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The MMPI–2 Restructured Clinical (RC) Scales and Restraints to Innovation, or "What Have They Done to My Song?"

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Rogers, Sewell, Harrison, and Jordan (2006/this issue) largely replicate in an independent clinical sample the MMPI–2 Restructured Clinical (RC) Scales developed by Tellegen et al. (2003). Nichols (2006/this issue) raises numerous concerns about the development and utility of the RC Scales, which on close appraisal did not change our view that the scales are well conceived and potentially valuable to researchers and clinicians alike. We present two case studies in which the RC Scales helped clarify complex MMPI–2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) profiles with multiple elevations on the Clinical, Content, Supplementary, and Personality Psychopathology Five (Harkness, McNulty, Ben-Porath, & Graham, 2001) scales. When interpretations refined by the RC Scales were discussed with the clients, each seemed to feel deeply understood. Reservations about instrument innovation can be appreciated as helping to counterbalance change and thereby ensure the MMPI–2's successful ongoing evolution. We discuss specific ways the MMPI–2 community could avoid polarization about the RC Scales.

The recently developed Minnesota Multiphasic Personality Inventory–2 (MMPI–2) Restructured Clinical (RC) Scales (Tellegen et al., 2003) have been the focus of fervent interest of both MMPI–2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) researchers and clinicians alike. In essence, the RC Scales are a set of nine nonoverlapping scales designed to measure the common factor—named *Demoralization*—and unique components of the eight original Clinical Scales. By addressing the longstanding MMPI (Hathaway & McKinley, 1943) problem of Clinical Scale covariation, the RC Scales aimed to improve the discriminant and convergent validity of the Clinical Scales.

This issue of the *Journal of Personality Assessment* includes articles by Nichols (2006/this issue) and Rogers, Sewell, Harrison, and Jordan (2006/this issue) that address the RC project in somewhat different ways, and we are delighted to have the opportunity to comment on these important studies. Rogers et al. provide a cross-validation study that tests the robustness of the derivation of the RC Scales. Nichols[1] raises various more or less conceptual concerns about the nature and composition of the RC Scales. We first briefly address Rogers et al.'s study, but the remainder of this section of the article is an appraisal of Nichols's main criticisms.

Overall, the efforts by Rogers et al. to replicate the RC Scales worked out well, suggesting that the RC Scales are robust. Further research may elucidate the origin of the relatively few divergent findings. Rogers et al. also present two conceptual concerns about "construct drift" and about the lack of fidelity to the Jacksonian (1971) construct development procedure. We return to the first issue later but briefly address the second issue here. Rogers et al. suggest the RC Scales were derived following a Jacksonian approach to

[1]References to Nichols without a specific citation pertain to his article in this issue, "The Trials of Separating Bath Water From Baby: A Review and Critique of the MMPI–2 Restructured Clinical Scales."

scale development, but note that Tellegen et al. did not first remove response style (e.g., social desirability) from the item pool before deriving the RC Scales, which would have been more consistent with Jackson's sequential system of scale development. What is puzzling about this objection is that in chapter 2 of the RC Scale monograph, Tellegen et al. specifically explain why they do not intend to follow Jackson's scheme. In any event, there are strong arguments to justify the decision to not first remove social desirability from scales that aim to measure psychopathology. Psychopathology, *qualitate qua,* tends to be judged as socially undesirable, especially its more antisocial and aggressive expressions. Removing this variance would likely have yielded impoverished constructs.

Nichols (2006/this issue), in the abstract to his target article, points to presumed conceptual and methodological flaws, unfortunate omissions, and warns the reader about construct drift resulting from the RC strategy. Moreover, Nichols claims the RC Scales are "highly redundant with … routinely scored content scales" (p. 134) and is overall quite skeptical about the potential contribution of the RC Scales. Although we applaud the close scrutiny Nichols has afforded the RC Scales, we disagree with the balance and thrust of many of his arguments.

CONCEPTUAL AND METHODOLOGICAL FLAWS?

Comparing Like With Like: Multivariate Scales and "Syndromal Fidelity"

Nichols laments the loss of "multivariate structure," which he also refers to as syndromal fidelity, in the restructuring of the Clinical Scales. We believe there are several reasons why unifactorial scales may be preferred over syndromal scales. One rather practical argument in favor of unifactorial scales is that syndromes such as those reflected in the Clinical Scales are generally not true taxa and go through changes in definitions over time. Indeed, in the case of the MMPI–2, some of the syndromes used to define the Clinical Scales are no longer widely recognized (e.g., hysteria, psychasthenia), and other distinctions not discerned at the time of their construction (e.g., between antisocial personality disorder and psychopathy) cannot be made from the outdated syndromal scales. Simply put, unifactorial scales have a much better chance of being useful over time.

