellectual Efficiency (Ie)	3	
18	Psychological-Mindedness	4	Conceptual interests
19	Flexibility (Fx)	4	
20	Femininity/masculinity (F/M)	4	

## Cattell's Sixteen Personality Factors (16PF)

One-hundred-and-eighty-five multiple-choice, yielding 16 bipolar dimensions, five global factors and three validity scales, based upon Cattell's factor analytic studies with a trait theory tradition.

Factor	Dimension		
A	Warmth	Reserved	vs. Warmth
B	Reasoning	Concrete	vs. Abstract
C	Emotional Stability	Reactive	vs. Emotionally Stable
E	Dominance	Deferential	vs. Dominant
F	Liveliness	Serious	vs. Lively
G	Rule-Consciousness	Expedient	vs. Rule-Conscious
H	Social Boldness	Shy	vs. Socially Bold
I	Sensitivity	Utilitarian	vs. Sensitive
L	Vigilance	Trusting	vs. Vigilant
M	Abstractness	Grounded	vs. Abstracted
N	Privateness	Forthright	vs. Private
O	Apprehension	Self-Assure	vs. Apprehensive
Q1	Openness to change	Traditional	vs. Open to Change
Q2	Self-Reliance	Group-Oriented	vs. Self-Reliant
Q3	Perfectionism	Tolerates Disorder	vs. Perfectionistic
Q4	Tension	Relaxed	vs. Tense
	<b>Global Factors</b>		
	Extraversion		
	Anxiety		
	Tough-Mindedness		
	Independence		
	Self-Control		
	<b>Validity Scales</b>		
	Impression management		
	Infrequency		
	Acquiescence		

## Chart of Interpersonal Reactions in Closed Living Environments (CIRCLE)

Two independent raters evaluate a patient's behaviour on eight scales (0 = Not at all, 1 = Occasionally, 2 = Fairly often, 3 = Usually, or frequently), the scores then being summed. This is based upon the raters' knowledge of the patients rather than following doing any particular tasks.

Scale Title	No. of items	Cronbach $\alpha$
Dominant (DOM)	5	.87
Coercive (COER)	8	.87
Hostile (HOST)	8	.84
Withdrawn (WITH)	4	.79
Submissive (SUB)	4	.49
Compliant (COMP)	5	.85
Nurturant (NURT)	9	.83
Gregarious (GREG)	5	.83

The authors make the following observation: 'As measures of maladaptive interpersonal style, CIRCLE scales may be particularly relevant to the evaluation of personality disorders.'

## Coolidge Axis II Inventory (CATI)

This is a 225-item self-report measure in a statements format with responses on a four-point Likert-type scale (Strongly false = 1 > Strongly true = 4). Its measures include all 10 of the *DSM-IV* personality disorders, together with two from the Appendix (depressive and passive-aggressive) and two from the *DSM-III-R* (self-defeating and sadistic).

In addition to this, it offers measures on the Axis I disorders as well as neurological dysfunction (including dysexecutive functions).

There is a parallel form for use by other informants.

## Diagnostic Interview for Personality Disorders (DIPD)

'Semi-structured interview designed to assess the presence or absence of each of the 11 Axis II disorders described in *DSM-III*.' There are 11 sections each of which explicitly inquires about the *DSM-III* criteria for each of the 11 forms of personality disorder. There are provided 252 questions to assess the presence of the 90 inclusion criteria for the Axis II disorders. Each criterion is scored 2 – Present and definitely clinically significant, 1 – Present and probably clinically significant, and 0 – Absent or clinically insignificant. It is for use with 18 years plus and takes 60 to 90 minutes to administer.

Inter-rater reliability:  $k = 1.0$  for Anti-social  $\rightarrow k = .86$  for Schizotypal.

Test-Retest:  $k = .85$  for Borderline  $\rightarrow k = .46$  for Passive-Aggressive.

## Dimensional Assessment of Personality Pathology (DAPP)

### Edward's Personal Preference Schedule (EPPS)

This is a forced choice, objective, non-projective personality inventory, derived from the personality theory of H.A. Murray. It measures the rating of individuals in 15 normal needs or motives. For each scale there are nine statements, with Social Desirability ratings made for each item.

