2-5 Pattern

Scale 2 (Dep)

Elevations of this magnitude for this Scale taking this group's data into consideration, indicate these clinical features could be present in this person's behavior and history:

They are worried, pre-occupied with their personal affairs, and carry the burden of a private sadness. Sadness is intermingled in most of their activities. They experience the new, unique, and unexpected as barriers they must expend inordinate amounts of energy to overcome. They are sad and unhappy most of the time. They look at the future through wistful eyes, and out of their reach. They are easily discouraged and quickly put off from initiating important plans and activities. They are depressed, pessimistic, and deeply worried. They feel unworthy and inadequate.
They could be silently angry and unable to admit it to themselves. A reactive depression could be present. They are severely depressed, tired, and indifferent to everyday human contacts. Mental retardation and lethargy interfere with everyday activities. Case review may indicate their need for medication referral.

Depressive Disorders

Mood is a pervasive, sustained emotion operating in the background of mental life that colors the person's outlook on the world (APA 2000).

American Psychiatric Association (2000). Practice guidelines for the treatment of psychiatric disorders. Washington, D.C.: American Psychiatric Press.

The predominant feature in depressive disorders is a disturbance of mood manifested by a loss of interest in personally valued activities in all cases. The loss of pleasure when the individual anticipated and engaged in these activities eventuates in the collapse of this emotional background. A sense of pain pervades the person's life and all of the activities in which they engage. They cannot adequately put the pain they feel into words.

Physically they loose or gain weight; have sleep disturbances, either sleeping less or more than usual; feel too tired to do engage in everyday activities, and have less of an appetite for intimacy. They feel guilty for no good reason. Thoughts of dying, death and of to taking their own lives come to plague them. Many may have attempted to kill themselves.

Sleep abnormalities occur in ninety percent of persons hospitalized fro treatment of major depressions (APA 2000). People treated in outpatient settings have a 40 to 60 percent chance of experiencing sleep disturbances. Sleep abnormalities persist after recovery from a depressive episode (Thase 1999).

Thase, M.E. (1999) Mood disorders: Neurobiology. In H.I. Kaplan and B.J. Sadock (Eds.), Comprehensive textbook of psychiatry (7th ed., pp. 1318-1327), Vol. I. Philadelphia: Lippincott, Williams & Wilkins.

Ninety seven percent of all cases report a loss of energy. Anxiety occurs in 60 percent of the cases (Zajecka (1995).

Zajecka, J. (1995). Treatment strategies to treating depressions complicated by anxiety disorder. Presented at the U.S. Psychiatric and Mental Health Congress. New York, November 16, 1995.

Thinking, concentration, and memory are impacted. They view themselves as failures in life. They recount their faults and flaws, but do not see their strengths and virtues. They say and say they are terrible persons. A sense of guilt, that has no realistic basis, fills their days. They feel worthless and helpless to change things around in their lives.

They pace about endlessly. They get no rest even when they do nothing at all. They have headaches, backaches, the blahs, constipation, and an all-pervasive sense of discomfort. Activities which once gave them pleasure no longer do so. All looks black to them.

Their health deteriorates. Complicated physical conditions arise. Their ability to work is impaired. Social activities are no longer important to them. A general decline in life activities takes place.

The community base rate for major depression in the United States is 3 to 5 percent. The lifetime risk for depression is 5 to 12 percent for men and 10 to 25 percent for women (Diagnostic and Statistical Manual for Mental Disorders, 4th edition, text revision 2000). Unipolar depression is twice as common I women as in men (Dubovsky and Buzan 1999).

Dubovsky, S.L., and Buzan, R. (1999) Mood Disorders in Hales, R.E., Yudofsky, S.C., & Talbott, J.A. (Eds.) Textbook of psychiatry (pp. 479-566) Washington, D.C.: American Psychiatric Press.

Postpartum depression occurs in 10 percent of mothers. The rates for reported depression in preadolescents is 18 percent (Dubovsky and Buzan 1999). Young people between the ages of 9 to 17 yield a 6 percent rate of depression (Varcaroles, E.M. (1999).

