3-0 Pattern

Clinical Scale Elevations

Scale 3 (Hy)

T-score 3 $\geq$ 75
T-score 9 $\leq$ 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 self-satisfied and immature. They are suggestible. They go with the flow. They have many aches and pains reflecting much dissatisfaction. They attract attention to themselves through thespian displays whenever they feel distressed.

Scale 3 (Hy)

T-score $\geq$ 75

Giving the right appearance is important to them. They go to considerable pains to make the right impression. They do not tolerate anything that is unpleasant, ugly, or the very thought of failure or the impact of being thwarted. They have an abiding dread and intolerance of emotional discomfort, pain, or any type of suffering.

Scale 3 (Hy)

General Overview

Elevations on Scale 3 (Hy) indicate the presence of multiple temperaments and traits:

> They have a profound fear of emotional and physical pain. Emotions easily overwhelm their thinking easily. They cannot portray or analyze their emotions in words. They have no words available to them upon which to anchor their feelings. Visual rather than verbal awareness dominates their mental life. They cannot accurately put their feelings and ideas into words easily. This inability to tell others what is bothering them forces other people to guess what is the matter. Most attempts to do so meet with failure and puzzlement. Words associated with painful experiences are banished from awareness reflexively. Stress registers as pain in the musculature. The capacity for intimacy and mutuality is limited. Self-

> examination is poorly tolerated or not at all. They are self-centered. They are relatively immature. They are not particularly sensitive to the feelings of other people. Their social interactions are superficial. They have limited interests. They are vulnerable to demands made upon them. Personal appearance and appearances in general are of major importance to them. Making just the right impression on others assumes a major part of their planning and behavior with others. They want, desire, and depend upon the approval of others in order to maintain their sense of social acceptability. They employ petty cunning to get their way. They have an eye for attaining and maintaining social advantage, often at the expense of others. Wealth and power entice them.

Hysteria

Paul Lerner (1998) said hysterics depict "the emotional way of life." Their lives are emotional reactions to their involvement with others. Lerner cites (Easser and Lesser 1966) who describe the hysterics emotionality, "as a jewel to be exhibited, fondled and cherished. Any attempt to move beyond it or remove it is viewed as an attack and is defended against with the total personality".

Lerner, P. M., (1998). "Psychoanalytic perspectives on the Rorschach". London: The Psychoanalytic Press, pp. 53-54.

Easser, R., & Lesser, S., (1966) Transference resistance in hysterical character neurosis-technical considerations. "Developments in Psychoanalysis at Columbia University". New York: Columbia University Press, pp. 69-80.

Hysterics remain anchored in the emotionality of their own childhood. Feelings dominate and often overrule their thinking. They need is to be appreciated, valued, recognized and loved. This is their "prime directive to themselves and others".

Freud (1915) in his article "The Unconscious" said, "….repression is essentially a process affecting ideas on the border between the Ucs and Pcs."

Freud, S., (1915) The unconscious. Standard Edition 14:159-216. London: Hogarth Press 1957. p. 180

Levine and Spivak (1964) theorize repression inhibits cognitive processes.

Levin, M., & Spivak, C., (1964). "The Rorschach Index of Repressive Style". Springfield, IL: Thomas.

Repression blocks entrance to awareness of ideas containing painful emotions. Hysterics welcome pleasurable emotions with open arms. The inability to integrate both painful and pleasurable emotions results in the failure to use all available information upon which to base reactions to the circumstances in which the hysterics

find themselves. So long as the hysteric receives adulation, they are happy. Disappointment, criticism, or rejection depresses them.

The hysteric repairs their injured sense of self by planting subtle suggestions upon which others are to act to supply them with those pleasant experiences they crave simultaneously avoiding any hint of plethora of approval (Easser and Lesser (1965).

Easser, R., & Lesser, S., (1965). Hysterical personality: A re-evaluation. Psychoanalytic Quarterly 43:390-405, p. 397.

