

SCALE 2: DEPRESSION (D)

Development

The criterion group for Scale 2 consisted of 50 cases manifesting “a clinically recognizable, general frame of mind characterized by poor morale, lack of hope in the future, and dissatisfaction with the patient’s own status generally” (Hathaway & McKinley, 1942/2000, p. 16). Most were considered to be in the depressed phase of manic-depressive illness and had been thoroughly evaluated to rule out nonpsychiatric causes of depressed mood. The authors recognized and tried to allow for instability in the construct by requiring that the criterion cases be considered depressed only at the time of testing, regardless of whether such mood was rooted in endogenous or situational factors. A preliminary scale of 70 items was formed by comparing the criterion group with 339 (139 men, 200 women) of the 724 Minnesota Normals, who had been roughly matched to the criterion group for age, and 265 (151 men, 114 women) students entering college. Scores on the preliminary scale were then obtained for 413 randomly selected psychiatric cases (“random psychiatrics”) and 690 of the Minnesota Normals.

On the basis of these comparisons, a group of 50 psychiatric patients who scored high on the preliminary scale but showed no depressive features clinically (“nondepressed”) and a group of 40 of the normals who scored high on the preliminary scale (“depressed normals”) were selected for further study. The items for the final scale were selected on the basis of a progressive increase in endorsement frequency from 690 of the Minnesota Normals, through the depressed normal group, to the criterion group. This procedure yielded 49 items. Eleven items that differentiated the nondepressed psychiatric cases from the criterion group were then added to the other 49 items and scored in the direction of the criterion group, for a total of 60 items on the final scale. This scale was then cross-validated on a new sample of 35 depressives, and these cases proved to separate themselves adequately from the 690 Minnesota Normals. They also achieved higher mean scores than the 50 nondepressed psychiatrics, the 413 randomly selected psychiatric patients (which included none of the criterion depressives), a subgroup of 223 of the latter patients who manifested some depressive symptoms but were given diagnoses other than depression (“symptomatic”), and 229 general medical patients. The order of these groups in terms of mean Scale 2 scores was: Criterion > Cross-validation > Nondepressed > Symptomatic > Random psychiatrics > Medical patients > Minnesota Normals. Three items with religious content were dropped from Scale 2 in the transition to the MMPI-2. Scale 2 is described in summary in Rapid Reference 6.2a; the subscales for Scale 2 are described in Rapid Reference 6.2b.

Rapid Reference 6.2a

Summary Descriptive Features of *D*

Number of Items: 57

True/False Balance: 20/37

Overlap: 13 items with *INTR*, 12 with Scale 7, 9 with Scale 1 and *DEP*, 8 with Scale 8 (5 with *Sc4*) and *RC2*, 7 with Scale 7, and 5 with *RCd*.

Content: Unhappiness, anxiety and worry, apathy and lethargy, nonimpulsiveness, inhibited aggression, physical symptoms, social withdrawal, and low self-esteem.

Relations with Other Scales: Among the basic clinical scales, Scale 2 is most highly correlated with Scales 1, with which it shares 9 items, at .82, and 7, with which it shares 12 items, at .80. These correlations are decreased with the addition of .5K to Scale 1 and 1.0K to Scale 7. Correlations with subscales are, in descending order, *D-O* (.95), *D1* (.95), *D4* (.90), *Hy3* (.90), *Hy-O* (.87), *D5* (.82), *Sc4* (.81), and *D3* (.80). Scale 2 is also highly correlated with *RC2* (.82), with the content scale *DEP* (.80), and with its component scales *DEP2* (.79) and *DEP1* (.77), and moderately correlated with *DEP3* (.64) and *DEP4* (.55).

Rapid Reference 6.2b

Subscales for *D*

The five Harris-Lingoes subscales for Scale 2 are extensively overlapping. Of the 49 items that appear on one of the subscales, 23 appear on two or more, for a total of 55 overlaps. *D1*, for example, overlaps with *D2* (8 items), *D3* (3 items), and *D4* (12 items), and contains all 10 of the *D5* items. Five *D2* items overlap with *D4* and two with *D5*; *D4* and *D5* overlap by four items.

