6-8 Pattern

Clinical Scale Elevations

Scale(s) 6 (Pa)

T-score # 65

All other scales # 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 exquisitely sensitive to the moods and emotions of others. They are adept at responding in tandem to the 'whatever' the other person, with whom they are speaking says, following each changing nuisance as if it was a fleeting shadow dogging the conversation. Their skillful maneuvering conceals their artful control of the other person's initiatives. They keep their opinions, plans, and goals to themselves. They carry many secrets. They deflect any inquiries into their private lives with élan and sly misdirection. They are exceptionally private individuals. They conceal many secrets.

Scale(s) 6 (Pa)

T-score 60-69

They are cold, touchy, resentful and suspicious. They make mountains out of molehills.
They carry in themselves a considerable amount or anger, which they effortlessly conceal. They strive to always be in control of any situation in which they find themselves. They are convinced they must be on guard, give the expected responses, and see beyond the immediate situation for signs of personal vulnerability in the face of all variety of threats, which may be approaching them as the future unfolds.

Paranoia

> Ayd, (1995) defines paranoia as a term employed by Kraepelin to describe, "…a group of patients with extensive delusional systems associated with suspiciousness and the belief that one is unfairly treated, harassed, and persecuted. Pervasive distrust underlies paranoid phenomenon."
>
> Ayd, F. J., (1995). "Lexicon of Psychiatry, Neurology, and the Neurosciences". Baltimore: Williams & Wilkins.

Fenigstein and Vanable (1992) identified public self-consciousness as a general factor consistently and significantly correlated with a heightened sense of being observed.

Fenigstein, A., & Vanable, P. A., (1992). “Paranoia and self-consciousness”. Journal of Personal and Social Psychology 62 (1): 129-138.

MMPI Scale 6 (Pa) items reflect sensitivity to the presence of others, self-righteousness, and a suspicious nature (Greene, 1991, p. 159).

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

The authors of Scale 6 (Pa) did not specify the parameters of the individuals included in the Paranoia group (Hathaway, 1980, pp. 65-75).

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

Wiener and Harmon (1948) point out the fact that only seven of the items making up Scale 6 are unique to this scale. The remaining items are contained in other scales. It is difficult to know from only seven items how Paranoia Scale scores are able to determine if such a complex condition as paranoia really exists.

Wiener, D. N., (1948). “Subtle and obvious keys for the MMPI”. Journal of Consulting Psychology. 12, 164-170.

Nichols and Greene, (1995) view Scale 6 (Pa) as, “…the most general measure of projection and is sensitive to both implicit and explicit operations to place or locate motives, responsibility, and other, especially undesirable attributes outside the self.” (p. 36). This occurs without the presence of collaborative evidence involved in forming a conclusion.

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

Romney, (1987) thinks the paranoid process is insidious, growing slowly into it final forms. A sequence of stages evolves, beginning with a hostile attitude and culminating in delusions of influence. The intensity of the paranoia process defines the end diagnosis, i.e., paranoia, paranoid personality, and paranoid schizophrenia.

Romney, D. M. (1987) “A simplex model of the paranoid process: Implications for diagnosis and prognosis”. Acta Psychiatria Scandinavia 75 (6): 651-655.

The empirical foundation for Scale 6 is weak. Researchers have found paranoid states over the entire range of scores on Scale 6. Low, medium, and high elevations have at one time or another indicated the presence of paranoia. The clinician alone must make the determination of the presence of absence of paranoia base upon information other than that provided by MMPI itself (Greene, 2000).

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

Duckworth (1995) is of the opinion that Scale 6 measures sensitivity to the behavior and opinions of others, the possibility that suspiciousness is present, and the unshakable conviction that others plan to harm them. (p. 213).

Duckworth, J. C., & Anderson, W. P. (1995) MMPI & MMPI-2: Interpretive manual for counselors and clinicians. (4th ed.) Bristol, PA: Accelerated Development.

Duckworth and Anderson (1995) say paranoid individuals are difficult to work with. They are confrontational. They question the credentials of any person who appears to be a person in authority. They feel they have the right to make judgments of others’ behavior and character based upon their own idiosyncratic ideas of right and wrong.

They believe they are always in the right. Added to this is a burning desire to know what is really going on around them. Their question everything. Their thinking is precise, sharp, and penetrating. They see features in situations that remain overlooked by other people. They see more deeply into the world and its workings than most (Kunce & Anderson, 1984).

Kunce, J., & Anderson, W. (1984) “Perspectives on the MMPI in non-psychiatric settings”. In P. McReynolds & G. J. Chelune (Eds.) Advances in psychological assessment. San Francisco: Jossey-Bass.