The emphasis upon the emotional side of existence overshadows the cognitive side. Hysterics avoid engaging in the mundane, dull, drudgery involved in most everyday activities like balancing the check book, house work, grocery shopping, getting the car serviced to mention only a few. These duties fall upon the shoulder of those closest to them. They would rather do things that get them the recognition they want.

Scale 3 (Hy)

Scale 3 (Hy) has 60 items on both the MMPI and MMPI-2. Forty-seven items are scored in the false direction and 13 of the items are scored in the true direction. A false response set will elevate Scale 3 (Hy). The K scale has 10 items in common with Scale 3 (Hy), which represents a built-in K correction. Item overlap is: L (0), F (1), K (10), 1 (20), 2 (13), 4 (10), 5 (4), 6 (4), 7 (0), 8 (8), 9 (6), Sie (13). Test-retest correlations range from .66 to .80 for intervals of 1 to 2 weeks on the MMPI (Dahlstrom et al. 1972) and 0.72 to 0.75 for a one-week interval on the MMPI-1 (Butcher et al. 1989).

Dahlstrom, W. G. Welsh, G. S., & Dahlstrom, L. E. (1972). An MMPI handbook: Vol. 1. Clinical Interpretation (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) 0 (Sie)

T-score >70

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 prefer their own company to that of others. Confrontations with other people force them to withdraw. They are generally fearful of people they do not know well. Trust builds slowly, if at all, for them. They are shy people who do not seek out or like the limelight. They prefer to work alone. They will not go to public events or attend public meetings if given the opportunity. They are unusually quiet persons. They can stand long silences and may even like it. They find it hard to startup a conversation even with people they know well. They dress conservatively. They do not like to attract attention to themselves.

Social Introversion Extroversion

(Sie)

The Social Introversion scale is based upon the work of Evans and McConnel (1941) who authored the Minnesota T-S-E Inventory. The investigation centered about the dimensions of Thinking, Social, and Emotional aspects of behavior and their manifestations in either the introverted or the extroverted aspects of a persons behavior.

Evans, C., & McConnell, T. R., (1941) A new measure of introversion-extroversion. Journal of Psychology 12, 111-124.

Drake (1946) based the Social Introversion (Sie) scale on Evans and McConnell's work with the Minnesota T-S-E Inventory's Social introversion items. Seventy items, which separated the top 65 percent and lowest 35 percent of 100 female college students who served as test subjects, formed the Sie scale.

Drake, L. E., (1946). A social I.E. scale for the Minnesota Multiphasic Personality Inventory. Journal of Applied Psychology 30, 51-54.

The Sie Scale criterion group is composed of healthy persons. Test norms for males were similar to the female norms; the two groups' combined results form the scale. The norms are composed of 350 female and 193 male college students. [An interesting aspect of this norming reflects the types of males in college during WW II. Those males capable of serving in the Armed Forces were not included or represented in this testing.

The 69 items (MMPI-2) composing the Social Introversion scale overlap with the other scales as follows: L (0), F (0), K (9), 1 (1), 2 (8), 3 (8), 4 (11), 5f (11), 5m (9), 6 (5), 7 (9), 8 (6), and 9 (6). 34 items are scored in the true direction, 35 in the false direction. Foerstner's (1986) studies reflect the multifactorial nature of the Sie scale.

Foerstner, S. B., (1986). The factor structure and stability of selected Minnesota Multiphasic Personality Inventory (MMPI) subscales: Harris and Lingoes subscales, Wiggins's content scales, Wiener subscales, and Serkownet subscales. Unpublished dissertation, University of Akron, Ohio.

The Sie scale indicates the degree of comfort a person experiences when they are in the company of other people. Lewak et al., (1990) writes concerning high Sie scale scores, a person had "…a childhood characterized by an absence of warmth and physical contact from others. Elevated scores suggest that these people have extinguished their feeling response to physical touch and affection. They suffer from "affect hunger" and yet, they feel conflicted about close, intimate relationships." (p. 273). Low scores on the other hand suggest an intense need for stimulation afforded by the close proximity of other peoples' energetic activities.