Scale	Description – A need to...
Achievement	...accomplish task well
Deference	...conform to customs and defer to others
Order	...plan well and be organised
Exhibition	...be the centre of attention in a group
Autonomy	...free of responsibilities and obligations
Affiliation	...form strong friendships and attachments
Intracception	...analyse behaviours and feeling of others
Succorance	...receive support and attention from others
Dominance	...be a leader and influence others
Abasement	...accept blame for problems and confess errors to others
Nurturance	...be of assistance to others
Change	
Endurance	...follow through on tasks and complete assignments
Heterosexuality	...be associated with and attractive to members of the opposite sex
Aggression	...express one's opinion and be critical of others

### Eysenck Personality Inventory (EPI)

Two dimensions, Neuroticism and Extraversion, and a Lie Scale.

### Eysenck's Personality Questionnaire (EPQ)

Three dimensions: Psychoticism, Extraversion and Neuroticism, together with a Lie Scale.

### International Personality Disorder Examination (IPDE)

'Prescribed set of carefully selected and researched questions, the examiner is expected to conduct an adequate clinical examination of the subject to provide clarification and confirmatory examples, anecdotes and details.' There are 157 items to match both *DSM-III-R* and *ICD-10* diagnostic categories, which are scored 0 = In normal range, 1 = present to an accentuated degree, 2 = Pathological/meets criterion. The item needs to have been present for the past five years.

<b>DSM-III-R</b>	<b>ICD-10</b>
Paranoid	Paranoid
Schizoid	Schizoid
Schizotypal	Dissocial
Obsessive Compulsive	Emotionally unstable
Histrionic	Impulsive
Dependent	Borderline
Anti-social	Histrionic
Narcissistic	Anankastic
Avoidant	Anxious
Borderline	Dependent
Passive-Aggressive	
Sadistic	
Self-Defeating	

## **Inventory of Interpersonal Problems**

‘Based upon decades of factor analytic research with both clinical and normal populations. The five domains measured in the instrument provide a clear and concise description summarising an individual’s emotions, interpersonal, experiential, attitudinal and motivational styles’. One-hundred-and-twenty-seven items claiming to address a comprehensive list of interpersonal problems in six scales. Five-point scale: 0 = not distressed at all by this problem to 4 = extremely distressed by this problem. Self-report and third person versions.

<b>Scale</b>
Hard to be assertive
Hard to be sociable
Hard to be intimate
Hard to be submissive
Too responsible
Too controlling

## **Inventory of Interpersonal Problems – 64 (IIP-64)**

Sixty-four-item version with eight circumplex scales corresponding to the eight octants of the Interpersonal Circle.

## **Karolinska Scales of Personality**

One-hundred-and-thirty-five items scored on a four-point Likert scale (1 = Does not apply at all to 4 = Applies completely), grouped into 15 scales.

Scale	No. of items
Psychic anxiety	10
Somatic anxiety	10
Muscular anxiety	10
Psychasthenia (lack of energy)	10
Inhibition of aggression (lack of assertiveness)	10
Detachment (distance)	10
Impulsiveness	10
Monotony avoidance (sensation-seeking)	10
Socialisation	5
Indirect aggression	5
Verbal aggression	5
Irritability	5
Suspicion	5
Guilt	5
Social desirability	10

### Millon Clinical Multiaxial Inventory-III – (MCM-III)

One-hundred-and-seventy-five items in True/False format, producing scores on 24 clinical scales. There is also a Validity Scale together with three Modifying Indices: ‘Disclosure’, ‘Desirability’ and ‘Debasement’.

Clinical Personality Patterns	Clinical Syndromes
Schizoid	Anxiety
Avoidant	Somatoform
Depressive	Bipolar-manic
Histrionic	Dysthymia
Narcissistic	Alcohol Dependence
Anti-social	Drug Dependence
Aggressive (Sadistic)	PTSD
Compulsive	
Passive-Aggressive (Negativistic)	<b>Severe Clinical Syndromes</b>
Self-defeating (Masochistic)	Thought Disorder
Major Depression	
<b>Severe Personality Pathology</b>	Delusional Disorder
Schizotypal	
Borderline	
Paranoid	

## Minnesota Multiphasic Personality Inventory-Revised

This has 567 items answered in a True/False format. There are 10 main 'clinical' scales, three validity scales, and many more subsidiary scales. The interpretation is generally conducted on the profile of the resulting results rather than on the basis of scores on individual scales, using a two- or three-point system with the highest scales in the profile. The scales were originally intended to measure symptomatology along particular dimensions, but results were found to correlate with other psychological descriptions.