Varcaroles, E.M. (1999) The invisible disease: Depression. National Institute of Mental Health. Washington, D.C.

Depression rates for the elderly living in the community is 3.5 percent; 16 percent for medically hospitalized elderly; 15 to 20 percent for our elderly living in nursing homes; and as high as 40 percent in selected groups of elderly (Dubovsky and Buzan 1999).

Depression is associated with general medical conditions, substance-induced mood disorders following the use of recreational and misuse of prescription drugs, bereavement and reaching the end-of-live.

Medical conditions and syndromes associated with Mood Disorders:

System	Diagnoses
Neurologic	Dementias
	Hydrocephalus
	Huntington's Chorea
	Infections, i.e., HIV, neurosyphilis
	Migrains
	Multiple Sclerosis
	Myasthenia Gravis
	Parkinson's Disease
	Seizure Disorders
	Stroke
	Trauma
	Tumors
	Vasculitis
	Wilson's Disease
Endocrine	Addison' Disease
	Cushing's Syndrome
	Diabetes Mellitus
	Hyperpapathyroidism
	Hypothyroidism
	Menses-related Depression
	Postpartum Depression
Metabolic/Nutritional	Folate Deficiency
	Hypercalcemia
	Hypocalcaemia
	Hyponatremia
	Pellagra
	Porphyria
	Uremia
	Vitamin B12 Deficiency

Infections/Inflammatory	Influenza
	Hepatitis
	Mononucleosis
	Pneumonia
	Rheumatoid Arthritis
	Sjoegren's Disease
	Systematic Lupus Erythematosus
	Tuberculosis
Mixed	Anemias
	Cardiopulmonary Disease
	Neoplasms
	Sleep Apnea

Mulner, K.K., Florence, T., & Clark, R.R. (1999). Mood and anxiety syndromes in emergency psychiatry. Psychiatric Clinics of North America, 22 (4): 761.

Depressions recur. Sixty percent of those people who have suffered on depressive episode can expect a second episode; seventy percent can expect a third episode; and ninety percent can expect three or more episodes (APA 2000).

Prescription medications associated with Mood Disorders:

Systems	Medication/Substance
Neurologic/Psychiatric	Amantadine
	Anticholinesterases
	Antipsychotics
	Baclofen
	Barbiturates
	Benzodiazepines
	Bromocriptine
	Carbamazepine
	Disulfiram
	Ethosuximide
	Levodopa
	Phenytoin
Antibacterical/Antifungals	Corticosteroids
	Grieseofulvin
	Metronidazole

	Nalidix Acid
Trimethoprim	
Anti-inflamatory/Analgesic	Corticosteroids
	Indomethacin
	Opiates
	Sulindac
Antineoplastic	Asparaginase
	Azothioprine
	Bleomycine
	Hexamethylamine
	Vincristine
	Vinblastine
Cardiovascular	Clonidine
	Digitalis
	Guanethidine
	Methyldopa
	Propanolol
	Resperine
Gastrointestinal	Cimetidine
	Ranitidine
Mixed	Alcohol
	Anxiolytics
	Cocaine
	Heroin
	Marijuana

(Mulner, et al 1999)

Research studies. Franklin et al. (2002) using Taxometric analyses tested directly whether the MMPI-2 depression scales could differentiate 2000 psychiatric patients with depressive symptoms from patients with other disorders. Taxometric analyses did **not** find a MMPI-2 Depression scale cut point that categorizes patients with depressive symptoms form other patients. The findings support the assumption that there is an underlying dimensionality of depression.

Franklin, C. L., Strong, D.R., & Greene, R.L. (2002) A Taxometric analysis of the MMPI-2 Depression Scales. Journal of Personality Assessment, August 79(1), 110-121.

Rohling et al. (2002) examined the effect of depression on neurocognitive performance in patients who passed symptom validity testing. No differences occurred on objective

cognitive and psychomotor measures in groups sorted based on their self-reported depression. These data suggest that depression has no impact on objective neurocognitive functioning.

