Disagreement in Personality Judgments in Relation to Personality Pathology

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Disagreement in Personality Judgments in Relation to Personality Pathology

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Abstract: Self-reports and three informant reports on a five-factor personality questionnaire were collected in two samples (N = 96 and N = 95) of psychotherapy patients. In one sample the Five-Factor Personality Inventory (FFPI) was used and in the other sample the NEO-Five Factor Inventory (NEO-FFI). Self-reports, averaged informant reports, as well as self-other discrepancies and inter-informant discrepancies were related to clinical judgment of personality pathology. The main hypothesis, stating that self-other disagreement would add to the value of self- and informant reports in predicting personality pathology, was not confirmed. Consistently across instruments, lower scores on both self-reports and averaged informant reports on Extraversion had the strongest associations with personality pathology. Self-other disagreement on FFPI Extraversion and FFPI Conscientiousness also predicted personality pathology, but the significance of these associations disappeared in partial correlations controlled for self- and informant reports. No associations were found between inter-informant disagreement and personality pathology. With regard to the predictive value of self-reports and inter-informant disagreement both questionnaires were concordant. However, on the predictive value of self-other disagreement the two instruments differed. In clinical practice this method may generate markers for the presence of personality pathology and offer a lead for the procedure of stepped assessment.

Keywords: personality, self-report, informant reports, self-other disagreement, personality pathology

Key Practitioner Message:

- Informant reports in personality assessment add to the predictive value of self-reports.
- Low self- and informant scores on Extraversion may signal personality pathology.
- High self-other disagreement on FFPI Extraversion and FFPI Conscientiousness may signal personality pathology
- Disagreement among informants is not associated with personality pathology.

Self-reported personality description is subject to several threats to validity, such as response styles (e.g., socially desirable responding, acquiescent responding, extreme responding) and response biases. Some of these biases may be intentional, others unintentional.

An intentional bias is, for example, presentation bias, which may stem from the desire to derive benefits or avoid negative consequences. A person may present himself or herself in an overly virtuous manner in order to avoid negative consequences, or may present himself or herself as overly dysfunctional in order to derive benefits like getting help. Other biases than presentation bias can be less deliberate. Even for the most honest self-assessor, information can be unavailable or simply overlooked. Also, self perceptions can be distorted because the person is unable or not

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sufficiently able to adopt an objective position to himself, for instance due to memory failure, deficits in thinking, or distorted affective states. In both clinical practice and clinical research, self-reported personality profiles are often taken to be suspect because patients show limited introspective capacity, distorted self-views, or both. Presumably, self report biases are particularly evident in the context of personality disorders and several authors have indeed highlighted the importance of the use of informants in assessing adult psychopathology and specifically personality disorders, to arrive at a more objective assessment (e.g. Meyer, 2002; Ready, Watson, & Clark, 2002; Kamphuis, Emmelkamp, & De Vries, 2004; Achenbach, Krukowski, Dumenci, & Ivanova, 2005; Oltmanns & Turkheimer, 2006; Connolly, Kavanagh, & Viswesvaran, 2007).

As there is no criterion variable available, however, which can function as a gold standard, objective personality assessment is not within reach. Rather than objectivity or subjectivity, Hofstee (1994, 2009) promoted intersubjectivity, in which multiple judges are used to capitalize on the common variance in judgments. An intersubjective understanding of personality implies that personality is preferably assessed by the combined perspectives of multiple informants, including the target person him- or herself. As different judges (self and others) each contribute unique information, combining these judgments will result in a more reliable and more valid description of the person than by any judgment in isolation, because response tendencies and measurement errors in part will average out.

But, in general, self-other agreement tends to be moderate. In their meta-analyses of 108 studies, Achenbach and colleagues (2005) found mean cross-informant correlations of .68 for substance use, .43 for internalizing problems, and .44 for externalizing problems. In the subset of ten studies regarding self-informant correlations on personality problems (self-clinician correlations excluded), a mean self-informant correlation of .53 was found. With respect to personality traits and personality disorders, Meyer (2002) found cross-informant correlations ranging from .27 to .44. Klonsky, Oltmanns and Turkheimer (2002), in their review of the literature on agreement between informant- and self-reports of personality disorder, found a median correlation of .36 regarding DSM-registered personality disorders and .47 for other types of personality pathology.

