Assessment Of Personality Disorder: A Review Of Existing Literature On Psychological Assessment

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This paper reviews the literature on the use of psychological assessments to identify personality disorders (PD). The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) categorise ten types of personality disorders according to symptoms in Section II and according to traits in Section III. Structured interviews and self-report questionnaires being two methods used to assess personality disorders are discussed. The suggested structured interview instrument used during the clinical intake interview is the structured clinical interview for DSM 5 (SCID-5), and where personality disorder is detected, the structured clinical interview for personality disorder (SCID-5-PD) is used. Self-report instruments commonly used to assess pathology are the Personality Inventory for DSM-5 (PID-5), the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), and the Million Clinical Multiaxial Inventory III (MCMI-III) are discussed. The paper ends with identifying some limitations arising from the use of assessments for identifying specific personality disorders(PDs), with suggestions for future research on the use of the PID-5 provided with the DSM-5 for the assessment.

Keywords: Assessments, personality disorder, DSM 5

Persons diagnosed with personality disorders (PDs) have patterns of behaviour that are deviant from the normal population. Such behaviours are stable, enduring over time, pervasive, and inflexible causing them significant impairment and distress. This condition is not caused by substance use, another mental disorder, or as a result of any general medical condition (American Psychiatric Association, 2013). The general symptoms of PDs can be complaints of general dissatisfaction of self and in interpersonal interactions. The client will report that she has been such trouble in since adolescence or early adulthood. In more severe cases, the client may present with other mental distress that is comorbid like anxiety and depression. These persons have difficulty in relating to family, friends, and colleagues as they may go about getting what they want using maladaptive behaviours that disrupt relationships. They are mostly unaware of the effect of their behaviour or are unable to learn from their experiences to change (Derlega, Winstead, & Jones, 2005). They usually "do not accept responsibility for their own behaviour and problems and typically blame people when things go wrong" (p.515).

The Section II of DSM 5 (American Psychiatric Association, 2013) organizes ten PDs into three clusters. Cluster A comprise of paranoid, schizoid, and schizotypal PDs, cluster B antisocial, borderline, histrionic, and narcissistic PDs, and cluster C avoidant, dependent, and obsessive-compulsive disorders. Each disorder has differing diagnostic criteria derived from a medical model of observed deviant behaviour enduring over time. In Section III for "emerging measures and models" an "Alternative DSM-5 model for personality disorders" is presented using a dimensional trait model that assumes a continuum of behaviour that can be quantitatively assessed from adaptive /normal to maladaptive/ deviant behaviour

(Derlega et al., 2005). This paper discusses existing research and findings of assessment of PDs.

Assessment of Personality Disorders

Clinicians conduct psychological assessments to assess symptoms of clients' complaints to diagnose and structure treatment plans. Structured interviews and self-report questionnaires are commonly used for assessing PDs. To build rapport, clinicians start with less structured interviews to obtain general information before progressing to more structured interviews. A mental status examination is usually used to assess the level of mental function, but this is not diagnostic for mental disorders (Norris, Clark, & Shipley, 2016). The Structured Clinical Interview for DSM-5 (SCID-5) by the American Psychiatric Association (2013) is focused on mental disorder diagnosis. From there, clinicians will determine the next assessment instrument to use for further diagnosis. The SCID-5-PD (American Psychiatric Association, 2013) for PD is used if clinicians find that there is serious dysfunction that has prevailed over time. The following are some personality assessments for testing for PDs.

Personality Inventory

The Personality Inventory for DSM-5 (PID-5) is a self-assessment instrument available with the DSM-5 to operationalize its Section III dimensional model of personality disorders (PD). It assesses personality pathology using measures for personal impairment and interpersonal functioning where personality traits are organized into five broad domains (Skodol, Morey, Bender, & Oldham, 2015). Four groups of personality functioning factors assessed are identity, self-direction, empathy, and intimacy factors, and five groups of personality trait

domains assessed are negative affectivity, detachment, antagonism, disinhibition, and psychoticism. Skodol et al. (2015) through a survey of clinicians' assessment found that this model is "more clinically useful than the DSM-5 Section II approach and is useful in "treatment planning and predicting its outcome". In the dimensional model the level of personality functioning is assessed for its severity, and the personality domains are assessed for the combinations of maladaptive traits. However, it is difficult to have cut-off points on scoring, but research has found that this dimensional system is also linked to the existing DSM-5 Section II model (Samuel, Hopwood, Krueger, Thomas, & Ruggero, 2013).

