5-9 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., (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 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. (1946). University of Akron, Ohio.

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 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.

Clinical Scale Elevations

Scale(s) 9 (Ma)

T-score ≥ 69

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 excitable, high-energy people. They enter social situations with ease. They probably do not need as much sleep as most people. They work with enthusiasm. Their movements are rapid, coordinated, and they can sustain physical effort for long periods. They speak more rapidly than most others do. They like to be in control of their activities. They are organized, efficient, and manage their affairs effortlessly. They like the excitement of new experiences. They will try anything. They thrive in the company of other people. These contacts stimulate them. The more intense the interactions, the more they enjoy the coming together. Partying, dancing, drinking, loud music and concerted muscular activities provide them with the heightening of sensations they crave and cherish.

Mood Disorder

Hypomania
And
Mania

DSM-IV-TR, (2000) lists the following criteria for Bi-polar Disorder, Hypomania, and Mania: A distinct period of abnormality and persistently elevated, expansive, or irritable mood for at least: 4 days of hypomania or one week for mania.

At **least three (or more)** of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree during the period of mood disturbance: inflated self-esteem or grandiosity; decreased need for sleep (e.g., the person feels rested after only three hours of sleep; more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are racing; distractibility (i.e., the person's attention is too easily drawn to unimportant or irrelevant external stimuli; increase in goal directed activity (either socially, at work or school, or sexually) or psychomotor activity; excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestricted buying sprees, sexual indiscretions, or foolish business investments).

Hypomania: The episode is associated with an unequivocal change in functioning that is not characteristic of the person when not symptomatic. Others observe the disturbance in mood and the change in functioning. There is an absence of marked impairment in social or occupational functioning. Hospitalization is not indicated. Symptoms are not due to direct physiological effects of substance (e.g., drug abuse, medication, or other medical conditions).

Mania: Mania severe enough to cause marked impairment in occupational activities, or relationships, or necessitated hospitalization to prevent harm to self and others, or there are psychotic features. Symptoms are not due to direct physiological effects of substance (drug abuse, medication) or general medical condition (e.g., hyperthyroidism).

The lifetime base rate for mood disorders associated with elevated mood worldwide is approximately one percent (DSM-IV-TR, 2000).

Substance abuse is common (Strakowski and Del Bello, 2000).

Strakowski, S. M., & Del Bello, M. P., (2000). The occurrence of bipolar and substance use disorders. Clinical Psychology Review 20(2): 191-206.

Bipolar manic persons who are also diagnosed with co-occurring personality disorders, have much poorer treatment outcomes 12 months after hospitalization (Dunayevich et al., (2000).

Dunayevich, E., et al., (2000). "Twelve-month outcome in bipolar patients with and without personality disorders". Journal of Clinical Psychiatry 61(2): 134-139.

Bipolar disorder is several disorders rolled into one diagnosis. **Bipolar I Disorder** includes psychosis, paranoia, rapid mood cycling, recurrent schizophrenia-like symptoms, recurrent depression, mania, bizarre behavior, substance abuse, and/or self-medication. **Bipolar II Disorder** includes personality disturbance or disorder of temperament (borderline-like), seasonal depression, alcohol and/or substance abuse, rapid mood cycling, premenstrual dysphoria; premenstrual mood disturbance, impulse

difficulties, interpersonal sensitivity, intermittent viciousness, backbiting, slander, manipulativeness, acts of bad-faith, recurrent depression, mood instability (Zerbe, 1999).

Zerbe, K. J., (1999). “Women’s mental health in primary care:. (p. 57). Philadelphia: W. B. Saunders.

Unipolar Depressive Disorders: The age of onset is usually between the ages of 40 to 44 years of age. Women are affected twice as often, as are men. Unstable ties to parents and families are frequently encountered. The divorce rate is no higher than for the population in general. Symptoms encountered during the depression include prominent guilt feelings, unresolved autonomy issues, and increased motor activity, insomnia, and health concerns.