There is no easy explanation for the moderateness of inter-judge agreement on personality pathology, nor on personality more generally. Several moderators of self-other agreement in personality judgments have been identified, like length of acquaintanceship (Funder & Colvin, 1988, Kurtz & Sherker, 2003); idiosyncratic understanding of items, reference to different time frames, and unavailability for the informant of covert experience of the subject (McCrae, Stone, Fagan, and Costa, 1998); consistency and stability of target's response patterns over time (Biesantz, West & Graziano, 1998; Biesanz, & West, 2000); trait visibility and assumed similarity between informant and subject (Watson, Hubbard, & Wiese, 2000); differences in judges' perspectives and differences in the context in which the behavior was observed (Kraemer, Measelle, Ablow, Essex, Boyce, & Kupfer, 2003; Noordhof, Oldehinkel, Verhulst, & Ormel, 2008); and frequency of interacting and interpersonal intimacy (Connelly & Ones, 2010). In short, moderate self-other agreement may be the result of different kinds of valid information of judges.

In the intersubjective approach to personality (Hofstee, 2009), the common component of personality judgments is assessed more precisely, which possibly means that discrepancies between self- and informant reports (i.e., the unique part of the variance) may contain additional portions of valid information which may be found clinically relevant. Mosterman and Hendriks (2011) followed this line of reasoning and investigated whether self-other disagreement on personality (SOD), rather than as unwanted error, could be conceptualized in part as an indirect measure of clinically relevant issues. They examined the content of disagreement on a broadband personality questionnaire in a clinical sample and found support for their hypothesis that SOD might reflect (personality) pathology of the target person. SOD predominantly was found in introverted, shy, hostile and depressed patients, who tended to have more personality problems and co-morbidity. Moreover, SOD on Conscientiousness proved to be a strong predictor of dropout. However, their study focused exclusively on discrepancies between self-report and averaged informant-reports. We were interested whether also inter-informant disagreement (IID) on a target person's personality contains clinically relevant information and whether this information differed from SOD.

In the present study we therefore extended Mosterman and Hendriks' (2011) line of inquiry by focusing on multiple disagreement measures in relation to clinician rated personality pathology, in two samples. In each sample we used a different five-factor personality questionnaire, to assess cross-instrument replicability of the findings. We examined the incremental contribution of SOD and IID to the contribution of self-reported personality and informant reports of personality to predicting clinician rated personality pathology. We expected that both SOD and IID would add to the value of self-reports and averaged informant reports in

Table 1. *Demographic statistics of the two samples*

	Sample 1		Sample 2 FFPINEO-FFI	
	N	*%*	*n*	*%*
Sex				
Female	76	79	70	74
Male	20	21	25	26
Age				
Mean (in years)	35		36	
SD (in years)	12		12	
Marital Status*				
Married/co-habiting	63	66	48	50
Single	33	34	47	50
Education				
Lower vocational level	5	5	9	9
Intermediate vocational level	36	38	38	40
Higher vocational level	45	47	36	38
University education	10	10	12	13
Work				
(Self-)employed	66	69	53	56
Unemployed/retired	17	18	23	24
Studying	13	13	19	20
Informant reports by				
Partners	71		56	
Family members	101		107	
Friends	82		91	
Other informants	34		31	
Total N	96		95	

Note. * = significant difference between samples: Pearson $Chi^2 = 4.47$; $p = .034$

relation to personality pathology. Whereas in SOD differences in *perspectives* of self and others are reflected, in IID differences in the breadth of *contexts* in which the target person is known by his or her informants play a role (Kraemer et.al., 2003; Noordhof et.al., 2008). Personality pathology may be differentially observable, depending for instance on the familiarity of the environment, or the people within the environment, to the target person.

SOD can be caused by distortions of self-reports, but also by invalid or distorted information from others, as multiple informants are more reliable according to the Spearman-Brown formula (Brown, 1910; Spearman, 1910), but not necessarily more valid. Therefore, we expected that SOD will be related to personality pathology (*distortion hypothesis*), in line also with findings from Mosterman and Hendriks (2011). Moreover, we expected SOD on one or more personality factors to show incremental predictive validity compared to self-reports and averaged informant reports on personality in the prediction of clinician rated personality pathology.

