5-8 Pattern

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. 8. They tend to look for energetic, take control persons. They do not particularly object to being a follower.

Scale(s) 5 (Mf)

Males T-score $80

Females T-score #45

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. They are drawn to bold, assertive, out-going, domineering partners. 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 may not be reciprocated in many instances. They find they attract people who are not willing or capable of returning their kindness, sensitivity, and generosity.

Scale(s) 5 (Mf)

Male T-score #45

He is practical, easy-going, earthy, and interested in sports, hunting, fishing technical employment. His attitudes are typically masculine in nature. He admires physical strength and agility. His humor is basic, course and often vulgar. He keeps a lid of his humorous impulses and is mindful of the company in which he finds himself.

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., (1936). 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 times 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 are 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).

Research Findings: 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). “Scale 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 be 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 in a series of extensive examinations of large psychiatric in- and outpatient 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”. University of Akron, Ohio: Doctoral Dissertation.

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

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 combined with low Scale 5 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 that 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.

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 0.79 to 0.83 for 1 to 2 day intervals with psychiatric patients, 0.79 to 0.79 for a 1 to 2 week interval for psychiatric patients and 0.72 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.

Scale(s) 8 (Sc)

T-score ≥75

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 get little satisfaction from the company of others. They prefer to live in a fantasy world of their own creation. Fantasy provides them with the satisfactions they cannot get from living in a world most people occupy. Their thinking can be original, but when expressed makes others just a little uncomfortable. They find it hard to get people to understand them. Their thinking rapidly becomes disorganized and fragmented when they find themselves under pressure to perform tasks, which they find, are beyond their ability to deal with effectively. They exist with a compromised capacity to meet social and economic demands. They live isolated, lonely lives. They find solace and comfort in alcohol and drugs of pleasure.

Schizophrenia

Wallace (2001) describes the most prominent or obvious feature of schizophrenic disturbance is incoherent, illogical, or inappropriate abstract thinking. Schizophrenia in all of its manifestations incoherent thinking involves a disruption in the sequence of thoughts so that one thought does not flow continuously and coherently from another. They lose track of what they are saying. They may express a series of loosely related ideas that is difficult to follow.

Wallace, J. L., (2001). "A Clinicians Guide to Minnesota Multiphasic Personality Inventory Interpretation". Ex Libris.

Schizophrenics, report they feel misunderstood, punished for no reason they can remember, and plotted against by persons who do not have their best interests at heart. They pull back from any person or situation they see as challenging them personally. They have few or no friends. Their social skills are not well developed. They relate in a clumsy and rigid way to others. They have little flexibility responding to others wishes, needs, or expectations. They are easily frightened. Nichols and Greene, (1995) note the schizophrenics' emotional disengagement reveals, "…pathological disengagement from life that discounts future interests, prospects, and engagement to the extent that they can no longer serve as incentives for continuing to live" (p. 29).

Nichols, D. S., & Greene, R. L., (1995). "MMPI-2 structural summary: Interpretive manual". Odessa, FL.: Psychological Assessment Resources.

Schizophrenics tell of their difficulties thinking straight. Schizophrenics are plagued with problems of attention, concentration, remembering, and arriving at a correct solution. They cannot formulate reasonable goals. They lack the intellectual energy required to plan, direct, correct processing errors, and rousing them to meet the occasions reflected in their goals.

Schizophrenics fear they will lose their minds. They cower at the prospect of suddenly finding they do not know who they are, the dying and death of their own self. They are at times restless, thin-skinned, and ultra sensitive to any think they construe as a reference to themselves. They can react violently to a perceived slight, threat, or insult.

Illogical thinking consists of reaching unreasonable conclusions based upon circumstantial evidence. Thinking at inappropriate levels of abstraction, is characteristic of person with schizophrenia. Schizophrenic people use words in an overly concrete or literal manner.

Perceptual distortions result in poor judgment. They cannot assess their experience realistically. They act in odd or queer ways. The lives of schizophrenic people are dotted with such instances of poor judgment, which stems from unrealistic assessment of a situation, and of themselves, or of the consequences of their actions. The disordered thinking and inaccurate perception of schizophrenic people often cause them to overlook or misjudge the feelings, motives, and actions of others.

They behave in ways that others find insensitive, self-centered, contentious, presumptuous, and suspicious or in some other way objectionable. Their poor social skills make it difficult for them to make or keep friends, even when they try. They frequently withdraw physically and become social isolates in their both work and recreation. They avoid situations that can bring them into close contact with others.

