4-8 Pattern

Clinical Scale Elevations

Scale(s) 4 (Pd)

T-scores 74-79

All other scale scores # 60

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 good tempered, enthusiastic and fearless. They are frank, open, talkative, generous, and fair-minded. They look forward to “Happy Hour.” They do not object to having a social joint or two. They cover-up the sensitive, sentimental side to their personality.

Scale 4 (Pd)

Tscore ≥74

They resent authority. They do not conform to customary social conventions or social expectations. A history of poor job performance, frequent changes in employment and inadequate total income is present. They do not maintain close personal ties with others. Loyalty is not a top priority to them. They are hard-bitten individuals who have little of the milk of human kindness flowing in their veins. They are self-seeking, self-infatuated, and self-indulgent. They are emotionally shallow and devoid of compassion. They habitually place the blame for all of the problems they experience on the backs of other people. They resent demands being placed upon them. They refuse to believe they have psychological or emotional problems. They are easily angered and frustrated. They simmer with resentment. They refuse to acknowledge criticism of themselves. They are slighted easily. Self-control is dependant upon high-intelligence along with a fear of the retaliatory power of their environment. They use intimidation and threats to induce fear in others in order to get what they want out of them. Lies and manipulation are the *lingua francae* of their way of life for them. Pain, punishment, injuries, and threats do not deter them. They do no learn from past mistakes. Narcissism is a core feature of their personality. There may be a history of involvement with the criminal justice system. They are contemptuous of people who follow the rules, hold steady employment, and engage in religious observations. They consider such people to be naïve and “easy pickings”. They engage in risky behaviors. They like the physical high such activities produce. They are easily bored. They do not tolerate having time on their hands. They do not like being alone for any period of time. They use alcohol and drugs intemperately. They are hard on other people.

Personality Disorders

The DSM-IV-TR (American Psychiatric Association 2000) definition for a Personality Disorder is:

1. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. The pattern manifests itself in two (or more) of the following areas:

    Cognition (i.e., ways of perceiving and interpreting self, other people, and events).

    Affect (i.e., range, intensity, lability, and appropriateness of emotional response).

    Interpersonal functioning.

    Impulse Control.

2. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

3. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

4. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

5. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

6. The enduring pattern is not due to direct physiological effects of a substance (i.e., a drug of abuse, a medication) or a general medical condition (i.e., head trauma).

Diagnostic & Statistical manual of mental disorders (4th ed. –TR) 2000, Washington, D.C.: American Psychiatric Association.

Frosch (1983) defines psychopathy as a deviant developmental disturbance characterized by an inordinate amount of instinctual aggression and the absence of an object relational capacity to bond.

Frosch, J., (1983). “The Psychotic Process”. New York: International Universities Press.

Meloy (1992) adds, “… a fundamental disidentification with humanity”.

Meloy, J.R., (1992). The psychopathic mind: origins, dynamics, and treatment. North Vale, N.J.: Jason Aronson, Inc.

Pinel (1801) described a group of persons who were impulsive and self-destructive, but without defects in reasoning.

Pinel, P., (1801). *Traite medico-philosophique sur l’alienation mentale. Paris: Richard, Caille et Ravier.*

Prichard (1835) coined the term “moral insanity” implying the damage to social relations observed in histories of persons diagnosed with Personality Disorders.

Prichard, J.C., (1835). “A Treatise on Insanity”. New York: Hafner.

Freud (1916) viewed psychopaths as, “…those who commit crimes without any sense of guilt, who have developed no moral inhibitions or who, in their conflict with society, consider themselves justified in their actions”.

Freud, S., (1916). Some character types met with in psychoanalytic work. Standard Edition 14: 309-333. London: Hogarth Press, 1957.

Cleckley (1976) theorized, …a selective defect…prevents important components of normal (emotional) experience from being integrated into…human interactions.” The vacuum or absence of genuine emotions may be the biological and psychodynamic hallmark of the psychopath’s existence.

Cleckley, H., (1976). Mask of Sanity. St. Louis: C. V. Mosby.