Bipolar Disorder: The age of onset is between 19 to 30 years of age. It is equally prevalent in women and men. A higher rate of divorce and marital conflict occurs. The need for independence, control of others and being the center of attention is central to this disorder. A significant increase in the drive for success and prestige occurs. Symptoms associated with the depressed phase of this illness are psychomotor retardation, increased sleep-intervals, few health concerns, and little anxiety or concern for self or others. A high frequency of relapse is associated with bipolar disorder as compared with (Unipolar) major depressive disorder (Varcarolis, 2002).

Varcarolis, E. M., (2002). “Foundation of Psychiatric Mental Health Nursing” (pp. 445-446). Philadelphia: W. B. Saunders Company.

Ethanol ingestion aggravates affective disorders. This combined with brain damage can lead to aggressive and violent behavior (Sweet, et al 1969).
The level of sensitivity to the effects alcohol has upon a person is associated with a diagnosis of “pathological intoxication” or ‘*manie* à potú in combination with head injury. A person evidences the pathological effects of alcohol with much smaller levels of alcohol in their blood. They behave violently while under the influence of alcohol, recalling nothing of the events surrounding their intoxication. There is ongoing controversy concerning this diagnosis.

Sweet, W.H., Ervin, F., & Mark, V.H., (1969). “The relationship of violent behavior to focal cerebral disease. In Aggressive Behaviour, Proceedings of international symposium on the Biology of Aggressive Behaviour”. Garattini, S. & Sigg, E. B. (Eds.) Exerpta Medica: Amsterdam (81, 82, 189).

Manic stupor can lead to elation and ecstasy. The patients’ report their mind fills to overflowing with ideas. They are unable to react to anything around them (Abrams and Taylor, 1976).

Abrams, R., & Taylor, M. A., (1976). “Catatonia: a prospective clinical study”. Archives of General Psychiatry 33, 579-581.

Schukla, et al., (1987) reports on 20 cases of the development of mania following head injury. There were no family histories of bipolar disorder. Epilepsy developed in one half of the cases. Irritable mood was more frequent than euphoria. Assaultive behavior often occurred. Fourteen of the patients had episodes of mania without depression.

Schukla, S., Cook, B. L., Mukherjee, S., Goodwin, C., & Miller, M. G., (1987). “Mania following head trauma”. American Journal of Psychiatry 144, 93-96.

Starkstein, et al., (1988) studied 12 patients who developed mania from brain lesions (tumors, strokes, and brain injuries). None has histories of affective disorders. Right hemisphere lesions were more common than those of the left hemisphere. Lesions of the orbitofrontal cortex were strongly associated with mania. Two patients had repeated manic episodes and another developed mania along with a marked change of personality two years after a head injury.

Starkstein, S. E., Boston, J .D., 7 Robinson, R. G., (1988). “Mechanisms of mania after brain injury. Twelve case reports and review of the literature”. Journal of Nervous and Mental Disease 176, 87-100.

Logsdail and Toone (1988) report twice as many tight hemisphere loci, which are similar to those, reported by Starkstein, et al., (1988).

Logsdail, S. J., & Toone, B. K., (1988). “Post-ictal psychoses. A clinical and phenomenological description”. British Journal of Psychiatry 152, 246-252.

Scale 9 (Ma) has 46 items. Item overlap is **L (12), F (1), K (5), 3 (6), 4 (7), 5 (3), 6 (3), 7 (6), and 8 (11).** Thirty-five items are keyed in the true direction. Scale 8 has one fourth of its items in common with Scale 9 (Ma). The reading comprehension level for Scale 9 is the highest (ninth grade reading level) of all of the MMPI scales Paolo et al (1991). The average reading level is the eighth grade in the US. Scale 9 (Ma) test scores may need to be verified if the subject gives evidence of reading comprehension difficulties. Test-retest correlations for the standardization sample (Butcher, et al 1989) are 01.68 for females and 0.83 for males.

Paolo, A.M., Ryan, J. J., & Smith, A. J., (1991). “Reading difficulty of MMPI-2 subscales”. Journal of Clinical Psychology July 47(4), 529-532

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.