Many withdraw emotionally while placing themselves physically in close proximity to others. Public events sometimes help schizophrenics preserve the fiction that they are meaningfully involved with others. Even when mingling with other people, they maintain

a psychological distance by keeping their thoughts and feelings to themselves and interacting only on a formal, impersonal level.

Schizophrenic persons are frequently unable to prevent anxiety-provoking and socially unacceptable ideas from occupying their minds. Uncontrollable aggressive and sexual fantasies and constant concern about terrible events they might cause or suffer from are particularly likely to make the schizophrenics existence a waking nightmare.

Schizophrenics are consequently subject to severe bouts of anxiety and self-disgust. They have difficulty distinguishing between their dreams and waking reality. Schizophrenics also suffer from poor integration of their feelings and thoughts. They may show blunted affect with little or no emotional response to any situations, or such inappropriate affect as giggling while relating a violently aggressive fantasy or crying while describing how good they feel.

Schizophrenics may be unable to prevent and control their aggressive and sexual ideas. When several of these impairments occur together and persist over any length of time, schizophrenia is present.

A prominent mood disorder coexists alongside a schizophrenia is present in schizoaffective disorders. Subtypes include affective bipolar and depressive types.

Schizophrenia, which exists along with grossly disorganized behavior, incoherence, marked loosening of associations; flat emotionally and grossly inappropriate affect is associated with disorganized schizophrenia.

Schizophrenia exists along with a preoccupation with systemized delusions, auditory hallucinations, argumentativeness, and possibility for violence and over-weaning suspiciousness is associated with paranoid schizophrenia.

Schizophrenia manifested by many or all of its variations including prominent delusions, hallucinations, incoherence, and grossly disorganized behaviors is associated with undifferentiated schizophrenia.

The DSM-IV-TR, (2000) list the diagnostic criteria for schizophrenia as:

A. **Characteristic Symptoms.** Two or more of the following during a one-month period (or less if successfully treated): **Delusions, hallucinations,** and disorganized speech (loosening of associations), grossly disorganized behavior or catatonic (with extreme motor retardation or extreme motor agitation), negative symptoms (e.g., emotional blunting, loss of interest in things and activities, inability to experience happiness).
If bizarre delusions or auditory hallucinations **and** a. voices keep a running commentary about the person's thoughts and behaviors **or** b. two or more voices converse with each other **then** only one criterion is needed.

B. **Social/Occupational Dysfunction. If** one or more major areas of the person's life are markedly below premorbid functioning (work, interpersonal relations or self-care) **or if** childhood or adolescence failure to achieve expected levels of interpersonal, academic, or occupational achievement **then meets** the **B** criteria.

C. **Duration.** Continuous signs persist for at least six months with at least one month that meets the **A** criteria (Active Phase) and may include prodromal (early warning signs) or residual symptoms.

D. Rule out all other mental diseases (e.g., schizoaffective/mood disorders) **All other medical conditions** (substance use/medications or general medical conditions) have been ruled out. **If a history of pervasive developmental disorders exists** then prominent, hallucinations or delusions for one month are needed to make the diagnosis of schizophrenia.

Diagnostic and Statistical Manual of Mental Disorders, Text Revision,
(4th Ed.) 2000 American Psychiatric Association.

Schizophrenia is a psychotic disorder, which encompasses delusions, hallucinations, and disorganized behavior and speech (DSM-IV-TR 2000, p. 297).

The symptoms of schizophrenia are classified further as positive, negative, cognitive, and disorganized. **Positive** symptoms are delusions, hallucinations, paranoia, and bizarre behavior. These symptoms have been historically the major focus of treatment. **Negative** symptoms are apathy, loss of pleasure, disordered thought, and the loss of interest in engaging in vital life activities. These negative symptoms are the most crippling. **Cognitive** symptoms refer to deficits in attention, concentration, memory, decision-making, and problem solving. Anderson et al. (1998) think cognitive symptoms are the principle disabilities associated with schizophrenia. **Disorganized** symptoms signify the degree of disorganization of affect or behavior.

Anderson, C., Chakos, M., Mailman, R., & Lieberman, J., (1998). "Emerging roles for novel antipsychotic medications in the treatment of schizophrenia". Psychiatric Clinics of North America 21(1), 151-179.

Research Findings: Lishman (1998) writes, "The acute organic reactions are called forth by a great number of different pathological processes affecting the brain…" (p. 9). A host of misfortunes follow-on brain insults, i.e., fragmentation of attention, thinking, and purposive reality based action, diminution of the powers of memory, and failures of judgment (p. 9-13).