Rohling, M.L., Green, Paul, Allen, L.M. III, & Iverson, G.L. (2002) Depressive Symptoms and neurocognitive test scores in patients passing symptom validity tests. Archives of Clinical Neuropsychology. April, 17(3), 205-222.

Scale 2 (Dep)

Scale 2 (Dep) measures the presence of clinical depression (Dahlstrom et al. 1972). The MMPI has 60 items. The MMPI-2 has 57 items. Thirty-seven of these items are scored in the false direction, 20 in the true direction. A false response set will elevate Scale 2 (Dep), along with Scale 1 (Hs) and Scale 3 (Hy). Item overlap is: **L (2), F (2), K (8), 1 (10), 3 (13), 4 (7), 5 (2), 6 (2), 7 (13), 8 (10), 9 (5), Sie (8).**

Dahlstrom, W.G., Welsh, G.S., & Dahlstrom, L.E. (1972) An MMPI hand-Book: Vol. 1. Clinical Interpretation (Rev. ed.). Minneapolis: University of Minnesota Press.

Hunsley et al. (1988) provided meta-analytic derived test-retest data for retest intervals of 1 day to 2 years. An average interval consistency of .87 was reported for 74 Scale 2 (Dep) studies. Butcher et al. (1989) reported Scale 2 (Dep) test-retest correlations in the .79 ranges for the MMPI-2.

Hunsley, J., Hanson, R.K., & Parker, C.H.K. (1988) A summary of the reliability and stability of MMPI Scales. Journal of Clinical Psychology, 44, 44-46.

Butcher, J.N., Dahlstrom, W.G., Graham, J.R., Tellegen, A., & Kaemmer, B. (1989) Minnesota Multiphasic Personality Inventory-2 (MMPI-2). Manual for administration and scoring. Minneapolis: University of Minnesota Press.

Clinical Scale Elevations

Scale(s) 5 (Mf)

Males T-score 60-79

Females T-score <45

Elevations on the present Scale(s), taking race, gender, age, education, marital and employment status into consideration for the corresponding group's data, indicate any or all of these clinical features could be present in this person's behavior and history:

They are inquisitive and curious. They are sensitive and imaginative. They take pains to have art and literature in their lives. They are inclined to pursue higher education when the opportunity presents itself. They do not usually enjoy the rough and tumble for it-self alone. They can be adventurous. They seek out the novel, unusual and unexpected. They seek out the companionship of like-minded persons. They tend to look for energetic, take control persons. They do not particularly object to being a follower. They are self-effacing. They prefer to influence others employing indirect means. They are concerned for the welfare and happiness of others. They are frightened of expressing their genuine felling and emotions to others. Bold, assertive, out-going, domineering partners attract them.
They have mastered the art of placating angry people. They are yielding collaborators given the opportunity. They are interested in the management of a domicile, decoration, fashion, art, music, and cultural pursuits. They are capable of taking on other person's burdens as their own. They go out of their way to maintain contacts with people who they consider need them in their lives. Their exertions meet with failure in many instances. They find they attract people who are not capable of returning their kindness, sensitivity, and generosity.

Scale 5 (Mf)

The Terman and Miles (1936) investigations, which commenced in 1922, into the masculine and feminine interest patterns of intellectually superior children, form the basis of the Masculinity/Femininity Scale of the MMPI and MMPI-2. A series of masculinity and femininity tests (M-F test) were developed. "…the scores tended to be correlated with general masculinity and femininity behavior and to reveal an important line of cleavage in personality and temperament." (p. 13).

Terman, L.M., & Miles, C.C. (19360. Sex and Personality. (2nd ed.). New York, McGraw-Hill.

Terman observed, "In modern Occidental culture, at least, the typical woman is believed to differ from the typical man in the greater richness and variety of her emotional life and in the extent to which her everyday behavior is emotionally determined. In particular, who is believed to experience in greater degree than the average man the tender emotions, including sympathy, pity, and parental love; to be more given to cherishing and protective behavior of all kinds. Compared to men she is more timid and more readily overcome by fear. She is more religious and at the same time more prone to jealousy, suspicion, and injured feelings. Sexually she is by nature less promiscuous that men, is coy rather than aggressive, and her feelings are less specifically localized in her body. Submissiveness, docility, inferior steadfastness of purpose, and a general lack of aggressiveness reflect her weaker conative tendencies (the ability to stick with a complex and demanding task and see it through to a successful completion). Her moral life is shaped less by principles that by personal relationships, but thanks to her lack of adventurousness she is much less subject than men to most types of criminal behavior. Her sentiments are more complex than man's and dispose her personality to refinement, gentility, and pre-occupation with the artistic and cultural." (p. 2).