Living without an “echo chamber of the emotions” eliminates the reflected emotional reverberations, which form the guiding support and “glue” of conceptual activities. The absence of this emotional background activity, or disruptions and distortions in it, produce strained, approximate, situationally bound reasoning to fill the gap. Sensations alone demand fulfillment. Intellect directs the individual’s efforts to satisfy the sensation seeking demands.

The object chosen are frequently other people, substances, fast vehicles, or any other means of increasing pleasurable sensations. Rationalization is a way of life for the psychopath (Wallace 2001). The gulf between the emotions that psychopaths experience and those of other people, with whom the psychopath

interacts, remains an unbridgeable chasm. A healthy person sees the psychopath as " just not getting it", i.e., the sense of the emotions involved in interactions.

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

Meloy focuses on the psychopath's "disidentification with humanity", which takes on many forms. Most of these forms fall short of those found in full-blown psychopathy. Character disordered individuals, broadly conceived, may experience temporary emptiness of emotional sensations. This emptiness is plastic, expanding and contracting in turn. Cognitive efficiency deteriorates into flawed thinking as the emotional depletion intensifies.

Meloy, J. R., (1992). They Psychopathic Mind: Origins, Dynamics, and Treatment. North Dale, NJ: Jason Aronson.

The absence of the fuel of emotions robs cognition of its energy and capacity to guide the formation of an idea. The dynamic force of the emotions' capacity to direct cognition's ability to participate in the creation of ideational mirrors reflecting the pleasure and pain, which could result from future acts, does not exist. An avalanche of interpersonal failures buries the development of empathy, compassion, and caring essential to all successful human acts.

Hare (1993) portrays "…***the crux of the issue*** *(*pertaining to the psychopath): ***Psychopaths do not feel they have psychological or emotional problems, and they see no reason to change their behavior to conform to societal standards with which they do not agree".*** *(p. 95).* Hare continues saying that psychopaths are satisfied with themselves the way they are. They find their behavior brings them those rewards they seek. They have no regrets or concerns for the future. "They perceive themselves as superior human beings in a hostile, dog-eat-dog world in which others are competitors for power and resources." (p. 195). Psychopaths are convinced it is their right to get what they want using any and all means available to them. Hare shares the conviction that psychopaths enjoy a "rock-solid" personality structure that is resilient and unchangeable.

Hare, R. D. (1993). "Without Conscience". New York: The Guilford Press.

Personality Disorders present with common features. Their response to stress is inflexible. They do not seem able to solve the situation leading up to the stress. Their inability to experience satisfaction in work and loving relationships is usually more evident when compared to other peoples' lives. Their inability to share emotions with others and grasp the salient features of the emotions other people experience because of interacting with them eventuates in misunderstanding and emotional upheavals all around. They have an unusually well developed ability to get under the skin of other people. They know how to make other people feel miserable, upset, and angry. The other person feels they

have done something wrong but cannot figure out why. They cannot put their finger on exactly why they feel the way they do after an encounter with a psychopath. The personality-disordered individual leaves a trail of emotional wreckage behind them. This is the hallmark of their journey through life.

The DSM-IV-TR (2000) divides the personality disorders into three groups:

Cluster A. Odd or Eccentric

Paranoid Personality Disorder: This is a pervasive distrust of others beginning by early adulthood where others' motives are interpreted as malevolent. The estimated base rate in the general population is 0.5 to 2.5 percent.

Schizoid Personality Disorder: This is a pervasive pattern of detachment from social relationships and a restricted range of (emotional) expression in interpersonal settings; beginning by early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 7.5 percent.

Schizotypal Personality Disorder: This is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relations as well as by cognitive or perceptual distortions and eccentricities of behavior; beginning by early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 3 percent. One forth of those persons so diagnosed develops schizophrenia.

Cluster B. Dramatic, Emotional, and Erratic.

Antisocial Personality Disorder: This is a pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15 is present. The estimated base rate in the general population is 1 percent for females and 3 percent for males.

Borderline Personality Disorder: This is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 2 percent.

Histrionic Personality Disorder: This is a pervasive pattern of excessive emotionality and attention seeking, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 2 to 3 percent.