Acute and chronic central nervous system conditions lead to psychotic reactions. Schizophrenia is one diagnostic possibility, which present with manifold symptoms. Head injuries at times lead to schizophrenic conditions. "All forms of schizophrenia have been reported after head injury…" (p. 190). "Paranoid forms are reported to be especially common…" (p. 190). Achté et al. (1969) followed 3552 head injured Finnish

WW II soldiers for over 20 years. Ninety-two of these cases developed schizophrenic-like symptoms (2.6 percent).

Achté, K. A., Hillbom, E., & Aalberg, V., (1969). “Psychoses following war brain injuries”. Acta Psychiatrica Scandinavica 45, 1-18.

Achté found that mild brain injuries produced schizophrenia more frequently than did severe brain injuries. Whether or not other precipitating factors, such as familial histories of schizophrenia, added to the vulnerability to develop schizophrenia after head injuries is not clear. Lishman (1998), p. 190, writes, “… the early onset of the psychosis (is) related to (the) severity of diffuse brain injury, and a possible special association with temporal lobe damage”. Achté reported 2.1 percent of the group of brain injured Finnish WW II soldiers he studied were diagnoses with paranoid conditions.

Tumors of the temporal lobe are associated with schizophrenia. This is a rare occurrence, but greater than the occurrence in the general population. Pituitary tumors are also associated with the development of schizophrenia (Davison and Bagley (1969).

Davison, K., & Bagley, C. R., (1969). “Schizophrenia-like psychoses associated with organic disorders of the central nervous system: a review of the literature” In Current Problems in Neuropsychiatry.

Herrington, R. N. (Ed.), (1958). British Journal of Psychiatry Special Publication No.4. Headly Brothers: Ashford, Kent.

Mendez et al., (1993) reports the excessive occurrence of schizophrenia with epilepsy. Interictal schizophrenia disorders occurred in 9.25 percent of 1611 epileptic patients. Complex partial seizures are associated with epilepsy and simultaneously occurring schizophrenia.

Mendez, M. F., Grau, R., Doss, R. C., & Taylor, J. L., (1993). “Schizophrenia in epilepsy: seizure and psychoses variables”. Neurology 43, 1073-1077.

Slater, et al., (1963) systematically collected 69 patients with unequivocal evidence of epilepsy that subsequently developed schizophrenia. The majority of these patients, 80 percent, experienced an insidious onset of symptoms with delusions as the first manifestation. Paranoid symptoms were present in the majority or the cases. Delusions were present in nearly all cases. Auditory hallucinations occurred in nearly half of the cases. Visual hallucinations were present in 16 percent of the cases. Thought disorders occurred in half of the patients.

Slater interpreted the changes observed in the epileptic schizophrenia patients as organic personality changes manifested by lack of spontaneity, dullness, (mental) retardation, concrete thinking, and memory deficits. The epileptic foci were in the temporal lobe in 2/3rds of the cases.

Slater, E., Beard, A. W., & Glithero, E., (1963). “The schizophrenic-like disorders of epilepsy”. British Journal of Psychiatry 109, 95-150.

Schizophrenic-like disorders are also associated with cannabis intoxication, general paresis, Huntington’s disease, hyperthyroidism, hypothyroidism, narcolepsy, systemic lupus erythematosus, Wilson’s disease, Korsakoff’s Syndrome, multiple sclerosis, stroke, uremia, among other physical conditions Lishman, (1998).

Lishman, W. A., (1998). “Organic Psychiatry: The Psychological Consequences of Cerebral Disorder”. London: Blackwell Science Ltd.

The causes of schizophrenia are unclear. Schizophrenia has multiple interrelated etiologies, i.e., biological, genetic, and developmental abnormalities of the brain (Varcarolis 2002, p. 525).

Varcarolis, E. M., (2002). “Foundations of psychiatric mental health nursing: a clinical approach” (Fourth edition). Philadelphia: W. B. Saunders Company.

A long list of chemical neurotransmitters has been identified, which are thought to be involved in the production of schizophrenic disorders. Dopamine, norepinephrine, serotonin, glutamate, GABA, and neuropeptides are among the many biochemical substances associated with the development of schizophrenia.

Genetic investigations with identical twins reveal a 45 percent chance of one twin developing a schizophrenic disorder if the other twin is so affected. If one twin has an autistic spectrum disorder, the other twin stands a 60 percent chance of developing impairments of communication and deficits in social interaction, i.e., Asperger’s Syndrome. Some twins do not develop these disorders, however. Genetic causation is only a partial answers to the conundrum of the causation of the schizophrenic disorders (Hyman 2003, p. 99).