A more important point relates to the nature of scales and constructs. Nichols (2005) stated that traits, states, and symptoms are probably best measured by scales of relatively homogeneous item content and high internal consistency, whereas psychiatric syndromes are probably best measured by scales with heterogeneous item content and more modest internal consistency; he referred to these types of scales as "content scales" and "clinical scales," respectively. This argument has some intuitive appeal but does not seem tenable. Specifically, the suggestion that heterogeneous scales will do better in predicting complex criteria is problematic. Classical test theory (e.g., Nunnaly & Bernstein, 1994) shows that conjunctive constructs like syndromes that consist of, for instance, subdomains A, B, C, and D, are better assessed by multiple-separate (i.e., disjunctive) measures of A, B, C, and D than by one composite amalgam. Elevation of the overall scale in the latter case may result from many different combinations of elevations of the components, some of which may not fit the syndromal quality at all. Typical examples of this problem are the MMPI–2 Clinical Scales 3, 4, and 8. Elevated scores on these scales can have many meanings, some of which are quite different from the original target syndrome and typically need clarification from other scales as acknowledged by Nichols (2001) in his own MMPI/MMPI–2 interpretative guide.

Confusing the Nature of the Clinical Scales, Content Scales, RC Scales and the *DSM–IV*

We believe that at different points, Nichols is imprecise about the nature of the items and the method of scale construction of the Clinical Scales, Content scales, RC Scales, and the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM–IV*]; American Psychiatric Association, 1994) criteria. For example, Nichols suggests that the nature of the Clinical Scales and their constituent items strongly resembles the *DSM–IV* diagnoses and their constituent criteria. We strongly disagree: The *DSM–IV* criteria define a disorder, whereas the MMPI–2 Clinical Scale items are heterogeneous fallible indicators of syndromes. As well, Nichols likens the RC Scales to Content scales. Nichols (2006/this issue) writes that the RC Scales are "similarly derived [as] content-based scales such as the MMPI–2 Content scales" (p. 128). To evaluate this statement, we compare the scale construction process for these two sets of scales. The Content scales of the MMPI–2 generally followed from rational scale construction efforts, that is, a group of experts defined a construct then sought items to capture the construct and followed up with statistical optimization. The RC Scales, on the other hand, were mainly inductively derived; Tellegen et al. examined the results of factor analyses and inspected those factors that did not load heavily on demoralization. In our opinion, these strategies have little in common and yield constructs that differ principally in their "openness." Indeed, the main thing the RC and Content scales have in common is their high internal consistency and subsequent face validity.

Item Composition and the "Credibility" of the RC Scales

Nichols presents ample selected data on overlap and correlations with various scales, typically implying that these numbers undermine the credibility of the RC Scales in question.

For example, fewer than half of the RC items derive from the parent Clinical Scales, whereas more than 50% of their items belong to the Content scales. Nichols seems to ask himself and the reader "Can this be the distinctive core of the Clinical Scales?" First criticizing the RC Scales for the injection of theory, Nichols now disapproves of the strong inductive, data-driven bent of the RC project. It seems important to remember that the RC Scales were not a priori meant to be the same as the Clinical Scales. Instead, the idea was to use factor analysis to reshuffle the MMPI–2 items such that eight nonoverlapping scales would emerge that captured unique components of the original Clinical Scales. Given this methodology, it seems essentially uninformative to point to statistics on overlap and correlation with the original scales. In our opinion, the credibility of the RC Scales should hinge instead on their predictive accuracy and clinical utility, relative to the extant scales.

UNFORTUNATE OMISSIONS?

Other Purely Empirical Ways to Solve the Clinical Scale Covariation Problem

Nichols embraces the "admirable goal" of reducing Clinical Scale covariation to improve discriminant validity. However, Nichols regrets that Tellegen et al. did not choose more modest ("nonintrusive") methods that might leave the Clinical Scales essentially intact. This option would allow the Clinical Scales to maintain their syndromal fidelity and would not lead to a set of new scales. As mentioned earlier, Tellegen et al. chose the Pleasantness–Unpleasantness (PU) dimension of the more or less consensual model of affect (Watson & Tellegen, 1985) as the theoretical starting point for the derivation of the general unhappiness factor DEM. To find trait markers of high Negative Emotionality (NEM) and low Positive Emotionality (PEM), Tellegen et al. turned to the Clinical Scales 2 and 7. Tellegen et al. first identified items that loaded highly on the first PU dimension and then identified items that loaded high on both (low) PEM and (hi) NEM to empirically select items that fit both criteria. Next, this set of core items (DEM) was factor analyzed with the remaining MMPI–2 item pool to yield an empirically augmented RCd. Clearly, this strategy involved theory guiding data and vice versa (leading to "open constructs" for all RC Scales), which characterizes the derivation of all RC Scales. Moreover, it is by virtue of their connection to a theory-based interpretation of the first factor that the RC Scales open up links to a vast domain of relevant personality and emotion research. Specifically, the RC Scales connect the MMPI–2 to a widely accepted model of affect (Watson & Tellegen, 1985) as well as to major trait models of normal personality variation, in particular, the Big Three.

