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6

Cluster C Personality Disorder as seen from the MMPI-2-RF Scale Hierarchy: Clinical and Theoretical Utility¹

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Abstract

Several studies have addressed the associations between the Minnesota Multiphasic Personality Inventory-2 Restructured form (MMPI-2-RF; Ben-Porath & Tellegen, 2008) scale scores and the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) Section II personality disorder (PD) criterion counts. While these studies show which variables are associated with the PDs as well as their combined predictive potency, no information is available on mean patterns of elevation associated with these conditions. As a test of clinical and theoretical utility, we describe the mean RF profiles of a psychiatric subsample with a Cluster C PD diagnosis. PD classification was based on the Structured Clinical Interview for the DSM-IV (SCID-II). Highly divergent patterns of elevation were observed across the three levels of the MMPI-2-RF that were consistently in line with theoretical expectation. In addition, elevated scores on several somatic/cognitive scales were noted. It is concluded that the MMPI-2-RF and the DSM Personality disorder models amplify each other.

Keywords: MMPI-2-RF, personality disorder, clinical personality assessment

Introduction

A growing body of research documents how the recently developed full MMPI-2-RF model of personality and psychopathology behaves in the context of the DSM defined categorical personality disorders (PD). Early studies focused on the clinical utility of the RC scales in the assessment of PD (Eaton et al., 2011; Kamphuis et al., 2008; van der Heijden et al., 2013). Two more recent studies have specifically addressed the empirical associations between MMPI-2-RF scales and the DSM-IV or DSM-5 personality disorders (Anderson et al., 2015; Sellbom et al., 2014). First, Sellbom and colleagues (Sellbom, et al., 2014) mapped the PSY-5 abnormal personality scales onto DSM-IV PDs in both clinical and forensic samples. Next, Anderson (2015) presented an in-depth conceptual analysis of how MMPI-2-RF variables would be associated with each of the different PDs. For example, in the context of Avoidant PD, an inspection of the DSM criteria yielded the following concepts: hypersensitivity to criticism, fear of negative evaluation and rejection, extreme social withdrawal and alienation, feelings of inadequacy and ineptitude, and general emotional misery. Each of these was translated to putative MMPI-2-RF scales, at the various levels of the overarching hierarchy. These educated conjectures were subsequently put to the empirical test (Anderson et al., 2015). Generally, results from these analyses emerged as conceptually expected, and provided evidence that the MMPI-2-RF scales can be useful in assessing PDs. Again, to illustrate for AVPD, significant predictors that emerged from the (count) regression analyses included Demoralization (RCd), Low Positive Emotions (RC2), and Dysfunctional Negative Emotions (RC7), as well as several matching facet scales.

Of course, significant predictive betas from regression scores do not readily translate to information that is useful to the clinician waiting to assess his or her next patient. More specifically, these associative measures do not tell the clinician much with regard to expected levels of scale elevation. Moreover, when multiple variables are included in the same regression equation, only yield “above and beyond” the other included variables are reflected in the estimates of their effects.

Accordingly, we wanted to examine whether the MMPI-2-RF yields a descriptive portrait in the context of PDs; in the present sample, as limited to cluster C PD. Our main interest was to examine to what extent the pattern of elevations a) made conceptual sense, b) was sufficiently specific to be clinically useful, and c) perhaps

may yield theoretically valuable hypotheses for diagnostic formulations beyond the DSM-5. While no specific level of scale elevation can be stipulated, we formulated some broad expectations for scale elevation for the indices that we considered consistent with emotional internalizing pathology at each level of the hierarchy (see Also Ben-Porath, 2012). Specifically, at the higher order level, we expected elevations for Emotional Internalizing Dysfunction (EID); at the RC level, we expected elevation for Demoralization (RCd), Low Positive Emotions (RC2), and Dysfunctional Negative Emotions (RC7); for the Specific Problem Scales we expected elevations among the Internalizing scales, but not for the Externalizing scales. Finally, of special interest for the PDs are the special problem scales that address interpersonal functioning, as well as the abnormal personality scale set provided by the PSY-5. With regard to the former, we expected elevations on Shyness and Avoidance among the Interpersonal SPs (core features or the cluster C pathology); with regard to the PSY-5, we expected high scores on Negative Emotionality-Revised (NEGE-r) and Introversion/ Low Positive Emotionality-Revised (INTR-r), while low scores for instrumental Aggressiveness (AGGR-r).