***D1* (Subjective Depression—32 items):** “A negation of joy in doing things; pessimism, poor morale and low self-esteem; complaints about psychological inertia and lack of energy for coping with problems” (Harris and Lingoes). One of the mood components of Scale 2, *D1* appears to operate as an analog of the full *D* scale. It is the longest of the *D* subscales, containing more than half of the *D* items. The items are the most obviously depressive of the Scale 2 items; *D1* is almost completely contained in and virtually identical to *D-O* ($r = .98$). It is highly correlated with *Hy3* (.91), *Sc4* (.89), *Sc3* (.81), *Sc2* (.78), *Pd5* (.79), and MMPI-2 content scales *DEP* (.89; *DEP1* [.86]; *DEP2* [.86]), *ANX* (.86), *WRK* (.85), *TRT* (.79; *TRT1* [.78]), *LSE* (.78; *LSE1* [.79]), *HEA* (.75), *OBS* (.72), and *SOD* (.68), as well as *INTR* (.79) and *NEGE* (.75). *D1* is probably the most sensitive MMPI-2 scale to short-term fluctuations in mood.

D2 (Psychomotor Retardation—15 items): “Non-participation in social relations; immobilization” (Harris and Lingoës). *D2* is the inhibition component of Scale 2 and only weakly correlates with its contrastingly named Scale 9 counterpart, *Ma2*, at $-.15$. It is composed of items whose content suggests withdrawal from social participation, lethargy/anergia, and denial of aggression and anger. The inhibitions involved appear to be more emotional than behavioral, judging from correlations with *R* (.52) and *DISC* ($-.32$). *D2* appears to be sensitive to passivity and submissiveness (Friedman et al., 2001). *D2* is moderately correlated with *INTR* (.66). Levitt (1989) has speculated that low scores on *D2* may suggest sufficient energy for suicide, and this would seem to apply especially when scores on the other Scale 2 subscales are high.

D3 (Physical Malfunctioning—11 items): “Complaints about physical malfunction; preoccupation with oneself” (Harris and Lingoës). This subscale encompasses the somatic component of Scale 2. Content predictably reflects the vegetative features of depression, such as loss of appetite, change in weight, weakness, and constipation. It may be noteworthy that three of the items (117T, 181T, and 238F) deny somatic problems. *D3* is highly correlated with Scale 1 (.82), *Hy3* (.82), *Hy4* (.72), and *HEA* (.76; *HEA3* [.76]; *HEA1* [.68]; *HEA2* [.67]). Caldwell (1988) speculated that *D3* may touch on the fear that one may never be restored to health, that there is nothing to look forward to but further physical decline.

D4 (Mental Dullness—15 items): “Unresponsiveness; distrust of one’s own psychological functioning” (Harris and Lingoës). *D4* reflects the cognitive debility of depression; it is the mental counterpart of *D3*. The items overlap with those of several other subscales, including *D5* (40%), *Sc3* (40%), and *Sc4* (36%), and describe an inability to comprehend one’s reading, distractibility, lapses in judgment, problems with memory, low energy, a lack of self-confidence and initiative, and a sense of the futility of caring and trying. It is highly correlated with *D1* (.94), *Sc4* (.90), *Hy3* (.88), and *Sc3* (.87). Eight of its items (53%) overlap with those of Scale 7. High scores imply a loss of interest, a sense of mental failure or decline, and the depletion of energy needed to accomplish mental work. Thinking and problem solving are experienced as effortful and as subject to going off course even when significant effort is made. The patient is likely to view his or her thinking as impaired and unreliable, and to have the sense that “I can’t seem to get my mind to work right.”

D5 (Brooding—10 items): “Ruminativeness; irritability” (Harris and Lingoës). The second of the mood subscales of Scale 2, *D5* is the most heavily saturated with obvious depressive content of the Scale 2 subscales. Eight of its 10 items overlap *DEP* (half of these on *DEP1*), amounting to 8 of the 9 items shared by Scale 2 and *DEP*. *D5* is highly correlated with Scale 7 (.89), *Hy3* (.81), *Pd5* (.82), *Sc4* (.85), *ANX* (.84), *DEP* (.92; *DEP2* [.91], *DEP1* [.86], *DEP3* [.80], *LSE* [.80]), and *NEGE* (.80). It combines a sense of being easily upset with that of misery and agitation. For interpretative purposes, it is most

(continued)

useful when compared with *DI* rather than the full Scale 2. *D5* is more angry and expunitive than *DI*.

D-O (Depression-Obvious—39 items): *D-O* contains 28 of the 32 items of *DI* ($r = .98$) and is nearly identical to the latter.

