3-6 Pattern

Clinical Scale Elevations

Scale 3 (Hy)

T-score $\geq$ 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:

> 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)

T-score 3 $\geq$ 75
T-score 9 $\leq$ 60

They are self-satisfied and immature. They are suggestible. They go with the flow. Their many aches and pains reflect much dissatisfaction. They attract attention to themselves through thespian displays whenever they feel distressed.

General Overview

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 predominate and often overrule their thinking. They need is to be appreciated, valued, recognized and loved. This is their “prime directive”.

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 0.66 to 0.80 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) 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 or does, 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 elan and sly misdirection. They are exceptionally private individuals. They conceal many secrets.

T-score 70-79

They are chronically doing a slow burn. The cause of their anger is indecipherable. They twist what others do and say in the telling of their experiences until the truth is unrecognizable. They take their own perceptions and feelings seriously. They have

convinced themselves that others will act with ill will towards them. People shy away from them due to their touchy, rigid, and stubborn natures. They develop long-standing feuds with people closest to them. They are demanding, critical, and controlling when involved in intimate relationships. They are convinced they are being or soon will be unfairly treated.

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 (Pa) 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 specifies such a complex condition as paranoia.

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 notes that Scale 6 measures an exquisite sensitivity to the behavior and opinions held by others, the possibility that concealed suspiciousness is operating behind the scenes, 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 everyone, anything, and 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 it's 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 two colleagues of the writer (Wallace) over the years and fortunately survived their attacks.

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., (1990). Psychiatric symptoms associated with Alzheimer’s disease. Journal of Neuropsychiatry & Clinical Neuroscience 2(1): (28-33).

Maier (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), 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.

Profile Characteristics

Base rates for adolescent males with the 3-6 Pattern on the MMPI-A are 0.60 percent and on the MMPI 0.40 percent. Base rates for adolescent females with the 3-6 Pattern are 1.40 percent and 0.70 percent respectively (Archer, 1997).

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

Marks et al., (1974) reported on 12 adolescents with the 3-6 Pattern. One-third of them was referred for treatment following suicide attempts. They had difficulties keeping friends. They see themselves as being wary, prejudiced, and indifferent to others. Their therapists saw them as suspicious and resentful. Half of the adolescents were substance abusers.

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

Greene (2000) claims the 3-6 Pattern reflects angry, hostile people who have their own reasons for justifying their thinking, feelings, and behavior. Family members are often the targets of their discontent. They think they are all right, but see others as being against them. They are narcissistic, uncooperative, and a pain in the neck.

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

The 3-6 Pattern patients are sensitive to any thing they see as a criticism of them. They have developed a polished self-control to social interactions. They are deeply self-involved. They focus on how they can manage their behavior to influence the behavior of others towards them. Their sophisticated social style conceals a tense, petty, distrustful, and demeaning orientation to others. They demand much of themselves and also of others. They are self-righteous. They use shaming to control others. They are judgmental. They see little that is positive in others. They are not on good terms with intimacy. Their selfish striving for control, prominence, social station, and adoration is bought with ruthless manipulations. Frustration of their demands leads to accusations, usually against males, of harassment, and assault. They blame others when things go wrong, never themselves.

Marks writes patients with this profile are usually extremely fearful of being criticized judged and rejected. They project themselves as conforming, cooperative, conscientious, and socially appropriate while denying any sexual or aggressive impulses. They often were model children. Frequently "teachers pets," and the favorite child of the opposite-sex parent, they experience little, if any, anxiety or self-doubt. It is hypothesized that as children they were subjected to demanding discipline. They learned to try and please others and thereby avoid criticism and judgment.

They also learned to avoid pain by denying it by "putting on a cheerful face." They often have a great deal of pride, which makes it difficult for them to discuss themselves or reveal their feelings.

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

They tend to be positive 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.

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

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.

They also 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, 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 would be 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.

Therapy should concentrate on helping them recognize and express anger and resentment, and be more assertive generally. Insight therapies could help them re-engage some of the painful and humiliating reprimands and punishments of their childhood. If they could unblock their anger and be more assertive they could learn that the feeling and expression of anger does not necessarily lead to overwhelming negative consequences. Therapy should move cautiously to avoid them feeling criticized, judged, or ashamed of their background experiences.

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	0.24
White Adult Males	0.90
White Adolescent Males	0.00
White Adult Females	0.62
White Adolescent Females	0.46
African American Males	0.07
African American Adolescent Males	0.00
African American Adult Females	0.29

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

81. Somatization Disorder
1. Delusional Disorder
44. Bipolar I Disorder, Most Recent Episode Manic, Unspecified
30. Schizophrenia, Paranoid Type

Axis II

301. Paranoid Personality Disorder
50. Histrionic Personality Disorder
301.83 Borderline Personality Disorder