With regard to IID two rival hypotheses could be formulated. On the one hand, one might expect that the rigid inflexibility that characterizes personality pathology gives rise to more stable observable behavior over contexts than observed among more healthy individuals, which would mean to expect less IID in case of personality pathology (*rigidity hypothesis*). On the other hand, based upon the finding that self-other correlations were highest when the informant was a spouse (Connelly & Ones, 2010), one might expect that problematic personality behavior in principle is best detected by partners because of intimacy and frequency of contact, which would mean to expect more IID in case of personality pathology (*intimacy hypothesis*). Because of the exploratory nature of our study concerning the predictive value of IID for personality pathology, we chose to leave these two alternative hypotheses concerning IID undecided.

Method

Participants

Sample 1. The 96 participants in sample 1 were part of the sample of the Mosterman and Hendriks' (2011) study. From the original sample of 105 participants, 9 patients who did not provide three informant reports were excluded. The patients were referred by a primary care physician at the first author's psychotherapy practice in the period 2006/2007. A description of the sample is shown in Table 1. The participants provided self-ratings on a number of questionnaires (here, we only report on the personality questionnaire relevant for answering our research questions). In addition, each participant was asked to obtain other-ratings on their personality by three well-acquainted informants. In total 288 informant-reports were actually returned, from 71 partners, 101 family members, 82 friends, 34 other or unspecified acquaintances.

Sample 2. The 95 participants of sample 2 were part of an initial sample of 110 patients referred at the first author's psychotherapy practice in the period 2008-2010. Excluded were 15 patients who provided two informant reports instead of three. A sample description is presented in Table 1. Self- and informant ratings on personality were collected. The informant reports were provided by 56 partners, 107 family members, 91 friends and 31 other acquaintances.

Measures

Five-Factor Personality Inventory (FFPI). In sample 1, personality was assessed with the FFPI (Hendriks, Hofstee, & De Raad, 1999a, 1999b, 2002, 2011), which assesses the Dutch psycho-lexically based Big Five personality dimensions Extraversion, Agreeableness, Conscientiousness, Emotional Stability, and (intellectual) Autonomy. The latter construct is a measure of independent decision making. The instrument is suitable for self- and other-ratings and has been designed to be broadly applicable because of its item format and wording. Ratings were made on a scale running from 1 (*not at all applicable*) to 5 (*entirely applicable*). Strict guidelines were used for item construction, such as to phrase items as brief and simple as possible, to avoid negations and modifiers, and to phrase items in observable terms. The 100 items satisfy the criterion of being comprehensible at lower levels of education. Reliability and construct validity of the FFPI were established in many general population samples in The Netherlands (Hendriks et al., 2002, 2011) as well as in multiple other countries (Hendriks, Perugini, et al., 2003). The structure of the FFPI in the present sample showed fair to good similarity with the intended structure, as established in a large and representative normative sample of adults (Hendriks et al., 1999b). In the present sample congruence coefficients Tucker's phi ranged from .86 (for Autonomy) to .94 (for Extraversion and Emotional Stability) for the self-reports and .91 (for Agreeableness) to .96 (for Extraversion and Emotional Stability) for the averaged other-reports. The internal consistency reliability (stratified alpha) of the FFPI-factors was good: the alpha's ranged from .81 (Autonomy) to .89 (Extraversion) for the self-reports, with a median alpha of .86, and from .83 (Autonomy) to .91 (Extraversion) for the averaged other-reports, with a median alpha of .87. FFPI-factor scores are anchored at the scale midpoint (Hofstee & Hendriks, 1998), therefore, contain absolute information on a person's standing on the Big Five as established with the FFPI.

NEO Five Factory Inventory (NEO-FFI). In sample 2, personality was assessed with the NEO-FFI, which is a shortened version of the NEO-PI-R (Costa & McCrae, 1992; Dutch version: Hoekstra, Ormel, & De Fruyt, 2007). This 60-item questionnaire assesses the five personality domains Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness, each measured with 12 items. The internal consistency reliability (Crohnbach's alpha) for self-reports ranged from .73 (for Openness to Experience) to .85 (for Neuroticism), with a median alpha of .78. For informant reports the median alpha was .80 (range .75 for Openness to .84 for Conscientiousness), which is consistent with the values found in the original normative samples (Hoekstra et al., 2007).