Narcissistic Personality Disorder: This is a pervasive pattern of grandiosity (in fantasy and behavior), need for admiration, and lack of empathy, beginning in

early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 1 percent.

Cluster C. Anxious and Fearful

Avoidant Personality Disorder: This is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 0.5 to 1 percent.

Dependant Personality Disorder: This is a pervasive pattern and need to be taken care of that lead to submissive and clinging behavior and fear of separation, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is among the most frequently encountered in the Personality Disordered group.

Obsessive-Compulsive Personality Disorder: This is a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency; beginning by early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 1 percent and is twice as common in males as in females.

Scale 4 (Pd)

Scale 4 (Pd) has 50 items in both the MMPI and MMPI-2. Twenty-four of the items are scored in the true direction. Twenty-six of the items are scored in the false direction. A K correction of 0.4 (K raw score multiplied by 0.4) is added to the Scale 4 (Pd) raw score. Item overlap is: **L. (0), F (4), K (8), 1 (1), 2 (7), 3 (10), 5 (3), 6 (8), 7 (6), 8 (10), 9 (7), Sie (11).**

Scales 3, 8 and Sie have many items in common with Scale 4 (Pd). Test-retest correlations for Scale 4 (Pd) are .74 with an interval of up to 1 year (McKinley and Hathaway 1944). Butcher et al. (1989) reports test-retest correlations of 0.80 with the MMPI-2 for an interval of one week with samples of healthy people.

McKinley, J. C., & Hathaway, S. R., (1944). The MMPI: “V. Hysteria, hypomania, and psychopathic deviate”. Journal of Applied Psychology 28, 153-174.

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.

Schizophrenia

Wallace (2001) describes schizophrenia's most prominent or obvious feature of schizophrenic disturbances 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.

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 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 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) lists 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
(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.

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).

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

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 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).

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”. 4th ed. 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 answer to the conundrum of the causation of the schizophrenic disorders (Hyman 2003, p. 99).

Hyman, S. E., (2003). “Diagnosing disorders”. Special issue: Better Brains in 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 (Sc) on the MMPI and MMPI-2 contains 78 items. These Scale 8 (Sc) 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 are added to the Scale 8 (Sc) raw score. Any 20 Scale 8 (Sc) 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. " "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 4-8 Pattern on the MMPI-A are 2.80 percent and on the MMPI 2.00 percent. Base rates for adolescent females with the 4-8 Pattern are 2.10 percent and 4.30 percent respectively (Archer, 1997).

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

Adolescents with the 4-8 Pattern (the aggregate base rate for 4-8 Pattern adolescents is 6.60 percent) are described as immature, selfish, and extremely resentful, provocative,

and impudent. They are indifferent to how others view their behavior. They are evasive. They lie a lot. They do poorly academically. They place little value in intellectual pursuits. They view themselves as shiftless, ungrateful, rude, and irresponsible. They like to 'hang' with their friends. They resent authority. They are perhaps the most unhappy and miserable of all adolescents (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

These 4-8 Pattern adolescents have constant conflicts with others. Treatment effects improvement in less than ten- percent of those treated. These adolescents' families are chaotic. Physical symptoms of stress develop over time, i.e., anorexia, encopresis, enuresis, and hyperactivity (Archer, 1997).

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

Adults with the 4-8 Pattern experience distress in intimate relationships. They distrust others. They withdraw when under stress. They just don't like people. They see them as being unreliable, dismissive, and potentially dangerous opponents. Suicide attempts are numerous. MMPI-2 items 150, 506, 520, and 524 should be checked. They behave unpredictably. They are nonconformists to the core. They do not think clearly, use sound judgment, or anticipate the consequences of their acts, and as a consequence, become involved in social and legal difficulties. Arrests for criminal acts are common. Their crimes are poorly planned, spontaneous, puzzling, and at times senselessly violent (Greene, R. L., (2000).

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

Caldwell, (1972) notes that persons with the 4-8 Pattern when Scale 9 (Ma) is especially low are viewed as 'the black sheep of the family'.

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

Some of the most vicious, senseless, and savage sexual and homicidal assaults are associated with the 4-8 Pattern (Pothurst, 1956).

