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Personality Disorders and Overseas Missions: Guidelines for the Mental Health Professional

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Mental health care professionals are in a unique position to advise mission organizations in the selection process. This is especially the case in helping newer inexperienced boards avoid overseas placement of personality disordered individuals. The article reviews specific personality disorders and their impact in the overseas setting. The dilemma of compassion vs. administrative wisdom is addressed. Suggestions are included to help missions refine selection policies using the MMPI, understanding its limits, using occupational history review, personal interviews, and individual follow-up on letters of recommendation. The article is not intended to be a handbook for the selection process, but to call attention to an often neglected area of psychopathology that needs to be addressed in the screening evaluation.

In spite of the availability of sophisticated selection tools for missions (Ferguson, Kliewer, Lindquist & Lindquist, 1981; Foyle, 1987; Gardner, 1987; Lindquist, 1983), not all sending organizations are utilizing these options. Occasional missionaries may be placed overseas who do not have the emotional stability to be there (Anonymous, 1990). Crises culminating in personal and organizational disasters have alerted many on-site mental health professionals to deficiencies in the selection process of some mission boards. I believe these deficiencies are most apparent in the inadvertent placement of people with personality disorders. In this article I will discuss the fact that some missionaries are personality disordered, investigate the selection process that allowed their overseas placement, discuss the unique aspects of overseas work that makes their presence untenable, and present what I believe can be done by mental health professionals to prevent these catastrophes in the future.

An extensive search of the literature revealed no studies of personality disordered missionaries in overseas settings. Two studies discussed the placement of individuals with personality disorders in other overseas organizations. An early study of the Peace Corps by Menninger & English (1965) reported that nine of the first 7,979 Peace Corps workers were psychiatric casualties due to personality disorders. These ranged in age from 19-41, evenly divided between men and women. Personality disorder types were schizoid, passive-aggressive, and narcissistic. The selection process involved an intensive training program, but no MMPI. Only about 20% received psychiatric interviews. The psychiatric interview alone did not appear to be particularly effective in anticipating these problems. A prior study by Glass, Ryan, Lubin, Ramana, & Tucker (1956) reported that the psychiatric interview contributed to predicting success of military recruits who remained in the U.S.; however, interviews alone were inaccurate in predicting outcomes in overseas placement or other situations of radical change.

Having devoted the last eight years to overseas consultations, preventive care, counseling, and medical treatment of depressed missionaries, I am seeing some patterns that deeply concern me. I strongly

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believe in treating unipolar major depressive disorders on the field, and I have been successfully doing so in most cases. I call these "healthy depressions" when talking with mission personnel. These illnesses respond well to counseling and medication, and clients can usually return to productive work wiser and more insightful. In addition, these people are saved the disgrace of returning to their constituency in a depressed condition.

In contrast, I am beginning to see more characterological, or "unhealthy depressions," occurring in missionary populations. These clients may initially respond to treatment, but an underlying personality pathology is uncovered that may preclude their continued missionary service. Individuals with personality disorders may have slipped through selection without adequate evaluation. Their presence on the field is usually surrounded by contention, dissension, disagreements, and exhaustion on the part of other missionaries and field executives who try to support them emotionally and spiritually.

The following case study is an example:

Herb N., a thirty four year old missionary candidate, is sent to an African country with his wife and three children, aged 10, 8, and 5. His mission organization believes in pre-field testing, but due to the pressing needs on the field, Herb and Mary do not participate in the entire battery of tests, interviews, and follow-up. Herb does not seem to mind the limited evaluation.

Once overseas, in planning sessions and team meetings, Herb has periodic rages followed the next day by abject repentance, tears, and the promise never to get angry again. He has difficulty submitting to authority or being a team player. The field leader is at a loss to know how to manage the situation, especially since Herb is so obviously sincere in his Christian commitment. Complaints begin to pour in from the national church regarding Herb.

Mary makes efforts to keep things smooth at home, trying to avoid conflict, but periodically the two school-age children are seen with unexplained bruises on their faces and bodies. One child shows evidence of chronic childhood depression associated with acting out; the other has frequent medical complaints which cannot be documented on physical exam or laboratory testing.

The family is strongly advised to return to the U.S. for family therapy and treatment of the children. They refuse, withdraw further into the family unit, eventually leave the mission, but remain on the field without accountability to anyone. The country in which they reside has no child abuse laws so that concerned missionaries there are unable to intervene in the obvious on-going abuse of the children.