We found no correlations between FFPI and NEO-FFI (12-items scales) reported in the literature. However, mean correlations between FFPI and the five domains of de NEO-PI-R (48-items scales) across three studies were .77 for Extraversion, .68 for Agreeableness, .77 for Conscientiousness, –.76 for Emotional Stability/Neuroticism, and .43 for the relationship between Autonomy and Openness to Experience (Hendriks et al., 2011).

Personality pathology: clinical judgment. Personality pathology was assessed by the first author, a licensed clinical psychologist, by means of an unstructured interview and clinical observation, complemented by information from self-reports of the patient on a number of questionnaires assessing complaints and psychopathological symptoms (not included in the current study). On the basis of a clinical evaluation of all available information, personality pathology was classified when patients met the DSM-IV Axis II general criteria for personality disorder, plus the manifesting features from one of the three Axis II clusters. Clinical diagnoses of personality pathology were re-coded into a binary variable indicating presence or absence of personality pathology. In both samples 51% of the patients were diagnosed with personality pathology (49 patients in sample 1 and 48 patients in sample 2, respectively).

Self-other disagreement and interinformant disagreement. Informant discrepancy measures vary widely between different studies, with important implications for interpreting the results. A main distinction can be made between *directional* (e.g., De Los Reyes & Kazdin, 2004; Noordhof et al., 2008), and *nondirectional* definitions of discrepancy (e.g., Pelton & Forehand, 2001; Mosterman & Hendriks, 2011). A nondirectional measure is inevitable when the discrepancy over all factors has to be assessed. Commonly in that case the Euclidean distance is used, as Mosterman and Hendriks (2011) did. Although Euclidean distances were not used in the current study, we preferred to continue to use the same underlying discrepancy construct. The merit of these discrepancy measures is their suitability for use in individual cases. That is, their meaning is defined at the individual level. These discrepancy measures are therefore easily applicable in clinical practice.

Table 2.
Descriptive Statistics of FFPI Factor Scores, NEO-FFI Scale Scores, and Pearson Correlations between Self-Reports and Informant Reports.

	self	partner		family		friend		average informant	
	M (SD)	*M (SD)*	*r*	*M (SD)*	*r*	*M (SD)*	*r*	*M (SD)*	*r*
FFPI									
E	0.35 (1.15)	0.78 (1.34)	0.74	1.01 (1.15)	0.67	0.78 (1.10)	0.69	0.87 (1.03)	0.80
A	2.21 (0.96)	2.05 (1.06)	0.41	2.13 (1.02)	0.17^{ns}	2.37 (1.15)	0.38	2.15 (0.76)	0.44
C	1.05 (1.11)	1.20 (0.99)	0.67	1.10 (1.02)	0.43	1.02 (1.10)	0.65	1.10 (0.85)	0.70
ES	−0.14 (1.14)	−0.36 (1.10)	0.68	−0.31 (1.16)	0.58	−0.10 (0.91)	0.52	−0.27 (0.84)	0.78
Au	0.90 (1.04)	0.97 (0.97)	0.55	1.03 (1.03)	0.27	1.18 (1.06)	0.63	1.06 (0.79)	0.61
NEO-FFI									
E	38.4 (7.7)	37.0 (6.9)	0.58	38.2 (7.3)	0.58	40.0 (6.0)	0.49	38.8 (5.3)	0.71
A	46.1 (6.7)	44.5 (7.4)	0.62	44.9 (6.5)	0.39	44.7 (7.0)	0.49	44.7 (5.5)	0.60
C	43.6 (7.5)	43.4 (7.6)	0.46	44.3 (8.0)	0.45	43.4 (7.0)	0.64	43.9 (6.0)	0.61
N	38.2 (9.7)	38.7 (8.3)	0.59	39.1 (7.0)	0.48	36.9 (7.0)	0.50	38.2 (5.7)	0.67
O	39.2 (7.7)	35.7 (6.8)	0.63	36.0 (5.3)	0.61	38.5 (6.9)	0.66	37.0 (5.2)	0.81