Volentine (1981) investigated femininity interest items on the Bem Sex Role Inventory and Scale 5 of the MMPI. The correlations supported the conclusion that Scale 5 more clearly reflects feminine rather that masculine interest patterns.

Volentine, S.Z. (1981). The assessment of masculinity and femininity: Scale 5 of the MMPI compared with the BSRI and PAQ. Journal of Clinical Psychology, 37, 367-374.

Hathaway and McKinley (1940) developed Scale 5 to identify homosexuals. Items from the Terman and Miles Attitude-Interest Analysis Test (1936) were incorporated into Scale 5 after the data had already been collected from the original normative sample. Dahlstrom (1972) said, “Scale 5 was designed to identify the personality features related to the **disorder** of male sexual inversion”. “Persons with the personality pattern often engage in homoerotic practices as part of their feminine emotional makeup; however, many of these men are too inhibited or full of conflict to make any overt expression of their sexual preference. (p. 201).

Hathaway, S.R. (1956). Scales 5 (Masculinity/Femininity), 6 (Paranoia), and 8 (Schizophrenia). In G.S. Welsh & W.G. Dahlstrom (Eds.), Basic readings on the MMPI in psychology and medicine (pp. 104-111). Minneapolis: University of Minnesota Press.

Dahlstrom, W.G., Welsh, G.S., & Dahlstrom, L.E. (1972). An MMPI handbook: Vol. I. Clinical interpretation (Rev. ed.) Minneapolis: University of Minnesota Press.

Terman and Miles (1936) concluded,” It (the M-F test) does not measure homosexuality, as that term is commonly used, but it does measure, roughly, (the) degree of inversion of the sex temperament …” (p. 467). “ … a serious limitation to the present usefulness of the (M-F) test lies in the fact that as yet too little is known about the behavior correlated with high and low scores”. (p. 9). This appears to by true to this day. “Most empathic warning is necessary against the assumption that an extremely feminine score for males or an extremely masculine score for females can serve as an adequate basis for the diagnosis of homosexuality, either overt or latent”. (p. 9). “…probably a majority of subjects who test as variates in the direction of the opposite sex are capable of making a perfectly normal heterosexual adjustment.” (p. 9).

Hathaway and McKinley (1956) concluded that Scale 5 did not identify homosexuals. Wong (1984) stated that subsequent attempts to construct independent scales to identify homosexuals have met a similar fate.

Foerstner (1946) investigated the bipolar construction of Scale 5 (Mf) in a series of extensive examinations of large psychiatric in- and out-patient populations. The MMPI subtests developed by Harris and Lingoes (1955), Serkownek’s 1975 in Schwerger (1987), Weiner (1948), and Wiggins (1966) were factor analyzed. Friedman, et al, (2001) commented, “It is clear from the data reported in Foerstner’s (1984) study that Scale 5 (and Scale 0) is multifactorial in nature; therefore, its composition is not limited to masculine-feminine factors. Scale 5 scores, whether high or low, may be achieved by item endorsements of any of the combination of at least 6 factors”. (Wong 1984).

Foerstner, S.B. (1984). The factor structure and stability of selected Minnesota Multiphasic Personality Inventory subscales: Harris and Lingoes subscales, Wiggins's content scales, Weiner subscales, and Serkownek subscales. Doctoral dissertation. University of Akron, Ohio.

Harris, R.E., & Lingoes, J.C. (1955). Subscales for the MMPI: An aide to profile interpretation. Department of Psychiatry. University of California.

Serkownek, K. (1975). Subscales for Scales 5 and 0 of the MMPI. Unpublished manuscript.