Lewak, R. W., Marks, P.A., & Nelson, G. E., (1990). Therapist's guide to the MMPI and MMPI-2: Providing feedback and treatment. Muncie, IN.: Accelerated Development.

The Sie scale also measures a person's willingness to be in the proximity of others. It includes a person's readiness to engage with others in social and work settings. Introverted people do not have social poise, engage in ready repartee, or involve themselves in quick witted, jocular, give-and-take. They ask themselves, "Why didn't I think of that" as a belated rejoinder to intentionally cutting comments. All those missed opportunities! They are usually not an insider; they are not even familiar with the current in-group's slang or the intimate references used by the in-group.

Introverted people isolate themselves when they feel under pressure. This could be due to the experiences of past disappointments and emotional injuries. They go it alone for lack of any other supportive options.

Extroverted people have learned to welcome the enjoyment they gain from the stimulation other people offer them. They are socially skilled. They give and take on an equal footing. They turn to others in times of difficulties, using these contacts as sources of emotional support and sources of solution to the problems facing them.
They learn from others more easily than they do when attempting to learn new information and skills by themselves. They do not like being alone.

Kunce and Anderson (1984) propose autonomy as the principal force under girding the Social Introversion scale. One can either function as a resourceful, self-directed, independent individual or withdraw into them-selves leaving the world of people behind.

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

Research Findings. Steyaert et al., (1994) investigated the higher incidence of psychiatric morbidity in female fragile X carriers (fragile X syndrome, also know as the Martin-Bell syndrome, after the British investigators who first reported it in 1943). The tip of the X chromosome tends to break off in many of those affected. Hence, the name Fragile X. Female carriers have more disorders that are schizophrenia-like. The sample mean MMPI scale scores fell within the normal range for a group of 11 females of normal intelligence. Low scores on the Sie scale reflected extraversion, not introversion, as expected.

Steyaert, J., Decruyenaere, M., Borghraef, M., & Fryns, J.P., (1994) Personality profile in adult female fragile X carriers: assessed with the Minnesota Multiphasic Personality Inventory (MMPI). American Journal of Medical Genetics 51(4), 370-373.

Meehl (1989) proposed a research model opposing biological vs. psychological causation in the genesis of schizophrenia. Meehl hypothesizes those given unfavorable polygenic potentiators (e.g., introversion, hypohedonia, and anxiety) and adverse life experiences (e.g., childhood trauma or adult misfortune), 10 percent of such individuals so afflicted develop schizophrenia. Meehl concludes, “Taxometric statistics are appropriate to testing a major locus model”.

Meehl, P. E., (1989). Schizotaxia revisited. Archives of General Psychiatry, 46(10), 935-944.

Gauci et al., (1993) used the MMPI to study women with allergic rhinitis. Twenty-two female suffers of perennial allergic rhinitis (inflammation of the nasal mucosa initiated by botanical airborne substances) and an 18 non-allergic female control group. Allergic sufferers scored significantly higher scores on the Sie scale along with high score on Scale 1 (Hs). Skin reactivity to house dust mite and grass pollen allergens correlated positively with scores on the Sie scale.

Gauci, M., King, M. G., Saxarra, H., Tulloch, B. J., & Husband, A. J., (1993). “A Minnesota Multiphasic Personality Inventory profile of women with allergic rhinitis”. Psychosomatic Medicine 55(6), 533-540.

Fals and Schafer (1993) examined the relationship between compliance with a behavioral therapy program and MMPI profiles of obsessive-compulsive disorder (OCD) outpatients. Compliance referred to the number of scheduled therapy sessions cancelled or missed. High scores on scales Sie, 2 (D), and 8 (Sc) predicted lower compliance with treatment for OCD patients engaged in behavioral therapy.