Later investigation into Herb's past reveals that prior to application to the mission, he was in a series of brief jobs followed by three pastorates that ended in termination—none lasting longer than a year.

His childhood had been chaotic, with profound disruption occurring in his first five years of life.

Once, while in college, he was seen by a psychologist who told him that lengthy counseling might help his problems with identity and emptiness, but Herb refused to return to the clinician, calling him an unqualified professional who did not know what he was doing.

As we recruit our missionary candidates from an enlarging pool of bruised individuals, mission board personnel departments may need more sophisticated selection tools to avoid placing well-meaning candidates in jobs beyond their emotional skills. The mental health care professional is an invaluable asset in preventing the overseas placement of personality disordered individuals.

Many large sending agencies utilize extensive pre-field testing, but smaller, newer organizations are often limited in experience, finances, and psychological expertise. I believe the mental health professional can help in suggesting policy changes for these boards.

Currently I provide official consultations to eight missions. I also frequently see individuals from other agencies both in the U.S. and overseas. All of the missions for which I consult use the MMPI in selection. In one mission that previously did not use the instrument, I discovered three individuals who met the criteria for personality disorders. All three needed to return to the U.S.; their families were disrupted, financial supporters disillusioned, field teams exhausted, and the mission financially stressed by the financial obligations of the emergencies.

Another self-insured mission that uses the MMPI accepted a missionary candidate against professional advice because of pressure from the sending church. The individual was never able to go overseas, could not find a job in the homeland office that he could adapt to, and ended up in a psychiatric hospital for months at mission expense. He was diagnosed with a personality disorder.

One other mission sent a couple overseas in spite of warning signs on the MMPI and from the psychological evaluation. After a difficult first term, the field recommended more intense homeland evaluation and review. Unfortunately the family was sent back to the field, the marriage failed, the field team was split, and repercussions were felt both overseas and in the homeland.

In spite of the anecdotal nature of the above comments, I can categorically say that I have yet to find a missionary with a personality disorder who

reached the field if the MMPI was done professionally with interviews, and if the recommendations of professionals were heeded. Clinical experience suggests some alarming trends that merit future quality statistical research. Unfortunately data is difficult to acquire from some organizations due to (a) issues of confidentiality, (b) embarrassment, (c) pastoral rather than psychological approach to selection, and, though this is rare, (d) a philosophy that spirituality surpasses all psychological problems.

Mental health professionals can occasionally be intimidated by the obvious spiritual qualifications of non-psychologist personnel directors. Nevertheless, we need to help educate toward the use of psychological tools in the selection process. At the same time, personnel directors must understand that candidates' own psychological agendas (Schubert, 1989; Sexton & Maddock, 1980) may be misinterpreted as a spiritual call to missions. Sending agencies cannot afford to be psychologically naive, especially now that our recruits often come from such varied and damaged backgrounds.

Uniqueness of Overseas Settings

Boundary issues are almost always problematic with persons having a personality disorder (Gabbard, 1990; Nicholi, 1988). North American professionals are protected from boundary violations by answering services, separate office and residential locations, and office staff. Overseas mental health care workers, field executives, fellow missionaries, and nationals are vulnerable to victimization in a setting where none of these protections exist. The assumption made overseas is that the missionaries are emotionally as well as spiritually mature. Since the personality disordered missionary has twenty-four hour access to others' homes, offices, and spheres of influence, his presence overseas resembles living day and night with a disordered family member. Naive nationals and loving fellow missionaries are quickly exhausted and frustrated by the unmeetable needs and demands. Boundaries are almost impossible to establish and there is often false guilt for trying to set these limits.

Also, since the majority of missionaries go overseas with training in theology or other non-psychological fields they are ill-prepared to deal with personality disordered individuals who may appear psychologically healthy, that is, not delusional or thought disordered, yet have deep-seated maladaptations.

Finally, the defense mechanisms employed by many people with personality disorders, especially splitting and projective identification, play havoc with team unity and individual relationships. I have seen field teams permanently split over these difficult personnel issues.