Hyman, S. E., (2003). “Diagnosing disorders. Special issue: Better Brains”. Scientific American 289(3) (pp. 96-103).

Jones and Cannon (1998) noted if one parent were schizophrenic, 12 percent of the children would become schizophrenic. If both parents are schizophrenic, 46 percent of the children will be also.

Jones, P., & Cannon, M., (1998). “The new epidemiology of schizophrenia”. Psychiatric Clinics of North America 12(1): 1-25.

Neuroimaging studies of individuals diagnosed with schizophrenia provide evidence of enlargement of the lateral ventricles, atrophy of the frontal lobes and the cortex in general as well as atrophy of the cerebellum, enlargement of the third ventricle and asymmetry of one or both ventricles (Kaplan and Shadock 1995).

Kaplan, H. I., & Shadock, B. J., (1995) Synopsis of psychiatry, 6th ed. Baltimore: Williams & Wilkins.

Thompson et al., (2001) found significant anatomical changes in brains of schizophrenic adolescents between the ages of 13 and 18 where a marked loss of gray matter in the cerebral cortex was demonstrated. This loss increased as the cellular losses progressed, spreading to other areas of the brain. These anatomical abnormalities were synchronous with the severity of the development of the psychotic symptoms and impairments produced by these diseases.

Thompson, P. M., Vidal, C., Giedd, J. N., Gochman, P., Blumenthal, J., Nicolson, R., Toga, A., & Rapoport, J. L., (2001). Proceedings of the National Academy of Sciences USA 98(20), 11650-11655.

Scale 8 on the MMPI and MMPI-2 contains 78 items. These Scale 8 items overlap with 11 other scales: **F (15), K (1), 1 (2), 2 (10), 3 (8), 4 (6), 5 (4), 6 (13), 7 (17), 9 (11), and Scale 0 (6).** It is not readily apparent with elevations on Scale 8 just which symptoms would be observed in any one patient who may or may not be diagnosed with schizophrenia. All of the K scale items answered in the deviant direction is added to the Scale 8 raw score. Any 20 Scale 8 items endorsed in the deviant direction are needed to produce a Tscore of 65 when the client has an average score on the K scale. (Greene, 2000).

Greene, R. L., (2000). The MMPI-2/MMPI: An Interpretive Manual (2nd Ed.). Boston: Allyn and Bacon.

The K scale was developed to improve the hit rate of Scale 8 (Dahlstrom and Dahlstrom, 1980). This results in the increase in the Scale 8 relative to the standardization group. This piggy backing on the norms group's data permitted the criterion group's data to be mounted above the normative group's score elevations in order to make Scale 8 elevations more prominent. Cross validation, studies were able to correctly identify no more than 60 percent of the total number of schizophrenics studied. Hathaway, (1980) reported that a considerable number of cases in 91 cross validation studies scored below a Tscore of 61 on Scale 8. Friedman et al., (2001) concluded, "A diagnostic conclusion of schizophrenia cannot be made solely on the basis of a Scale 8 elevation" (p. 132). Butcher and Williams, (1992) are of the opinion that Scale 8 clinical elevations can be due to severe depression, severe personality disorders, a 'rebel without a cause' attitude, sensory deficits, or a "cry-for-help". Anderson and Kunce, (1984) found high scoring Scale 8 college students, who suffered from social isolation, loneliness, and the inability to engage with others, were not schizophrenic.

Psychiatric settings yielding similar MMPI scores lead to different interpretations than those gotten in non-psychiatric settings. Greene, (2000) investigated MMPI data collected on psychiatric inpatients and out patients. The most frequent code pattern for men was 8-6, for women the 4-8, 8-4, and 8-6 code patterns were prominent.

Psychiatric diagnoses were wide ranging. There is no assurance that Scale 8 elevations are associated exclusively with schizophrenic disorders.

Hathaway, S. R., (1980). “Scale 5 (Masculinity-Femininity), 6 (Paranoia), and 8 (Schizophrenia)”. In W. G. Dahlstrom & L. Dahlstrom (Eds.), (1980). Basic reading in the MMPI: A new selection on personality measurement (pp. 65-75). Minneapolis: University of Minnesota Press.

Greene, R. L., (1991). The MMPI-MMPI-2: An interpretive manual. Boston: Allyn & Bacon.

Friedman, A. F., Lewak, R., Nichols, D. S., & Webb, J., (2001). Psychological Assessment with the MMPI-2 L. (1992). “Essentials of MMPI-2 and MMPI-A interpretation”. Minneapolis: University of Minnesota Press.

