MMPI-2-RF: Use in Trauma- and Stressor-Related Disorders

Paul A. Arbisi, Ph.D., ABAP, ABPP
Overview

- Definition of trauma-related conditions and PTSD
- Practical consideration in the use of the MMPI-2-RF in the assessment of trauma-related disorders
  - Approach to the assessment
    - Role of Validity Scales
  - Trauma-related conditions as evidenced by the MMPI-2-RF
  - Implications for treatment of the MMPI-2-RF
- Case illustration
Impact of Life Events?

- A range of adverse experiences can lead to emotional disturbance:
  - Interpersonal violence
  - Sexual maltreatment or assault
  - Combat
  - Industrial accident
  - Motor vehicle accident
  - Bullying
  - Harassment
  - Sudden death of loved one
Trauma-Related Disorders

- Adjustment Disorders
- Acute Stress Disorder
- Post-Traumatic Stress Disorder

Unique because causal factor identified
  - Event directly causes the emotional disturbance
Why Use the MMPI-2-RF in Assessment of Trauma-Related Conditions?

- MMPI-2-RF provides
  - Objective means of assessing emotional disturbance in response to life event
    - Support diagnostic formulation
  - Assessment of credibility of self-reported symptoms
  - Measure of treatment readiness and response to intervention
PTSD and Trauma-Related Conditions Are Easy to Feign

- Entirely subjective: Few signs, many symptoms
  - Clinicians never test objective signs of PTSD, e.g., increased startle response
  - Actors who faked PTSD after a reported automobile accident went undetected by clinicians
- Symptoms widely available and distributed on internet
- Stressful life events occur frequently
  - Many people have experienced symptoms for a brief period without significant disruption in activities or function
- Symptoms tend to be vague and non-specific (occur in other conditions e.g., depression)
- Attend to MMPI-2-RF Validity Scales to evaluate credibility of self-report!
Use of MMPI-2-RF in Detection of Feigned PTSD Symptoms

- Mason et al., (2013)
  - RF Validity Scales discriminate college students feigning PTSD from veterans diagnosed with PTSD who passed the MFAST

- Goodwin, Sellbom, & Arbisi (2013)
  - RF Validity Scales distinguished veterans seeking service connection for PTSD who either exaggerated PTSD or responded candidly from mental health professionals directed to feign PTSD and avoid detection.
    - Fp-r ≥ 90 best predictive characteristics
    - FBS-r smaller effect size
Detection of Feigned PTSD by the MMPI-2-RF

Goodwin, Sellbom & Arbisi (2013)
Score Report

MMPI-2-RF®
Minnesota Multiphasic Personality Inventory-2 Restructured Form®
Yossef S. Ben-Porath, PhD, & Auke Tellegen, PhD

ID Number: 999
Age: 37
Gender: Male
Marital Status: Never Married
Years of Education: 12
Date Assessed: 08/30/2012
### MMPI-2-RF Validity Scales

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>T Score</th>
<th>Response %</th>
<th>Cannot Say (Raw)</th>
<th>Percent True (of Items answered)</th>
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The highest and lowest T scores possible on each scale are indicated by a "-"; MMPI-2-RF T scores are non-gendered.
Use of MMPI-2-RF to Facilitate Diagnosis and Treatment of Trauma

- Once adequate engagement in the evaluation process is established
  - What to look for on the MMPI-2-RF in trauma-related conditions?
    - RF scale elevations consistent with trauma-related conditions?
  - What MMPI-2-RF defined factors influence treatment engagement and outcome?
    - Barriers to care
    - Timing of intervention
Mean MMPI-2-RF Scale Differences in Trauma-Related Conditions

- Wolf et al., (2008) PTSD vs. non-PTSD
  - Male veterans
    - RCd, RC1, RC2, RC7, and RC 8 elevated in PTSD
  - Women veterans
    - RCd, RC1, RC2, RC7, (almost RC 8)
- Arbisi et al., (2011)
  - Non-treatment-seeking male National Guard Veterans screened positive for PTSD
    - EID, RCd, RC1, RC4, RC7, ANX**, AGG, and NEGE-r