Scale 9 (Ma) presumably measures mood elevations. Scale 9 (hypomania) reflects heightened motor activity levels. Associated features are grandiosity, Green-Spanian irrational exuberance, and decreased need for sleep, suspiciousness, and a hot temper.

The original clinical group of inpatients who served as criterion subjects in the construction of Scale 9 (Ma) numbered 24 (Dahlstrom and Dahlstrom 1980). They pointed out the small number of cases used in the construction of Scale 9. “It is the best (data) that we could derive from the patients seen over a 5-year period” (p. 57).

Individuals who are in the throes of a genuine manic episode will render invalid MMPI results. Distractibility, ideational flooding, and increased motor activity levels are the cause.

Dahlstrom, W. G., & Dahlstrom, L. E., (Eds.) (1980). Basic readings on the MMPI: A new selection on personality measurement. Minneapolis: University of Minnesota Press.

Langer (2003) defines Scale 9 (Ma) as a focus on achievement. Self-worth rests upon career success, material acquisition, and fame. Ready response to stimuli is a core feature. Tension is high between aspiration and accomplishment.

Langer, F. (2003). frank.langer@ALIENS.Com Wednesday 3 Sept 2003. Re: MMPI-2/ Rorschach Confusion. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Increased motor behavior follows the anticipation of failure. “If they see a looming catastrophe, they pull out all stops to do everything possible to avert it” (Langer 2003). The relative vacuum of insight into their thinking and feeling is addressed by a focus upon externalities. This is the focus, which rushes in to fill the void left in the wake of the flight away from the threat of the recognition of their weaknesses, anxieties, incompetence, and fear for the future. Grim determination and “…sticking to one’s guns in the face of an unbending environment…” addresses the roadblocks facing them. Achievement supplants the quality and extent of connectedness with others.

Langer, F., (2003). frank.langer@ALIENS.COM Sunday 7 Sept 2003. Re: MMPI-2/ Rorschach follow-up. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Scale 9 (Ma) may also reflect a fear of frustrations to come, which displaces the enjoyment of the present moment (Caldwell, 1984).

Caldwell, A. B., (1984). Clinical decision making with the MMPI. Advanced Psychological Institute. Chicago, IL: Northwestern University.

Duckworth and Anderson (1995) say that Scale 9 (Ma) “…is a measure of psychic energy,” upon which the person “…feels compelled to act…” (p. 267).

They think the number of thoughts a person experiences also increases during hypomanic episodes. Scale 9 (Ma) is the most common scale elevation with college students.

Duckworth, J.C., & Anderson, W .P., (1995). MMPI and MMPI-2: Interpretation Manual for Counselors and Clinicians. Fourth Ed. Bristol, PA: Accelerated Development.

Scale 9 (ma) descriptors of healthy persons include the terms friendly, expansive, active, enthusiastic, talkative, and involved. Kunce and Anderson, (1976), Hovey and Lewis (1967).

Kunce, J., & Anderson, W., (1976). Normalizing the MMPI. Journal of Clinical Psychology 32, 776-780.

Hovey, H., & Lewis, E., (1967). “Semi-automated interpretation of the MMPI”. Journal of Clinical Psychology 23, 123-124.

Scale 9 (Ma) may also measure sensation seeking, self-confidence, a sense of being indestructible and disdain for others’ weaknesses (Lachar 1974).

Lachar, D., (1974). The MMPI: Clinical Assessment and Automated Interpretation. Los Angeles, CA: Western Psychological Services.

Archer, (1992) lists the following Scale 9 (Ma) features applying to adolescents: Increased personal tempo with increased activity occurs. Action is preferred over thought and contemplation. Impulsivity, restlessness, and distractibility are present. Unrealistic aspirations and goal setting is a problem, which guarantees failure for them. They are extroverted, gregarious, talkative, and filled with energy. They are narcissistic, self-involved, self-infatuated, insensitive to others feelings and ideas as well as prone to rule breaking.