Scale	Scale Title
L	Lie
F	Infrequency
K	Correction
Hs (+ .5K)	Hypochondriasis
D	Depression
Hy	Conversion Hysteria
Pd (+ .4K)	Psychopathic Deviate
Mf	Masculinity-Femininity
Pa	Paranoia
Pt (+ 1K)	Psychasthenia
Sc (+ 1K)	Schizophrenia
Ma (+ .2)	Hypomania
Si	Social Introversion

## Multidimensional Personality Questionnaire (MPQ)

Composed of 276 items, most of which are answered True/False. There are 18 scales, 11 primary trait dimensions, four broad trait scales, and three scales as validity indicators – ‘Unlikely Virtues’ (UV), ‘True Response Inconsistency’ (TRIN) and ‘Variable Response Inconsistency’ (VRIN).

Primary Trait	Low scorers say	High scorers say
Well-Being (WB)	I am seldom really happy	I am a happy person
Social Potency (SP)	On social occasion, I like to stay in the background	I like to take charge of things
Achievement (AC)	I usually work hard enough just to get by	I like to put in long hours to accomplish something
Social Closeness (SC)	I would be happy to live alone	I prefer living with other people than living alone
Stress Reaction (SR)	I seldom get worried	I easily get upset
Alienation (AL)	People treat me fairly	Life has given me a raw deal
Aggression (AG)	I prefer to turn the other cheek	If someone crosses me, I will let them know about it
Control vs Impulsivity (CON)	I usually act before thinking	I like to have detailed plans before doing something
Harm Avoidance vs. Danger Seeking (HA)	I like to do something dangerous just of the thrill of it	I prefer to remain safe and sound in most things
Traditionalism (TR)	Traditional values of obedience and morality need to be rethought	People should have more respect for authority than they do
Absorption (AB)	Music never reminds me of colours, smells or sights	I can lose contact with reality watching a beautiful sunset
‘Broad’ Trait		Description
Positive Emotional Temperament (PEM)		High end: ‘extraverted’ temperament traits conducive to joy, excitement and vigour. Low end: joylessness and loss of interest. Associated with WB, SP and AC.
Negative Emotional Temperament (NEM)		High end: proneness to experience anxiety, anger and other negative emotions. Low end: phlegmatic temperament. Associated with SR, AL and AG.
Constraint (CON)		High end: tendency to inhibit and restrain impulse expression, risk-taking and unconventionality. Low end: the opposite. Associated with CO, HA and TR.
Absorption (ABS)		Openness to wide array of absorbing and self-involving sensory experiences.

## Neuroticism, Extraversion, Openness Personality Inventory-Revised (NEO PI-R)

‘Based on decades of factor analytic research with both clinical and normal populations. The five domains measured in the instrument provide a clear and concise description summarising an individual’s emotional, interpersonal, experiential, attitudinal and motivational styles.’

Two-hundred-and-forty items scored on a five-point scale on five factors each with five facets. As well as a self-report version, there is also a version for completion by a third party.

<b>Factor</b>	<b>Facets</b>
Neuroticism (N)	N1 Anxiety
	N2 Angry Hostility
	N3 Depression
	N4 Self-Consciousness
	N5 Impulsiveness
	N6 Vulnerability
Extraversion (E)	E1 Warmth
	E2 Gregariousness
	E3 Assertiveness
	E4 Activity
	E5 Excitement-Seeking
	E6 Positive Emotions
Openness (O)	O1 Fantasy
	O2 Aesthetics
	O3 Feelings
	O4 Actions
	O5 Ideas
	O6 Values
Agreeableness (A)	A1 Trust
	A2 Straightforwardness
	A3 Altruism
	A4 Compliance
	A5 Modesty
	A6 Tender-mindedness
Conscientiousness (C)	C1 Competence
	C2 Order
	C3 Dutifulness
	C4 Achievement Striving
	C5 Self-Discipline
	C6 Deliberation

## Personality Assessment Inventory (PAI)

A self-report inventory of adult psychopathology. Three-hundred-and-forty-four items scored on four-point ordinal scale, yielding four validity scales, 11 clinical scales, five treatment scales and two interpersonal scales.