Anderson, W. P. & Kunce, J. T., (1984). “Diagnostic implications of markedly elevated MMPI Sc (Scale 8) scores for non-hospitalized clients”. Journal of Clinical Psychology 40, 925-930.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 5-8 Pattern on the MMPI-A are 0.10 percent and on the MMPI 0.70 percent. Base rates for adolescent females with the 5-8 Pattern are 0.70 percent and 0.40 percent respectively (Archer, 1997).

Archer, R. P., (1997). MMPI-A: Assessing Adolescent Psychopathology (2nd Ed.). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

The 5-8 adolescent Pattern is rarely encountered. No descriptors are listed.

Family histories of alcohol and drug abuse, psychiatric illnesses, and cruelty directed at family members are frequently encountered with the 5-8 Pattern adult. Depression is also frequently diagnosed. These people are viewed as being ‘different’. They cannot bring themselves to get along with others (Greene, 2000).

Greene, R. L., (2000). The MMPI-2/MMPI: An Interpretive Manual (2nd Ed.). Boston: Allyn and Bacon.

Women with the 5-8 Pattern will control others whenever possible and particularly when their own interests are more important to them than those of others. They are most comfortable when others are subjugated to their will and under their control. They are viewed as idiosyncratic, quirky, and nonconformists (Friedman et al., 2001).

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

Marks has written that with women it is likely that they 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 women, this suggests a close girl-father (or male surrogate) childhood relationship, with the girl playing with boys, being a "tomboy," and participating in activities traditionally confined mostly to boys. The girl-mother (or female surrogate) relationship in this instance is assumed to have been less close, present or intense. There may also be a genetic component to this type of role scenario.

Women with this type of profile tend to have been independent, practical and adventuresome as girls.

It is likely that patients with this profile had a childhood characterized by being despised and rejected by a person upon whom life and security depended. Perhaps in some instances the child expressed some peculiar habit or eccentricities or was handicapped in some way, which led others to express anger, hatred and resentment towards the child. A child would self-protect by "shutting down" cognitively and emotionally, which would lead in turn to impairments in cognitive and emotional functioning.

Therapy with these patients should concentrate on helping them feel comfortable at the moment. Moving into uncovering therapy too quickly is highly disorganizing to these patients, and change should be avoided. Achieving insight often leads these patients to feeling even more alien and defective. They are very sensitive to hostility and will require a consistent, warm, interactive and positive therapeutic relationship.

Marks writes for **males** 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 relationships in which the mother would confide in the boy and discourage displays of "masculine" aggression.

The boy-father (or male surrogate) relationship is assumed to have been 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.

It is likely that patients with this profile had a childhood characterized by being despised and rejected by a person upon whom life and security depended. Perhaps in some instances the child expressed some peculiar habit or eccentricities or was handicapped in some way, which led others to express anger, hatred and resentment towards the child. A child would self-protect by "shutting down" cognitively and emotionally, which would lead in turn to impairments in cognitive and emotional functioning.

Therapy with these patients should concentrate on helping them feel comfortable at the moment. Moving into uncovering therapy too quickly is highly disorganizing to these patients, and change should be avoided. Achieving insight often leads these patients to feeling even more alien and defective. They are very sensitive to hostility and will require a consistent, warm, interactive and positive therapeutic relationship (Marks, P.A., 1987).

Marks, P. A. (1987). The Marks MMPI Adolescent Report and Manual. Wakefield, RI: Applied Innovations.

The base rates derived from a clinical sample of 15,316 from 52 JCAHO accredited psychiatric and substance abuse outpatient, partial hospitalization, and inpatient facilities are:

	Base Rate
Aggregate	0.40
White Adult Males	0.53
White Adolescent Males	0.30
White Adult Females	0.07
White Adolescent Females	0.83
African American Males	0.73
African American Adolescent Males	1.51
African American Adult Females	0.12

DSM-IV DIAGNOSTIC CONSIDERATIONS

The following spectrum of diagnostic considerations has been derived from a clinical sample of 15,316 patients from 52 JCAHO accredited psychiatric and substance abuse outpatient, partial hospitalization, and inpatient facilities. The numbers in parentheses indicate ascending base rates of specific DSM-IV disorders diagnosed within this normative clinical population.

Axis I

309. Adjustment Disorder With Depressed Mood
8. Brief Psychotic Disorder
305. Alcohol Abuse
40. Schizophreniform Disorder
1. Delusional Disorder
300. Anxiety Disorder NOS
30. Impulse Control Disorder NOS

Axis II

20. Schizoid Personality Disorder

301.7 Antisocial Personality Disorder