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Objective: The Personality Assessment Inventory (PAI; Morey, 1991; 2007) is a 344 item self-report measure of personality, psychopathology, and factors affecting treatment. The PAI short form (PAI-SF) contains the first 160 items of the PAI and is often favoured as a screening tool or brief version to mitigate respondent burden and fatigue. The PAI has been psychometrically validated among numerous populations (Slavin-Mulford et al., 2012), while psychometric research on the PAI-SF is gradually emerging. The psychometric properties of the PAI-SF range from adequate to strong in psychiatric (Sinclair et al., 2009), forensic (Sinclair et al., 2010), outpatient and nonclinical (Ward et al., 2018), and stroke (Udala et al., 2020) samples. To advance research validating the PAI-SF among diverse populations, this project investigated the psychometric comparability between the PAI and the PAI-SF in a neuropsychiatric population. Based on previous literature, it was hypothesized that the PAI-SF would produce congruent results to the PAI in this sample.

Participants and Methods: For this study, participant files (N=214) were collected retrospectively from short- and long-term residential psychiatric and substance use treatment facilities in Minnesota for patients with neurological and cognitive concerns referred for neuropsychological evaluation. The PAI-SF was scored using the first 160 items from a patient's long-form PAI protocol. To determine the psychometric comparability of long- and short-forms, paired-samples t-tests, intraclass correlations, and percent agreement in clinical classification between forms were analyzed.

Results: Analyses of participant data found that intra-class correlations ranged from .87 to .98 for each subscale on the PAI when compared to the PAI-SF, demonstrating good to excellent reliability between forms. Symptoms are considered clinically elevated when they exceed the clinical significance threshold for a subscale (typically a T-score of 70+). Agreement between the PAI and PAI-SF subscales in the classification of clinically elevated scores ranged from 86% to 100%. When forms did not agree, the PAI-SF was more likely to be clinically significant relative to the PAI. A comparison of subscale means between forms was examined

by independent samples T-tests with a Bonferroni correction. Results revealed significant differences between the PAI and PAI-SF on one validity scale (Negative Impression Management), three clinical scales (Anxiety; Depression; Antisocial Features), and one treatment scale (Treatment Rejection).

Conclusions: Results demonstrated that the PAI and PAI-SF have high reliability between forms in a neuropsychiatric population. Although mean scores differed on a small number of subscales between the PAI and PAI-SF, differences did not appear sufficiently large enough to shift clinical classifications, as the two forms performed similarly in their identification of clinically elevated scales. Findings align with previous literature and suggest that the PAI-SF may perform adequately in a neuropsychiatric population if brevity or participant burden is of concern. However, caution is warranted when making clinical decisions with the PAI-SF as more research is needed.

Categories:

Assessment/Psychometrics/Methods (Adult)

Keyword 1: assessment

Keyword 2: psychometrics

Keyword 3: neuropsychological assessment

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2 Mask Wearing During Neuropsychological Assessment Negatively Impacts Performance on Verbal Tests in Older Patients

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Objective: Face masks are required in many healthcare settings. Face masks have well documented health advantages, but they can negatively impact interpersonal communication, an essential element of neuropsychological assessment. The purpose of this study was to quantify the impact of face masks on neuropsychological assessment in a large clinical setting.

Participants and Methods: Participants included 755 pre-pandemic onset (51.3 % men, $M = 59.54$ years, $SD = 17.23$) and 838 (51.7% men, $M = 60.63$ years, $SD = 16.71$) post-pandemic onset outpatients from a large academic medical center in the Midwest. Performance was compared on selected assessments characterized by visual function (WAIS-IV Block Design, WAIS-IV Matrix Reasoning, and the Rey-Osterrieth Complex Figure Test – Copy trial) and assessments characterized by verbal function (WAIS-IV Digit Span (DS), Rey Auditory Verbal Learning Test (AVLT) total score, and Complex Ideational Material). Secondary analyses compared performance between the groups by age: in an older group (greater than 65 years old) and a younger group (less than 65 years old).

Results: The pre-and-post pandemic onset groups did not differ with respect to age, gender, education, or clinical diagnosis. Independent Samples T-tests showed that the post-pandemic onset group performed significantly worse on two verbal tests, DS ($p = .005$, Cohen's $d = 0.131$) and the AVLT ($p < .001$, Cohen's $d = 0.245$). Within the older group, the frequency of patients with dementia (54.1 vs 54.8 percent), and all other diagnoses, was comparable pre-and-post pandemic onset. The younger group also had comparable rates of clinical diagnoses at each time point. Secondary analyses showed that the older group was the only group to perform significantly worse on the two verbal tests post-pandemic onset: DS ($p = .004$, Cohen's $d = 0.20$) and AVLT ($p < .001$, Cohen's $d = 0.39$). The younger group had no differences in their performance on any of the verbal tests. For both the primary and secondary analyses, none of the groups had a significant change in performance on the tests that were characterized by visual function.

Conclusions: These results suggest that mask use during neuropsychological assessment may hinder performance on tests that require close attention to verbal output in older patients. This finding is not otherwise explained by demographic or clinical differences. In fact, these patients had nearly identical rates of dementia before and after the onset of the pandemic. In contrast, performance on tests that rely mainly on visual function was not affected. Attending to masked speech may be more cognitively demanding for older individuals, thus influencing their performance during testing. This may be particularly relevant for neuropsychologists working in geriatric settings.

Neuropsychologists performing assessments in-person, with masks, should be aware that patient scores on certain tests may be artificially deflated for reasons unrelated to cognition or clinical condition.

Categories:

Assessment/Psychometrics/Methods (Adult)

Keyword 1: neuropsychological assessment

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3 Validity of the tele-administered Montreal Cognitive Assessment for identifying geriatric neurocognitive disorders

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Objective: With the emergence of the coronavirus 2019 pandemic, investigating the validity of tele-screenings for neuropsychological status has become increasingly necessary. While the telephone version of the Montreal Cognitive Assessment (MoCA-T) has been validated for use in patients with Parkinson's and stroke/cerebrovascular disease, the clinical utility of this instrument in geriatric patients with other suspected cognitive disorders has yet to be determined. Thus, the present study aimed to examine the classification accuracy of the MoCA-T in a mixed clinical sample of patients with mild cognitive impairment (MCI) or dementia.

Participants and Methods: Ninety-one older adults were administered the MoCA-T via videoconferencing technology as part of a comprehensive neurocognitive evaluation performed by a multidisciplinary treatment team within a dementia specialty clinic. Based on this evaluation, 51 (56.0%) patients were diagnosed with dementia, 27 (29.7%) with MCI, and 13 (14.3%) with no neurocognitive diagnosis (i.e., subjective cognitive complaints). In addition to MoCA-T total and item scores, we also computed subscale scores for between-group comparisons as the sum of items assessing