Scales	Title
<i>Validity</i>	Inconsistency
	Infrequency
	Negative Impression
	Positive Impression
<i>Clinical</i>	<i>Somatic Complaints</i> Conversion Somatisation Health Concerns
	<i>Anxiety</i> Cognitive Affective Physiological
	<i>Anxiety-Related Disorders</i> Obsessive-compulsive Phobias Traumatic stress
	<i>Depression</i> Cognitive Affective Physiological
	<i>Mania</i> Activity level Grandiosity Irritability
	<i>Paranoia</i> Hypervigilance Persecution Resentment

Scales	Title
	<i>Schizophrenia</i> Psychotic experiences Social detachment Thought disorder
	<i>Borderline Features</i> Affective instability Identity problems Negative relationships
	<i>Anti-social Features</i> Anti-social behaviours Egocentricity Stimulus-seeking
	<i>Alcohol Problems</i>
	<i>Drug Problems</i>
<i>Treatment</i>	<i>Aggression</i> Aggression attitude Verbal aggression Physical aggression
	<i>Suicidal Ideation</i>
	<i>Stress</i>
	<i>Non-support</i>
	<i>Treatment Rejection</i>
<i>Interpersonal</i>	<i>Dominance</i>
	<i>Warmth</i>

## Personality Assessment Schedule (PAS)

Twenty-four personality attributes are introduced to the patient or informant with one or two obligatory questions and further questions are asked to elucidate the replies, with a nine-point scale evaluation.

Personality attribute	Inter-rater reliability
Worthlessness	.91
Shyness	.90
Hypochondriasis	.85
Irresponsibility	.84
Dependency	.84
Lability	.82
Anxiousness	.82
Conscientiousness	.82
Suspiciousness	.80
Sensitivity	.79
Vulnerability	.77
Pessimism	.77
Aggression	.76
Submissiveness	.76
Aloofness	.74
Rigidity	.74
Resourcefulness	.73
Callousness	.72
Childishness	.66
Impulsiveness	.65
Irritability	.59
Eccentricity	.52
Optimism	.51
Introspection	

## Personality Disorder Interview-IV (PDI-IV)

### PDQ

This self-report measure was developed from 125 items of the SHAPS forming six scales, consisting of four 'primary' scales and two factor scales. Norms are based upon Special Hospital patients.

Name of scale	No. of items	Norms (Male $N = 366$ )
Anxiety (A)	32	14.26 (8.32)
Hostility (H)	29	10.84 (6.20)
Social Extraversion (E)	18	12.84 (3.66)
Lack of Control ©	31	14.78 (6.46)
Psychopathy/ Anti-social Aggression (F1)	40	18.35 (8.31)
Social Withdrawal (F2)	27	10.75 (5.60)

### Personality Disorder Questionnaire-IV (PDQ-4)

'A 163-item, true/false questionnaire that takes approximately 20 to 40 minutes to complete. The items are specifically keyed to the diagnostic criteria for the 11 personality disorder diagnoses of the *DSM-III*. The face validity of each item was subjected to content analysis to ensure that the item accurately reflected the criteria it purported to measure.' Comprehension is at the eighth grade. The items are worded both positively and negatively with True/False format to avoid response bias.

Internal consistency reliability based upon Kuder Richardson Formula 20.

$\alpha = .84$  for Dependent  $\rightarrow \alpha = .56$  for Schizoid.

Correlation between clinical diagnoses and self-report measured on Pearson's  $r$ .

$r = .16$  for Compulsive  $\rightarrow r = .51$  Borderline, significant at  $p < .001$

## Psychopathy Checklist (PCL)

It could be argued that this is not a personality measure, but rather a risk assessment tool. However, it is included here. Originally there were 22 items, which with subsequent versions have been reduced to 16. The items are scored following interview and consideration of prior description of behaviours contained in reports and other documentation. This is on a three-point scale: 0, 1, and 2.

Glib, superficial charm
Previous diagnosis of psychopathy
Egocentric, grandiose sense of self-worth
Easily bored, low tolerance of frustration
Pathological lying and deception
Con-man, lacking sincerity
Lack of remorse or guilt
Lacks affect or emotional depth
Callous, lack of empathy
Parasitic life style
Short-tempered, poor behavioural control
Sexually promiscuous
Early behavioural problems
Lack of realistic long-term goals
Impulsivity
Irresponsibility as a parent
Numerous marital relationships
Juvenile delinquency
Poor probation or parole risk
Failure to accept responsibility for own actions
Multiple types of offences
Drug or alcohol abuse not direct cause of anti-social behaviour

## Psychopathy Checklist-Revised (PCL-R)

Glib, superficial charm	1
Egocentric, grandiose sense of self-worth	1
Easily bored, low tolerance of frustration	2
Pathological lying and deception	1
Con-man, lacking sincerity	1
Lack of remorse or guilt	1
Lacks affect or emotional depth	1
Callous, lack of empathy	1
Parasitic life style	2
Short-tempered, poor behavioural control	2
Sexually promiscuous	–
Early behavioural problems	2
Lack of realistic long-term goals	2
Impulsivity	2
Irresponsibility as a parent	2
Numerous marital relationships	–
Juvenile delinquency	2
Poor probation or parole risk	2
Failure to accept responsibility for own actions	1
Multiple types of offences	–

*Factor 1:* Selfish, Callous and Remorseless use of others.