I believe that the deterioration of the family in Western society, the erosion of stable traditions, and the frequency of child abuse, sexual abuse, neglect, alcoholic families and other dysfunctional families contribute to the marked increase in personality disorders seen in missionary candidates and selected missionaries. Christian organizations such as Inter-Varsity Christian Fellowship are noticing a marked increase in chapter members who come from dysfunctional families. Don Fields (personal communication, Nov. 19, 1990) commented that twenty-five years ago 20% of their college age members came from dysfunctional families. Currently the figure is between 60-70%.

Some of these individuals with emotional bruising can do a good job overseas if issues are worked through psychologically first (Schubert, 1989). However, if the damage is intense enough, and unhealthy traits are maladaptive and inflexible enough to be considered a true personality disorder, that individual should not be placed overseas.

Types of Personality Disorders

The Diagnostic and Statistical Manual (DSM-III-R) classifies personality disorders in three clusters. We will briefly note clusters "A" and "C" and then concentrate attention on cluster "B."

Cluster A includes paranoid, schizoid, and schizotypal personality disorders. The Christian with paranoid personality disorder may be rigid, dogmatic, and suspicious. In mission settings this person's pathology may be focused on legalisms, divisive doctrines, and theological deficiencies of others. There is little humor in interactions and a great deal of sensitivity to power and rank. The schizoid personality disorder manifests extreme shyness, aloofness, and insensitivity to others' feelings. When overseas, the individual may be reclusive, a loner, and have few, if any, friends within the mission group. The schizotypal person has a tenuous hold on reality, may have eccentric convictions and beliefs, and may have what they believe to be religious experiences that are actually the result of psychotic processes. (Oates, 1987). Missionary candidates with cluster A disorders often appear so odd or eccentric that they are eliminated from selection

by interview, along with close scrutiny of letters of recommendation and telephone calls to authors of the letters.

Cluster C includes avoidant, dependent, obsessive-compulsive, and passive aggressive personality disorders. Candidates with avoidant personality disorder who proceed through the selection process may be seen in missionary settings as loners who may function to some degree in a solo placement as independents or pioneers. Oates (1987) describes Christians with this disorder as "actively detached adults" with histories of rejection and a deep fear of being hurt (pp. 102-103). Persons with dependent personality disorder place responsibility for life decisions on others, subordinate personal needs to others, have markedly low self esteem, and cannot tolerate being alone. They drain fellow missionaries emotionally in the overseas community where boundary setting is so difficult. They are particularly unable to deal with the separations that are an inherent part of missionary living. Obsessive-compulsive personality disorder (ego-syntonic) must be distinguished from obsessive-compulsive disorder (ego-dystonic), (Gabbard, 1990). The ego-syntonic individual is comfortable with his or her symptoms while the ego-dystonic individual recognizes his or her symptoms as maladaptive or pathological. The personality disordered obsessive-compulsive individual may simply appear overly conscientious and scrupulous, but be so exacting that conflict arises over criticism of other missionaries. Though occasionally these people can function in a book work, laboratory, or isolated office setting, their rigid, controlling, lack of people orientation is destructive to the necessary cohesive missionary team. Finally, the individual with passive-aggressive personality disorder may appear to be a fine Christian who never gets angry. Unfortunately, in overseas situations which are already fraught with frustrations, this person's obstinacy and anger will be expressed indirectly with procrastination, delay, and discreet refusal to follow orders. Other missionaries are puzzled by their own angry reactions to such a nice person. Candidates with avoidant and dependent personality disorders are often filtered out by interview and non-psychological evaluation, but those with obsessive-compulsive and passive agressive personality disorders may progress through the selection process if more sophisticated testing is neglected.

Persons with cluster B personality disorders are particularly destructive if sent overseas. They may appear dramatic, suave, emotional, yet deceptively healthy. Their erratic, impulsive, disruptive, and splitting behaviors are not always apparent until they are stressed with the cultural adjustments of living overseas without their usual support systems. Each of these aspects will be discussed in more detail. Millon and Everly (1987) have written extensively on personality disorders; Oates (1987) and Landorf (1982) provide Christian perspectives of these disorders.

I. Antisocial personality disorder was formerly referred to as sociopathy or psychopathy (Magid & McKelvey, 1987). The newer title is deceptive in that these people are often smooth, good talkers, and sociable on a superficial level. In the mission setting they make wonderful deputation speakers, possibly raising their full support in a month when the rest of the mission candidates take six months to two years.