Scale 6 (Pa) scores may reflect a fear of physical attack. They anticipate being on the receiving end of severe and unfair judgments (Caldwell, 1985).

Caldwell, A. (1985) “MMPI clinical interpretation”. Los Angeles: Advanced Psychological Studies Institute.

Hovey and Lewis (1967) think Scale 6 (Pa) reflect long-standing resentment towards relatives, exceptional sensitivity to the opinions held about themselves by others, a touchy nature, and the willingness to blame others for their problems.

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

Carson (1969) views paranoid individuals as registering and remembering any hint of criticism of their person. All rejections, slights, and snubs are stored in perpetuity. They will seek vengeance at an appropriate time and place in the future at the offended parties choosing. They have histories of throwing monkey wrenches into employers’ business operations in order to get even with perceived slights and injustices. Going ‘postal’ is a modern day phenomenon. This is a tragic and exceptionally dangerous phenomenon, to say the least. They do not expose information about themselves. They are tight lipped. They are guarded. They defend themselves against any possible threat. They do not open up in treatment. They distrust therapists. Paranoid characters have shot three colleagues of this writer (Wallace) over the years, two survived, fortunately. Another did not, however.

Carson, R. (1969) “Interpretive manual to the MMPI”. In J. Butcher (Ed.) MMPI: Research developments and clinical applications (pp. 279-296). New York: McGraw-Hill.

Lewak, (1993) reports a case of a police officer that gave a within normal limits MMPI profile with an exceptionally low Scale 6 score. This man has now served many years in prison. Extremely low Scale 6 scores are usually associated with a presumed paranoid condition.

Lewak, R. (1993) “Low scores on Scale 6: A case history”. Paper presented at the annual convention of the Society of Personality Assessment, San Francisco.

Medical conditions can lead to paranoid presentations. The classic picture of an acute paranoid illness virtually indistinguishable from paranoid schizophrenia is particularly common after an injection of methyl- amphetamine (Lishman, 1998, p. 617).

Cocaine psychosis represents an end on the progression to extreme paranoia, which begins with suspiciousness, ideas of reference, and verbal hallucinations (Lishman, 1998, p. 619).

General paresis, associated with syphilitic disease, may eventuate in paranoid delusions (Lishman, 1998, p. 341).

Migraine suffers report complex visual and auditory hallucinations with a distinct paranoid component. A paranoid psychosis may result from an acute exacerbation of a migraine attack (Lishman, 1998, p. 405-406).

Lishman, W. A., (1998). “Organic Psychiatry. The psychological consequences of cerebral disorder” (3rd ed.) Malden, MA: Blackwell Science, Inc.

Toxic cannabis psychosis occurred in a group of 100 black South Africans, wherein one fourth of the cases were diagnosed with paranoia. (Solomons, et al., 1990, pp. 476-481).

Solomon, K., Neppe, V. M., & Kuyl, J. M., (1990). “Toxic cannabis psychosis is a valid entity”. South African Medical Journal 20, 78 (8): 476-481.

Mendez, et al., (1990) reported the results of a retrospective chart review with 217 patients diagnosed with Alzheimer’s disease wherein 35 percent of the cases presented with suspiciousness and paranoia.

Mendez, M. F., Martin, R. J., Smyth, K. A., & Whitehouse, P. J, Maier, W.(1994) wrote that Paranoid Personality Disorders occur much more frequently in relatives with histories of major depression than in control subjects.

Maier, W., Lichermann, D., Minges, J., & Heun, R., (1994). “Personality Disorders among the relatives of schizophrenia patients”. Schizophrenia Bulletin, 20 (3): 481-493.

The DSM-IV-TR (2000) defines the Paranoid Personality Disorder as a pervasive distrust of others such that their motives are malevolent, beginning by early adulthood and present in a variety of settings. [The estimated base rate for the general population is 0.5 to 2.5 percent]. Individuals with this disorder believe other people will exploit, harm, or deceive them even though there is no evidence upon which to base such judgments. They expect others will plot against them and attack them from ambush. They are convinced others have irreparably damaged them. They doubt the trustworthiness and loyalty of family members, friends, and co-workers. They scan and survey in excruciating detail any hint of hostile intentions of the people around them. Their limited perspectives and narrow understanding of people in general facilitates their erroneous justifications of disloyalty. They do not let others get close to them. They do not share personal information. They fear attack if a personal weak spot is revealed. They read hidden meanings into benign remarks, which they see as reflecting threat or demeaning attitudes towards them. They bear grudges. They do not forgive other people mistakes or insults. Hostile feelings are their hallmark. They are always on their guard. They can be extremely jealous. They accuse partners and spouses of being unfaithful. They are control freaks. They insist on a complete accounting of their whereabouts, activities, and associates.