Minnesota Multiphasic Personality Inventory -2

The Minnesota Multiphasic Personality Inventory -2 (MMPI-2) is a 567 item self- assessment questionnaire that assesses a wide range of personality and interpersonal behaviour with focus on dysfunctional aspects. It is extensively researched and the "first choice of mental health practitioners" (MacCluskie, Welfel, & Toman, 2002). The MMPI-2 can screen for validity of test results, has ten basic clinical/ personality scales, and fifteen content scales measuring the problems that clients report. The content scales are used to further explain the meanings of the clinical scales (Groth-Marnat, 2009). The MMPI-2 scales scores are converted to T scores where t >65 require further investigation as they are elevated scores compared to the general population (Gregory, 2011). The MMPI-2 supplementary scales enable fine-tuning the interpretation of the validity and clinical scales. Of interest to this paper is the personality psychopathology five (PSY-5) supplementary scales (Harkness, McNulty, Ben-Porath, & Graham, 2002) which is used together with the MMPI-2. The PSY-5 scales measure Aggressiveness, Psychoticism, Disconstraint, Negative Emotionality/ Neuroticism, and Introversion/ Low positive emotionality, and "suggest a configuration of personality traits" (p.8). Persons scoring t > 65 on the Aggressiveness scale are aggressive, dominant, may enjoy intimidating others. In clinical samples, those who have elevated Aggressiveness scores are linked with being physically abusive (p.3) and women are extroverted. Psychoticism assesses connection to reality and those with elevated scores above 65 tend to have disorganised thinking, disoriented, and delusional reference. They can be lower functioning, having few friends, feeling sad, depressed and anxious. Persons scoring t>65 on the Disconstraint scale tend to accept higher physical-risk taking, are impulsive and less bounded by rules, easily bored with routine, and tend to have history of substance abuse. They could be aggressive and anti-social. Persons with elevated scores in Negative emotionality/ Neuroticism are likely diagnosed with depression, low functioning, anxiety, and have few friends. They tend to be pessimistic, self-critical, and lack achievement orientation. (p.4). Elevated scores on introversion /low positive emotionality will present in those who are depressed, anxious, introverted, pessimistic and have somatic symptoms. Those who score t <40 provides an extraverted / high positive emotionality pattern will be able to experience pleasure, more sociable and not depressed. However, those with very low scores may have hypomanic features (p.5). The MMPI-2-RF PSY-5 scales have high correlations with PID-5 assessment (J. L Anderson et al., 2013).

Million Clinical Multiaxial Inventory-III

The Million Clinical Multiaxial Inventory-III (MCMI-III) is a shorter self-assessment inventory that can be used in diagnosis and treatment planning of PDs

meant for adults above 18 years of age. It is organised to identify clinical patterns consistent with the DSM-5 Section II and is guided by Millon's theories of personality (Gregory, 2011). The clinical personality and the personality pathology scales cover all the DSM-5 Cluster classifications of PDs. Details of the scales are in Appendix 1. Raw scores are converted to base rates (BR) and BR scores >75 are indications of psychopathology (Erford, 2013). Normative samples of MCMI-III are from patients across the United States and the BR scores are consulted from the general population in calibrating the cut off points on the scales (Gregory, 2011).