Nevertheless, Nichols is right in that it is not inconceivable that there are other, possibly superior ways to attack Clinical Scale covariation. More specifically, we agree that "it is an empirical question whether any of these alternative markers would be superior to Dem in drawing away from the Clinical Scales those items most responsible for their covariation from those that best reflect the residual core dimension(s) of each" (Nichols, 2006/this issue, p. 129). Repeatedly throughout the manuscript, Nichols regrets the "omission" or "silence of the manual" on the prior efforts at reducing Clinical Scale covariation (e.g., Finney, 1968). It would seem, however, that the discussion would best be furthered if Nichols and other like-minded individuals demonstrated the advantages of other methods based on different theoretical choices; this would involve showing equal or superior patterns of convergent and discriminant validity with key external correlates. In other words, how well did Finney (1968) and other efforts do? The replication study by Rogers et al. shows that Tellegen et al. described their methodology in sufficient clarity and detail to allow for cross-validation. Moreover, Tellegen et al. showed how well their approach fared empirically and through the presented case analyses, to some extent clinically. So far, Tellegen et al. seem to have the numbers on their side.

On the Nature of DEM and Construct Drift

Nichols (2006/this issue) characterizes DEM as "the theoretically inspired and depressively biased marker" (p. 137) that simultaneously overextracts and underextracts unwanted variance from the Clinical Scales, in turn resulting in construct drift in the next step of the RC Scales' derivation. Nichols sees this problem as particularly evident for RC7, RC9, and RC3. Indeed, Tellegen et al. opted for a theoretically informed, substantive interpretation of the shared variance across the Clinical Scales. It is in that sense different from a purely empirically derived first factor, as advocated by Nichols. Both Nichols and Rogers et al. are concerned about the possibility of construct drift. Construct drift, however, is by its very nature a relative phenomenon, that is, it is relative to some other target construct. Nichols takes the original Clinical Scales as the target constructs. This is evident, for example, when he discusses RC7. According to Nichols, this scale overselected aggressive content at the expense of ("desirable") psychasthenia variance. However, RC7 is labeled "dysfunctional negative emotions" and not psychasthenia. Again, the aim of the RC project was not to preserve the original constructs underlying the Clinical Scales. The RC Scales were not designed to be proxies of the Clinical Scales—for that, one might use the Clinical Scales themselves—they were meant to measure the common factor (named Demoralization) and unique components of the eight original Clinical Scales. As such, the RC Scales describe related but different constructs than the original Clinical Scales, which in most cases measure several things at once.

REDUNDANT? RESTRUCTURED? CLINICAL?

Nichols (2006/this issue) notes "extremely high levels of redundancy between [multiple] RC Scales and content-based scales that are already in use" (p. 127). In fairness, one would expect that the RC Scales are going to overlap with something on the MMPI–2. Moreover, Tellegen et al. never claimed they discovered entirely new meaningful variance in the well-researched MMPI–2 item pool, but they did claim they restructured the Clinical Scales such that they measure the first factor once instead of eight times and that they identified meaningful substantive core variance of each Clinical Scale.

Additional empirical support for this claim was presented recently by Tellegen (2005). A fixed factor analysis of the orthogonalized RC and Clinical Scales together yielded a factor correlation matrix of a clear, simple structure, with each RC Scale correlating highly with its corresponding Clinical Scale and low with all other Clinical Scales. In short, the RC Scales show meaningful relations to the Clinical Scales but are not identical to nor "proxies" for the Clinical Scales nor were they meant to be. Rather, they aim to represent the substantive core component. These substantive components may include a degree of overlap with general unhappiness, particularly among the internalizing conditions.

CLINICAL UTILITY OF THE RC SCALES

As mentioned earlier, Nichols argues that information in the RC Scales is already adequately represented elsewhere in the MMPI–2 and implies that the scales will not have incremental utility for clinicians in their day-to-day work with clients. This does not fit with our experience, and we illustrate one situation in which we have found the RC Scales to be extremely valuable, that is, in making sense of profiles with multiple, highly elevated Clinical Scales. Although other scales (e.g., the Content scales) also assist in deconstructing such profiles, we find that the RC Scales typically do a better job of clearly identifying clients' central concerns, which is important to assist clinicians in helping clients feel understood.

S. E. Finn saw the following two clients at his private practice clinic in the last several years. We have changed nonessential information to protect the clients' identities.