** largest effect size
MMPI-2-RF Based Prediction of PTSD Symptoms

- Sellbom et al., (2012)
  - Large sample of injured workers administered multiple self-report inventories including MMPI-2-RF and PTSD symptoms
  - Identified latent dimension of PTSD and examined ability of MMPI-2-RF scales to predict both global PTSD and composite dimensions (re-experiencing, avoidance, hyperarousal)
    - RCd, RC2, RC7, RC8 → PTSD
      - ANX → re-experiencing, avoidance, hyperarousal
      - ANP → hyperarousal
      - SAV & SFD → avoidance
MMPI-2-RF Profile Consistent with PTSD

- Elevations on RCd, RC2, RC7, (RC 8?)
  - RC 1
    - > 65  Seem in OEF/OIF veterans screening positive for PTSD
    - > 65  Found in women with MST and PTSD (Arbisi, et al., 2010)

- Specific Problems Scales
  - ANX **
  - ANP
  - SFD
  - SAV

** largest effect size
Comorbidity and PTSD

- Comorbidity is the rule, rather than the exception, with PTSD due to,
  - Symptom overlap
  - Trauma causing generalized distress or other disorders in addition to PTSD
- Response to stressful life events assessed by MMPI-2-RF with implications for treatment engagement
  - Internalizing
  - Externalizing
Internalizing vs. Externalizing Response to Trauma

- Clinical manifestation of PTSD affected by personality (Miller, Kaloupek, Dillon, & Keane, 2004; Miller, Greif, & Smith, 2003)
  - Low PEM and high NEM: Internalizing
  - Low CON and high NEM: Externalizing

- Forbes et al., (2010) Four classes of PTSD defined by PSY-5 Scales
  - High internalizing: NEGE, INTR, & PSYC
  - Moderate internalizing: NEGE & INTR
  - Externalizing: AGGR & DISC
  - Low pathology

- Subtypes of PTSD or response to stressful life events?
  - Longitudinal studies indicate presence before life events
    - Koffel et al., (2012)
In both men and women veterans (Wolf et al., 2008) found RCd and RC7 linked to internalizing comorbidities (MDD in PTSD)

- RC1 moderately related to internalizing
- RC4 to externalizing

Forbes et al. (2010)

- RC Scales defined three groups based on severity. However, RC3, RC4, & RC 9 were more highly elevated in the severe group suggesting externalizing behaviors associated with more severe PTSD

Rielage, Hoyt, & Renshaw (2010) found two groups: externalizing and internalizing

- Externalizing defined by RC4, RC9, RC3.
- Internalizing defined by RC1, RC2, RC7, RC8, and with RCd highest elevation.
Summary of MMPI-2-RF Scales in Trauma-Related Comorbidity

- **Internalizing**
  - Depression
    - EID, RCd, RC2, HLP, SUI
    - PSY-5-r INTR
  - Anxiety
    - EID, RCd, BRF, MSF, SAV
    - PSY-5-r NEGE
- **Externalizing**
  - Substance Misuse
    - BXD, RCd, RC4, SUB, DISC
    - PSY-5-r DISC and AGGR
Role of the MMPI-2-RF in Treatment Readiness and Outcome

- Evaluate approach to treatment and impact on outcome
- Identified patient: the role of distress in motivating engagement
- The usual suspects: drugs/alcohol, antisocial behavior, and disordered thinking
- Less obvious culprits: cynicism, a barrier to care?
- How is the client likely to engage (or not) with the treatment provider?
  - Interpersonal factors
First Step in Treatment?

- Ability to benefit from treatment based on accurate communication between patient and treatment provider
- MMPI-2-RF Validity Scales provide information regarding accuracy of self-report
  - Cooperative or oppositional
  - Minimize or fail to report problems
    - Selective Self Report
  - Over-report
    - Distress
    - Severe psychiatric illness
    - Somatic symptoms
    - Cognitive symptoms/impairment
Use MMPI-2-RF to Assess Approach to Treatment

- **TRIN-r**
  - After ruling out problems with reading or comprehension, suggests **OPPOSITIONALITY**

- **F-r**
  - Reflects distress and genuine severe pathology unless extreme elevation (> 100)

- **F_p-r**
  - Non-credible report of symptoms thus violation of social/therapeutic contract

- **FBS-r, RBS**
  - Impact will depend on setting and presenting complaint

- **K-r**
  - Minimization of problems and false claim of emotional stability. Failure (either conscious or unconscious) to accurately report condition

- **L-r**
  - Claim of uncommon virtues and denial of uncomplimentary attributes or behaviors
Prediction of Treatment for Trauma-Related Conditions

- Prolonged Exposure and Cognitive Processing Therapy are ESTs for PTSD endorsed by Society for Clinical Psychology.