Method

Participants

Patient records between 2005 and 2010 from *De Viersprong*, a tertiary mental health facility specialized in the assessment and treatment of adolescents and adults with personality pathology, were retrieved when both structured clinical interview data and MMPI protocols were available. As part of the standard intake procedure, all *De Viersprong* patients are administered Structured Clinical Interviews for the DSM-IV Axis-I and Axis-II (SCID-I, II; First, Gibbon, Spitzer, William, & Benjamin, 1997), but only patients ($N = 239$ valid cases)¹ who were referred to treatments addressing primary cluster C (the so-called anxious cluster) personality pathology or mixed anxious/externalizing (Cluster B and C) were also administered the Minnesota Multiphasic Personality Inventory-Revised (MMPI-2). From these, we selected “pure” Cluster

1 39 invalid protocols were excluded conform the standard criteria outlined in the MMPI-2-RF; cannot say >17; VRIN or TRIN > 79T; F-r =120T; Fp-r > 99T; see Ben-Porath & Tellegen, 2008)

C records ($N = 73$); i.e., patient who met criteria for Avoidant PD (79.5%, or $n = 58$), Obsessive Compulsive PD (24.7%, or $n = 19$), and/or Dependent PD (4.1%, or $n = 3$), but no cluster B or Cluster A personality disorder. Slightly over half of the sample (56.2%) was female, with a mean age of 28.8 ($SD = 9.5$). Eighty percent of the sample had comorbid Axis-I disorders, most notably unipolar mood disorders (28.8%, or $n = 21$), social phobia (31.5%, or $n = 23$), and/or Post Traumatic Stress Disorder (13.7%, or $n = 10$).

Measures

MMPI-2-RF (Ben-Porath & Tellegen, 2008/2011)

Patients were administered the Dutch MMPI-2, from which the MMPI-2-RF scales can be scored without decrement in psychometric functioning (van der Heijden, Egger, & Derksen, 2010). The MMPI-2-RF consists of 338 binary items, and comprises nine validity scales, three Higher-Order scales (H-O), nine Restructured Clinical Scales (RCs), 23 Specific Problems scales (SPs), two Interest scales, and the Personality Psychopathology Five scales (PSY-5).

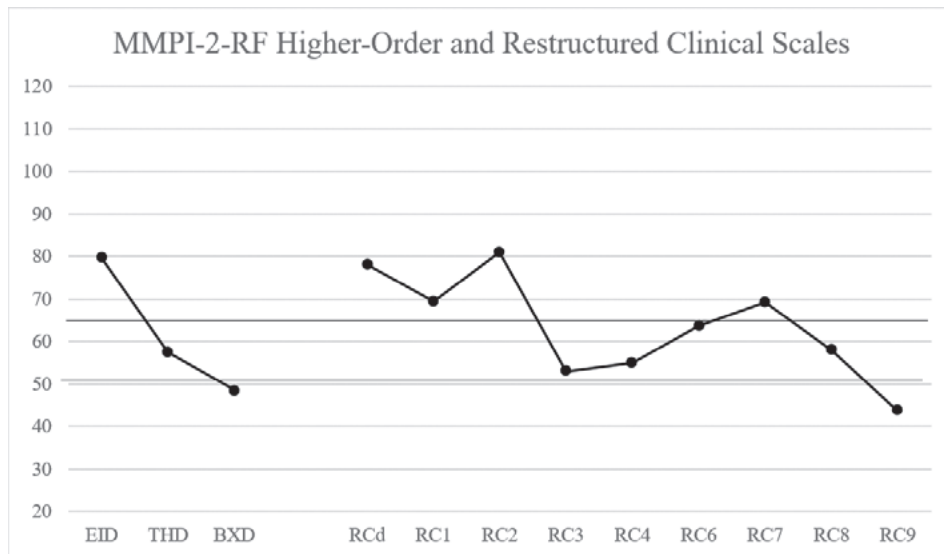
SCID-II (First, Gibbon, Spitzer, William, & Benjamin, 1997; Weertman, Arntz, & Kerkhofs, 2000)

The SCID-II is widely used semi-structured interview for the assessment of Axis II PDs. The inter-rater reliability of the Dutch SCID II has been demonstrated in several studies (Lobbstael, Leurgans, & Arntz, 2010; Weertman, et al, 2000), but unfortunately no inter-rater reliability data were specifically collected for this study. To mitigate this concern, we note that all SCID-II interviewers were extensively trained (e.g., including national trainers), and Cronbach alphas indicated satisfactory internal consistency for the SCID-II PD dimensional scores (ranging from .74 to .84).