Note. FFPI: self: *n* = 96, partner: *n* = 71, family: *n* = 101, friends: *n* = 82, averaged informant: *n* = 96.
E = Extraversion; A = Agreeableness; C = Conscientiousness; ES = Emotional Stability; Au = Autonomy.
NEO-FFI: self: *n* = 95, partner: *n* = 56, family: *n* = 107, friends: *n* = 91, averaged informant: *n* = 95.
E = Extraversion; A = Agreeableness; C = Conscientiousness; N = Neuroticism; O = Openness for Experiences.
Correlations are significant at the 0.01 level (1-tailed).

So, for each participant, self-other disagreement (SOD) per FFPI factor (sample 1) and per NEO-FFI domain (sample 2) was determined by calculating the absolute discrepancy scores between self-reports and averaged informant reports. Inter-informant disagreement (IID) was determined by the average absolute discrepancy among the three informants.

Procedure

Prior to the first appointment the patients completed a short questionnaire about socio-demographic characteristics, which also included some open-end questions about perceived problems and symptoms, as well as the requested help. The manifesting problems and symptoms were assessed in detail during the first interview. At the end of this session the patients were handed the self-report questionnaires to be completed at home. In addition, they received three envelopes, each containing the FFPI (sample 1) or NEO-FFI (sample 2), to be handed to informants who the patient believed to know him or her well. The explicit instruction was not to discuss these ratings. Informants were instructed to seal the envelope after completion of the questionnaire and return it to the patient. The informants were assured that their ratings would remain confidential. They were explained that an average personality profile of their target person across judges would be calculated and that no individual answers would be discussed with the target person.

The completed questionnaires were collected during the patient's second interview session. Subsequently, the diagnostic procedure was continued by assessing the patient's developmental history and personal biography. The questionnaires were scored subsequent to the interview. Based on clinical interview and observation, supported by results of the self-report questionnaires, the DSM-IV classification was determined. Neither the information from the informant reports nor the self-other discrepancies were used in determining diagnoses or in carrying out therapy. A psychological report was written summarizing the results of the assessment procedures, including the questionnaire interpretation, DSM-IV classification, and treatment design.

The third session entailed the feedback session during which the report was discussed with the patient and informed consent for treatment was asked. The results for the self- and averaged

Table 3. Descriptive Statistics of Self-Other Disagreement and Inter-Informant Disagreement on Personality

Factor	Self-Other Disagreement (SOD)		Inter-Informant Disagreement (IID)	
	Range	M (SD)	Range	M (SD)
FFPI				
Extraversion	0.01-2.40	0.70 (0.52)	0.05-2.29	0.84 (0.46)
Agreeableness	0.02-2.17	0.72 (0.57)	0.06-2.45	1.05 (0.54)
Conscientiousness	0.00-2.03	0.62 (0.51)	0.22-2.02	0.87 (0.40)
Emotional stability	0.02-1.78	0.58 (0.42)	0.12-2.42	0.95 (0.50)
Autonomy	0.01-2.44	0.66 (0.53)	0.02-2.55	0.85 (0.47)
NEO-FFI				
Extraversion	0.00-14.00	4.34 (3.21)	1.33-18.00	6.19 (3.19)
Agreeableness	0.00-18.00	4.35 (3.65)	0.67-14.67	5.64 (3.10)
Conscientiousness	0.00-19.00	4.76 (3.84)	0.67-14.00	6.08 (3.23)
Neuroticism	0.00-20.67	5.76 (4.30)	0.67-24.00	6.15 (3.65)
Openness	0.00-12.00	4.12 (3.15)	0.67-14.00	5.48 (2.75)

Note. FFPI: n = 96. NEO-FFI n = 95. Disagreement = absolute difference in FFPI-factor scores or NEO-FFI scale scores.

informant reports were fed back only globally: for the FFPI in sample 1 according to the nine verbally limited intervals based upon transformation of the anchored scores in 0.66 intervals (= 2/3 standard deviation), and for the NEO-FFI in sample 2 conform the stanine interval distribution, as specified in the manuals of the FFPI (Hendriks et al., 1999b, 2011) and NEO-FFI (Hoekstra et al., 2007), respectively. No interpretation of possible meanings of any discrepancies were given. For instance, the patient was told that she rated herself on the FFPI as clearly extraverted, while her informants rated her, on the average, as less clearly extraverted, but still as fairly extraverted. Subsequently, therapy took place according to standard practice.