- Veterans diagnosed with PTSD who are currently receiving care through the VA are required to be offered evidence based treatment for PTSD (Cognitive Processing Therapy or Prolonged Exposure). Both CPT and PE last 12 weeks and involve 90-minute interventions conducted by trained clinicians who maintain fidelity to the treatment.

- CPT and PE have demonstrated efficacy, but require adherence and commitment.
Most Likely to be Recommended for Trauma-Specific Treatments

- Consistent with literature, elevation on
  - EID, RC7, STW, ANX, ANP, NEGE-r
  - RC6, RC8, PSYC-r
  - RC9, AGG, AGGR-r
  - RC1, HPC, NUC
- Lower score on IPP
- Screening psychologist had no access to MMPI-2-RF
Failure to Engage in Treatment for Trauma-Related Conditions

- In a VA setting 26% of veterans referred for PTSD treatment produced invalid profiles based on standard invalidity indices with an additional 20% producing some level of non-credible reporting related to report of somatic and cognitive complaints
  - Compares to 11% in non-PTSD samples

- VRIN & TRIN associated with number of missed therapy appointments, TRIN with failure to complete homework assignment

- Fp-r elevation associated with number of sessions and lower therapist-rated engagement
Characteristics of Treatment Dropout

- Veterans who were most severely distressed and miserable, i.e., higher scores on NEGE-r, AXY, HLP, ACT were more likely to drop out of exposure-based treatments.
- Veterans referred for CPT/PE had high levels of anxiety and distress, but those with the highest levels may not have been ready for such a demanding treatment.
Compliance with Treatment

• MMPI-2-RF scales predictive of process-associated outcomes
  • Number of failed appointments
    • RCd, NFC, AXY
• Number of times late for appointment
  • NFC, AXY, AES
• The more distressed, ineffective, and symptomatic are again less likely to be able to actively engage in treatment demanding a high level of investment
RC3 Cynicism as a Barrier to Care

- **RC3**
  - Degree to which someone holds
    - Misanthropic, negativistic, or mistrustful world view
    - Empirical research primarily in areas of behavioral medicine and police misconduct
  
  - Emerging evidence that cynicism can serve as a barrier to care
    - Prevents engagement in treatment and inhibits therapeutic alliance
    - **RC3** independently (beyond stigma or attitudes toward mental health care) predicts access to needed MH care (Arbisi et al., 2013).

- Being broadly mistrustful (non-self-referential) impedes ability to perceive treatment as particularly useful or to view treatment provider as motivated to fulfill his or her portion of therapeutic contract
Summary of Treatment Implications

- MMPI-2-RF can help address:
  - Patients’ willingness to engage in treatment
    - Accepting the social contract in therapeutic alliance by reporting condition in open and accurate manner
  - Level of motivation:
    - RCd
    - For some structured compliance-intensive treatments, amelioration of acute symptoms and distress reduction techniques may be necessary before referral to trauma-focused treatment.
  - Attitudes toward treatment provider
    - Externalized traits (RC4; RC9, AGGR-r, DISC-r)
    - IPP, ↓ AGGR-r
    - RC3
CASE EXAMPLE

- 43-year-old woman suffered work-related injury when hand was avulsed in a machine. Surgically reattached and has limited utility. PTSD symptom with significant avoidance and hyperarousal.
# Score Report

**MMPI-2-RF®**  
Minnesota Multiphasic Personality Inventory-2-Restructured Form®  
*Yossef S. Ben-Porath, PhD, & Auke Tellegen, PhD*  

| ID Number:  | 10136  |  
| Gender:     | Female |  
| Age:        | 43     |  
| Marital Status: | Never Married |  
| Years of Education: | 13 |  
| Date Assessed: | 11/13/2014 |  

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**PEARSON**

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MMPI-2-RF Validity Scales

Raw Score: 6 12 8 2 3 19 9 3 6
T Score: 63 57 T 79 59 66 86 67 52 45
Response %: 100 100 100 100 100 100 100 100 100
Cannot Say (Raw): 1 Percent True (of items answered): 38%

Comparison Group Data: Outpatient, Community Mental Health Center (Women), N = 582
Mean Score (---): 52 51 T 75 58 68 70 67 53 41
Standard Dev (----): 10 9 23 14 21 15 19 11 10
Percent scoring at or below test taker: 91 80 64 69 61 86 59 61 75

