5-7 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.

Male(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 times more prone to jealousy, suspicion, and injured feelings. Sexually she is by nature less promiscuous that men, is coy rather than aggressive, and her feelings are less specifically localized in her body. Submissiveness, docility, inferior steadfastness of purpose, and a general lack of aggressiveness reflect her weaker conative tendencies (the ability to stick with a complex and demanding task and see it through to a successful completion). Her moral life is shaped less by principles that by personal relationships, but thanks to her lack of adventurousness she is much less subject than men are to most types of criminal behavior. Her sentiments are more complex than man's and dispose her personality to refinement, gentility, and pre-occupation with the artistic and cultural." (p. 2).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wallace (2001) suggests the psychiatric male population with high Scale 4 (Pd) combined with low Scale 5 (Mf) scores are seen a vigorously seeking out opportunities for narcissistic masculine self-indulgence. These men use other people to satisfy their urges. They are indifferent to the impact their behavior has upon others. Female psychiatric populations who have high Scale 4 (Pd) and low Scale 5 (Mf) scores suggest angry hostile females who are provocative troublemakers. They twist what is said to them to the point that the original message is unrecognizable. This maneuver puts the recipient of her retorts off balance and more easily confused and manipulated They use guilt to dominate those relationships they find useful to achieving their own interests and goals. They have little to no capacity for empathy.

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

Twenty-three of the Scale 5 (Mf) items are from the item pool of Terman and Miles work, Sex and Personality (1936). Thirty-seven items are from the MMPI pool. The MMPI-2 has 56 items for Scale 5 (Mf). Scale 5 (Mf) measures masculinity/femininity attitudes wherein high Scale 5 (Mf) scores reflect more feminine attitudes in males and low Scale 5 (Mf) scores indicate attitudes that are more feminine with females. Twenty-five of the MMPI-2 Scale 5 (Mf) items are scored in the true direction and 31 are scored in the

false direction for men. Twenty-three of Scale 5 (Mf) items are scored in the true direction for females and 33 items are scored in the false direction. Scale 5 (Mf) norms are formed from linear Tscores instead of the Uniform Tscores utilized in the norming of the MMPI-2. Test-retest correlations on Scale 5 (Mf) run from 0.79 to 0.83 for 1 to 2 day intervals with psychiatric patients, 0.79 to 0.79 for a 1 to 2 week interval for psychiatric patients and 0.72 for 1 to 2 week intervals with college students (Dahlstrom 1975). Item overlap is: **L (1), F (2), K (3), 1 (0), 2 (2), 3 (4), 4 (3), 6 (2), 7 (1), 8 (4), 9 (3), Sie (9).**

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

## Clinical Scale Elevations

### Scale(s) 7 (Pt)

### T-score 60-69

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 have a low threshold for anxiety. They are methodical, punctual, and organized. They are productive, hard working persons. They are sensitive to the moods and feelings of others. They do not wish to give offense. They follow the rules. They drive at or very near the speed limit. They may not be particularly original in their approach to problems, but once they have mastered a task, they perform it without errors or complaints. They prefer routine, changeless futures, and the predictable. They have a high tolerance for boredom.

### Scale(s) 7 (Pt)

### T-score 70-84

They are dissatisfied with their social relationships. They are not confident about what to expect from others much less themselves. They are rigid, habit bound, and self-critical. They cannot stop themselves from thinking unpleasant and frightening thoughts. They sweat the small things. They often overlook the most important parts of the "Big Picture." They often overlook salient features of a problem or social situation. They can feel "dumb" when they realize what they had missed or left out. They are meticulous about their work and person. They drive themselves hard to reach personally import goals. They are unusually persistent. Their rigid approach to life may intensify should they become ill, suffer accidents or injuries.