Results

Descriptive Statistics and Self-Informant Agreement on Personality

The most frequently asked informants were partners, family members and friends. In Table 2 descriptive statistics of self-reports and informant reports are presented, as well as Pearson correlations between self-reports and informants differing in role relation (partner, family, friend). It can be seen that judgments of the target's personality traits varied over type of judge (self, informant) and role relation. Not surprisingly, the largest amount of agreement was found between self-reports and aggregated informant reports.

Disagreement on Personality and its Association with Personality Pathology

Table 3 shows the range, mean, and standard deviation of SOD and IID per FFPI-factor and NEO-FFI scale. For both samples, mean IID was larger than mean SOD, which illustrates that aggregating judgments cancels out disagreement to some extent.

Of the 96 patients in sample 1, having completed the FFPI, 49 were diagnosed as having personality pathology. Independent samples t-tests with personality pathology as the grouping variable revealed two significant differences in SOD. Patients with personality pathology showed larger SOD on Extraversion than patients without personality pathology, $t(94) = -2.37$, $p = .020$. Also, patients with personality pathology showed larger SOD on Conscientiousness than patients without personality pathology, $t(94) = -2.40$, $p = .018$. We found no differences between patients with and without personality pathology in relation to IID. With regard to sample 2, having completed the NEO-FFI, the 48 patients with personality pathology showed larger SOD on Agreeableness, $t(93) = -2.25$, $p = .027$ than the 47 patients without personality pathology diagnoses. No differences between the patients with and without personality pathology were found with regard to IID.

As the two samples differed with regard to marital status, we checked a possible relationship between marital status and personality pathology. No such relationship was found.

Table 4. Predictive Associations between Various Forms of Personality Assessment and Personality Pathology

	Point-biserial zero-order correlations with personality pathology			Point-biserial partial correlations with personality pathology		
	SR	IR	SOD	IID	SOD	IID
FFPI						
Extraversion	−0.32**	−0.28**	0.24**	0.03	0.18	−0.04
Agreeableness	−0.03	−0.09	−0.09	−0.03	−0.09	−0.06
Conscientiousness	−0.13	−0.22	0.24**	−0.03	0.19	−0.06
Emotional Stability	−0.16	−0.11	0.01	0.00	0.06	−0.03
Autonomy	−0.08	−0.12	−0.06	−0.04	0.07	−0.05
NEO-FFI						
Extraversion	−0.32**	−0.27**	0.02	0.03	−0.06	−0.02
Agreeableness	0.07	−0.04	0.23	0.02	0.20	−0.01
Conscientiousness	−0.11	−0.12	−0.01	−0.04	−0.03	−0.07
Neuroticism	0.16	0.17	0.01	−0.08	0.01	−0.08
Openness	−0.09	−0.03	−0.14	−0.01	−0.09	−0.01

Note. FFPI: $N = 96$. NEO-FFI: $N = 95$. SR = self-report, IR = averaged informant reports, SOD = self-other discrepancy, IID = inter-informant discrepancy. Partial correlations are controlled for variance attributable to self-report and averaged informants reports on personality.
**$p < .01$, one-sided.

To test our hypotheses about the incremental value of SOD and IID over and above self-reports and averaged informants reports in predicting personality pathology, we computed (a) point-biserial zero-order (Pearson) correlations and (b) partial correlations adjusting for self-reports and averaged informant reports. In that way it is possible to establish the independent contribution of self-reports and averaged informant reports, and the incremental predictive contributions of the between-judge discrepancy data. The results are presented in Table 4.