*Factor 2:* Chronically Unstable and Anti-social life style.

## PCL:SV (Screening Version)

Superficial	
Grandiose	
Deceitful	
Lacks remorse	
Lacks empathy	
Doesn't accept responsibility	
Impulsive	
Poor behavioural controls	
Lacks goals	
Irresponsible	
Adolescent anti-social behaviour	
Adult anti-social behaviour	

## Psychopathic Personality Inventory (PPI)

One-hundred-and-eighty-seven items, answered on a four-point Likert scale: 1 = False, 2 = Mostly False, 3 = Mostly True, 4 = True.

There is a Global Index Score and eight subscales.

Factor	Subscale	Items	Description of high scorers
1 (.67)	Impulsive Non-conformity	17	Reckless, rebellious, unconventional
1 (.57)	Blame Externalisation	18	Blames others and rationalises own transgressions
1 (.70)	Machiavellian Egocentricity	30	Aggressive and self-centred in interactions with others
1 (.37)	Carefree Non-planfulness	20	Present-oriented; lacks forethought and planning
2 (.93)	Stress Immunity	11	Experiences minimal anxiety
2 (.52)	Social Potency	24	Able to manipulate and influence others
2 (.45)	Fearlessness	19	Willing to take risks; lacks concern for harmful consequences
	Cold-heartedness	21	Unsentimental; lacks imaginative capacity; un-reactive to others' distress

*Factor 1:* Imperturbability, social dominance and venturesomeness.

*Factor 2:* Unconventional attitudes, poor planning, aggressiveness and estrangement from others.

(From, Benning et al. (2003), Factor structure fo the Psychopathic Personality Inventory: Validity and implications for clinical assessment. *Psychological Assessment*, 15, 340–350.)

## Quick Personality Assessment Schedule (PAS-Q)

### Schedule for Non-adaptive and Adaptive Personality (SNAP)

This is a 375-item self-report test with a True/False format, from which 34 scales are derived, based upon factor-analytical techniques. Descriptive statistics and psychometric data are available for both in-patients and out-patients.

Trait Scales	Temperament Scales	Diagnostic Scales
Mistrust	Negative Temperament	Paranoid
Manipulativeness	Positive Temperament	Schizoid
Aggression	Disinhibition	Schizotypal
Self-Harm		Anti-social
Eccentric Perceptions	<b>Validity Scales</b>	Borderline
Dependency	Variable Response Inconsistency	Histrionic
Exhibitionism	Deviance	Narcissistic
Entitlement	True Response Inconsistency	Avoidant
Detachment	Rare Virtues	Dependent
Impulsivity	Desirable Response Inconsistency	Obsessive-Compulsive
Propriety	Invalidity Index	Passive Aggressive
Workaholism		Sadistic
		Self-Defeating

### Self-Report Psychopathy Scale – II (SRPS-II)

Primary Psychopathy Scale (16 items), relating to Selfish, Uncaring Manipulative.

Secondary Psychopathy Scale (10 items), relating to Impulsivity and Self-defeating lifestyle.

These items use a four-point Likert scale with 1 = Disagree strongly, 2 = Disagree Somewhat, 3 = Agree Somewhat and 4 = Agree Strongly.

Anti-social Action (24 items) with four endorsement options I have done this Never (0), Once (1), Twice (2), a Few Times (3) or Frequently (4).

Also four 10-item scales from the Zuckerman Sensation-Seeking Scale (Form 4): 'Disinhibition', 'Boredom Susceptibility', 'Experience-Seeking' and 'Thrill & Adventure Seeking'.

Also two scales from the MPQ: 'Stress Reaction' and 'Harm Avoidance'.