### Scale(s) 7 (Pt)

T-score >85

They ruminate about their problems. They go over and over their problems, but rarely find satisfactory solutions for them. They feel miserable most of the time. They suffer from chronic tension. They sometimes find themselves so tied up in their own thoughts that they cannot make decision or attend adequately to everyday duties. They bear a heavy sense of responsibility, which is not called for by the objective facts of the situations in which they find themselves. They get little to no joy or satisfaction out of life. They are long suffering, as are their partners. They are not considered"The Life of the Party." They find it hard to laugh. Life is too serious for them to bear the thought of anything racy, erotic, or improper. They are good, if not, inspiring neighbors. They are dependable. Their sense of morality demands exceptionally high standards, for both themselves and others. They are straight laced. Most people would probably not want to go to lunch with them, unless job or social demands required it. They freeze when suddenly confronted with off colored jokes. They panic when faced with an insensitive "move" is placed upon them.

Psychasthenia

Pierre Janet, (1903) defined psychasthenia as "…the lack of psychological strength associated with a narrowing of consciousness. (Ellenberger 1970, (p. 375).

Ellenberger, H. F., (1970). The Discovery of the Unconscious: the history and evolution of dynamic psychiatry. New York: Basic Books, Inc., Publishers.

Janet distinguishes "…two types of psychasthenia crises, fits of anxiety, and all kinds of conspicuous manifestations related to fixed ideas". "…Those fixed ideas were conscious in the form of obsessions and phobias". (Ellenberger 1970 (p. 376).

Janet (1930) wrote, "In my description of the symptoms of the psychasthenic neurosis (Janet 1903), I stressed particularly the pathological feelings (*sentiments pathologiques*), which I designated at the time as feelings of inadequacy (*sentiments d'incomplétude*) and which have become in my last book a part of the feelings of emptiness (*sentiments du vide*)". Janet includes the symptom of "…the maladies of doubt".

Janet, Pierre, (1903). *Les obsessions et la psychasthenia*, 2 volumes (Paris: Alcan) Vol. I by Pierre Janet. Vol. II by F. Raymond and P. Janet.

Neurotic disorders were the preferred designation of all anxiety related mental disorders prior to the development of the Diagnostic and Statistical Manuals classifications, which now lists them as anxiety disorders. The DSM-IV-TR (2000) classifies anxiety disorders into nine categories.

**Panic Disorder** is the recurrent episodes of panic attacks. At least one month (or more) has followed one of the attacks of the following: Persistent concern about having additional attacks. Worry about the consequences of an attack, i.e., “I’m going crazy”, having a heart attack, and loosing self-control. Significant changes in behavior are feared. Panic disorder with and without agoraphobia and additional diagnoses with panic disorder is also a possible diagnosis.

**Phobic Disorder** is an irrational fear of an object or situation that persists although the person recognizes the fear is irrational. These specific phobias are **Agoraphobia**, the fear of being alone in an open or public area where escape might be difficult. The person is often terrified of leaving their home or residence; **Social Phobia**, the fear of situations where one might be seen and embarrassed or criticized. Speaking to person in authority, speaking in public or performing before an audience are avoided; **Specific Phobia**, a fear of a specific object, activity, or situation, i.e., fear of flying (Jong’s Syndrome), snakes, mice, and closed places, amongst others.

Common Phobias

| Feared Object Or Situation | Clinical Name |
|---|---|
| Animal | Zoophobia |
| Being Alone | Monophobia |
| Blood | Hematophobia |
| Closed Places | Claustrophobia |
| Darkness | Nyctophobia |
| Electrical Storms | Astrophobia |
| Fire | Pyrophobia |
| Germs/Dirt | Mysophobia |
| Heights | Acrophobia |
| Open Spaces | Agoraphobia |
| Strangers | Xenophobia |
| Talking | Glossophobia |
| Water | Hydrophobia |

**Obsessive-Compulsive Disorder (OCD)** defines a preoccupation with persistent intrusive thoughts, impulses, or images. **Compulsions** are repetitive behaviors or mental acts that the person feels driven to perform in order to reduce distress or prevent a dreaded event or situation.