Fals, W. W., & Schafer, J., (1993). MMPI correlates of psychotherapy compliance among obsessive-compulsives. Psychopathology 26(1), 1-15.

Danjou et al., (1991) screened 62 young healthy volunteers with the MMPI for eligibility to participate in psychopharmacology studies. The most striking differences occurred on the Sie scale, which was lower than even the controls Sie scores, but significantly higher than controls on Scales 4 (Pd), 9 (Ma), and 8 (Sc). The low Sie scale scores were significant at the .0001 levels. Bias is possible in the selection of psychopharmacology research volunteer subjects. Drug seeking may be an important factor urging young healthy males to volunteer.

Danjou, P., Warot, D., Weiller, E., Lacomblez, L., & Puech, A. J., (1991). Personality of healthy volunteers: Normality and paradox. Therapie, 46(2), 125-129.

Siegler et al., (1997) utilized the MMPI to study 796 women and 3,630 men enrolled in the University of North Carolina Heart Study to test the predictive power of personality on adult exercise behavior. Lower scores on Scales 0 (Sie), 2 (D), and 4 (Pd) are predictive of an increased probability of exercising in mid life for both women and men.

Siegler, H. D., Blumenthal, J. A., Barefoot, J. C., Peterson, B. L., Saunders, W. B., Dahlstrom, W. G., Costa, P. T., Suarez, E. C., Helms, M., Maynard, K. D., & Williams, R. B., (1997). Personality factors differentially predict exercise behavior in men and women. Women 3(1.1), 61-70.

Richman (1983) used the MMPI to study 30 adolescents with cleft lips and palates. Heightened social introversion was associated with increased self-consciousness centering on their cleft lips and palates when the adolescents found themselves in social situations.

Richman, L. C., (1983). “Self-reported social, speech, and facial concerns and personality adjustment of adolescents with cleft lip and palate”. Cleft. 20(20), 108-112.

Peterson and Knudson (1983) cross-validated several measures of anhedonia and the MMPI Sie scale. The results of multiple statistical measures lead to the

conclusion, “The high degree of relationship between anhedonia and introversion, long suggested by clinicians, is confirmed”.

Peterson, C. A., & Knudson, R. M., (1983). Anhedonia: a construct validation approach. Journal of Personality 47(5), 539-555.

Kling et al., (1978) studied the scoring norms on adolescent psychiatric drug users and non-users MMPI profiles. Sie scale scores differentiated the users from non-user profiles. Low Sie scores were more frequently associated with drug use.

Klinge, V, Lachar, D., Grisell, J., & Berman, W., (1978). Effects of scoring norms on adolescent psychiatric drug users and non-users MMPI profiles. Adolescence 13(49), 1-11.

Ansseau et al., (1986) investigated the relationship between MMPI scale scores and dexamethasone suppression tests (DST) with42 patients diagnosed with major depression. The Sie scale scores correlated positively with depression and negatively with Scale 9 (Ma) scale scores.

Ansseau, M., Frenckell, R., Frank, G., Geenen, V., & Legros, J. J., (1986). Dexamethasone suppression test and MMPI scales. Neuropsychobiology 16(2-3), 68-71.

Nocita et al., (1986) used the MMPI to investigate the relationship between the MMPI Sie scale and the experience 83 introverted clients had in counseling sessions. Clients with higher Sie scale scores rated their sessions as uncomfortable, unpleasant, tense, rough, and difficult. They rated their post-session mood as unfriendly, uncertain, sad, angry, and afraid.

Nocita, A., & Stiles, W.B., (1986). Client introversion and counseling session impact. Journal of Counseling Psychology 33(3), 235-241.

Yen and Shirley (2003) investigated MMPI subscales’ ability to differentiate male suicide completers, clinically depressed men, and a control group of men who died of medical causes. Suicide completers have significantly higher Sie scores when compared to depressed and deceased controls.