Case 1

This 32-year-old man was referred by his psychiatrist for an assessment following a suicide attempt in which he overdosed on an antidepressant he was taking. After ingesting the pills, he became frightened about what he had done and almost immediately told his parents who took him to the hospital. Following gastric lavage, he was judged not to be at immediate risk for further self-harm; hence, he was discharged the same evening with instructions to follow up with his outpatient psychiatrist. This psychiatrist had been treating the client for depression for 3 years, following the client's having been fired from his job as a computer programmer. Despite having participated in an occupational retraining program, the client was still unemployed, isolated, and financially dependent on his parents who were increasingly frustrated with him. When queried at the hospital, the client said he had overdosed when he thought death was "the only way to get out of the pain." When interviewed by Finn, the client said the major question he hoped to address through the assessment was "Why can't I seem to get going with work and a social life after all the help people have given me? Am I just a total loser?" He took the MMPI–2 and several other tests, but we concentrate only on the MMPI–2. Figures 1 through 4 show the Basic (K corrected) MMPI–2 profile, Content scales, Supplementary scales, and PSY–5 scales for this client. Figure 5 shows the profile of RC Scales.

The Validity scales (Figure 1) suggested that the client responded consistently and in an unguarded (perhaps even self-critical) manner. There were no clear-cut signs of malingering, and the high elevations on F and F-back were consistent with the highly elevated Clinical Scales in suggesting that the client was highly distressed and in acute crisis. Almost all the Clinical Scales were elevated, with the exception of Scale 1 and Scale 9 (which was depressed). The basic profile suggested severe mixed symptomatology including a severe lethargic depression, severe anxiety, suicidal rumination, social withdrawal, angry explosions and impulsive acting out, possible thought disorder, and suspiciousness and/or paranoid ideation. Basic profiles like this are very difficult to interpret because of the number of near-

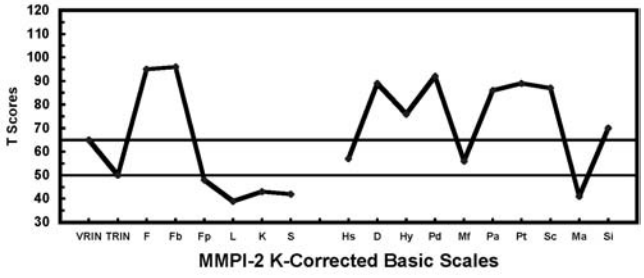

FIGURE 1 32-year-old male. This and all other figures are excerpted from the *MMPI–2™ (Minnesota Multiphasic Personality Inventory-2™) Manual for Administration, Scoring, and Interpretation, Revised Edition,* Copyright © 2001 by the Regents of the University of Minnesota Press. All rights reserved. Used by permission of the University of Minnesota Press. VRIN = Variable response inconsistency scale; TRIN = True-Response inconsistency scale; F = Infrequency; Fb = Infrequency Back Page; Fp = Infrequency Psychopathology; S = Superlative Self-Presentation; Hs = Scale 1, Hypochondriasis; D = Scale 2, Depression; Hy = Scale 3, Hysteria; Pd = Scale 4, Psychopathic Deviate; Mf = Scale 5, Masculinity–Femininity; Pa = Scale 6, Paranoia; Pt = Scale 7, Psychasthenia; Sc = Scale 8, Schizophrenia; Ma = Scale 9, Hypomania; Si = Scale 0, Social Introversion.

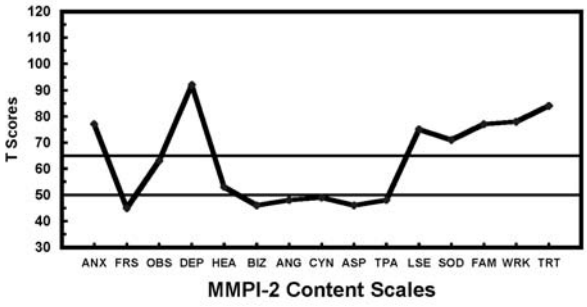

FIGURE 2 32-year-old male. ANX = Anxiety; FRS = Fears; OBS = Obsessiveness; DEP = Depression; HEA = Health Concerns; BIZ = Bizarre Mentation; ANG = Anger; CYN = Cynicism; ASP = Antisocial Practices; TPA = Type A; LSE = Low Self-Esteem; SOD = Social Discomfort; FAM = Family Problems; WRK = Work Interference; TRT = Negative Treatment Indicators.

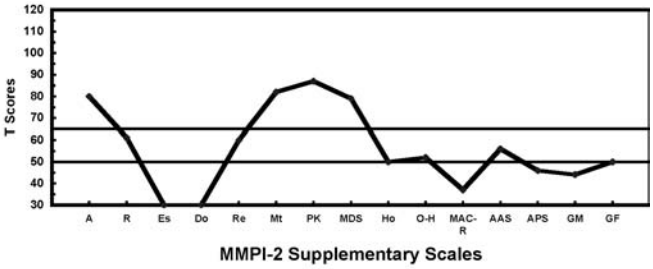

FIGURE 3 32-year-old male. A = Anxiety; R = Repression; Es = Ego Strength; Do = Dominance; Re = Responsibility; Mt = Maladjustment; PK = Posttraumatic Stress Disorder Scale–Keane; MDS = Marital Distress Scale; Ho = Hostility; O-H = Overcontrolled Hostility; MAC–R = MacAndrew Alcoholism Scale–Revised; AAS = Addiction Admission Scale; APS = Addiction Potential Scale; GM = Gender Masculine; GF = Gender Feminine.

