2-3 Pattern

Clinical Scale Elevations

Scale 2 (Dep)

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 depressed, pessimistic, and deeply worried. They feel unworthy and inadequate. They could be silently angry and unable to admit it to themselves. A reactive depression could be present.

Depressive Disorders

Mood is a pervasive, sustained emotion operating in the background of mental life that colors the person's outlook on the world (APA 2000).

American Psychiatric Association (2000). Practice guidelines for the treatment of psychiatric disorders. Washington, D.C.: American Psychiatric Press.

The predominant feature in depressive disorders is a disturbance of mood manifested by a loss of interest in personally valued activities in all cases. The loss of pleasure when the individual anticipated and engaged in these activities eventuates in the collapse of this emotional background. A sense of pain pervades the person's life and all of the activities in which they engage. They cannot adequately put the pain they feel into words.

Physically they loose or gain weight; have sleep disturbances, either sleeping less or more than usual; feel too tired to do engage in everyday activities, and have less of an appetite for intimacy. They feel guilty for no good reason. Thoughts of dying, death and of to taking their own lives come to plague them. Many may have attempted to kill themselves.

Sleep abnormalities occur in ninety percent of persons hospitalized fro treatment of major depressions (APA 2000). People treated in outpatient settings have a 40 to 60 percent chance of experiencing sleep disturbances. Sleep abnormalities persist after recovery from a depressive episode (Thase 1999).

Thase, M.E. (1999) Mood disorders: Neurobiology. In H.I. Kaplan and B.J. Sadock (Eds.), Comprehensive textbook of psychiatry (7^{th} ed., pp. 1318-1327), Vol. I. Philadelphia: Lippincott, Williams & Wilkins.

Ninety seven percent of all cases report a loss of energy. Anxiety occurs in 60 percent of the cases (Zajecka (1995).

Zajecka, J. (1995). Treatment strategies to treating depressions complicated by anxiety disorder. Presented at the U.S. Psychiatric and Mental Health Congress. New York, November 16, 1995.

Thinking, concentration, and memory are impacted. They view themselves as failures in life. They recount their faults and flaws, but do not see their strengths and virtues. They say and say they are terrible persons. A sense of guilt, that has no realistic basis, fills their days. They feel worthless and helpless to change things around in their lives.

They pace about endlessly. They get no rest even when they do nothing at all. They have headaches, backaches, the blahs, constipation, and an all-pervasive sense of discomfort. Activities which once gave them pleasure no longer do so. All looks black to them.

Their health deteriorates. Complicated physical conditions arise. Their ability to work is impaired. Social activities are no longer important to them. A general decline in life activities takes place.

The community base rate for major depression in the United States is 3 to 5 percent. The lifetime risk for depression is 5 to 12 percent for men and 10 to 25 percent for women (Diagnostic and Statistical Manual for Mental Disorders, 4th edition, text revision 2000). Unipolar depression is twice as common I women as in men (Dubovsky and Buzan 1999).

Dubovsky, S.L., and Buzan, R. (1999) Mood Disorders in Hales, R.E., Yudofsky, S.C., & Talbott, J.A. (Eds.) Textbook of psychiatry (pp. 479-566) Washington, D.C.: American Psychiatric Press.

Postpartum depression occurs in 10 percent of mothers. The rates for reported depression in preadolescents are 18 percent (Dubovsky and Buzan 1999). Young people between the ages of 9 to 17 yield a 6 percent rate of depression (Varcaroles, E.M. (1999).

Varcaroles, E.M. (1999) The invisible disease: Depression. National Institute of Mental Health. Washington, D.C.

Depression rates for the elderly living in the community is 3.5 percent; 16 percent for medically hospitalized elderly; 15 to 20 percent for our elderly living in nursing homes; and as high as 40 percent in selected groups of elderly (Dubovsky and Buzan 1999).

Depression is associated with general medical conditions, substance-induced mood disorders following the use of recreational and misuse of prescription drugs, bereavement and reaching the end-of-live.