Results

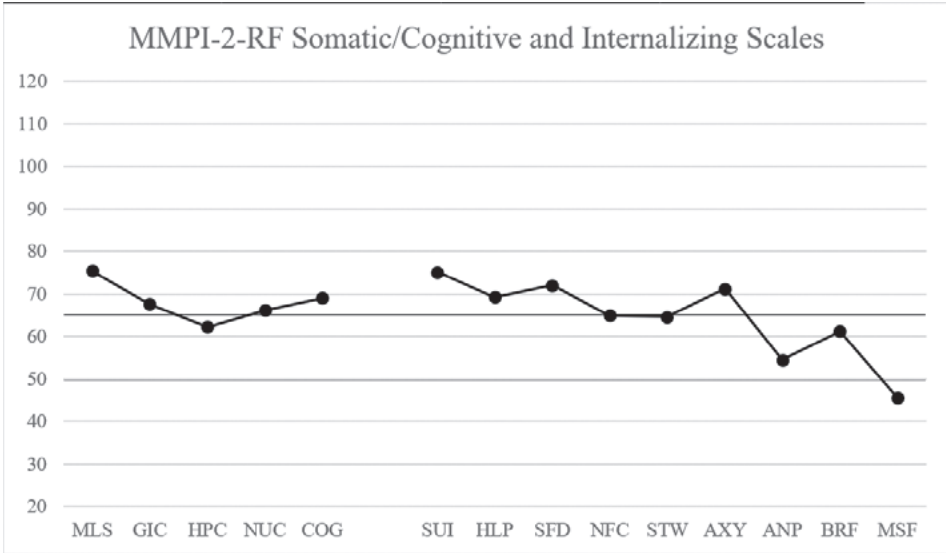
Consistent with expectation, an exclusive elevation on Emotional Internalizing Dysfunction was observed at the higher order level (EID; $M = 79.8$, $SD = 9.0$). Elevations on RC scales included Demoralization (RCd; $M = 78.1$, $SD = 8.0$), Somatic Complaints (RC1; $M = 69.5$, $SD = 13$), Low Positive Emotions (RC2; $M = 81$, $SD = 11.9$), and Dysfunctional Negative Emotions (RC7; $M = 69.1$, $SD = 11.2$); See Figure 1.

Figure 1: MMPI-2-RF Higher-Order (H-O) and Restructured Clinical (RC) Scales Mean Profile



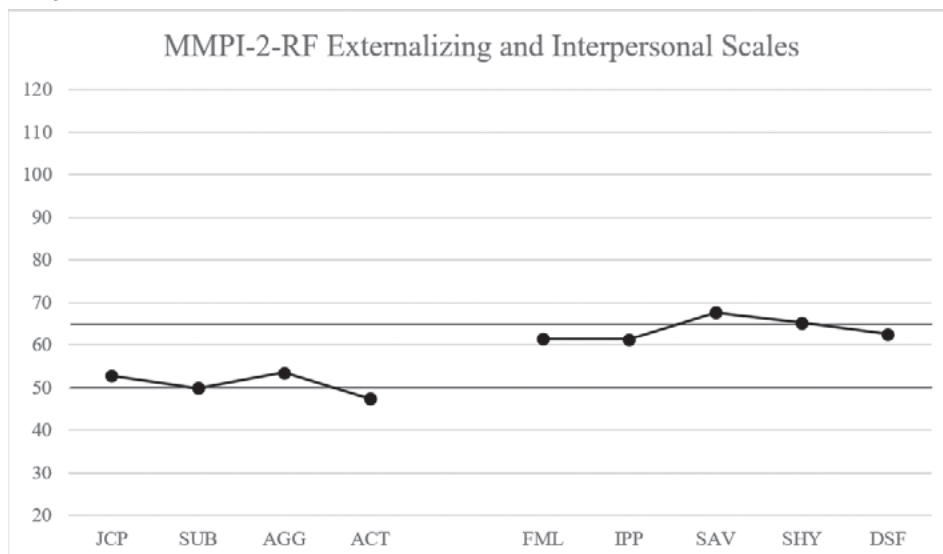
Note. EID = Emotional/Internalizing Dysfunction; THD = Thought Dysfunction; BXD = Behavioral/Externalizing Dysfunction; RCd = Demoralization; RC1 = Somatic Complaints; RC2 = Low Positive Emotions; RC3 = Cynicism; RC4 = Antisocial Behavior; RC6 = Ideas of Persecution; RC7 = Dysfunctional Negative Emotions; RC8 = Aberrant Experiences; RC9 = Hypomanic Activation.