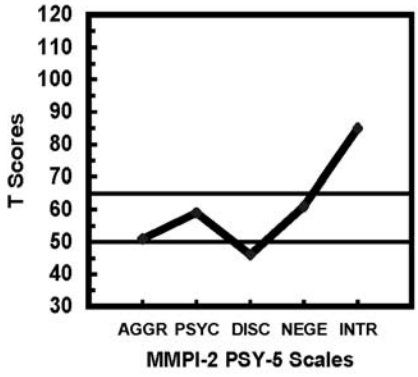

FIGURE 4 32-year-old male. AGGR = Aggressiveness; PSYC = Psychoticism; DISC = Disconstraint; NEGE = Negative Emotionality/Neuroticism; INTR = Introversion/Low Positive Emotionality; PSY–5 = Personality Psychopathology Five.

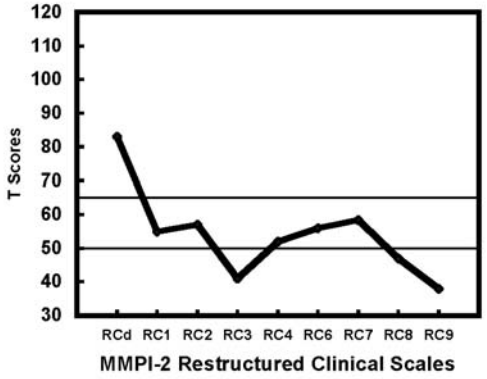

FIGURE 5 32-year-old male. Rcd = Demoralization; RC1 = Somatic Complaints; RC2 = Low Positive Emotions; RC3 = Cynicism; RC4 = Antisocial Behavior; RC6 = Ideas of Persecution; RC7 = Dysfunctional Negative Emotions; RC8 = Aberrant Experiences; RC9 = Hypomanic Activation.

equal scale elevations, and a perusal of interpretive texts mentioning the component 3- and 4-point codes (e.g., 4-2-7, 4-2-8, 4-2-6, 2-7-8-0) suggests a confusing range of possible diagnoses from severe personality disorders, psychotic disorders, dissociative disorders, and posttraumatic stress disorder (e.g., Friedman, Lewak, Nichols, & Webb, 2001; Graham, 2006).

The Content scales (Figure 2) appeared to confirm the client's severe depression and anxiety (DEP = 92T; ANX = 77T), social discomfort (SOD = 71T), and negative feelings about himself (LSE = 75T). They also were helpful in speaking against an overt psychotic process (BIZ = 46T), in highlighting the conflict in his family situation (FAM = 77T), and in suggesting that overt acting out behaviors were probably not prominent in this client's history or symptomatology (ANG = 48T, ASP = 46T). In fact, this "concave" Content scale profile (with elevations on each side and a dip in the middle) has been noted to be indicative of emotional distress and emotional constraint (Tonsager & Finn, 1992), a combination that was also reflected in scores on the Supplementary scales profile (Figure 3): A = 80T, R = 61T, MAC-R = 37T, Mt = 82T, AAS = 56T, and APS = 46T. The PSY–5 Scales (Figure 4) also spoke against psychoticism (PSYC = 59T) or impulsive acting out (DISC = 46T) and emphasized low "hedonic capacity" (INTR = 85T; Harkness, McNulty, Ben-Porath, & Graham, 2001).

Finn found the profile of RC Scales to be extremely clarifying in this case, and he relied heavily on these scales in giving feedback to the client (as we discuss below). As can be seen (Figure 5), the only significant elevation was on RCd (83T), which suggested that this client was highly demoralized, distressed, and discouraged and that he felt overwhelmed, helpless, and a failure (Tellegen et al., 2003). The lack of elevations on the other RC Scales strongly suggested that the multiple high scores on the Clinical Scales were largely due to the common first-factor variance saturating these scales. The RC

Scales also succinctly and efficiently indicated what was deduced previously from a combination of various Content, Supplementary, and PSY–5 scales: The client did not appear to be paranoid or psychotic (RC6 = 56 T; RC8 = 47 T), and there were no strong indications of antisocial tendencies (RC4 = 52T). Having settled these questions, the RC Scales also highlighted two other features—the client's naivete and tendency to trust too easily (RC3 = 41T) and his low energy and lack of positive entitlement (RC9 = 38T)—which was also suggested by the low elevation on Scale 9.