Medical conditions and syndromes associated with Mood Disorders:

System	Diagnoses
Neurologic	Dementias
	Hydrocephalus
	Huntington's chorea
	Infections, i.e., HIV, neurosyphilis
	Migrains
	Multiple Sclerosis
	Myasthenia Gravis
	Parkinson's disease
	Seizure Disorders
	Stroke
	Trauma
	Tumors
	Vasculitis
	Wilson's Disease
Endocrine	Addison' Disease
	Cushing's Syndrome
	Diabetes Mellitus
	Hyperpapathyroidism
	Hypothyroidism
	Menses-related Depression
	Postpartum Depression
Metabolic/Nutritional	Folate Deficiency
	Hypercalcemia
	Hypocalcaemia
	Hyponatremia
	Pellagra
	Porphyria
	Uremia
	Vitamin B12 Deficiency
Infections/Inflammatory	Influenza
	Hepatitis
	Mononucleosis
	Pneumonia
	Rheumatoid Arthritis
	Sjoegren's Disease

	Systematic Lupus Erythematosus
	Tuberculosis
Mixed	Anemias
	Cardiopulmonary Disease
	Neoplasms
	Sleep Apnea

Mulner, K.K., Florence, T., & Clark, R.R. (1999). Mood and anxiety syndromes in emergency psychiatry. Psychiatric Clinics of North America, 22 (4): 761.

Depressions recur. Sixty percent of those people who have suffered on depressive episode can expect a second episode; seventy percent can expect a third episode; and ninety percent can expect three or more episodes (APA 2000).

Prescription medications associated with Mood Disorders:

Systems	Medication/Substance
Neurologic/Psychiatric	Amantadine
	Anticholinesterases
	Antipsychotics
	Baclofen
	Barbiturates
	Benzodiazepines
	Bromocriptine
	Carbamazepine
	Disulfiram
	Ethosuximide
	Levodopa
	Phenytoin
Antibacterical/Antifungals	Corticosteroids
	Grieseofulvin
	Metronidazole
	Nalidix Acid
	Trimethoprim
Anti-inflamatory/Analgesic	Corticosteroids
	Indomethacin
	Opiates
	Sulindac
Antineoplastic	Asparaginase
	Azothioprine

	Bleomycine
	Hexamethylamine
	Vincristine
	Vinblastine
Cardiovascular	Clonidine
	Digitalis
	Guanethidine
	Methyldopa
	Propanolol
	Resperine
Gastrointestinal	Cimetidine
	Ranitidine
Mixed	Alcohol
	Anxiolytics
	Cocaine
	Heroin
	Marijuana

(Mulner, et al 1999)

Research studies: Franklin et al. (2002) using Taxometric analyses tested directly whether the MMPI-2 depression scales could differentiate 2000 psychiatric patients with depressive symptoms from patients with other disorders. Taxometric analyses did **not** find a MMPI-2 Depression scale cut point that categorizes patients with depressive symptoms form other patients. The findings support the assumption that there is an underlying dimensionality of depression.

Franklin, C. L., Strong, D.R., & Greene, R.L. (2002) A Taxometric analysis of the MMPI-2 Depression Scales. Journal of Personality Assessment, August 79(1), 110-121.

Rohling et al. (2002) examined the effect of depression on neurocognitive performance in patients who passed symptom validity testing. No differences occurred on objective cognitive and psychomotor measures in groups sorted based on their self-reported depression. These data suggest that depression has no impact on objective neurocognitive functioning.

Rohling, M.L., Green, Paul, Allen, L.M. III, & Iverson, G.L. (2002) Depressive Symptoms and neurocognitive test scores in patients passing symptom validity tests. Archives of Clinical Neuropsychology, 7(3), 205-222.

Scale 2 (Dep)

Scale 2 (Dep) measures the presence of clinical depression (Dahlstrom et al. 1972). The MMPI has 60 items. The MMPI-2 has 57 items. Thirty-seven of these items are scored in the false direction, 20 in the true direction. A false response set will elevate Scale 2 (Dep), along with Scale 1 (Hs) and Scale 3 (Hy). Item overlap is: **L (2), F (2), K (8), 1 (10), 3 (13), 4 (7), 5 (2), 6 (2), 7 (13), 8 (10), 9 (5), Sie (8).**

Dahlstrom, W.G., Welsh, G.S., & Dahlstrom, L.E. (1972) An MMPI hand-Book: Vol. 1. Clinical Interpretation (Rev. ed.). Minneapolis: University of Minnesota Press.