   In candidate school they are seen as manipulators and exploiters, usually lacking real empathy and compassion. They seem to be born with a social and moral learning disorder (Pollock, 1990). Their sociopathic "swiss cheese" conscience or *superego lacunae* predispose to sexually immoral behavior even while they loudly proclaim moral purity from the mission pulpit.

   Boundary violations for the sociopath revolve around the superego deficiencies. They include sexual morality, ethics, business dealings, money management, parenting, and work behavior. The obvious discrepancies between talk and walk are devastating to the mission setting as well as to the constituency.

   Occasionally evangelicals find it hard to acknowledge that there can be a disorder that leaves the individual truly incapable of moral decision-making. They want scriptural documentation of this difficult concept. I have suggested they study Deuteronomy 21:18-21, which describes capital punishment applied to incorrigible teen-agers prior to marriage and the potential genetic components of this disorder.

II. Borderline personality disorder was not clearly defined until the past decade. It is characterized by instability of mood, interpersonal relationships, and self-image. Identity disturbance is almost always present especially in self view, sexual identity, long term goals, career, types of friends, and values. There are usually symptoms of emptiness and boredom (Gabbard, 1990).

   Persons with this disorder have unstable and

intense relationships often alternating between the extremes of over-idealization and devaluation. They cannot tolerate being alone, and frequent outbursts of anger occur for which they may later be sorry, or they may deny that they were angry. Self mutilation or suicide gestures may be frequent.

Individuals with borderline personality disorder are frequently involved in *splitting*. The outward behavior associated with this is seen in two settings overseas. The first occurs in one to one relationships, that is alternating between the extremes of idealizing a person, then suddenly devaluing the same person. This leaves missionary colleagues with no consistent frame of reference for interaction and relationships. The second situation where splitting occurs is in group and team functioning where several team members will be strongly in favor of the borderline and easily manipulated by him or her, whereas others see the dysfunctional patterns of behavior and feel that the individual is a detriment to the team effort. With the passage of time and the onset of exhaustion most of the team will perceive the destructive impact of continued interaction.

People with this disorder have not completed important developmental milestones, some of which can never be reclaimed (Gabbard, 1990). Fear of abandonment is intense and may persist in spite of therapy. This is exacerbated by the frequent separations that characterize missionary living. Many borderlines were sexually abused as children (Audio-Digest, 1989; Gabbard, 1990). For this reason history taking in selection needs to include questions regarding childhood sexual abuse.

In orientation programs, these individuals may be observed in frequent anger-remorse-depression cycles. Once they arrive overseas their disruption to the field ministry team is almost as severe as that occurring with the antisocial personality. At times the borderline appears normal, therefore other missionaries are caught off guard when outbursts or decompensation occurs.

Identity establishment is so incomplete in people with this disorder that they find it almost impossible to successfully integrate into a new culture, hence the basic incompatibility of this personality disorder with overseas missionary service. They may look to the mission to provide their identity. Their identity is diffuse enough that they often do not know what boundaries are, and their limited capacity for empathy precludes understanding others' needs for privacy and time alone.

The borderline's inability to self soothe (Audio-Digest, 1989), creates demands on other missionaries to be the sole source of a holding environment. Busy missionaries without the capacity to set limits are unable to provide this.

III. Narcissistic personality disorder is marked by a pervasive pattern of grandiosity, hypersensitivity to the evaluation of others, and lack of empathy (DSM-III-R). People with this disorder think of themselves as special, but when faced with the normal disappointments of life, they may decompensate. They often feel that they are unique and entitled to special treatment. Their feelings of entitlement seldom have a corresponding sense of reciprocal responsibility. We live in a somewhat narcissistic society, therefore, cultural traits must be distinguished from a true personality disorder.

Gabbard (1990) distinguishes between the oblivious narcissist who "has a sender, but no receiver," and the hypervigilant, who is exquisitely sensitive to how others react. In either case, people with this disorder have a very fragile self-esteem. They have the exaggerated sense of self-importance of a small child. Becoming a star missionary may further feed this pathology, though the stardom is usually short-lived. The developmental stages of learning to face gradual, limited disappointments with parental support may not have occurred. Consequently they do not develop the mature ability to withstand disappointment and failure that are a part of mission life while retaining self-regard. They then alternate between feelings of grandiosity and inferiority. Often they appear to have individuated but not separated (Gabbard).

