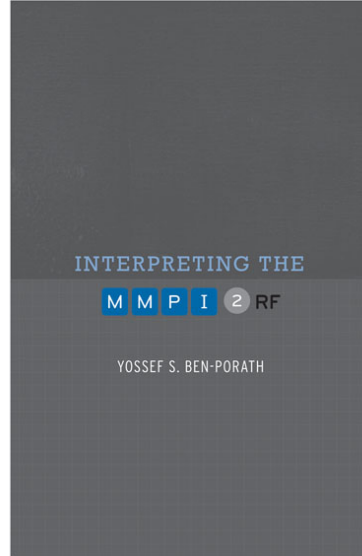


TRAINING SLIDES FOR:

INTERPRETING THE MMPI-2-RF



MMPI-2-RF Training Slides, University of Minnesota Press, 2015. Copyright for all MMPI® and MMPI-2-RF® materials are held by the Regents of the University of Minnesota.

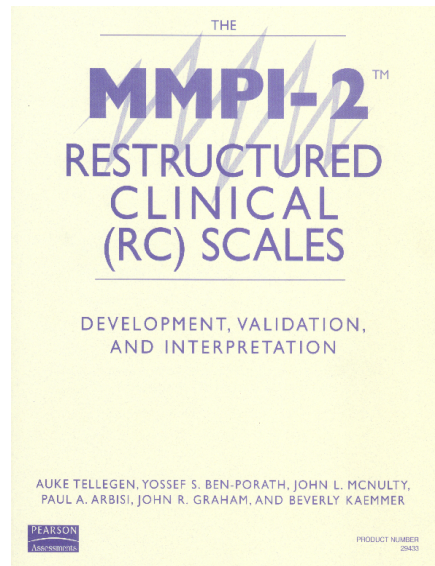
MINNESOTA

INTERPRETING THE MMPI-2-RF

CHAPTER 2: RESTRUCTURED CLINICAL (RC) SCALES

MMPI-2-RF Training Slides, University of Minnesota Press, 2015. Copyright for all MMPI® and MMPI-2-RF® materials are held by the Regents of the University of Minnesota.

MINNESOTA



Why Restructure the Clinical Scales?

- While they contain compelling informative *items*, it has long been recognized that as *aggregate measures* the Clinical Scales are not psychometrically optimal:
 - Excessive intercorrelations
 - Item overlap
 - Over-inclusive content (including “subtle” items)
- Pre-RC Scale Solutions:
 - Code types
 - Subscales
 - Supplementary Scales

Developing the RC Scales

- Step 1: Defining and Capturing Demoralization

it is generally the case that correlations between measures of adjustment tend to be substantial, giving rise to a large—sometimes very large—general demoralization or subjective discomfort factor in such inventories as the MMPI. . . . One challenge in developing new self-report scales is to find ways of *not* measuring this general factor. (Tellegen, 1985, p. 692)

Developing the RC Scales

- Step 1: Defining and Capturing Demoralization

- Tellegen’s concept of Demoralization similar to that of Jerome Frank:

- only a small proportion of persons with psychopathology come to therapy; apparently something else must be added that interacts with their symptoms. This state of mind, which may be termed “demoralization,” results from persistent failure to cope with internally or externally induced stresses. . . . Its characteristic features, not all of which need to be present in any one person, are feelings of impotence, isolation, and despair. (Frank, 1974 p. 271)

- Capturing Demoralization guided by Tellegen’s research on Mood

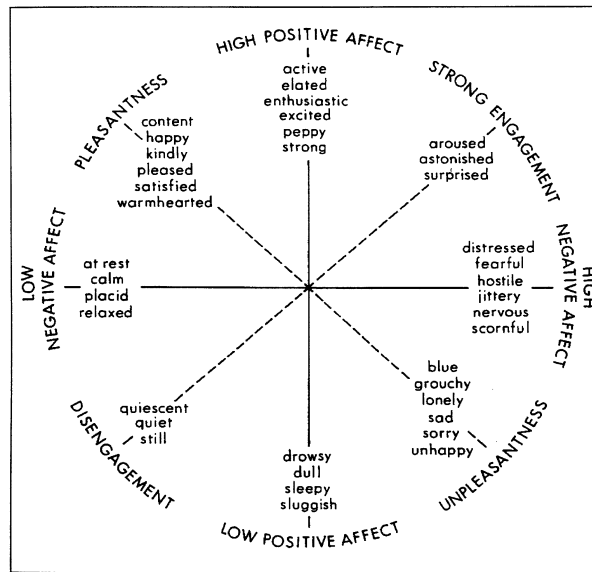


Fig. 1. Watson and Tellegen's (1985) two-dimensional map.

MMPI-2-RF Training Slides, University of Minnesota Press, 2015. Copyright for all MMPI® and MMPI-2-RF® materials are held by the Regents of the University of Minnesota.

