3-5 Pattern

Clinical Scale Elevations

Scale 3 (Hy)

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 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.

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.

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. Their many aches and pains reflect much dissatisfaction. They attract attention to themselves through thespian displays whenever they feel distressed.

Clinical Scale Elevations

Scale 3 (Hy)

T-score 3 $\geq$ 75

T-score 9 ≤ 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:

Scale 3 (Hy)

General Overview

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

> 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. 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 the matter is. Most attempts to do so meet with failure and puzzlement. Words associated with painful experiences are reflexively banished from awareness. 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”.

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) 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) 5 (Mf)

Males T-score 60-79

Females T-score <45

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 inquisitive and curious. They are sensitive and imaginative. They take pains to have art and literature in their lives. They are inclined to pursue higher education when the opportunity presents itself. They do not usually enjoy the rough and tumble for it-self alone. They can be adventurous. They seek out the novel, unusual and unexpected. They seek out the companionship of like-minded persons. 8. They tend to look for energetic, take control persons. They do not particularly object to being a follower.

Scale(s) 5 (Mf)

Males T-score >80

Females T-score <45

They are self-effacing. They prefer to influence others employing indirect means. They are concerned for the welfare and happiness of others. They are frightened of expressing their genuine felling and emotions to others. They are drawn to bold, assertive, out-going, domineering partners. They have mastered the art of placating angry people. They are yielding collaborators given the opportunity. They are interested in the management of a domicile, decoration, fashion, art, music, and cultural pursuits. They are capable of taking on other person's burdens as their own. They go out of their way to maintain contacts with people who they consider need them in their lives. Their exertions may not be reciprocated in many instances. They find they attract people who are not willing or capable of returning their kindness, sensitivity, and generosity.

Scale(s) 5 (Mf)

Male T-score <45

He is practical, easy-going, earthy, and interested in sports, hunting, fishing technical employment. His attitudes are typically masculine in nature. He admires physical strength and agility. His humor is basic, course and often vulgar. He keeps a lid of his humorous impulses and is mindful of the company in which he finds himself.

Scale 5 (Mf)

The Terman and Miles (1936) investigations, which commenced in 1922, into the masculine and feminine interest patterns of intellectually superior children, form the basis of the Masculinity/Femininity Scale of the MMPI and MMPI-2. A series of masculinity and femininity tests (M-F test) were developed. "…. the scores tended to be correlated with general masculinity and femininity behavior and to reveal an important line of cleavage in personality and temperament.". (p. 13).

Terman, L. M., & Miles, C. C. (1936). Sex and Personality (2nd Ed.). New York: McGraw-Hill.

Terman observed, "In modern Occidental culture, at least, the typical woman is believed to differ from the typical man in the greater richness and variety of her emotional life and in the extent to which her everyday behavior is emotionally determined. In particular, who is believed to experience in greater degree than the average man the tender emotions, including sympathy, pity, and parental love; to be more given to cherishing and protective behavior of all kinds. Compared to men she is more timid and more readily overcome by fear. She is more religious and at the same times more prone to jealousy, suspicion, and injured feelings. Sexually she is by nature less promiscuous that men, is coy rather than aggressive, and her feelings are less specifically localized in her body. Submissiveness, docility, inferior steadfastness of purpose, and a general lack of aggressiveness reflect her weaker conative tendencies (the ability to stick with a complex and demanding task and see it through

to a successful completion). Her moral life is shaped less by principles that by personal relationships, but thanks to her lack of adventurousness she is much less subject to most types of criminal behavior than men. Her sentiments are more complex than man's and dispose her personality to refinement, gentility, and pre-occupation with the artistic and cultural." (p. 2).

Volentine (1981) investigated femininity interest items on the Bem Sex Role Inventory and Scale 5 of the MMPI. The correlations supported the conclusion that Scale 5 more clearly reflects feminine rather that masculine interest patterns.