In the selection process, individuals with this disorder may be detected by an inability to accept criticism, disappointment, or suggestions. They seem unable to love. On the field they may project a favorable image, but are unable to consider the needs of others. Because these individuals feel that they are special and entitled they do not maintain social distance. Consequently, their boundary violations tend to emotionally drain other missionaries. They are also poor team players. In the face of disappointment they may respond with a brief reactive psychosis which can

be very disruptive to the work of the mission. Treatment, if possible, often involves providing a holding environment that allows development to proceed. This is simply not feasible overseas.

IV. Histrionic personality disorder manifests itself with excessive emotionality and attention seeking. People with this disorder constantly seek and demand reassurance, praise, approval, and affirmation. They need to be the center of attention. Their emotions seem shallow and rapidly shifting. Loss and rejection, perceived or real, create severe distress. They may be creative and imaginative, but they lack analytical decision-making skills. (Review of General Psychiatry, 1988).

It is important to distinguish between the more healthy hysterical personality and the true histrionic personality disorder (Gabbard, 1990).

Causes of the disorder may be early life separations and disturbance in attachments, as well as poor bonding and limited role modeling. Self-esteem for the adult histrionic is centered on physical attractiveness, often to the point of seductiveness. This person has a limited capacity to tolerate delayed gratification, which does not blend well with missionary service. The constant need for reassurance and affirmation wears down other missionaries and nationals, creating a level of exhaustion in the entire team.

In candidate school or orientation programs, histrionic individuals seem overly emotional, flighty, and seductive. They may be the center of every party, but in a very superficial way. Letters of recommendation often comment on these characteristics. These people are so desperate for attention that they may cross any boundary to get it. Their seductiveness may be either social, sexual, or both. It is possible for a person to display mixed features of personality disorders, now titled "Personality disorder, NOS."

In advising mission boards one must distinguish between the healthy depression mentioned at the beginning of the article, and the unhealthy depression accompanying personality disorders. The former usually is clinically responsive to medication and counseling. In contrast, characterological depressions are only symptoms superimposed on fixed, maladaptive traits. These unhealthy depressions occur when the style of the personality disordered individual is not succeeding in day to day life. Productivity in stressful settings is out of the question for these individuals. The mental health care professional is uniquely positioned to help mission boards gain sophistication and use appropriate tools in treatment (when possible), and in providing expertise in preventive selection procedures.

Mission personnel are sometimes uncomfortable with the fact that most discriptions of personality disorders include some characteristics that remind them of themselves. The key to overcoming this discomfort is to remember that to diagnose a personality disorder, the patterns must be lifelong, pervasive, inflexible, and maladaptive enough to cause either impairment in interpersonal or occupational functioning, or subjective distress.

Compassion for the Individual vs. Protection of the Overseas Team

One of the most difficult issues any mission has to face is what to do when a person with one of these personality disorders progresses through the selection process, arriving overseas with all of his or her emotional difficulties. The individual's behavior quickly results in credibility gaps with the nationals, exhaustion on the part of field executives, and frustration and sometimes resignations from other missionaries.

Compassion would suggest an extended effort to work with the person in the field environment. Unfortunately we are all aware that the statistical probability of success anywhere, much less in the heat of the battle overseas, is negligible. Meanwhile, the work, the other missionaries, the nationals, and the field leader suffer immense pain.

Can a Christian have a personality disorder? Yes. Is that emotional damage healed by a committed Christian experience? Not necessarily. We understand that a person with physical crippling such as polio is not necessarily made whole by salvation and growth. We must communicate that psychological crippling is not automatically healed with Christian commitment.

In talking with mission executives, the analogy I draw is that we would not send a physically wheelchair-bound individual to the battlefront in war. I contend that we must not send our psychological wheelchair cases to the spiritual battlefront overseas. When we do, we compromise the work and expose the individual to unnecessary failure. We also add frustration, anger, and decreased effectiveness and efficiency to the stresses with which coworkers are already dealing. We can use the mistakes made in the past to educate our missions to

the need for quality prevention.

In many cases people with personality disorders are intelligent and educated. They may appear to be very spiritual, and their skills may seem to be just what a particular field needs. Too often, though, the mission has chosen people to fill the immediate needs overseas without selecting according to emotional qualifications.