The DSM-IV-TR (2000) notes the essential feature of the Paranoid Type of Schizophrenia is the presence of prominent delusions or auditory hallucinations in the context of a relative sparing of cognitive functioning and affect. Delusions are typically persecutory or grandiose, and can include both. Delusions with other themes (e.g., jealousy, religiosity, or Somatization) may also occur. The delusions may be multiple and organized around coherent themes. Hallucinations relate to

the content of the delusional themes. Associated features include anxiety, anger, aloofness, and argumentativeness. Extreme intensity in interpersonal relations is prominent. Grandiose delusions with anger predispose the individual to violence. These individuals may be post office employees. They evidence little or no impairment on neuropsychological or cognitive testing.

Scale 6 (Pa)

Scale 6 (Pa) has 40 items in both the MMPI and MMPI-2. Twenty-five of the items are scored in the true direction. Fifteen items are scored in the false direction. An "all true" response set will elevate the Scale 6 (Pa) profile. Item overlap is: L (0), F (9), K (2), 1 (4), 2 (10), 3 (8), 4 (10), 5 (2), 7 (4), 8 (13), 9 (6), and Sie (5). Test-retest correlations range from 0.61 to 0.71 for an interval of 1 to 2 days for psychiatric patients and between 0.59 to 0.65 for and interval of one year for psychiatric patients (Dahlstrom et al. 1975). Butcher et al., (1989) reported similar test-retest correlations for the MMPI-2 norm group.

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.

Clinical Scale Elevations

Scale(s) 8 (Sc)

T-score ≥75

Elevations on the present Scale(s), taking race, gender, age, education, marital and employment status into consideration for the corresponding group's data, indicate any or all of these clinical features could be present in this person's behavior and history:

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

Schizophrenia

Wallace (2001) describes schizophrenia as 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 illusionary fiction that they are meaningfully involved with others. Even when mingling with other people, they maintain a psychological distance by keeping their thoughts and feelings to themselves and interacting only on a formal, impersonal level.

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

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

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

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

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

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

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

The DSM-IV-TR (2000) 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 least six months with at least one month that meets the 'A' criteria (Active Phase) and may include prodromal (early warning signs) or residual symptoms.

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

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

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

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

symptoms are the principle disabilities associated with schizophrenia. Disorganized symptoms signify the degree of disorganization of affect or behavior.

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

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

Acute and chronic central nervous system conditions lead to psychotic reactions. Schizophrenia is one diagnostic possibility, which present with manifold symptoms. Head injuries at times lead to schizophrenic conditions. “All forms of schizophrenia have been reported after head injury…” (p. 190). “Paranoid forms are reported to be especially common…” (p. 190). Achté et al., (1969) followed 3552 head injured Finnish WW II soldiers for over 20 years. Ninety-two of these cases developed schizophrenic-like symptoms (2.6 percent).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Genetic investigations with identical twins reveal a 45 percent chance of one twin developing a schizophrenic disorder if the other twin is so affected. If one twin has an

autistic spectrum disorder, the other twin stands a 60 percent chance of developing impairments of communication and deficits in social interaction, i.e., Asperger's Syndrome. Some twins do not develop these disorders, however. Genetic causation is only a partial 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. 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, 2000).

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

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

Psychiatric settings yielding similar MMPI scores lead to different interpretations than those gotten in non-psychiatric settings. Greene (2000) investigated MMPI data collected on psychiatric inpatients and out patients. The most frequent code pattern for men was 8-6, for women the 4-8, 8-4, and 8-6 code patterns were prominent. Psychiatric diagnoses were wide ranging. There is no assurance that Scale 8 elevations are associated exclusively with schizophrenic disorders.

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

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

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

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

Base rates for adolescent males with the 6-8 Pattern on the MMPI-A are 3.20 percent and on the MMPI 2.40 percent. Base rates for adolescent females with the 6-8 Pattern are 3.40 percent and 2.30 percent respectively (Archer, 1997).