Archer, R. P., (1992). MMPI-A: Assessing Adolescent Psychopathology. Hillsdale, NJ: Lawrence Erlbaum Associates Publishers.

Research findings: Siblerud et al., (1998) examined the effect of dental amalgam mercury removal with nine patients on manic depression and related symptoms. The Scale 2 (Dep) and Scale 9 (Ma) score showed significant improvement for the amalgam removal group. The amalgam removal group reported a 42% decrease in the number of somatic health problems after amalgam removal.

Silerud, R. L., Motl, J., & Kinholz, E., (1998). “Psychometric evidence that the dental amalgam mercury may be an etiological factor in manic depression”. Journal of Orthomolecular Medicine 13(1, 31-40.

Comrey (1958) studied the factor content of Scale 9 (Ma). He concluded that this scale has the most content diversity of all of the MMPI scales. Scale 9 (Ma) does not possess the needed factor homogeneity needed to establish statistical and logical relationships.

Comrey, A. L., (1958). A factor analysis of items on the MMPI Hypomania scale. Educational & Psychological Measurement 18, 313-323.

Kalichman (1988) collected demographic information and Minnesota Multiphasic Personality Inventory profiles with 16 adult women convicted of murdering their (domestic) partners and 20 adult men convicted of murdering strangers during the course of the crime. The men convicted of murdering strangers had higher elevations on the Hypomania scale than men who murdered (domestic) partners. Women who murdered (domestic) partners had higher elevations on Scale 6 (Pa) and Scale 0 (Sie).

Kalichman, S. C., (1988). MMPI profiles of women and men convicted of domestic homicide. Journal of Clinical Psychology 44(6), 847-853.

Duckworth and Levitt, (1985) evaluated 30 swingers from a private metropolitan swinging club with the MMPI. One half had significant clinical scale elevations, most of on Scale 9 (Ma). Two thirds of the group was judged emotionally disturbed, however, they had sufficient ego resources to enable them to cope with their problems.

Duckworth, J., & Levitt, E. E., (1985). “Personality analysis of a swinger’s club”. Lifestyles 8(1), 35-45.

Baetsen et al., (1985) examined personality characteristics and demographic factors of 23 pregnant women who intended to have an abortion and 23 women who planned to carry to term with the MMPI. Only the Hypomania scale differentiated between the groups, with the abortion group scoring significantly higher on Scale 9 (Ma).

Baetsen, K. L., Rankin, R. E., Fuller, G. B., & Stack, J. M., (1985). A comparative MMPI study of abortion-seeking women and those who intend to carry their pregnancies to term. Family Practice Research Journal 4(4), 199-207.

Jurko et al., (1974) administered the MMPI to eight patients who received a pre-thalamotomy. The only significant long-term change was a decrease in the elevation of Scale 9 (Ma).

Jurko, M. F., Andy, O. J., & Giurintano, L .P. (1974). Changes in the MMPI as a function of thalamotomy. Journal of Clinical Psychology 30(4), 569-570.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 5-9 Pattern on the MMPI-A are 0.30 percent and on the MMPI 2.80 percent. Base rates for adolescent females with the 5-9 Pattern are 2.60 percent and 1.20 percent respectively (Archer, 1997).

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

Adolescents with the 5-9 Pattern appear to be less troubled than do the adolescents with other sorts of Patterns. Therapists indicate these young people have problems with

being assertive as well as being dependent. Half of the 5-9 Pattern adolescents had histories of drug involvement. Their parents said they were rebellious and unmanageable. Family conflict was reported frequently (Marks et al., 1974).

Marks et al., (1974) describe the 5-9 Pattern adolescents in mixed terms. These young people are said to be, "…peaceable, rational, and ambitious", on the one hand as well as "…lying, stealing, engaging in breaking and entering, vandalism, receiving stolen goods, traffic violations, dealing in drugs, and running away from home", on the other hand.