Taking a Bonferroni correction into account to control for inflation of the Type I error rate due to multiple significance tests, we set the level of significance per instrument (FFPI, NEO-FFI) at *familywise* $\alpha = .05/5 = .01$. With respect to self-report, only (lower) standings on Extraversion were predictive of clinician-rated personality pathology, $r = -.32$ ($p < .01$, one-sided) for both FFPI and NEO-FFI. The same was true for informant reports, $r = -.28$ and $r = -.27$ ($p < .01$, one-sided) respectively. Although SOD on both FFPI Extraversion and FFPI Conscientiousness were predictive of personality pathology, after controlling for patients' standings on these factors based on self-report and based on averaged informant reports, these SOD-pathology-associations were reduced and were no longer significant at an alpha level of .01 anymore. For none of the NEO-FFI scales significant associations between SOD and diagnoses of personality pathology were found. Consistent across both personality questionnaires, no associations were observed between IID and personality pathology, whether it concerned zero-order correlations or partial correlations adjusted for variance attributable to self- and averaged informant reports.

Discussion

In the present study, we investigated whether self-other discrepancies (SOD) and inter-informant discrepancies (IID) in personality judgments have incremental predictive validity for personality pathology over and above the predictive validity of self- and averaged other reports of personality. We reasoned that both SOD and IID may contain valid information, which might reflect personality pathology. We investigated three hypotheses. First, our *distortion hypothesis* stated that patients may have distorted self-knowledge, reflected in a relatively large amount of SOD, which may indicate personality pathology. Second, the *rigidity hypothesis* stated that the rigid inflexibility of behavior found in personality pathology would be reflected in less IID than in patients without personality pathology, therefore, a *negative*

association between IID and personality pathology was to be expected. The *intimacy hypothesis*, on the other hand, stated that partners would be better detectors of personality pathology than less close acquaintances, which would be reflected in more IID than in patients without personality pathology, resulting in a *positive* association between IID and personality pathology. The findings show that none of these hypotheses were supported.

While SOD on FFPI Extraversion and FFPI Conscientiousness predicted clinician-rated personality pathology, the significance of these relationships disappeared after correcting for the contributions of self-reports and averaged informant reports. SOD on NEO-FFI domains did not predict personality pathology. Based on these results, we have to conclude that SOD on a patient's personality traits do not seem to add predictive information over and above the information based on self- and averaged informant reports on the pertaining personality traits with respect to personality pathology.

The same conclusion applies to IID on a patient's personality traits. IID did not play a role at all in predicting clinically judged personality pathology. At least with regard to personality pathology, this finding may mean that it should not be necessary to control for and select on informants, as long as they are well acquainted with the target person, which simplifies application of informant data in clinical practice.

The results further show that self-reports and averaged informants reports on Extraversion were found to be predictive of personality pathology. For both self- and informant judgments, the association was negative, which means that low scores on Extraversion tend to covary with more personality pathology. This finding makes sense if we realize that most personality pathology found in our samples reflected the more inhibited cluster C pathology (avoidant, dependent, or obsessive-compulsive traits). In the literature, low extraversion scores have been found to be associated with avoidant personality disorder (e.g., Saulsman & Page, 2004; Samuel & Widiger, 2008).

It appeared that self-reports on both instruments highly corresponded to each other in their association with personality pathology. This may indicate that clinicians' diagnoses of personality pathology are stable across samples and primarily rely on patients' self-presentation, which is in agreement with the fact that informant measures were not taken into account in diagnosing personality pathology. Also the findings for IID generalized over both instruments, suggesting a general absence of any relationship between IID on personality traits and personality pathology. In contrast, the findings for SOD were not concordant for both instruments. A remarkable finding was that SOD on Extraversion and Conscientiousness on the FFPI was significantly associated with personality pathology, whereas SOD on Extraversion and Conscientiousness on the NEO-FFI showed no relationship with personality pathology at all. It is not clear what the reason might be for this cross-instrument discrepancy. Likely, there are small differences in content between the two Big Five instruments, next to small differences in reliability with which the NEO-FFI scale scores and FFPI factor scores were assessed. From associations between the FFPI and the 48-item constructs established with the NEO-PI-R (Hendriks et al., 2011; see also De Fruyt, McCrae, Szirmàk, & Nagy, 2004), it is known that there is a considerable amount of overlap in content, except between (intellectual) Autonomy and Openness to Experience. Still, Andresen (2000) found that FFPI Extraversion loaded on a General Dysfunctional Personality (GDP) factor (r = -.23), characterized mainly by cognitive aberrations (e.g., delusional beliefs, perceptual distortions), whereas NEO-FFI Extraversion did not (r = -.09). When looking at item content, FFPI Extraversion may contain somewhat more (lack of) social withdrawal while NEO-FFI Extraversion may measure somewhat more dynamism and social dominance. On the other hand, in the study of Andresen, both FFPI Conscientiousness (r = -.25) and NEO-FFI Conscientiousness (r = -.24) loaded on this GDP factor. Furthermore, also other factors of both instruments loaded on the GDP factor, particularly Emotional Stability/Neuroticism, which showed no predictive role for SOD in the present study.