The person knows the obsessions/compulsions are excessive and unreasonable. The obsession/compulsion is time consuming and can cause distress.

**Generalizes Anxiety Disorder (GAD)** is defined as excessive worry and anxiety more days than not over a period of the preceding six months. The person cannot control their worrying. The anxiety and worry is associated with three or more of these six symptoms: Restlessness, feeling keyed-up, easy fatigue ability, difficulty concentrating, irritability, muscular tension, and sleep disturbances. The anxiety, worry, as well as physical symptoms which follow on the anxiety and worry, cause significant impairment in other areas of important functioning.

Clinical Presentation of Anxiety Disorders

**Panic Disorder:** A panic attack is the sudden appearance of intense fear or dread, which may announce impending doom. Terror paralyzes its victim. Terror shakes the individual's hold on the elements of reality. They can neither see nor think clearly. They may think they are loosing their minds. Physical sensations including palpitations, chest pain, suffocation, nausea, chills and hot flashes erupt unexpectedly. The abrupt onset of these attacks last a number of minutes and then subsides.

**Panic Disorder and Agoraphobia** characterizes recurring panic attacks, which combine with agoraphobia.

**Phobias** are persistent, irrational fears of specific objects or situations, which an individual avoids. High levels of anxiety and distress arise from contact with objects or situations, which most people find innocuous, i.e., the sight of blood, looking down from heights, thunder and lightening, viewing open expanses over water, enclosed spaces, among many others.

**Social Phobias** involve fear and anxiety arising from engagement in social situations or situations in which a performance is expected of the person. Afflicted persons fear they will say something foolish, which would expose them to ridicule or shame; not being able to answer a simple question, which would reveal they are stupid; forgetting their lines or saying them wrong in a play would expose them as inept are examples of social phobias. Fear of speaking in public is a common social fear. The life of persons living with social phobias becomes more and more constricted as they avoid more and more objects and situations which cause them to be paralyzed with fear. Alcohol and drugs reduce the distress they experience.

**Obsessive-Compulsive Disorder:** Obsessions are experienced as thoughts or images that keep recurring without let-up. They are meaningless in and of themselves. They occur within a matrix of persistent intense anxiety.

Compulsions are procedures adopted and followed rigorously, to control the experience of anxiety and reduce the intensity of the anxiety. These procedures lead to temporary relief. A tune repeated repeatedly is one's head is such an example. Repeated questioning such as, "Did I turn off the stove," "Did I turn off

the lights," and "Did I lock the door?" drive the person to check their activities many times over and often lead to self-dissatisfaction. Crippling doubts centering on violence, illness or death, contamination, and sexuality cause the individual to feel humiliated, shamed, and disgusted with him or herself. The demand-performances, procedures, and rituals involved in compulsions interfere with accomplishing necessary everyday activities and the fulfillment of obligations to other people.

**Generalized Anxiety Disorder** is overweening worry and anxiety, which has persisted over the foregoing six months and is present along with sleeplessness, tension, irritability, poor concentration, tiredness, and fidgeting. The person worries about letting people down, not being able to earn enough money, illness with family members, doing poorly at work with a fear of being fired, and feeling they are not up to the task of effective living. They spend their nights going over the day's failures, seeking means to make things come out right and solving problems in their heads. They continuously review past mistakes, problems and fret over future developments. They fear making mistakes of even the simplest sorts. They view their own decisions as inadequate and problematical.

**Posttraumatic Stress Disorder** is intense fear, helplessness, and terror associated with the repeatedly re-experiencing memories of traumatic events where threatened or actual injury or death has occurred. Intrusive recall of these events in flashbacks, dreams, or incidental everyday experiences bring the recollected trauma backs to life in full force. The person refrains from reawakening memories of the trauma.