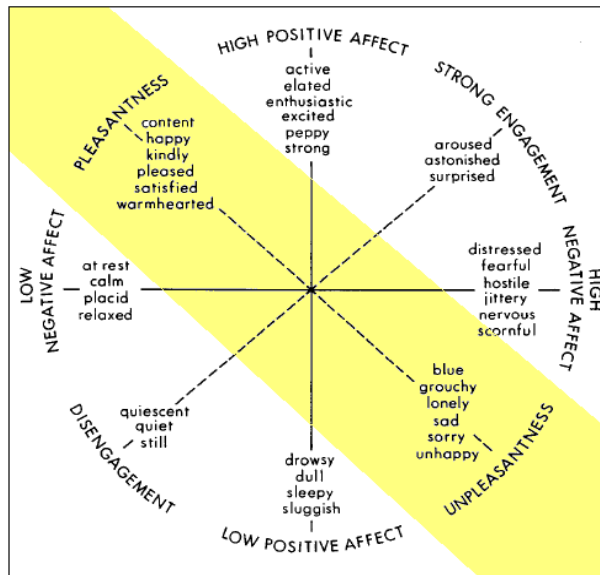


Fig. 1. Watson and Tellegen's (1985) two-dimensional map.

MMPI-2-RF Training Slides, University of Minnesota Press, 2015. Copyright for all MMPI® and MMPI-2-RF® materials are held by the Regents of the University of Minnesota.



Developing the RC Scales

- Step 1: Defining and Capturing Demoralization
 - Factor analysis of items of Clinical Scales 2 and 7 (measures of depression and anxiety) leads to identification of a set of items that load on a common factor
 - Identified items denote features of demoralization:
 - Unhappiness
 - Poor self-concept
 - Feeling overwhelmed
 - Desire to give up
 - Consistent with Tellegen's and Frank's conceptualizations

Developing the RC Scales

- Step 2: Identifying Clinical Scale Core Components
 - Assumption: Each clinical scale includes at least one major distinctive core component
 - Method: Factor analyses of the items of each of the ten Clinical Scales along with the Demoralization markers identified in Step 1
 - Outcome: Subset of Clinical Scale items marking a major distinctive core component of each scale of the ten scales (2 sets for Scale 5)

Developing the RC Scales

- Step 3: Deriving Seed Scales
 - Goal: Optimize internal coherence and mutual distinctiveness of eventual RC Scales
 - Method:
 - Only items with highest loading on the component marker for which they were designated are retained (yields 11 non-overlapping provisional seed scales)
 - Deletion of items that did not correlate sufficiently, or consistently highest with designated provisional seed scale
 - Addition of 12th seed scale representing Demoralization (deleting 4 weakest items from demoralization markers used in Step 2)
 - Outcome: 12 Seed Scales made up of relatively small, mutually exclusive subsets of original Clinical Scale items

Developing the RC Scales

- Step 4: Deriving the Final RC Scales
 - Goal: Build on structural changes attained in Steps 1-3 by recruiting additional items from the entire MMPI-2 pool (including new MMPI-2 items)
 - Method:
 - Calculate correlations between the 12 Seed Scales and 567 MMPI-2 items in four samples
 - Add item to Seed Scale if:
 - Correlation with that seed higher than the 11 others
 - Correlation with that seed was “high enough”
 - Correlations with the remaining seeds were “low enough”
 - Calculate correlations between resulting items and available external criteria for some scales (small number deleted at this point)
 - Outcome: 9 RC Scales (Seeds for Clinical Scales 5 and 0 not used to derive final RC Scales)

Delineating the RC Scale Constructs

- RCd – Demoralization
 - Happy/Unhappy Pleasant/Unpleasant dimension of mood
 - Dohrendwend: Analogous to taking patient’s temperature in medicine (i.e., indicates a problem and its severity, but not etiology)
 - Items reflect dysphoric affect, distress, self-attributed inefficacy, low self esteem, and a sense of having given up
 - Associated with increased risk for suicidal ideation and recent suicide attempt

Delineating the RC Scale Constructs

- RCd – Demoralization
 - Considerable phenotypic overlap with depression, however
 - Vegetative symptoms such as poor sleep, low appetite, and anhedonia are more specific to depression
 - Dysphoric affect found in medical patients more likely to be a product of demoralization, than depression
 - When asked about their mood, patients/clients who are demoralized are more likely to complain about depression and anxiety

Delineating the RC Scale Constructs

- RC1 – Somatic Complaints
 - Unexplained somatic complaints long a focus of medicine (e.g., *Hysteria*=wandering uterus in ancient Egypt)
 - 19th century French psychiatrist Briquet attributes symptoms to nervous system
 - Charcot and Janet, after collaborating with Freud conceptualize as a *disease of the mind*, adopting his notion of *conversion* – psychological trauma converted into physical symptoms
 - In DSM-IV conditions labeled *Somatoform Disorders*
 - DSM-5 rebranded *Somatic Symptom Disorders*