Our findings are in line with earlier studies, showing the importance of informant judgments in gathering information on patients with respect to personality pathology (e.g. Achenbach, Krukowski, Dumenci, & Ivanova, 2005; Oltmanns, & Turkheimer, 2009). However, in predicting personality pathology from the Big Five personality traits, inspecting self and informant reports will suffice: Contrary to our expectations, we found no incremental predictive value for SOD or IID. Moreover, for none of the personality traits in our study IID was associated with personality pathology, suggesting that this discrepancy measure of disagreement among informant judgments has no content validity for assessing personality pathology.

Still, the present findings are relevant for clinical practice, for several reasons. First, our results underscore the importance of the use of informant judgments in personality assessment and specifically to check on an individual level the discrepancies between self- and average informant judgments. Self-informant discrepancies may provide leads for a simple, efficient and client-friendly method to check for *red flags* indicating

the possible presence of personality problems, as is the case with SOD on FFPI Extraversion and Conscientiousness (see also Mosterman & Hendriks, 2011). Both for the diagnostic process as well as for the purpose of choice of treatment, SOD on personality offers a lead for the procedure of stepped assessment. One may think of using self-other discrepancies as a screening instrument for personality pathology and to distinguish patients that need further assessment or specialized treatment from those for who further assessment steps or adjusted treatment are not necessary. Second, our results suggest that one may leave it to the patient to choose which informants to approach to ask whether they are willing to provide other reports of the patient's personality.

Third, in the present study as well as an earlier study (Mosterman & Hendriks, 2011), an additional benefit from the use of informant reports and self-other discrepancies appeared providing feedback to patients with personality pathology. Discussing the results of the self-other discrepancies with the patient appears to improve self-insight and self-other communications on this subject. We found most patients to be very interested in and eager to learn more from others' views about themselves. We noticed that it sometimes could be very confronting for a patient to see, for example, that her self-reports revealed her to be extremely agreeable, while, on average, others judged her standing on this trait as neutral. This feedback might enhance self-reflection. According to Hofstee (2009, p. 225), "In clinical diagnosis and treatment, discrepancies are potentially much more relevant than would appear from the virtual absence of self-other comparisons in practice. At the very least, a client could benefit from a systematic confrontation between the two perspectives; the exclusive self-report approach, which implicitly grants sovereignty to the individual's subjective definition of his or her personality, is hardly productive in this respect." The implications and effects of the feedback to clients, as well as developing therapeutic interventions aimed to establish more realistic self-knowledge, and therefore diminishing self-other discrepancies, may be elaborated and investigated in future research.

However, also, the current study shows a number of limitations. One major limitation is the assessment of personality pathology by means of clinical judgment by a single clinician. The reason was that our study was integrated in daily practice and administering a semi-structured interview to assess DSM-IV axis II pathology to each patient is not standard usage in primary or secondary mental health care assessment in the Netherlands. Evidence-based assessment of personality disorders requires the use of a semi-structured interview. In case the administration of an entire semi-structured interview is not feasible, Widiger and Samuel (2005, p. 284) recommend to first administer a self-report inventory, followed by a semi-structured interview that focuses on the disorders that received elevated scores. Clearly, in the present study, this recommendation has not been followed. A replication of our results in future studies after applying these requirements in the assessment of personality pathology would obviously strengthen our findings. Also, the sample sizes were rather small, which limits the power in detecting associations. In future studies, larger samples are needed and we may work toward specific hypotheses per factor or scale.

Notwithstanding these limitations, this practice-based evidence for the use of informant reports and the derived self-other disagreement measures in personality assessment may be an onset to a promising and challenging extension of the current evidence-based practice guidelines.

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