2-6 Pattern

Clinical Scale(s) Elevations
Scale

Scale 2 (Dep)

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:

They are worried, pre-occupied with their personal affairs and carry the burden of a private sadness. Sadness is intermingled in most of their activities. They experience the new, unique, and unexpected as barriers they must expend inordinate amounts of energy to overcome. They are sad and unhappy most of the time. They look at the future through wistful eyes, and out of their reach. They are easily discouraged and quickly put off from initiating important plans and activities. 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 (7th 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 is 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, 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,17(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.

Scale(s) 6 (Pa)

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 cool, 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. 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 treated unfairly.

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 a general factor, public self-consciousness, which correlates consistently and significantly with a conviction that they are observed secretly by others.

Fenigstein, A., & Vanable, P.A. (1992). Paranoia and self-consciousness. Journal of Personal and Social Psychology. Jan; 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. (1991). The MMPI-2 /MMPI: An Interpretive Manual. Boston: Allyn and Bacon.

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

Hathaway, S.R. (1980). Scales 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 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. 1987 Jun; 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 1991, p. 163).

Duckworth (1995) is of the opinion that Scale 6 measures sensitivity to the behaviors and opinions of others, the possibility that suspiciousness is present, and the unshakeable 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. Fourth 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 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 an employers' business operation 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. This writer (Wallace) had a colleague shot by a paranoid character many years ago.

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. Third 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.1990, 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. . Fifteen items are scored in the false direction. An “all true” response set elevates Scale 6 (Pa). Item overlap are as follows: **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 .61 to .71 for a retest interval of 1 to 2 days for psychiatric patients and from .59 to .65 for a one-year retest interval for psychiatric patients (Dahlstrom et al. 1975). Butcher et al. (1989) reported similar test-retest correlations for the MMPI-2 with the standardization sample.

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 (MMPI-2): Manual for administration and scoring. Minneapolis: University of Minnesota Press.

PROFILE CHARACTERISTICS

Marks said this type of patients often report feeling trapped, bitter and resentful. They feel like they are in a hopeless situation, which is not of their own choosing. They are resentful about it but whenever they focus on a possible solution they feel vulnerable to attack or criticism. They see their predicament as unfair and unreasonable and respond by withdrawing and by "suffering" and becoming a martyr.

It is likely that adults were quick to reprimand raised them and criticize them no matter how hard they tried to do things right. Their response was to block their anger and turn it inward against themselves. They assumed a passive attitude whenever someone criticized or confronted them with unreasonable demands.

They often experience fear of irretrievable loss of some highly valued physical or emotional object. They tend to respond to this loss by blocking of further needing or "wanting". They find themselves locked in the "despair" phase of the mourning process and are afraid to cry and feel angry. They will need to express anger and "rage at fate" in order to finish the grieving process. Frequently these patients will discuss past losses and present feelings of hopelessness about ever being happy, and they ignore any positive feelings or events that happened to them in the present.

Attempts to reassure these patients about their health and focus them on their psychological problems only increases their fear that they will be overwhelmed by pain with nobody to turn to. A more effective approach would be through desensitization by the patient re-telling the frightening earlier experiences relating to pain and fear of death and thereby diffusing the emotional charge that led the client to overprotect against bodily harm and loss of bodily function.

They may exhibit a history of fear of attack on one's abilities and beliefs, and domination over one's will. If in reality, they had been subjected to varying degrees of attack, criticism, and judgment, it is assumed that the more significant the clinical characteristics of this type of 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 the 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 into the reasons for the criticism, humiliation and unfair treatment also is useful. Engaging their rage at the hurtful treatment they have received energizes them to pursue a goal of becoming whole again.

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 unblock the anger part of the mourning-process, and

on helping them become more assertive and willing to relinquish their martyr role. They are uncomfortable with exploratory therapy. They will view it as possibly intrusive and humiliating (Marks, P.A., 1987).

The base rate for the 2-6 Pattern in the total aggregate population of 15,361 cases which were drawn from 52 JACHO accredited hospitals is 1.12 percent.

DSM-IV diagnoses rendered for the 2-6 Pattern are:

Axis I:	295.30	Schizophrenia, Paranoid Type
	297.1	Delusional Disorder
	296.30	Major Depressive Disorder, Recurrent Episode, Unspecified
	300.4	Dysthymic Disorder
	8.	Alcohol Induced Mood Disorder
	309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood
	300.00	Anxiety Disorder NOS
	296.90	Mood Disorder NOS
Axis II	301.0	Paranoid Personality Disorder
	301.50	Histrionic Personality Disorder
	301.83	Borderline Personality Disorder