Delineating the RC Scale Constructs

- RC2 – Low Positive Emotions
 - Lack of positive emotional responsiveness, anhedonia, is a core personological risk factor for depression
 - But not unique to depression; can also occur in Schizophrenia, PTSD, and certain medical conditions
 - In depression, low positive emotions associated with greater likelihood of biologically (rather than situationally)-linked depression, and hence may be more amenable to treatment with antidepressant medication (Klein, 1974)

Delineating the RC Scale Constructs

- RC3 – Cynicism
 - Degree to which individual holds misanthropic, negativistic, and mistrusting view of others
 - Beliefs are non-self-referential
 - Dysfunction is largely interpersonal
 - “Active ingredient” in Type A Personality associated with increased risk for cardiovascular disease
 - Risk factor for burnout and misconduct in law enforcement officers

Delineating the RC Scale Constructs

- RC4 – Antisocial Behavior
 - Core feature of Antisocial Personality Disorder and, depending upon model, either core feature or consequence of Psychopathy
 - Item pool includes several elements of diagnostic criteria for ASPD, but not all
 - Also includes substance abuse and familial discord items that are not associated with specific ASPD diagnostic criteria
 - Hence, Antisocial Behavior and ASPD are not veridical

Delineating the RC Scale Constructs

- RC6 – Ideas of Persecution
 - Self-referential beliefs that one is being singled out for mistreatment
 - Persecutory beliefs are a feature of *Paranoia*, but can stem from other causes as well
 - Actually being persecuted (refugees, racial minorities)
 - Projection of blame for shortcomings or difficulties onto others
 - Alienation

Delineating the RC Scale Constructs

- RC6 – Ideas of Persecution
 - Freeman (2007) characterized paranoia as a hierarchical phenomenon, characterized by five levels of perceived threat ranging from
 - (1) Social evaluative concerns (fear of rejection and feelings of vulnerability)
 - (2) Ideas of reference (being talked about or watched by others)
 - (3) Mild threat (people trying to cause minor distress such as irritation)
 - (4) Moderate threat (people going out of their way to get at the individual)
 - (5) Severe threat (people trying to cause significant physical, psychological, or social harm to the individual)
 - RC6 items fall mainly in mild to severe range

Delineating the RC Scale Constructs

- **RC7 – Dysfunctional Negative Emotions**
 - A personality trait characterized by a tendency to worry, be anxious, feel victimized and resentful, be angry, and appraise situations generally in ways that foster negative emotions
 - Is correlated with, but distinct from Demoralization, which is associated more specifically with dissatisfaction, unhappiness, and distress
 - Associated with increased risk for anxiety-related psychopathology

Delineating the RC Scale Constructs

- **RC8 – Aberrant Experiences**
 - Sensory, perceptual, cognitive, and motor experiences that fall well outside the range of normal experiences
 - Associated with, but not unique to thought disturbance
 - Items include positive symptoms of Schizophrenia, such as hallucinations (e.g., visual, auditory), and non-persecutory delusions (e.g., thought broadcasting)
 - Associated with increased risk for psychotic disorder, but can co-occur with other conditions (e.g., dissociative symptoms of PTSD)

Delineating the RC Scale Constructs

- RC9 – Hypomanic Activation
 - Focuses primarily on Kraepelin’s:
 - *Manic Temperament*, marked by constitutional excitability, carelessness, and marked self-confidence
 - *Irritable Temperament*, marked by irritability, volatility, and occasional outbursts of violence
 - Some items also focus on Kraepelin’s *manic states*, associated with pressure of activity
 - Most individuals with hypomanic personality traits do not go on to develop a full fledged bi-polar disorder, but it is associated with elevated risk for this condition

Empirical Findings with the RC Scales

- Reported in MMPI-2-RF Technical Manual and an extensive peer-reviewed literature
 - Adequate reliability
 - Good evidence of construct validity
 - Broad range of replicable empirical correlates reflected in interpretive recommendations in MMPI-2-RF Manual for Administration, Scoring, and Interpretation

Appraisals of the RC Scales

- Positive appraisals based on data analyses that included external criteria
- Negative appraisals based on beliefs about the nature of the constructs assessed by the Clinical Scales and “internal” analyses limited to correlations between subsets of MMPI-2 items
 - Smaller number of elevated scales does not reflect low sensitivity, but rather greater discriminant validity
 - “Construct Drift” is actually “Construct Shift”

For additional information on this chapter, please reference:

Ben-Porath, Y.S. (2012). *Interpreting the MMPI-2-RF*. Minneapolis: University of Minnesota Press.