Schwerger, J.M., Foerstner, S.B., Serkownek, K., & Ritz, G. (1987). History and validities of the Serkownek subscales for MMPI Scales 5 and 0. Psychological Reports, 61, 227-235.

Weiner, J.S. (1948). Subtle and obvious keys for the MMPI. Journal of Consulting Psychology, 12, 164-170.

Wiggins, J.S. (1966). Substantive dimensions of self-report in the MMPI item pool. Psychological Monographs, 80, (22, Whole No. 630).

Wong, M.R. (1984). MMPI Scale 5 meaning or lack thereof. Journal of Personality Assessment, 48, 279-284.

Friedman, A.F., Lewak, R., Nichols, D.S., & Webb, J.T. (2001). Psychological Assessment with the MMPI-2. Mahwah, N.J.: Lawrence Erlbaum Associates, Publishers.

Kunce and Anderson (1984) think normal men who have high Scale 5 scores entertain many interests and are tolerant of diversity. Low Scale 5 score in normal men may reflect assertiveness, a need for physical activity, competitiveness, enthusiasm for sports, and little interest in revealing much about themselves. Normal females who score high on Scale 5 may be seen as confident, energetic, and in control of their lives. Low Scale 5 scores for normal females suggest an acceptance of the attitudes and interests of a typically feminine person as defined by the current cultural milieu.

Kunce, J., & Anderson, W. (1984). Perspectives on uses of the MMPI in psychiatric settings In P. McReynolds & G.T. Chelvne (Eds.). Advances in psychological assessment (Vol.6, pp. 41-76.

Wallace (2001) suggests the psychiatric male population with high Scale 4 (Pd) combined with low Scale 5 (Mf) scores are seen a vigorously seeking out opportunities for narcissistic masculine self-indulgence. These men use other people to satisfy their urges. They are indifferent to the impact their behavior has upon others. Female psychiatric populations who have high Scale 4 and low Scale 5 scores suggest angry hostile females who are provocative troublemakers. They twist what is said to them to the point the original

message is unrecognizable. This maneuver puts the recipient of her retorts off balance and more easily confused and manipulated. They use guilt to dominate those relationships they find useful to achieving their own interests and goals. They have little to no capacity for empathy.

Wallace, J.L. (2001). A Clinician's Guide to Minnesota Multiphasic Personality Inventory Interpretation. Ex Libris.

Scale 5 (Mf)

Twenty-three of the Scale 5 (Mf) items are from the item pool of Terman and Miles work, Sex and Personality (1936). Thirty-seven items are from the MMPI pool. The MMPI-2 has 56 items for Scale 5 (Mf). Scale 5 (Mf) measures masculinity/femininity attitudes wherein high Scale 5 (Mf) scores reflect more feminine attitudes in males and low Scale 5 (Mf) scores indicate attitudes that are more feminine with females. Twenty-five of the MMPI-2 Scale 5 (Mf) items are scored in the true direction and 31 are scored in the false direction for men. Twenty-three of Scale 5 (Mf) items are scored in the true direction for females and 33 items are scored in the false direction. Scale 5 (Mf) norms are formed from linear Tscores instead of the Uniform Tscores utilized in the norming of the MMPI-2. Test-retest correlations on Scale 5 (Mf) run from .79 to .83 for 1 t 2 day intervals with psychiatric patients, .79 to .79 for a 1 to 2 week interval for psychiatric patients and .72 for 1 to 2 week intervals with college students (Dahlstrom 1975). Item overlap is: **L (1), F (2), K (3), 1 (0), 2 (2), 3 (4), 4 (3), 6 (2), 7 (1), 8 (4), 9 (3), Sie (9).**

Dahlstrom, W.G., Welsh, G.S., & Dahlstrom, L.E. (1975) An MMPI handbook: Vol. II. Research applications. (Rev. ed.). Minneapolis: University of Minnesota Press.