Pothurst, M. D., (1972). "A personality study of two types of murders". Unpublished doctoral dissertation of the Michigan State University.

The 4-8 Pattern was found to be the exclusive code type in one study of call-girls (Caldwell, 1972).

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

Homeless street people, the nomadic, and those wanderers from one state hospital to another, and one jail to another, whose MMPI yields this pattern, carry the mark and stigma of the 4-8 Pattern.

Educational levels are associated with different expressions of the 4-8 Pattern. Outpatients of average abilities with the 4-8 Pattern present with damaged self-esteem, suspicions about the motives that others may hold toward them and intense discomfort when in the company of others. Highly intelligent persons with the 4-8 Pattern present with a history of personal contacts, which are best, described as amorphous, aimless, and cheerless. They get little if any comfort from the presence of other people.

Women with the 4-8 Pattern have histories of low self-esteem. They favor relationships with people who view the world and themselves the same way as they do. They fear being close to others. They get little comfort or pleasure from intimacy. They will ‘shake hands with their genitals’ when compelled to do so out of economic pressures or to assure them personal safety. Sexuality represents an instrumentality through which others get yielded up to themselves desires and selfish pleasures rather than as a transport to the women of affection, fidelity, and constancy.

Marks write that patients with this profile at upper elevations often feel depressed and confused. They may complain of "black moods," difficulties concentrating and making decisions, intrusive and disturbing thoughts and of having low self-esteem. The "black moods" are their emptiness feelings that arise from the "shutting-down" of emotional responding.

It is likely that this profile represents a defensive response to a childhood of neglect and uncaring. As children these patients often felt defective and unlovable. It was as though the parents had "pushed them" away and they had experienced the rejection as proof that they were somehow "damaged" or "broken". Confused by these thoughts and a negative self-image, they escaped into fantasy and survived by lying and manipulating.

Patients with this type of profile may chronically experience profound fear of being unwanted or abandoned. They are often afraid of becoming emotionally invested in relationships with others and in establishing long-term goals. Typically, during periods of stress in childhood they had no one to turn to and developed a defense in which their feelings were suppressed and "numbed" out. They now will appear aloof, distant, and hard to engage in meaningful relationships although some of them are superficially charming.

They will require constant working on the therapeutic relationship just to keep them involved. These patients often feel that the therapist cannot be trusted. Frequently, this is a projection of their own view of the world as a "dog eat dog" place where people play games and don't really care about anyone but themselves.

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.

Exploratory and insight therapy is usually contradicted. These clients seem to benefit from a supportive approach, dealing with transference and their fear that the therapist will dislike and reject them. A clinician should expect a number of "trust tests" and the taking of periodic breaks from therapy. Once the tests are "passed," the breaks will lessen and the client will make a more definite commitment.

These clients do rather poorly in group therapy because of the tendency to see others as "wearing masks." It is extremely difficult for them to open up and reveal themselves for fear that they will be humiliated and rejected, recapitulating their childhood experiences.

Approaches most likely to succeed would include gestalt techniques of forcing the client to engage ongoing feelings in "real life" situations. Dealing with transference on a regular basis is also important. Patients with this profile may show a positive response too if they can re-engage the painful experience of feeling unwanted or emotionally abandoned as children, and thereby reactivate their "numbed out" feelings (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	5.48
White Adult Males	4.12
White Adolescent Males	5.04
White Adult Females	4.77
White Adolescent Females	8.68

African American Males	5.77
African American Adolescent Males	5.54
African American Adult Females	5.03

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

90.	Alcohol Dependence
305.	Alcohol Abuse
90.	Other (Or Unknown) Substance Abuse
1.	Delusional Disorder
30.	Schizophrenia, Paranoid Type
90.	Schizophrenia, Undifferentiated Type
50.	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
3.	Obsessive-Compulsive Disorder
89.	Anxiety Disorder Due To (existing medical condition)
30.	Impulse Control Disorder NOS
40.	Dysthymic Disorder
8.	Conduct Disorder

Axis II

22.	Schizoid Personality Disorder
301.	Paranoid Personality Disorder
7.	Antisocial Personality Disorder
301.83	Borderline Personality Disorder