The highest and lowest T scores possible on each scale are indicated by a "---". MMPI-2-RF T scores are non-gendered.
MMPI-2-RF Higher-Order (H-O) and Restructured Clinical (RC) Scales

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Comparison Group Data: Outpatient, Community Mental Health Center (Women), N = 582
Mean Score (---): 68 59 54 68 67 65 57 59 62 62 57 50
Standard Dev (------): 14 13 11 13 15 15 12 11 15 13 13 10
Percent scoring at or below test taker: 62 44 6 49 70 80 41 9 58 69 43 22

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.
MMPI-2-RF Somatic/Cognitive and Internalizing Scales

**Raw Score:**
- Somatic/Cognitive: 7 2 2 7 4 0 2 3 3 6 4 4 3 2
- Internalizing: 81 72 59 86 64 45 60 65 51 73 91 59 71 46

**T Score:**
- Somatic/Cognitive: 100 100 100 100 100 100 100 100 100 100 100 100 100 100
- Internalizing: 100 100 100 100 100 100 100 100 100 100 100 100 100 100

**Response %:**
- Somatic/Cognitive: 100 100 100 100 100 100 100 100 100 100 100 100 100 100
- Internalizing: 100 100 100 100 100 100 100 100 100 100 100 100 100 100

**Comparison Group Data:** Outpatient, Community Mental Health Center (Women), N = 582
- Mean Score: 66 67 63 62 64 61 59 64 61 62 67 59 59 54
- Standard Dev: 13 18 14 16 16 21 15 12 13 12 17 12 15 10
- Percent scoring at or below test taker: 89 65 48 92 54 58 65 56 32 90 95 62 85 22

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.

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<td>Self-Doubt</td>
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<td>Cognitive Complaints</td>
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MMPI-2-RF Externalizing, Interpersonal, and Interest Scales

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Comparison Group Data: Outpatient, Community Mental Health Center (Women), N = 582

- Mean Score (---): 57 51 54 52 63 54 56 55 54 48 44
- Standard Dev (-----): 12 11 12 12 14 12 13 13 12 13 10 7
- Percent scoring at or below test taker: 19 39 52 82 23 72 92 85 78 50 81

The highest and lowest T scores possible on each scale are indicated by a "---"; MMPI-2-RF T scores are non-gendered.
MMPI-2-RF PSY-5 Scales

Raw Score:
- AGGR-r: 5
- PSYC-r: 1
- DISC-r: 2
- NEGE-r: 16
- INTR-r: 14

T Score:
- AGGR-r: 41
- PSYC-r: 47
- DISC-r: 38
- NEGE-r: 80
- INTR-r: 74

Response %:
- AGGR-r: 100
- PSYC-r: 100
- DISC-r: 100
- NEGE-r: 100
- INTR-r: 95

Comparison Group Data: Outpatient, Community Mental Health Center (Women), N = 582

Mean Score (n=582):
- AGGR-r: 48
- PSYC-r: 58
- DISC-r: 50
- NEGE-r: 65
- INTR-r: 59

Standard Dev (n=582):
- AGGR-r: 10
- PSYC-r: 13
- DISC-r: 9
- NEGE-r: 13
- INTR-r: 14

Percent scoring at or below test taker:
- AGGR-r: 29
- PSYC-r: 28
- DISC-r: 15
- NEGE-r: 91
- INTR-r: 85

The highest and lowest T scores possible on each scale are indicated by "-----"; MMPI-2-RF T scores are non-gendered.

AGGR-r Aggressiveness-Revised
PSYC-r Psychoticism-Revised
DISC-r Disconstraint-Revised
NEGE-r Negative Emotionality/Neuroticism-Revised
INTR-r Introversion/Low Positive Emotionality-Revised
# MMPI-2-RF T Scores (By Domain)

## Protocol Validity

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## Substantive Scales

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### Thought Dysfunction

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### Interests

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Summary

- Trauma-related conditions well characterized by the MMPI-2-RF
  - Marked by elevations on EID, RCd, RC7, STW, ANX, ANP, NEGE-r
  - Frequently RC1
- Based on individuals’ pre-existing temperament, trauma-related conditions can be expressed through externalized or internalized behaviors
- Trauma-specific exposure treatments may not be well-tolerated by acutely distressed and more symptomatic patients
Questions?