D-S (Depression-Subtle—18 items): *D-S* is a subtle measure, not of depression as such, but of the inhibition of crude affect. It reflects passivity, subassertiveness, and tolerance for domination/subordination. It overlaps *D2* by seven items and is moderately correlated with *ANG* ($-.59$), *Re* ($.57$), *ANG1* ($-.57$), *Ma4* ($-.57$), *TPA* ($-.56$), *TPA2* ($-.55$), and *ASP* ($-.55$). It and *AGGR* (low) are probably the best traditional MMPI-2 measures of inhibited aggression (but see *Dr2*, as follows).

Revised Subscales for D

As noted previously, the Harris-Lingoes subscales for Scale 2 are extensively overlapping, compromising both their distinctiveness and their discriminant validity. There are 55 total overlaps among the *D* subscales, averaging 11 overlaps per subscale, far more than for any of the other Harris sets; for any given pair of these five subscales, there are four to five overlapping items (range: 0–12), amounting to 27% of average scale length. Eight (14%) of the Scale 2 items appear on none of the subscales.

The set of five alternative *D* subscales (Nichols, 2009a) presented in the Appendix has at least two advantages over the original Harris set. First, the number of overlaps has been reduced to six, averaging 1.2 per scale; any given pair of scales average only .6 overlapping items (range: 0–3), amounting to 5% of average scale length. Second, each *D* item appears on at least one subscale. A possible disadvantage is that two of the new subscales contain only 8 items (vs. a minimum of 10 items for the Harris *D* subscales).

Interpretive Implications

General

Carson (1969) describes Scale 2 as “the best single—and a remarkably efficient—index of immediate satisfaction, comfort, and security” (p. 285). Concerns center on mood, morale, and efficiency. Scores have implications for experienced physical health and well-being; the level of interest and engagement with the environment, including the social environment; and general feelings of satisfaction, contentment, and security. Scale 2 scores tend to be highly responsive to fluctuations in mood and to the situational factors that may influence such changes, and are generally more sensitive to true health/illness status than Scale 1 scores. Scale 2 is rarely elevated in isolation, and its interpretation is highly dependent on

its patterns of combination with other scales. For example, many of the aforementioned correlates actually reverse when Scale 2 is paired with Scale 4; this configuration predicts externalization, undercontrol, and much higher levels of substance abuse, acting out, aggression, anger, and hostility than when Scale 2 shows an isolated spike. Elevations on Scale 8 tend to emphasize endogenous features, whereas elevations on Scale 3 tend to deemphasize them.

Presenting Problem

The presenting problem is highly variable. Complaints of depression and depressed mood are probably most frequent, but physical symptoms and illness (so-called masked depression); insomnia or hypersomnia; weight loss or gain; weakness, fatigue, and exhaustion, or a lack of energy and vigor; guilt, low self-esteem, and a lack of self-confidence; distractibility, forgetfulness, and indecision; tension, anxiety, and worry; and irritability, being easily upset or agitated, and even anger, are all common as well. Situational or interpersonal problems often lead to the initial contact, which may be incited or even arranged by others. The presenting complaint often involves a profound sense of loss or grief that precedes the onset of symptoms and has adversely affected the patient's security and self-esteem. Not uncommonly, the crisis involves the loss of a loved one through separation or death, the loss of employment, financial reverses, the collapse of a cherished aspiration, or the failure of some strongly desired achievement.

Symptomatic Pattern

These patients feel unhappy, sad, blue, and dissatisfied with themselves and their life situations. They take little pleasure in events and activities that they formerly enjoyed, feel discouraged and pessimistic about the future, and are slowed down in their thinking and movement. They also lack motivation and initiative, find it difficult to overcome a sense of inertia to get going, or to resume a task once it has been interrupted or set aside, and tend to give up in the face of obstacles. Problems with appetite and sleep disturbance are common. Guilt, self-deprecation, and low self-esteem impair self-confidence, and past accomplishments are disparaged for no good reason. They withdraw from normal physical and social activities into silence and self-absorption. Turning inward avails them little, however, because their mental function is compromised. Problems with attention, concentration, memory, judgment, and indecision make thinking and problem solving effortful, taxing, stereotyped, and often fruitless. They may focus on minor matters as if they were important, making mountains out of molehills. Information is processed slowly and incompletely and is often given a gloomy bias. Patients tend to turn away from present and future concerns, with an unavailing focus on the

past. Ruminative worry, preoccupation, and self-recrimination create a downward spiral leading to despair, hopelessness, and thoughts of suicide.