Clinicians use psychological assessment results for diagnosis and to tailor suitable treatment interventions for clients and should be aware of the limitations of the instruments selected.
Table 1 shows types of assessments for personality disorders

Limitations in assessment of personality disorders

Hood and Johnson (2007) and Gregory (2011) noted some shortcomings in the MMPI-2 where there is heterogeneous item content within clinical scales and overlap of item content among scales. (Groth-Marnat, 2009) cautioned on the use of the MMPI-2 due to the "low scale reliabilities (<0.90). This makes the MMPI-2 "more helpful as a test for understanding individual pathology and exploring intrapersonal hypotheses than for making diagnoses" (Erford, 2013). He notes extensive item overlaps for the MCMI-III. There is also "low inter-diagnostician agreement" (Groth-Marnat, 2009) between the MCMI-III, MMPI-2 and structured interviews instruments used for diagnosing PDs. Clinicians are required to have appropriate graduate level degree in psychology, training and

appropriate licensing requirements to use the MMPI-2 and MCMI-III.
Minority groups are under-represented in the MCMI-III, and "Hispanic, Asian Americans, and older women were underrepresented" in the MMPI-2 database (Erford, 2013). Clinicians should beware of inferring results of Malaysian clients using the norming data of the MMPI-2 and MCMI-III since Asians would also be under represented in these instruments. However there have been some "international adaptations" of the MMPI-2 and cross-cultural research on the adaptability of the MMPI-2 (Groth-Marnat, 2009).

The assessment of PDs is limited to the reporting ability of the client. Some clients may think more positively of themselves than they may be, and others think negatively of themselves and under report. Assessments relying on self-report measures are dependent on the insight and awareness of the client. The MMPI-2 and MCM-III require an English reading proficiency at 8th grade level for the assessment (Erford, 2013). The clinician should evaluate the client's level of functioning and comprehension levels before using these assessments.

With the above limitations professional judgement is required on the clinician's choice of assessments. The competency of the clinician in interpreting the diagnosis also affects the treatment planning and outcome of a client. Although research showed that clinicians believe that psychological assessments are valuable in making diagnosis and treatment recommendations, there is limited evidence in proving effective treatment outcomes for clients after the use of assessments for treatment planning (Yates & Taub, 2003). In their research, Wright et al. (2017) raised potential concerns relating to the "small percentage of treatment outcome assessments conducted by practicing psychologists".

Discussion on the assessment of personality disorders

We have reviewed several established instruments for the assessment of personality disorders and discussed the limitations in accurate diagnosis of personality disorders. No one instrument may provide a complete diagnosis of the range of personality disorders in the DSM-5, and therefore it is best not to depend on any one instrument, but to use a combination of assessments including using clinical judgement for diagnosis.

From the review in this paper it seems that the MCMI-III is better positioned to assess PDs as it is designed for such a focus. The scales refer directly to the PDs in DSM-5 but it is based on a continuum of normal to abnormal personalities (Groth-Marnat, 2009). Scale elevation is assessed together with the client's functioning to see if there is an enduring pattern of dysfunction with significant distress and impairment in social functioning. Where there is no distress and impairment, a diagnosis should not be considered. In the items where the MCMI-III relates closely to the DSM-5 diagnosis criteria, it inherits the weaknesses of overlapping diagnosis, but (Groth-Marnat, 2009) explained that in the MCMI-III the "combinations of scale elevations can be used to give added meaning to each other" and this provides clearer direction for treatment. Fusté, Ruiz, and García (2014) found that several MCMI-III's scales related to PDs correlates with the PID-5 assessment that operationalise the DSM-5 Section III dimensional trait classifications.

In the case of the MMPI-2, its heterogeneous scales are used in many settings to measure a wide number of areas. Some of these scales represent measures of personality traits rather than diagnostic categories (Groth-Marnat, 2009). For the diagnosis of PDs, the MMPI-2's supplementary PSY-5 assessment and the MMPI-2-RF are found to be correlated to the PID-5 and DSM-5 mentioned earlier (J. L. Anderson et al., 2015). Sellbom, Anderson, and Bagby (2013) also identified that the MMPI-2-RF scales scores converge with the PID-5 dimensional traits.