PROFILE CHARACTERISTICS

Marks said female patients are often unhappy, withdrawn, guilty, and shy. They feel isolated, lack self-confidence and have limited tolerance for social and emotional relationships. It is likely that as children they received very little physical warmth, affection, and contact. Usually the parents were not outwardly cruel and hostile but rather were withdrawn, socially inept or retiring and limited in their ability to receive or give physical warmth and comfort themselves.

In some instances, the parent has viewed the outward display of emotion as weakness and the child learned how to control feelings and stop emotional wanting. These patients typically have difficulty touching, holding, caressing, or kissing. The profile reflects a stable personality pattern, which is quite resistant to therapeutic exploration.

Patients with this profile often experience fear of irretrievable loss of some highly valued physical or emotional object. They tend to respond to this loss by blocking of further needing or "wanting". They are blocked in the "despair" phase of the mourning process and are afraid to cry and feel angry. They will need to express anger and "rage at fate" in order to finish the grieving process. Frequently these patients will discuss past losses and

present feelings of hopelessness about ever being happy, and they ignore any positive feelings or events that happen to them in the present.

Attempts to reassure these patients about their health and focus them on their psychological problems only increases their fear that they will be overwhelmed by pain with nobody to turn to. A more effective approach would be through desensitization by the patient re-telling the frightening earlier experiences relating to pain and fear of death and thereby diffusing the emotional charge that led the client to overprotect against bodily harm and loss of bodily function.

Clinical studies indicate that introvert tendencies tend to be stable over long periods. People who were shy and socially uncomfortable as children often remain so as adults. Some elements may have been determined genetically, but this type of profile also reflects a childhood characterized by an absence of outward human warmth and physical contact.

The socially extroverted adolescent who has trouble studying because of frequent socializing and social drifting, often become the adult who is constantly trying to be in the middle of social events. A significant degree of insecurity, rather than a need for more intense social experiences, drives a person who has increased needs for social stimulation.

Therapy for these patients should concentrate on helping them find ways to accept and enjoy their shyness rather than trying to change through desensitization and possibly expose themselves to what they may feel as degrading experiences. Therapy could help the client learn the importance of physical contact and, through the developing of social skills, how to be more assertive and comfortable with others. They need help to feel comfortable with their own feelings.

For those patients who are more socially mobile, effective therapeutic interventions should concentrate on helping them accept, reinforce and enhance their self-confidence and structure their socializing so that it doesn't interfere with their responsibilities (Marks, P.A., 1987).

Marks said male patients with this profile often experience fear of irretrievable loss of some highly valued physical or emotional object. They tend to respond to this loss by blocking of further needing or "wanting". The "despair" phase of the mourning-process blocks them from crying and feeling angry. They will need to express anger and "rage at fate" in order to finish the grieving process. Frequently these patients will discuss past losses and present feelings of hopelessness about ever being happy, and they ignore any positive feelings or events that happen to them in the present.

Attempts to reassure these patients about their health and focus them on their psychological problems only increases their fear that they will be overwhelmed by pain with nobody to turn to. A more effective approach would be through desensitization by the patient re-telling the frightening earlier experiences relating to pain and fear of death and

thereby diffusing the emotional charge that led the client to overprotect against bodily harm and loss of bodily function.

It is likely that these patients are experiencing disturbances in role functioning such as gender identity issues and not one's sexual preference. The stronger the role dissatisfaction, the more the individual identifies with values, interests, and behaviors stereotypic of the opposite sex. For men, this may suggest a close boy-mother (or female surrogate) childhood relationship in which the mother would confide in the boy and discourage displays of "masculine" aggression.

The boy-father (or male surrogate) relationship was less close, intense, or present. There may also be a genetic component to such role instability. Male patients tend to have been non-aggressive and sensitive as boys (Marks, P.A., 1987).

The base rate for the 2-5 Pattern in the total aggregate population of 15,361 cases drawn from 52 JACHO accredited hospitals is 1.14 percent.

DSM-IV diagnoses rendered for the 2-5 Pattern are:

Axis I:	296.30	Major Depressive Disorder, Recurrent Episode, Unspecified
	300.4	Dysthymic Disorder
	302.71	Hypoactive Sexual Desire Disorder
Axis II:	301.6	Dependant Personality Disorder