These patients' coping styles tend to be highly internalized. Emotionality is constricted and overcontrolled, and they tend to be impassive, conventional, unassertive, nonaggressive, and unlikely either to act out in self-defeating or anti-social ways, or to engage in substance abuse. Most experience weakness, tiredness, and fatigue; have little energy or initiative; and manifest some degree of psychomotor slowing or retardation. Aggression and hostility tend to be strongly inhibited. In a minority of cases, however, tension, agitation, impatience, irritability, and frustration intolerance are seen, and short-lived angry flare-ups occur about which the patient may experience an exaggerated sense of guilt afterward.

At higher elevations, these patients may feel defeated and utterly useless, helpless, hopeless, and worthless. Moreover, they may feel that their physical health has embarked upon an inexorable decline toward ruin and permanent physical suffering, especially when coupled with elevations on Scale 1. Objectively, such patients tend to be severely withdrawn emotionally, immobilized, and even mute.

Suicide Risk

An assessment of suicide risk is generally indicated when Scale 2 is elevated. Reference to the patient's responses to the Koss-Butcher Depressed Suicidal Ideation set of critical items, and to the Suicide Potential Scale (SPS: items 150, 303, 506, 520, 524, and 530; Glassmire, Stolberg, Greene, & Bongar, 2001) is recommended in this regard. Hopelessness is a stronger predictor of suicidal ideation, intent, and completed suicide than is depression in adolescents and adults, and in patients with depression and schizophrenia diagnoses (e.g., Beck, Brown, Berchick, Stewart, & Steer, 1990; Ganzini, Silveira, & Johnston, 2002; King et al., 2001; Kopper, Osman, & Barrios, 2001; Nordentoft et al., 2002; Pompili et al., 2008; Saarinen, Lehtonen, & Lonnqvist, 1999). For this reason the author developed an MMPI-2 *Hopelessness (Hp)* scale of 12 items based on the item-total correlations of each of these items with each of the 6 SPS items listed above (Nichols, 2010). It may have particular value in detecting suicide risk among patients wishing to conceal suicidality, possibly a plan, by avoiding the more explicit suicide items. The scoring key and norms for *Hp* are given in Appendix.

Interpersonal Relations

Retiring and socially reserved, these patients tend to shrink from conflict and confrontation and are generally seen as timid. Intimates and others find them distant and difficult to reach emotionally, which tends to create stress in the lives of those close to them. Although not necessarily dependent on a characterological basis,

their passivity and gloominess often result in others' having to take responsibility for them by default. Those close to them are likely to feel that they must offer assistance, propose solutions, and take up responsibilities that the patient has dropped, as well as to provide reassurance that the patient is cared for and that things will improve, and to make efforts to boost the patient's self-esteem. The patient's lack of response to these well-intended ministrations may create a sense of alarm and exasperation in the caretakers. However, the patient's self-criticism tends to blunt and frustrate caretakers' candid expressions of annoyance, so that words and acts designed to comfort and encourage the patient will often become more grudging and resentful with the passage of time. This trend may lead to the rejection and abandonment the patient has both feared and longed for, confirming the patient's view of him or herself as hopeless, worthless, and an unworthy burden to others.

Patients often report school or work problems, such as difficulty completing work on time; conflicts with other students or coworkers or with a teacher/supervisor because of underperformance, excessive absences, inattentiveness, and related difficulties. They may also report problems with the spouse (including a lack of sexual interest) or letting financial obligations slide. Such problems are often internalized by the patient as guilt or feeling like a failure.

Behavioral Stability

The behavior pattern is inherently unstable and subject to a wide variety of influences—environmental, interpersonal, and biochemical. Scale 2 is highly sensitive to such instability and tracks changes in symptom status fairly well. As such, it tends to function more as a state than a trait scale.

Defenses

The defensive patterns associated with high scores on Scale 2 are many and varied, depending on other features of the profile. In general, Scale 2 elevations tend to signal some degree of failure, if not a breakdown of whatever defensive posture preceded it (Trimboli & Kilgore, 1983). Many defenses, such as intellectualization, rationalization, or reaction formation, may be observed as the patient deals with anger. Other defenses, such as denial, displacement, suppression, and repression, may be directed at the anger or at the depression itself. Somatization, too, may be directed at the depression, thereby masking it from the patient and others.