The lack of significant elevation on RC2 (57T) was particularly interesting with this client and highlights a possible important distinction between depression and demoralization. Recently, Joiner, Walker, Pettit, Perez, and Cukrowicz (2005) summarized evidence that depressed mood may be common to many psychological disorders and that low positive emotionality (which they called anhedonia) is a much more specific indicator of major depression. This is supported by research by Santor and Coyne (2001) and is consistent with Clark and Watson's (1991) tripartite model of depression and anxiety. Could it be that this client's failure to respond to a succession of antidepressant medications was because he did not have a classic major depression but rather was intensely demoralized? More research is needed to answer such questions; however, Finn kept this possibility in mind when he discussed the MMPI–2 results with the client. The following excerpts were transcribed from a tape of the session and occurred right after Finn's introduction when he showed the profile of basic scales to the client, explained where the average score on each scale falls and what is considered a significant elevation, and interpreted that the client "responded to the items carefully and really told it just like it is."

Finn: As you can see, the first thing that stands out is that you have a lot of high … very high elevations on the problem scales.

Client: I'm pretty screwed-up, aren't I?

Finn: Well, I'm not reading it that way, myself. What I see and I want to check this out with you is that you're … your main problem seems to be that you are extremely *miserable*. This page (shows RC Scales) breaks these other scores down, and you can see you have one really really high score—on a scale that measures psychological misery. Everything else going on with you seems to pale by comparison to that. Am I right? The test says you are feeling *really* badly lately and that it is overshadowing everything and affecting you in lots of ways.

Client: Definitely. (Sighs.) I just can't seem to … I can't do anything right and I feel terrible about that. My parents are totally fed up with me and I can't explain why I can't get going.

Finn: Well, I think this one scale really answers your question of why you can't get going even after all the help you've been given. No one could look for work or get together with friends when they were feeling this miserable. All their energy would be taken up just surviving. They would feel hopeless and completely demoralized. Does that fit?

Client: Yes! And I just wanted a break from the pain, but then I realized I didn't really want to die … Do you think we'll be able to explain this to my parents?

In the rest of the session, Finn and the client went on to talk about an apparent identity crisis that had been precipitated by the client's losing his job and not finding work in his field. The client seemed to see this sequence of events as the source of his demoralization and kept using the words *miserable* and *lost* to describe his experience. It seemed clear that the client felt very mirrored by Finn's interpretation, which purposefully avoided the use of the word *depression.* Of course, there is no control group for a single case, but we wonder if Finn would have been as successful in helping the client feel understood without the benefit of the RC Scales.

Case 2

This 27-year-old man was referred for assessment and treatment by his parents after a 7-day stay at a public mental hospital. He had been hospitalized after the parents found him at home (where he lived with them) in his bedroom with multiple cuts to his wrists from a razor blade. The client appeared calm, denied suicidal intent, and said that he was simply "letting the evil energy out" of his body. This resulted in his first hospitalization, but he had seen various outpatient therapists over the years, starting at age 12, to get help with his "social problems." The client had graduated 3 years previously from a local college with a Bachelor of Science in biology but had been unable to find a job and lived at home. During his hospitalization, he was cooperative with the ward activities and with staff except that he refused to take medication or do any psychological testing. As he no longer seemed to be a danger to himself, he was discharged with tentative diagnoses of brief psychotic episode and schizotypal personality, with a rule-out diagnosis of schizophrenia.

After three outpatient sessions with Finn, the client agreed to take the MMPI–2, and his major question for the test was "Why do I have so much difficulty concentrating? My brain isn't working the way it used to." He explained that he could no longer read or concentrate on TV but would not or could not say more about these difficulties. In the three previous sessions, the client had been reluctant to talk about the circumstances leading up to his hospitalization and instead had talked at length about his interests in biology and evolution. Figures 6 through 9 show the basic (K corrected) MMPI–2 profile, Content scales, Supplementary scales, and PSY–5 scales, respectively, for this client. Figure 10 shows the profile of RC Scales.

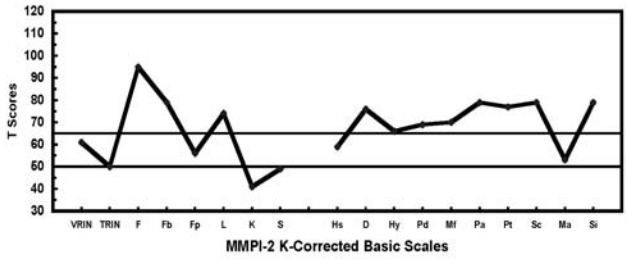

FIGURE 6 27-year-old man. For scale names, see Figure 1.

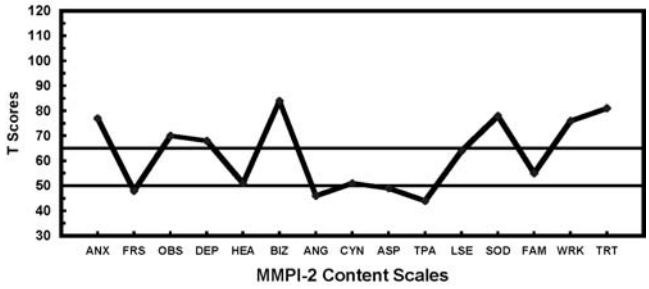

FIGURE 7 27-year-old man. For scale names, see Figure 2.

