2-8 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 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 for treatment of major depressions (APA 2000).

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

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).

DSM-IV-TR (2000). Diagnostic and statistical manual of mental disorders (4th ed., test revision). Washington, D.C.: American Psychiatric Association.

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).

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

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

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 with groups sorted based on their self-reported depression. These data suggest that depression have 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 with patients passing symptom validity tests. Archives of Clinical Neuropsychology. 17(3), 205-222.

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 range 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.

Scale 8 (Sc)

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 schizophrenia in all of its manifestations, as the most prominent or obvious feature of schizophrenic disturbance is incoherent, illogical, or inappropriate abstract thinking. 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.

Schizophrenic's 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 themselves 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 no know who they are, the dying 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, 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 along side 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 lest six months with at lest 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, Fourth ed. (2000). American Psychiatric Association.

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

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.

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.). 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 two-thirds 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).

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. 4th 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. September 2003. Scientific American, 289(3), 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 1991, p. 169).

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 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 86, for women the 48, 84, and 86 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) Scales 5 (Masculinity-Femininity), 6 (Paranoia), and Scale 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. Mahwan, N.J.: Lawrence Erlbaum Associates Publishers.

Butcher, J. N., & Williams, C. 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 2-8 Pattern on the MMPI-A are 0.10 percent and on the MMPI 0.50 percent. Base rates for adolescent females with the 2-8 Pattern are 0.30 percent and1.00* percent respectively (Archer, 1997).

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

Emotional inappropriate behavior is the principle reason for referral for the 2-8 Pattern adolescent. Quarrels within the family are recorded in the majority of cases. The 2-8 Pattern adolescent experiences rejection at every level. Therapists call them timid, distant emotionally, fearful of being put down and criticized, and unfavorably judged. They isolated themselves from confrontations. They are insecure. Once their emotions are aroused they find it difficult to respond or act in a fashion that a pleasant outcome is assured. They are afraid of making 'stupid' mistakes when called upon to recite in school. Nearly without exception drug abuse is present. Suicide attempts are frequent. Suicide protocols are recommended. Histories of disordered brain-behavior relations are frequently encountered in these adolescents histories (Marks et al., 1974).

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

Marks et al. (1974) broadly characterizes the 2-8 Pattern adult as one in which the individual avoids close emotional relationships. Mistrust of others intentions prevents closeness. These people resent others and are prone to be envious of the achievements, worldly goods, and social position. Ruminations, obsessive thinking, and cognitive rigidity prevent them from reaching satisfactory solutions to life's' problems. They do not easily reveal their inner thoughts and feelings. In the 2-8 groups of their studies, 85 percent showed "no change" or "small improvement" to treatment.

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

The 2-8 adult Pattern reflects severe depression, anxiety, and agitation. Patients tell of their confusion, forgetfulness, holding onto an idea for seemingly ever, and inability to follow a conversation. They have poor unrefreshing sleep and feel terrible tired most of the time. They avoid demands they know they can not met. They want to be left alone.

Suicide is a possibility. Check MMPI item 339 or MMPI-2 items150, 506, 520, and 524 to see how they are willing to describe their situations (Greene 2000).

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

A history of childhood mistreatment, neglect, and abandonment is frequently reported. A fear of closeness and being hurt develops (Caldwell 1972).

Caldwell, A., (1972). Families of MMPI patterns. Mexico City: Seventh Annual Symposium on the MMPI.

The 2-8 Pattern includes people who feel they are loosing their minds (Friedman et al., 2001).

Caldwell, A., (1972). Families of MMPI patterns. Mexico City: Seventh Annual Symposium on the MMPI.

Marks writes patients with this profile are depressed and will often feel somehow "broken," defective and unlovable. They complain of poor memory and of inability to concentrate, make decision and think clearly. They may also believe they are deteriorating or somehow "falling apart."

It is possible that they were raised in families where they were treated with coldness and indifference, which were internalized into a negative self-image and "proof" of their being defective. Often, the precipitating circumstance is usually somebody who was previously supportive withdrawing from them and treating them with hostility and uncaring.

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 doom and 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 they 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.

These patients do not do well with exploratory therapy, and will experience uncovering of their intimate reactions as confirming of their negative self-image. They do better with a nurturing and supportive approach that helps them feel acceptable and likable. Relaxation techniques are also useful (Marks, P.A., 1987).

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	5.55
White Adult Males	6.89
White Adolescent Males	1.19
White Adult Females	5.98
White Adolescent Females	2.74
African American Males	5.24
African American Adolescent Males	1.51
African American Adult Females	3.18

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

70. Schizoaffective Disorder
90. Schizophrenia, Undifferentiated Type
30. Major Depressive Disorder, Recurrent Episode, Unspecified
4. Dysthymic Disorder
2. Generalized Anxiety Disorder
21. Panic Disorder Without Agoraphobia
50. Bipolar Disorder I, Most Recent Episode Depressed, Unspecified
81. Posttraumatic Stress Disorder
34. Intermittent Explosive Disorder
9. Alcohol Related Disorder NOS
8. Alcohol Induced Mood Disorder
83. Mood Disorder Due To…(existing medical condition)

Axis II

22. Schizotypal Personality Disorder
301. Paranoid Personality Disorder
6. Dependant Personality Disorder
301.82 Avoidant Personality Disorder