History

Look for the loss or death of a parent or other loved one in childhood; exposure to neglect, abuse, or emotional cruelty, whether at first or second hand, while growing up; the experience of being frequently uprooted; or the loss of what was

felt to be a major opportunity, especially if the patient responded to such losses passively. More recent losses that may be relevant include separation from an important source of emotional support or companionship such as a spouse or close friend, as through death or desertion; losses related to employment or economic security; and losses related to accident, injury, or loss of function resulting from injury or disease.

Diagnostic Considerations

Diagnosis is generally within the mood disorders: Dysthymic Disorder, Major Depression, Depressive Disorder NOS, or Adjustment Disorder with Depressed Mood.

Treatment Considerations

Elevations on Scale 2 are associated with favorable treatment outcomes using a wide variety of treatments. The cognitive and interpersonal therapies have established a good track record in this regard, especially when accompanied by antidepressant medication. However, many patients will respond well to much more conservative measures, including exercise and environmental manipulation (e.g., transfer to a different department) and the simple passage of time.

The patient's level of discomfort is generally favorable to establishing rapport. These patients require an initial level of support commensurate with the severity of depression. In the more severe cases (e.g., Major Depression), the onset of psychotherapeutic work may have to await at least partial response to antidepressant medication, because the patient may be too immobilized and emotionally withdrawn for productive interaction with the therapist. At a minimum, the patient must have passed beyond the period of greatest suicide risk and be largely restored to a normal sleep cycle.

Early goals in treatment include providing for the patient's safety through supervision, continuing contact with intimates and close friends, suicide contracts, and restoring morale. Supportive family can be especially important in the initial stages of treatment. Excessive support from the therapist may be counterproductive, however, potentially undermining the development of a more independent and assertive coping style.

Much of the treatment process may involve the review and correction of maladaptive cognitive and emotional reaction patterns, and working through grief and loss. In particular, helping the patient gain release from an overly passive, inhibited, and conscientious emotional style and from the tendency to internalize stresses may be helpful. These patients are overly quick to accept blame and responsibility for circumstances over which they may have little or no control.

Learning a style of relating that enables greater self-expression and a sense of enhanced self-determination, including the expansion of the patient's ability to make selfish or self-indulgent choices, to decline excessive or unwanted responsibilities, and to pursue his or her rights and preferences assertively in relationships with others is the usual end goal of therapy.

Low Scores

Low scores reflect buoyancy, optimism, cheerfulness, and a capacity for enthusiasm; heightened activity and social interest; and mental alertness and facility. With very low scores, however, these trends can become problematic. Excessive optimism can lead to poor judgment; excessive cheerfulness can take on a relentless and impervious character; excessive activity or enthusiasm can lead to disinhibition and recklessness; an excess of social interest can lead to superficial and opportunistic relationships, ostentation, fickleness, insensitivity, or intrusiveness; excessive mental facility can lead to ill-considered judgment and an impressionistic or careless style of information processing. The quick-wittedness of emotional buoyancy and cognitive facilitation may lead to expressions that are irrepressible but inappropriate, or at the expense of others' feelings. Although they occur infrequently, low scores on Scale 2 can reflect the grandiosity, euphoria, and undercontrol seen in mania.

SCALE 3: HYSTERIA (Hy)

Development

McKinley and Hathaway (1944/2000) mentioned several criterion groups, but the final primary group contained 50 cases, most diagnosed Psychoneurosis, Hysteria. Then, as now, the clinical concept of hysteria was ill-defined and controversial. Hathaway tried to emphasize cases with "a simple conversion symptom such as aphonia, an occupational cramp, or a neurologically irrational anesthetic area" (p. 34), but so few such patients were available that several probable but less clear-cut cases had to be included. A set of discriminating items was identified early, and these repeatedly surfaced in various group comparisons, although these comparisons are not described. It was immediately evident that most of the items fell into two categories: somatic complaints and "statements tending to show that the patient considered himself unusually well socialized" (p. 34).

Because of the conceptual similarity between the hypochondriasis and hysteria constructs, a great deal of effort went into testing Scale 3 against new cross-validation samples of hysterics and cases of hypochondriasis to ensure that the appropriate conceptual similarities were preserved without rendering the two