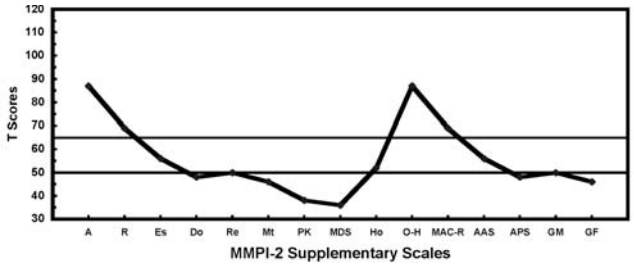

FIGURE 8 27-year-old man. For scale names, see Figure 3.

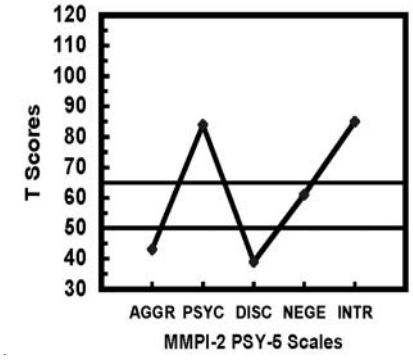

FIGURE 9 27-year-old man. For scale names, see Figure 4.

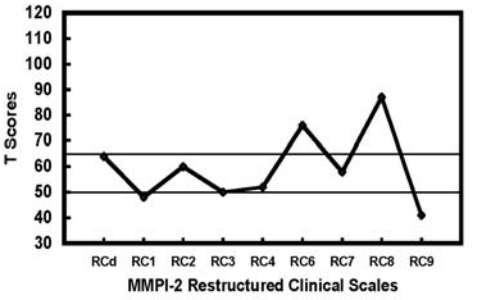

FIGURE 10 27-year-old man. For scale names, see Figure 5.

The Validity scales indicated that the client responded to the test items in a consistent manner but endorsed a number of unlikely virtues (L = 74T). Given the low scores on K (41T) and Fp (56T) and the elevations on F (95T), F-back (79T), and the Clinical Scales, most likely his score on L did not represent an overt attempt to make himself look good on the test. Rather, probably the client was prone to black-and-white thinking, lacking in insight, psychologically constricted, and morally judgmental. As with Case 1, there were many highly elevated Clinical Scales, and the 6-8-0-7-2 profile suggested a mixed symptom picture including possible delusions and thought disorder, overideation, difficulties concentrating, distrust and suspicion, anxiety, depression, social isolation, and conflicts about sexuality (Friedman et al., 2001; Graham, 2006).

The Content, Supplementary, and PSY–5 scales confirmed aspects of this presentation, giving further evidence of psychotic thinking (BIZ = 84T; PSYC = 84T), social discomfort and emotional constraint (SOD = 78T; R = 63T; INTR = 73T), and anxiety (ANX = 77T; A = 75T). These various scales also downplayed the client's potential for antisocial or angry acting out (ASP = 49T; ANG = 46T; MAC-R = 50T; Re = 55T; AAS = 46T; DISC = 39T). Still, Finn found that it was the RC Scales that best illuminated the central features in the case by de-emphasizing the depression (RC2 = 60T) and anxious rumination (RC7 = 58T) and highlighting the delusional beliefs (RC6 = 76T) and disordered thinking (RC8) of the client.

This conceptualization appeared to be confirmed by Finn's discussion of the MMPI–2 results with the client as illustrated by the following excerpts. In this instance, after an introduction, Finn went directly to the RC Scale profile:

Finn: You see you have high scores on these two scales. They share something in common … both have to do with the kinds of thoughts and perceptions people have. I'm wondering from these if you're having trouble concentrating lately because you're having some bothersome thoughts and experiences.

Client: Hmmm … like what?

Finn: You'll have to tell me, but maybe you feel like others are out to get you or thinking bad things about you?
Client: Sometimes.
Finn: And does that get in the way or make it hard to read or watch TV?
Client: Sure. When people want to punish you, a person doesn't just sit and watch his favorite TV program or anything.
Finn: I can understand that. And are there other similar things distracting you?
Client: Like what?
Finn: Well, for example hearing things or seeing things other people can't see?
Client: Maybe they don't want to see it … the blackness of soul … the evil stuff … lust and perdition and greed … it's all around us, in me and you and everyone. …

The client went on to talk about his belief that people are basically good but struggle with "demons" that tempt them to be evil. A bit later in the session, Finn probed about emotional distress and depression:

Finn: And does all this get you down sometimes? Do you get depressed?
Client: No, just disturbed … that there's so much … it's so hard to resist the evil … and there's no easy way to be cleansed. …