The 'good ones' (sic), "…are serious people who anticipate problems and difficulties". Drug involvement was reported in 56 percent of the sample (N=16). They did well in school. They entertained high aspirations. They got along well with their friends, but not with their parents who viewed them as rebellious and unmanageable.

Marks, P. A., Seeman, W., & Haller, D. L., (1974). "The Actuarial Use of the MMPI with Adolescents and Adults". New York: Oxford University Press.

Nelson and Marks (1985) studied a non-clinical group of 726 volunteer subjects engaged in a career evaluation program. Ninety-two percent were college graduates. Twenty subjects generated a 5-9 Pattern. They described themselves as outgoing, sociable, fun loving people. They had, "…lot of friends". They liked to dress well. They are viewed as attractive persons. They considered the descriptors vain, hardheaded, and ungracious to be accurate when applied to them.

Nelson, L. D., & Marks, P. A., (1985). "Empirical Correlates of Infrequently Occurring MMPI Code Types". Journal of Clinical Psychology 41, 477-482.

Tanner, (1990) studied eleven men of a psychiatric group with the 5-9 Pattern who were referred by courts or brought to treatment by their families. They were described as impulsive, grandiose, and agitated. They were violent when intoxicated.
Tanner, B. A., (1990). "Composite descriptions associated with rare MMPI two-point code types: Codes that involve Scale 5". Journal of Clinical Psychology 46, 425-431.

The 5-9 Pattern adult is comfortable in his or her own skins. They are active, self-confident, and socially adept. They make a good impression. Men with the 5-9 Pattern want the approval of others. Women with the 5-9 Pattern are described as aggressive. They are energetic, confidant, competitive, self-centered, and domineering (Friedman et al., (2001).

Marks write that for **women** 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 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.

These patients have a chronic pattern of protecting themselves against the frustration and unhappiness associated with failure. It is very likely that parents who had high expectations of success for which the child was given only partial or periodic rewards raised them. Thus, the parents were seen as constantly pushing the child to achieve while at the same time trying to control the resulting surges of energy and impulsivity. The child's needs for reward were then met by the parent's withholding of regular rewards, which increased the drive-state and, in effect, increased the manic tendencies.

The purpose of therapy should be to help the patient stop and enjoy the "here and now." These patients often are future oriented and fearful of the present where they would have to deal with the pain and disappointment of slowing down. They are afraid that if they stop driving themselves they might achieve less in the future. They need help to distinguish between their own needs and what they want in order to please others.

Gestalt techniques are usually effective in "forcing" them to express their feelings now, rather than trying to deal with events of the past or anticipated events in the future.

Marks write that for **men** 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 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.

These patients have a chronic pattern of protecting themselves against the frustration and unhappiness associated with failure. It is very likely that parents who had high expectations of success for which the child was given only partial or periodic rewards raised them. Thus, the parents were seen as constantly pushing the child to achieve while at the same time trying to control the resulting surges of energy and impulsivity. The child's needs for reward were then met by the parent's withholding of regular rewards, which increased the drive state and, in effect, increased the manic tendencies.

The purpose of therapy should be to help the patient stop and enjoy the “here-and-now." These patients often are future oriented and fearful of the present where they would have to deal with the pain and disappointment of slowing down. They are afraid that if they stop driving themselves they might achieve less in the future. They need help to distinguish between their own needs and what they want in order to please others.

Gestalt techniques are usually effective in "forcing" them to express their feelings now, rather than trying to deal with events of the past or anticipated events in the future (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	0.65
White Adult Males	1.01
White Adolescent Males	0.74
White Adult Females	0.29
White Adolescent Females	0.46
African American Males	0.70
African American Adolescent Males	0.00
African American Adult Females	0.46

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

28. Anxiety Disorder With Mixed Anxiety And Depressive Mood
1. Delusional Disorder
305. Alcohol Abuse
30. Impulse Control Disorder NOS
3. Obsessive-Compulsive Disorder
300. Anxiety Disorder NOS

Axis II

2. Schizoid Personality Disorder
7. Antisocial Personality Disorder
301.0 Paranoid Personality Disorder