The mental health professional may also need to remind his organization that a mission that accepts a candidate with a personality disorder who decompensates while in their employ may be responsible to provide hospitalization. The workman's compensation matters involved in these cases can bankrupt a self-insured mission board since the cost to the organization may reach as high as $1,000 per day.

Prevention

It would seem that the obvious long-term solution for missions resides in the selection process. Consulting professionals may help avoid inadvertent recruitment of personality disordered individuals by suggesting the following:

1. All candidates and spouses should receive the MMPI. (MMPI II may correct for some ethnic bias.) The MMPI is the gold standard of personality inventories, in my opinion, though some professionals use the MCMI.

   Mission groups need to understand that these tests must be interpreted by a seasoned professional who should also conduct an interview (Lindquist, 1983). The primary objection is the cost; however, this seems a small price to pay in comparison to the financial and human toll involved with sending personality disordered individuals overseas.

   Missions need to understand the limitations of the MMPI; for instance it will not detect sexual deviancy. The three mistakes I see regarding the use of the MMPI in mission selection and personality disorders are (a) not doing it, (b) not doing it well, and (c) not listening to the professionals providing the assessments.
2. In-depth personnel interviews must be conducted for all candidates. This should include separate interviews with the spouse and any older children (Foyle, 1987). Delicate matters such as childhood sexual abuse, dysfunctional families of origin, and alcoholic backgrounds must be addressed.
3. All recommendation letters should be followed up by a personal telephone call. Letter writers will often be more candid regarding problems if their opinions do not appear in print.
4. All candidates should submit a detailed occupational and social history which has been verified by outside sources. My experience has been that many people with personality disorders have frequent job changes, though short term jobs related to schooling should be clarified.
5. If any questions surface, the candidate should be interviewed in several additional sessions by a seasoned mental health professional with experience in diagnosing personality disorders and with awareness of the unique stresses of overseas living.

Summary

This article should not be considered a complete psychological handbook for the missionary selection process. Rather, it is intended to help avoid the overseas placement of individuals with personality disorders. There may be useful places of service for these people within the church at large, but not overseas.

Selection committees need to be especially careful in placement procedures. Prevention is the best cure, with heavy emphasis on psychological testing and wise use of interviews, job records, and personal histories.

Addendum

Although this article is geared to detection of adults with personality disorders, families with a child or adolescent with this type of problem may also not be able to serve overseas as long as the child is living in the home. Care needs to be exercised during the selection process and testing problem children prior to overseas placement is critical. Families who adopt troubled youngsters may find that those children are too damaged or identity disordered to adjust to overseas settings.

The titles of personality disorders listed here are applicable only to individuals aged eighteen and older. Comparable childhood disorders have different titles.

There has been recent discussion about the possible use of the MMPI-II rather than the MMPI. Many professionals still feel that the MMPI-II is experimen-

tal and that there is not enough experience using it with the missionary population. It does offer the advantage of having less ethnic bias, and when it is translated into other major languages, it may be helpful in multi-national missions, such as those that send other nationalities (i.e., Koreans or Taiwan Chinese) to other countries. The MMPI-II has also deleted some outdated questions such as reference to the game "drop the handkerchief" and other era-limited contexts. Religious individuals will look more rigid and more likely to have elevated L scales.

The advantages of the continued use of the MMPI are several. First, it has stood the test of time, been translated into most major languages of the world, been well-adapted and normed for the missionary population, and can be used exceptionally effectively for Americans, Canadians, Britishers, and (some psychometrists believe) Northern Europeans.

Secondly, the MMPI has five scales that are important for missionaries that have been deleted on the MMPI-II. Five of these are research scales, specifically Dy (dependency) indicative of marital interaction and health, and also valuable in helping to determine the type of field location; Pr (prejudice) which shows rigidity in thinking; St (status) the need for recognition, opportunities to better oneself, and a desire for nice things, esthetics, etc.; Lb (low back) may reveal a friendly facade with underlying conflict or irritability; and Cn (control) which may help predict the individual's capacity for controlling negative impulses. In addition, Wiggins' content scale REL (religious fundamentalism) has been deleted in the MMPI-II.

For the above reasons, I am still utilizing the MMPI rather than the MMPI-II. Research results and field utilization over the next few years could influence and change my opinion on this matter.

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