Discussion

To us, these two cases—both concerning young men who had engaged in acts of self-harm—illustrate one situation in which the RC Scales show substantial clinical utility. Both clients had complex, confusing presentations and MMPI–2 profiles with multiple elevations on the Clinical Scales, Content scales, Supplementary scales, and PSY–5 scales. In the first case, the RC Scales powerfully focused the clinician's attention on the client's extreme demoralization and away from other possible indicators of depression, anxiety, impulsivity, and thought disorder. In the second instance, the RC Scales highlighted the client's delusional and disordered thinking, which although prominently featured in the Clinical, Content, and PSY–5 scales, emerged more clearly on the RC Scale profile as the central clinical issue. In both instances, the RC Scales enabled the clinician to more accurately "mirror" the clients' experiences, which opened up a dialogue that was invaluable in treating the clients. If tests and test scores are "empathy magnifiers" as Finn and Tonsager (1997) claimed, then the RC Scales appear to permit a new level of refraction when looking at complex, highly elevated MMPI–2 profiles; and the case studies included in the RC Scale monograph suggest that there may be other clinical situations in which they are equally valuable.

It is not difficult to understand how the RC Scales would show clinical utility with clients who are severely distressed and disturbed. Not only are the Clinical Scales saturated with an underlying factor of emotional distress, so are many of the Supplementary, PSY–5, and Content scales. For example, Tonsager and Finn (1992) showed that a great deal of the variance in the Content scales was accounted for by a first factor that correlated highly with A, Mt, and other markers related to what Tellegen et al. called demoralization. This lack of psychometric discriminant power obviously leads to difficulties discriminating clinically between highly different psychiatric presentations. The two clients we illustrated had very different reasons underlying their attempts to harm themselves; however, we posit that many clinicians would have had difficulty determining this from their MMPI–2 profiles without the RC Scales.

CLOSING: OPTIMAL RATES OF CHANGE IN CLINICAL INNOVATION

When all is said and done, the proof of the pudding is in the eating: We agree with Tellegen et al. that the justification of the RC Scales is how well they work in both research and in clinical practice. The RC Scales are probably not definitive—no scales can ever be—nor exhaustive (new scales are in progress), nor, apparently, were they meant to be. On the other hand, they do—with far fewer items—generally show stronger and more discriminative associations with external correlates than the original Clinical Scales. We make a plea for a dispassionate evaluation of the RC Scales, to treat their value for research and practice as a predominantly empirical question. It would seem to us, however, that the methodology undergirding the RC Scales is one of which Hathaway and McKinley might have approved. The approach maintains a data-driven construct development stance but profits from modern computational power and statistics to derive sharper constructs.

Having said this, we also recognize the inevitable tension that exists between making a major change to a beloved and widely used assessment instrument and maintaining, as closely as possible, the status quo. For example, a debate highly similar to that concerning the RC Scales occurred when Tellegen's (Tellegen & Ben-Porath, 1992) uniform T scores were introduced with the publication of the MMPI–2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). As best we can tell, that particular controversy has now largely died down.

We hold the position articulated by Lewin (1951) and a succession of other systems theorists (e.g., Agazarian & Gantt, 2000; Papp, 1983) that restraints to change in any human community or system (such as some individuals voicing serious concerns about the RC Scales) need not be seen as troublesome "resistance." Rather, such "restraining forces" are potentially beneficial contributions that counter "driving

forces" and help to create an optimal rate of change, thereby ensuring the system's survival. Systems that change too rapidly have been known to lose their cohesion and spin out of control. In family therapy, such restraining forces have been called "persistence" (Anderson & Stewart, 1983). In this light, Nichols and to a lesser extent Rogers et al. can be seen as voices of those individuals who fear (or better yet, of that part of all of us MMPI-ers that fears) the MMPI–2 will change so fast as to be unrecognizable or no longer valuable. Tellegen and others (Tellegen et al., 2003) currently seem to hold the other side of the conflict: If the MMPI–2 does not change rapidly enough, it may be overtaken and rendered obsolete by shorter and more contemporary instruments such as the Personality Assessment Inventory (Morey, 1991).

If all parties step back to acknowledge the truth in both stances, unhelpful polarization can be avoided, and it is more likely that the MMPI–2 will undergo an optimal rate of development and continue to improve clinicians' ability to "put themselves in their clients' shoes" and researchers' ability to predict desired outcomes. In practice, this kind of coming together might be furthered by the MMPI–2 publishers stating explicitly that they realize many long-term users of the MMPI–2 value the Clinical Scales highly and that the scales will remain available for the foreseeable future; and Nichols and others could help by recognizing the need to update this venerable inventory and undertaking their own attempts to address the problems of Clinical Scale covariation and the outdated constructs underlying those scales. In such ways, the MMPI–2 "family" could avoid splintering into competing factions and could work together to make sure the MMPI–2 is relevant for years to come.

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