Figure 2: MMPI-2-RF Somatic/Cognitive and Internalizing Scales Mean Profile



Note. *MLS = Malaise; GIC = Gastrointestinal Complaints; HPC = Head Pain Complaints; NUC = Neurological Complaints; COG = Cognitive Complaints; SUI = Suicidal/Death Ideation; HLP = Helplessness; SFD = Self-Doubt; NFC = Inefficacy; STW = Stress/Worry; AXY = Anxiety; ANP = Anger Proneness; BRF = Behavior-Restricting Fears; MSF = Multiple Specific Fears.*

Figure 3: MMPI-2-RF Externalizing and Interpersonal Scales Mean Profile



Note. JCP = Juvenile Conduct Problems; SUB = Substance Abuse; AGG = Aggression; ACT = Activation; FML = Family Problems; SAV = Social Avoidance; SHY = Shyness; IPP = Interpersonal Passivity; DSF = Disaffiliativeness.

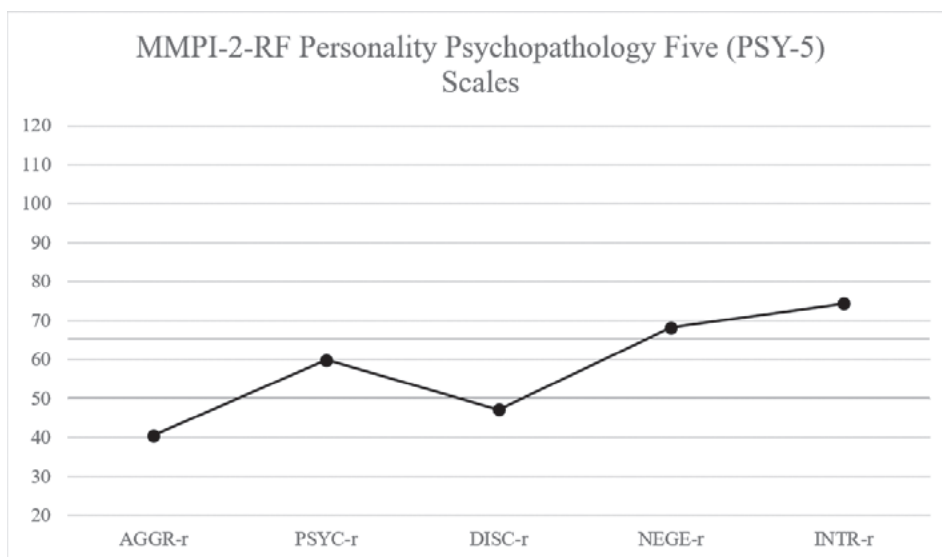
As can be seen from Figure 2, the following Somatic/Cognitive scales showed mean scores above the $T=65$ cut-off point: Malaise (MLS; $M = 75.4$, $SD = 9.5$), Gastrointestinal Complaints (GIC; $M = 67.6$, $SD = 16.9$), Neurological Complaints (NUC; $M = 66.2$, $SD = 10.8$), Cognitive Complaints (COG; $M = 69.1$, $SD = 12.6$). As might be expected, several internalizing SPS were elevated: Suicidal/Death Ideation (SUI; $M = 75.1$, $SD = 23.0$), Helplessness (HLP; $M = 69.3$, $SD = 12.2$), Self-Doubt (SFD; $M = 72.1$, $SD = 7.5$), and Anxiety (AXY; $M = 71.2$, $SD=16.9$).

No elevations were noted for any of the externalizing SPS; see Figure 3. Elevated Interpersonal Problems Scales include Social Avoidance (SAV; $M = 67$, $SD=11.4$), Shyness (SHY; $M = 65.3$, $SD=11.3$).

Finally, at the level of abnormal personality pathology (PSY-5), as depicted in Figure 4, Negative Emotionality (NEGE-r; $M = 68.2$, $SD = 11.1$), Introversion/Low Positive

Emotions (INTR-r; $M=74.4$, $SD = 12.9$) were elevated. Conversely, a low mean score on (instrumental) Aggressiveness (AGGR-r; $M = 40$, $SD = 7.5$) was noted.

Figure 4: MMPI-2-RF Personality Psychopathology Five (PSY-5) Scales Mean Profile



Note. AGGR-r = Aggressiveness, PSYC-r = Psychoticism, DISC-r = Disconstraint, NEGE-r = Negative Emotionality, INTR-r = Introversion/Low Positive Emotions.