The PID-5 instrument from DSM-5 Section III with its measures on dimensional traits shows promise as an alternative way in assessing personality functioning. The classification of PD is shifting towards the DSM-5 alternative model on dimensional traits (Widiger, 2013) as it addresses limitations of the categorical model in DSM-5 Section II. Various researches mentioned above have been comparing the convergence of psychological assessments such as the MMPI-2 and MCMI-III with the DSM-5 trait-based measurements in PID-5. It seems to the authors that these assessments show alignments with some, if not all the DSM-5 trait-based classifications of PDs. The authors recommend that when clinicians conducting clinical interviews using SCID-5 identifies possibilities of personality disorders, they should continue with an assessment to confirm the presence of PD using the SCID-5-PD (American Psychiatric Association, 2013). When more information is required, the client is given the self-assessment PID-5 to fill which can then be used for the assessment of PDs. Another instrument can also be used to validate the diagnosis. As the PID-5 is newer compared to the MMPI-2 and MCMI-III, further research is required for comparing whether it is effective to yield a diagnosis and inform treatment planning, compared to the outcome results of other assessments.

Table 1
Types of assessments for personality disorders

Psychological assessment instrument	Factor analysis	Description / Aim	Reference
Administration : Interview Based			
Structured Clinical Interview for DSM 5 disorders (SCID-5)		Used a part of the clinical intake procedures, and for semi-structured guide for making DSM diagnosis	First, Williams, Karg, Spitzer (2013)
Structured Clinical Interview for DSM 5: Personality Disorders (SCID-5-PD)		Assessment for 10 DSM-5 personality disorders for clusters A, B and C. Diagnosis can be made either categorically (present or absent) or dimensionally	First, Williams, Benjamin, & Spitzer, (2016)
Administration: Self Report Questionnaires			
Personality Inventory for DSM 5 (PID-5)	**4 Personality functioning factors** (identity, self-direction, empathy & intimacy) **5 Personality trait domains**; (negative affectivity, detachment, antagonism, disinhibition, & psychoticism)	Assessment of (i) personality functioning; severity of impairment in self & interpersonal and & (ii) 25 pathological personality traits organized into 5 broad domains.	Krueger, Derringer, Markon, Watson, & Skodol (2013)

Psychological assessment instrument	Factor analysis	Description / Aim	Reference
Minnesota Multiphasic Personality Inventory- (MMPI-2)	**Validity scales** **Basic clinical scales**; 1.Hypochondriasis, 2.Depression, 3.Hysteria, 4.Psychopatic deviate, 5.Masculinity-feminity, 6.Paranoia, 7.Psychasthenia, 8.Schizophrenia, 9.Hypomania, 10.Social introversion **Clinical subscales** **Content scales**: Anxiety, Fears, Obsessiveness, Depression, Health concerns, Bizarre mentation, Anger, Cynicism, Antisocial practices, Type A Personality, Low Self-esteem, Social discomfort, family problems, work interference, negative treatment indicators. **Content component scales** **Supplementary scales**	Assessment of a wide range of personality and interpersonal behaviour with focus on dysfunctional aspects of personality and measures the test taking attitude of the client.	Anderson J.L. et al., (2015) Erford B.T. (2013) MacCluskie et al', (2002)
Minnesota Multiphasic Personality Inventory- Restructured Form (MMPI-2-RF)	3 higher order scales; emotional-internalising, thought dysfunction, and behavioural-externalising dysfunction. 9 restructured clinical (RC) scales 23 specific problem (SP) scales	Recent version of the MMPI that maps to models of personality from the dimensional trait perspective.	Erford B.T. (2013) Sellbom et al., (2013)
Million Clinical Multiaxial Inventory, 3rd edition (MCMI-III)	**11 Clinical personality pattern**s; schizoid, avoidant, depressive, dependent, histrionic, narcissistic, antisocial, aggressive, compulsive, passive-aggressive, self-defeating **3 severe personality pathologies**; schizotypal, borderline, paranoid **7 clinical syndromes**; anxiety, somatoform, bipolar manic, alcohol & drug dependence, PTDS, Dysthymia **3 severe clinical syndromes**; thought disorder, major depression, delusional disorder 4 modifying indices	This is designed to diagnose several personality disorders as well as other mental disorders	Erford E.T (2013) Nelson-Gray et al (2009)

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