Feelings of emptiness, the loss of the capacity to respond emotionally, being distant and unavailable to others, the incapacity to connect and a hopeless sense of detachment lead to the conviction life must be lived in a vacuous isolation. Exaggerated startle responses, an all-pervasive guardedness, heightened vigilance, and a sense of an irremediable loss and death of essential portions of their emotional lives form barriers to full and productive lives. Self-medication, chemical abuse, re-fighting the traumas in real time with real people, physical abuse of family members, and brushes with the law complicate social, economic, and civic behaviors.

**Acute Stress Disorder** is the reaction to an immediate stressor, which abates when the issues involved in causing the stress cease.

The Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Test-Revised, (DSM-IV-TR, and APA 2000) lists a mixed anxiety-depressive disorder wherein a dysphoric mood has lasted for a least one month; the dysphoric mood is associated with four or more of the following symptoms.

Difficulty concentrating, the mind goes blank, difficulty falling asleep or staying asleep or unsatisfying sleep, fatigue and low energy, irritability, worry, easily

moved to tears, heightened vigilance, anticipating the worst, catastrophizing, hopelessness, all encompassing pessimism, a bleak out look on the future, low self-esteem and a sense of being worthless. Additional comorbid disorders include substance abuse, Somatization, and physical disorders.

| Anxiety Disorder | Base Rate | Comorbid Diagnosis |
|---|---|---|
| Generalized Anxiety Disorder | 4-5 | Agoraphobia<br>Major Depression<br>Panic Disorder<br>Somatoform Disorder |
| Panic Disorder | 1-3.5 | Agoraphobia (30-40 %)<br>Major Depression |
| Phobias<br>Major Depression | 21.3% | Agoraphobia |
| 2.8-5.3% | | Anxiety Disorder<br>Alcohol |
| and Substance Abuse | | |
| Social Phobia | 7.9-13 | Alcohol and Substance Abuse |
| Obsessive-Compulsive Disorder<br>Major Depressions | 2-2.5 | Panic Disorder<br>Phobias |
| Posttraumatic Stress Disorder | 1.0 | |
| General Population | 20 | |

Traumatized Persons
Panic Attacks

Substance Abuse
Depression
Somatization

(Welkowitz, et al. 2000, and Horworth and Weisman 2000).

Welkowitz, L. A., Strvening, E. L., Pittman, J., Guardino, M., and Welkowoitz, J., (2000). “Obsessive-compulsive disorder and comorbid anxiety problems in a national anxiety-screening sample”. Journal of Anxiety Disorders 14(5): 471-482.

Horworth, E., and Weissman, N. M., (2000). “The epidemiology and cross-national presentation of obsessive-compulsive disorder”. Psychiatric Clinics of North America 23(3): 493-507.

**Research Findings:** Tellegen, et al., (2003) created the MMPI-2 Restructured Clinical (RC) Scales as a response to the need to clarify the saturation of the MMPI scales with a common, emotionally saturated factor, which can be broadly specified as generalized anxiety. This emotional factor colors all emotional life. The negative manifestations are termed Demoralization.

This Demoralization Scale is composed of only 24 items drawn from clinical Scale 2 (Depression) and Scale 7 (Psychasthenia). The Demoralization Scale reflects overall emotional discomfort, which combines feelings of demoralization, discouragement, insecurity, pessimism, and poor self-esteem. A sense of failure pervades a person’s evaluations of their life’s achievements. The individual feels helpless, overwhelmed, and unable to make things turn out satisfactorily.

The RC factor corresponds well with Janet’s descriptions of his patients who suffered from Psychasthenia. Statistical confirmation of a century old clinical phenomenon is a hopeful sign.

Tellegen, A., Ben-Porath, Y. S., McNulty, J. L., Arbisi, P. A., Graham, J. R., and Kaemmer, B., (2003). “The MMPI-2 Restructured Clinical Scales: Development, validation, and interpretation”. Minneapolis, MN: University of Minnesota Press.