## Screening Test for Co-morbid Personality Disorders (STCPD)

There are 51 items in a format of statements rather than questions. Subject has to respond with either 'True' (generally true) or 'False' (generally false). The personality types identified are:

Histrionic Personality Disorder
Dependent Personality Disorder
Avoidant Personality Disorder
Borderline Personality Disorder

## Shedler-Westen Assessment Procedure-200 (SWAP-200)

This method of assessment is based upon Q-Sort approach, the theoretical underpinning being the Five Factor Theory of personality rather than DSM-IV 'diagnoses'. Two-hundred personality-descriptive statements are printed on separate index cards which the clinician has to sort into eight categories from those that are not descriptive (score 0) to those highly descriptive (score 7). There are 12 factors:

Factor
Psychological Health
Psychopathy
Hostility
Narcissicism
Emotional Dysregulation
Dysphoria
Schizoid orientation
Obsessionality
Thought disorder
Oedipal conflict
Dissociation
Sexual conflict

## Screening Test for Co-morbid Personality Disorder (STCPD)

This is a modification of the PDQ-4, with both subject and informant versions. There are 51 questions with True/False answers.

## Special Hospitals Assessment of Personality and Socialisation (SHAPS)

'The SHAPS aims to measure personality traits (and in Foulds' terms, deviant traits) rather than psychiatric symptoms.' The self-administered questionnaire consists of 213 items, developed from the MMPI, presented as questions with 'Yes/No' format, yielding scores on the scales below. A factor analysis yields two broad factors:

*Factor 1:* Psychopathy or Anti-social Aggression (mainly Im and Ag, and negatively L).

*Factor 2:* Withdrawal versus Sociability (mainly I).

Scale title	No. of items	Norms:	
		Male (N = 180)	Female (N = 146)
Lie (L)	15	3.4 (2.20)	3.75 (2.1)
Anxiety (A)	39	10.41 (7.49)	14.36 (8.16)
Extraversion (Ex)	41	23.88 (6.08)	21.81 (3.12)
Hostility (Ho)	30	5.48 (3.82)*	-
Introversion (I)	17	5.12 (4.54)	6.05 (4.59)
Depression (D)	17	3.78 (3.72)	5.24 (3.95)
Tension (T)	17	3.83 (2.97)	5.90 (3.78)
Psychopathic deviate (Pd)	50	16.0 (5.0)	15.42 (4.91)
Impulsivity (Im)	31	16.19 (4.75)	15.09 (4.79)
Aggression (Ag)	31	14.04 (5.29)*	

\*N = 95 (male student nurses)

## Standardised Assessment of Personality (SAP)

Use of informant rather than patient, who is asked to give a description of the patient. A checklist of adjectives facilitates the assessor placing the patient in the following types: Self-conscious, Schizoid, Paranoid, Cyclo-thymic, Obsessional, Anxious, Neurasthenic, Explosive, Sociopathic, Hysterical and Normal. Also 'the description indicates that the patient is very unusual or handicapped in day-to-day life by reason of this personality'.

## Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II)

### Structured Interview for DSM-III-R Personality Disorders (SIDP-R)

There are 160 questions grouped under 16 topical sections, such as 'Self-esteem', 'Level of social interaction' and 'Dependency'. Each section takes about five minutes, so that total interview lasts 60 to 90 minutes with subject and a further 30 minutes for informant. There are three levels of severity for each diagnostic criterion. The interviewer is encouraged to focus on 'usual' behaviour rather than occasional or rare idiosyncratic behaviours.

<b>Diagnosis</b>
Paranoid
Schizoid
Schizotypal
Histrionic
Narcissistic
Anti-social
Borderline
Avoidant
Dependent
Compulsive
Passive-aggressive
Atypical
Multiple

## Structured Interview for the Five Factor Model of Personality (SIFFM)

### Temperament and Character Inventory (TCI)

### Tridimensional Personality Questionnaire (TPQ)

This questionnaire is allied to Cloninger's theory of personality, and is unusual in having such theoretical underpinning. There are 100 items with True/False responses.

Dimension		Scale	No. of items
Novelty Seeking (NS)	NS1	Exploratory Excitability vs. Stoic Rigidity	9
	NS2	Impulsiveness vs. Reflection	8
	NS3	Extravagance vs. Reserve	7
	NS4	Disorderliness vs. Regimentation	10
Harm Avoidance (HA)	HA1	Anticipatory Worry vs. Uninhibited Optimism	10
	HA2	Fear of Uncertainty vs. Confidence	7
	HA3	Shyness with Strangers vs. Gregariousness	7
	HA4	Fatigability & Asthenia vs. Vigour	10
Reward Dependence (RD)	RD1	Sentimentality vs. Insensitiveness	5
	RD2	Persistence vs. Irresoluteness	9
	RD3	Attachment vs. Detachment	11
	RD4	Dependence vs. Independence	5

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