Hunsley et al. (1988) provided meta-analytic derived test-retest data for retest intervals of 1 day to 2 years. An average interval consistency of .87 was reported for 74 Scale 2 (Dep) studies. Butcher et al. (1989) reported Scale 2 (Dep) test-retest correlations in the .79 ranges for the MMPI-2.

Hunsley, J., Hanson, R.K., & Parker, C.H.K. (1988) A summary of the reliability and stability of MMPI Scales. Journal of Clinical Psychology, 44, 44-46.

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.

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

Scale 3 (Hy)

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, failure or having their plans thwarted. They have an abiding dread and intolerance of emotional discomfort, pain, or any type of suffering. They harbor a profound fear of emotional and physical pain. Emotion overwhelms thought.
Emotions block access to words. The availability of words to analyze or clearly define emotions is absent. They have no words available to them upon which to anchor and understand 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 in the musculature; pain results. 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.

General Overview

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

A profound fear of emotional and physical pain exists. Emotions overwhelm thinking. Emotions block access to words. They have no words available to them upon which to anchor or understand 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 in the musculature. This produces pain. 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 a limited number of 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.

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. Hysterics view any attempt to move beyond it or remove it, as an attack upon them, and they defend against it with their 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 childhoods. Feelings dominate 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 hysteric finds 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.

Hysteria

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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 .72 to .75 for a one-week interval on the MMPI-1 (Butcher et al. 1989).

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PROFILE CHARACTERISTICS

These patients have symptoms related to long-standing worry, tension, anxiety, depression, self-doubt, apathy, and pent-up over-controlled anger. They feel insecure and distracted (Wallace 2001). Somatic complaints, fatigue, and sleep disturbances are noted. They have little or no interest in having sex.

They cannot express feelings of anger and sadness directly. Indirect expression of anger, resentment, and disappointment take the form of reproaches of significant others failures to care enough for them or how important and wonderful they are. They withdraw their support from those closest to them. They become inert. The duties they once performed fall of other shoulders.

Hysterics are not psychologically minded. They are not interested in examining their lives, behavior, or relationships. They react passively in therapy. They expect other people to fix what is wrong with them. They do not directly confront the deep-seated anger they harbor for all of the disappointments they have experienced.

Marks said that patients with this type of profile chronically experience profound fear of being unwanted and abandoned. They are often afraid to invest in emotional relationships with others where establishing long-term goals are important. They found their feelings suppressed and “number out” after periods of stress in childhood when they had no one to turn. They now will appear aloof, distant, and incapable of engaging in meaningful relationships. Some of them could be superficially charming, in any case.

They will constantly require working on the therapeutic relationship to keep them involved. These patients often do not trust their therapist. Frequently, this is a projection of their own view of the world as a "dog eat dog" place where people play games and don't really care about anyone, but himself or herself.

These patients long for caregivers to give them reassurance that their personal care, needs for acceptance, the requirements they set for their physical care will meet with continuous support. They may chronically perpetuate a fear of bodily harm, physical illness, pain, and death.

An early illness in the patient or patient's family, or an early experience of physical abuse, conditions various overprotective behaviors, which shielded the client from

physical injury by reducing the rate and incidence of motor activity. Their awareness focuses on maintaining their physical-integrity and the availability of medical help.

Approaches most likely to succeed would include gestalt techniques; force the client to engage ongoing feelings in "real life" situations. Dealing with transference on a regular basis is also important. Patients who have this profile may show a positive response if they can re-engage the “numbed out” painful experience of feeling unwanted or emotionally abandoned as children (Marks, P.A., 1987).

The base rate for the 2-3 Pattern in the total aggregate population of 15,361 cases drawn from JACHO accredited hospitals is 2.74 percent. The base rate for white females is 3.49 percent, for white males, it is 0.44 percent.

DSM-IV diagnoses rendered for the 2-3 Pattern are:

Axis I	296.30	Major Depressive Disorder, Recurrent Episode, Unspecified
		Somatization Disorder
	300.10	Adjustment Disorder with Depressed Mood
	22.	Agoraphobia Without History of Panic Disorder
	50.	Bipolar Disorder I, Most Recent Episode Depressed, Unspecified
	302.70	Specified Sexual Dysfunction, NOS
Axis II	301.6	Dependant Personality Disorder
	50.	Histrionic Personality Disorder
	301.82	Avoidant Personality Disorder