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

6-8 Pattern adolescents are bizarre. This is reflected in their behavior. Turmoil and physical abuse characterize their family life. They have tempers. They have few friends. They fail in school. They expect to fail. They cannot devise ways to be successful. They fell they do not have what it takes to make a good, happy life. Therapists describe them as being awkward. They do not present themselves in an attractive manner in either dress or deportment. They are not socially facile, self-confident, or at ease in the company of others. They are not subtle or sophisticated. Guilt and shame stalk them everywhere they go. They live in fantasy worlds to experience those pleasures and satisfactions denied them in their daily life. Many are delusional. Their thoughts are filled with grand plans and projects, heroic and admirable deeds, awe-inspiring scenes, and luxurious surrounding, which stand in stark contrast to their own bleak realities. Drug use is associated with suicide attempts. In the eventuality that they should develop psychoses, their therapists describe them as hostile, prone to hallucinate, become delusional, think others are out to bring them harm, and occasionally turn violent. At this point, they are usually hospitalized where they sit staring out into empty space, rocking back and forth while talking nonsense (at least to others listening to them) to themselves, all of which makes ordinary people rather uncomfortable. They are not considered to be particularly bright people. Traumatic brain injuries are often reported. They do not understand their own behavior or what is happening to them (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

Archer (1997) describes the 6-8 Pattern adolescents are inappropriate socially as well as withdrawn and isolated. Many have been subjected to physical punishment in order to get them to behave properly (sic). Many of their fathers are criminals. These adolescents have tempers. They hit others to express in a most direct fashion their displeasure with others. Their peers do not like them. They are not members of school in-groups. They are usually depressed.

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

Adults with the 6-8 Pattern seen in psychiatric settings are described as having thought disorders. Systematized delusions are reported. They are resentful, suspicious, and angry. They are unpredictable. They ruminate and talk in abstractions. They speak of religious and erotic obsessions. The 6-8 Pattern mirrors chronic maladjustment. Descent into frank psychosis is an ever-present peril and pregnability (Greene, 2000).

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

African American psychiatric patients' MMPIs yield many more of the 6-8 Pattern profiles than do those of Caucasian psychiatric patients matched for age, gender, socioeconomic status, and length of illness (Costello and Tiffany, 1972).

Costello, R., & Tiffany, D., (1972). "Methodological issues and racial (Black-White) comparisons on the MMPI". Journal of Consulting and Clinical Psychology 38, 161-168.

College students with the 6-8 Pattern are confused, indecisive, and dissatisfied. Female college students are seen as depressed, fidgety, and ill at ease around males (Drake and Oetting, 1959).

Drake, L. E., & Oetting, E. R., (1959). "An MMPI code book for counselors", Minneapolis: University of Minnesota Press.

Adults with the 6-8 Pattern frequently have long histories of employment, which can be interrupted by psychotic breaks. Marriage partners are often much like each other, i.e., peculiar and alienated (Friedman et al., 2001).

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

Marks wrote these patients may exhibit a history of fear of attack on one's abilities and beliefs, and domination over one's will. In reality, they indeed may have been subjected to varying degrees of attack, criticism, and judgment. It is assumed that the more significant the clinical characteristics of this profile are the more they reflect the more extreme, the more will-breaking, and the more humiliating history of such attacks

When engaging in a therapeutic alliance, these patients need to trust that their therapist will not humiliate or control them. They are usually very perceptive and have a "sixth sense" as to whether a person is frightened or intimidated by them, or is not telling them the truth. Many techniques can be effective with them once basic trust is established. Giving them permission to be angry and empathizing with their sensitivity to humiliation is vital in the initial stages of therapy. Encouraging insight and engaging their rage at having been criticized and humiliated unfairly also are useful.

Typically these patients were not allowed to retaliate against criticism with anger for fear that it would lead to further attacks and criticism. They now need to learn how to "fight for themselves" before their anger leads to overwhelming negative consequences.

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. This would then 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. They will require a consistent, warm, interactive and positive therapeutic relationship (Marks, P. A. (1987).

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

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

	Base Rate
Aggregate	2.22
White Adult Males	0.60
White Adolescent Males	0.30
White Adult Females	3.16
White Adolescent Females	3.42
African American Males	1.47
African American Adolescent Males	0.50
African American Adult Females	6.47

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

30. Schizophrenia, Paranoid Type

1. Delusional Disorder
9. Alcohol-Related Disorder NOS
90. Other (Or Unknown) Substance Abuse
80. Conduct Disorder
90. Cognitive Disorder NOS
3. Obsessive-Compulsive Disorder
70. Schizoaffective Disorder
40. Bipolar I Disorder, Most Recent Episode Manic, Unspecified

Axis II

2. Schizoid Personality Disorder
301. Paranoid Personality Disorder
301.83 Borderline Personality Disorder