Yen, S., & Shirley, I. C., (2003). Self-blame, social introversion and male suicides: Prospective data from a longitudinal study. Archives of Suicide Research, 7(1), 17-27.

Craig and Bivens (2000) examined the relationship between psychological needs of 198 non-clinical subjects using the Adjective Check List and the MMPI. Scale O (Sie) scale scores were positively associated with need for receiving support, showing deference to others, and a preference for being a follower

rather than a leader. The same scores were negatively associated with needs for achievement, dominance, autonomy, and exhibitionism.

Craig, R. J., & Bivens, A., (2000). “Psychological needs associated with MMPI-2 scales in a non-clinical sample”. Journal of Personality Assessment 74(3), 439-446.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 3-0 Pattern on the MMPI-A are 0.10 percent and on the MMPI 0.00 percent. Base rates for adolescent females with the 3-0 Pattern are 0.40 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 3-0 adolescent Pattern is rarely encountered. No descriptors are listed.

Adults with the 3-0 Pattern describe themselves as law-abiding and conventional. They are shy and socially reserved. They are quietly nice persons.

Marks writes that these patients typically suffer from fear of psychological or emotional pain. They need to be liked. They try to avoid conflict. It is important for people to see them as psychologically healthy. They will often seek reassurance that they are likable and will try to elicit that by flattering and complimenting others.

They maintain a positive attitude in the face of adversity, anger and hostility, and will develop somatic symptoms when faced with stress and conflict situations. Often gestalt implosion and systematic desensitization will help them face painful situations and unblock the anger and sadness related to frightening past events. It is helpful to look for what they explicitly deny because that is often at the center of their conflict.

They have difficulty remembering painful events. Techniques to elicit catharsis are often helpful in extinguishing the strong fears that painful feelings will overpower them.

Marks writes that patients with this profile complain of fatigue and exhaustion, and often are seen as "difficult" cases. Their ambivalence toward therapy may reflect their fear that they will somehow be seen as "bad" and rejected. Seeing physicians for their physical symptoms acts as a source of reality testing, and that confronting them with non-organic or psychological issues is frightening and they may therefore resist it.

They typically block the anger and sadness aspects of the mourning process. They often cry, but not about painful losses. They may also get angry, but not about past painful events, or the person seen as responsible for the painful events. Their

response to pain is to deny it, to look at the bright side of things and to develop increasingly more severe physical symptoms. Insight therapies might focus on the early frightening experiences as a way of helping them work through the mourning process. Assertiveness training is useful to help deal with confrontations in the present.

Clinical studies indicate that introvert tendencies tend to be stable over long periods of time. People who were shy and socially uncomfortable as children often remain so as adults. Some elements may have been determined genetically, but this type of profile also reflects a childhood characterized by an absence of outward human warmth and physical contact.

The socially extroverted adolescent who has trouble studying because due to frequent socializing and social drifting, often becomes the adult who is constantly trying to be in the middle of social events. This possibly suggests a person whose increased need for social stimulation may be driven by a significant degree of insecurity rather than a need for more intense social experiences.

Therapy for these patients should concentrate on helping them find ways to accept and enjoy their shyness rather than trying to change through desensitization and the unacceptable possibility of exposing themselves to what they may feel as degrading experiences.

For those patients who are more socially mobile, therapeutic interventions should concentrate on helping them accept, reinforce and enhance their self-confidence and structure their socializing so that it doesn't interfere with their responsibilities.

Catharsis and systematic desensitization might help relieve the stored up feelings, which prevent them from engaging pain, while relaxation is useful to help relieve some of their physical symptoms (Marks, P.A., 1987).

Marks, PA. (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	0.01
White Adult Female	0.04

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

11. Conversion Disorder
81. Somatization
23. Social Phobia
40. Schizophreniform Disorder
90. Mood Disorder NOS
300. Anxiety Disorder NOS
4. Dysthymic Disorder

Axis II

301.82 Avoidant Personality Disorder