Discussion

The main findings of the present MMPI-2-RF investigation build a hierarchical rendering of cluster C personality pathology. More specifically, starting at the higher order broadest level, our results indicate that these patients are likely to experience a broad range of symptoms and difficulties associated with demoralization, low positive emotions, and high negative emotional experiences (e.g. low morale, depression, anxiety, feeling overwhelmed, helpless, and pessimistic). Narrowing down to the core dimensions of psychopathology as captured by the RCs, mean scores in our sample were indicative of individuals who tend to be pessimistic, socially introverted and disengaged, and lacking in energy (RC2); and who tend to be behaviorally inhibited, stress reactive, and prone to excessive worry. They are likely to perceive others as

overly critical, and are themselves intropunitive and self-critical and guilt prone (RC7). While these results are fully consistent with a priori conceptual analysis, more surprising was the robust evidence for these patients to experience multiple somatic complaints, including fatigue that may be associated with stress responses (RC1). The pertinent Special Problem Scales specifically suggest that these physical problems may relate to sleep disturbance, fatigue, and low energy (MLS); dizziness and sensory problems (NUC); concentration and memory difficulties (COG), and gastro-intestinal problems (GIC). From the plane provided by internalizing SP scales, particularly the Demoralization-related facets were endorsed (suicidal ideation, hopelessness, feelings of insecurity and inferiority; SUI, HLP, SFD) as well as general anxiety (AXY).

As noted, given the nature of personality pathology, the Interpersonal SPS and the abnormal personality dimensions provided by the PSY-5 are of special significance. As expected, elevations were observed for both Social Avoidance (SAV) and Shyness (SHY), indicating that our sample (more than 92% of the general population; i.e. $T > 65$) do not enjoy social events and avoid social situations and report being shy, easily embarrassed, and uncomfortable around others, respectively. Also, in line with expectation were the elevated scores on NEGE-r and INTR-r, indicating anxiety, insecurity and worry, as well as a lack of positive emotional experiences, interests, respectively. Moreover, these scores are indicative of individuals who have difficulty asserting themselves (Low AGGR-r).

With regards to discriminant validity, it bears mentioning that no elevations were noted for any of the extant indices of thought (THD; RC6, RC8) or behavioral disorders (BXD, RC4, RC9, and its facets at the special problems scale level). In fact, even within the Internalizing set of SPS, the more narrowly defined anxiety disorder related facets (Multiple specific Fears [MSF], and Behavioral Restricting Fears [BRF] were not elevated) were not elevated, while more trait like facets (Anxiety [AXY], and Stress and worry [STW]) were. The specificity of the observed findings may attest to the success and yield of separating out the general demoralization variance that was core to the original restructuring project (Tellegen et al., 2008).

Of theoretical interest are the observed marked elevations on Low Positive Emotions (RC2) and Introversion (INTR-r). Roughly four out of five patients in our sample met criteria for Avoidant PD, which is often hard to differentiate from generalized

social phobia (see DSM-5, differential diagnosis). Social Phobia, despite being defined as an anxiety disorder, tends to align itself in studies on latent psychopathology dimensions (e.g. Krueger, 2000) more with the unipolar mood disorders than with the anxiety disorders; the same appears to hold for the present sample of cluster C PD patients.

Finally, to offer some speculative theorizing, we surmise that high scores on indices of stress-related somatic complaints may point to an area for further study for future diagnostic systems; e.g. as experimental, alternative criteria for field trials. The current DSM criteria for Cluster C pathology do not specifically include somatic or cognitive problems. This may be because of many reasons, not least of which is that these symptoms probably lack adequate diagnostic specificity for classification purposes. In a different diagnostic system, perhaps using dimensions, as opposed to symptom / criteria counts, these symptoms may deserve more attention in describing the psychological functioning of this patient group. The undifferentiated somatic symptoms may harken back to what Freud (Freud, 1914) and other psychodynamic thinkers thought of as so-called *Aktual Pathology*; i.e., symptoms reflecting a failure in to handle arousal processes in a representational way. Alternatively, they may also be related to the comorbid conditions present in our sample (e.g. about one in three patients suffered from a unipolar mood disorder); these conjectures are in need of further empirical testing.

Overall, we believe the present report shows that the MMPI-2-RF provides the clinician with a clinically coherent portrait of cluster C personality pathology that makes conceptual sense and is sufficiently specific to raise clinical flags. Moreover, the robust elevation of somatic/ cognitive indicators provides an interesting theoretical hypothesis with respect to the nature of the more internalizing personality disorders.

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