Scale 7 (Pt) has 47 items in both the MMPI and MMPI-2. Thirty-nine items are scored in the true direction and nine are scored in the false direction. A K correction multiplier of 1.0 is added to the Scale 7 (Pt) raw score. Item overlap is: **L (0), F (1), K (2), 1 (2), 2 (13), 3 (7), 4 (6), 5 (1), 6 (4), 8 (17), 9 (3), Sie (9).** Scale 7 (Pt) and Scale 8 (Sc) have many items in common. Elevations on Scale 7 (Pt) will raise the score and Scale 8 (Sc). High scores may measure any of a variety of subjective difficulties ranging from concentration problems to frank psychoses (Comrey 1958). Test-retest correlations on Scale 7 (Pt) range from 0.83 to 0.86 in a 1 to 2 day interval for psychiatric patients and from to 0.49 to 0.58 for a one year interval, also for psychiatric patients (Dahlstrom et al. 1975).

Butcher et al., (1989) reported similar results with the MMPI-2 with normals for intervals of 1 to 2 days.

Comrey, A. L., (1958). “A factor analysis of items on the MMPI Psychasthenia scale”. Educational and Psychological Measurement 18, 293-300.

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

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.

## PROFILE CHARACTERISTICS

Base rates for adolescent males with the 5-7 Pattern on the MMPI-A are 0.10 percent and on the MMPI 0.50 percent. Base rates for adolescent females with the 5-7 Pattern are 0.10 percent and 0.10* percent respectively (Archer, 1997).

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

The 5-7 adolescent Pattern is rarely encountered. No descriptors are listed.

The adult 5-7 Pattern individual hesitates when faced with decisions to go one way or the other. They are troubled people with much on their minds. They are shy, thoughtful people who take pains not to offend. They do not have much joy in their lives. They get down on themselves, sometimes badly so. Education attenuates some of the worst of these features. 5-7 Pattern women are aggressive and hardheaded.

Marks writes for **women** with the 5-7 Pattern 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.

Additional clinical characteristics of this profile include a profound fear of unpredictable frightening events. It is likely that this type of patients were at an early age teased and humiliated, or experienced some unpredictable and catastrophic event which led them to over-protect against unanticipated future events by thinking ahead and worrying.

Worrying is seen as trying to predict the future by thinking ahead of all possible eventualities.

These patients are amenable to almost any form of therapy. Implosion techniques in conjunction with insight therapy can be particularly useful as can desensitization to the originally unpredictable and frightening experiences
Marks has written that for **males** it is likely that these patients are experiencing disturbances in role functioning such as gender identity issues and not one's sexual preference. The stronger the role dissatisfaction, the more the individual identifies with values, interests and behaviors stereotypic of the opposite sex.
For men, this may suggest a close boy-mother (or female surrogate) childhood relationship in which the mother would confide in the boy and discourage a 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.

Additional clinical characteristics of this profile include a profound fear of unpredictable frightening events. It is likely that this type of patients were at an early age teased and humiliated, or experienced some unpredictable and catastrophic event which led them to over-protect against unanticipated future events by thinking ahead and worrying.

Worrying is seen as trying to predict the future by thinking ahead of all possible eventualities.

These patients are amenable to almost any form of therapy. Implosion techniques in conjunction with insight therapy can be particularly useful as can desensitization to the originally unpredictable and frightening experiences (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 | 0.15 |
| White Adult Males | 0.24 |

| | |
|---|---|
| White Adolescent Males | 1.19 |
| White Adult Females | 0.15 |
| White Adolescent Females | 0.23 |
| African American Males | 0.07 |
| African American Adolescent Males | 0.25 |
| African American Adult Females | 0.00 |

## DSM-IV DIAGNOSTIC CONSIDERATIONS

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

Axis I

309. Adjustment Disorder With Depressed Mood
90. Other (Or Unknown) Substance Abuse

Axis II

301.20 Schizoid Personality Disorder