Volentine, S. Z., (1981). "The assessment of masculinity and femininity: Scale 5 of the MMPI compared with the BSRI and PAQ". Journal of Clinical Psychology 37, 367-374.

Hathaway and McKinley (1940) developed Scale 5 to identify homosexuals. Items from the Terman and Miles Attitude-Interest Analysis Test (1936) were incorporated into Scale 5 after the data had already been collected from the original normative sample. Dahlstrom (1972) said, "Scale 5 was designed to identify the personality features related to the disorder of male sexual inversion". "Persons with the personality pattern often engage in homoerotic practices as part of their feminine emotional makeup; however, many of these men are too inhibited or full of conflict to make any overt expression of their sexual preference. (p. 201).

Hathaway, S. R., (1956). "Scale 5 (Masculinity/Femininity), 6 (Paranoia), and 8 (Schizophrenia)" In G. S. Welsh & W. G. Dahlstrom (Eds.), Basic readings on the MMPI in psychology and medicine (pp. 104-111). Minneapolis: University of Minnesota Press.

Dahlstrom, W. G., Welsh, G. S., & Dahlstrom, L. E., (1972). "An MMPI Handbook: Vol. I. Clinical interpretation" (Rev. Ed.) Minneapolis: University of Minnesota Press.

Terman and Miles (1936) concluded," It (the M-F test) does not measure homosexuality, as that term is commonly used, but it does measure, roughly, (the) degree of inversion of the sex temperament…" (p. 467). "…. a serious limitation to the present usefulness of the (M-F) test lies in the fact that as yet too little is known about the behavior correlated with high and low scores". (p. 9). This appears to be true to this day. "Most empathic warning is necessary against the assumption that an extremely feminine score for males or an extremely masculine score for females can serve as an adequate basis for the diagnosis of homosexuality, either overt or latent". (p. 9). "…. probably a majority of subjects who test as variates in the direction of the opposite sex are capable of making a perfectly normal heterosexual adjustment." (p. 9).

Hathaway and McKinley (1956) concluded that Scale 5 did not identify homosexuals. Wong (1984) stated that subsequent attempts to construct independent scales to identify homosexuals have met a similar fate.

Foerstner (1946) investigated the bipolar construction of Scale 5 in a series of extensive examinations of large psychiatric in- and outpatient populations. The MMPI subtests developed by Harris and Lingoes (1955), Serkownek's 1975 in Schwerger (1987), Weiner (1948), and Wiggins (1966) were factor analyzed. Friedman, et al, (2001) commented, "It is clear from the data reported in Foerstner's (1984) study that Scale 5 (and Scale 0) is multifactorial in nature; therefore, its composition is not limited to masculine-feminine factors. Scale 5 scores, whether high or low, may be achieved by item endorsements of any of the combination of at least 6 factors" (Wong 1984).

Foerstner, S. B., (1984). "The factor structure and stability of selected Minnesota Multiphasic Personality Inventory subscales: Harris and Lingoes subscales, Wiggins's content scales, Weiner subscales, and Serkownek subscales". Doctoral dissertation. University of Akron, Ohio.

Harris, R. E., & Lingoes, J. C., (1955). "Subscales for the MMPI: An aide to profile interpretation". Department of Psychiatry. University of California.

Serkownek, K., (1975). "Subscales for Scales 5 and 0 of the MMPI". Unpublished manuscript.

Schwerger, J. M., Foerstner, S. B., Serkownek, K., & Ritz, G., (1987). "History and validities of the Serkownek subscales for MMPI Scales 5 and 0". Psychological Reports 61, 227-235.

Weiner, J. S., (1948). "Subtle and obvious keys for the MMPI". Journal of Consulting Psychology 12, 164-170.

Wiggins, J. S., (1966). Substantive dimensions of self-report in the MMPI item pool. Psychological Monographs 80, (22, Whole No. 630).

Wong, M. R., (1984). MMPI Scale 5 meaning or lack thereof. Journal of Personality Assessment 48, 279-284.

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

Kunce and Anderson (1984) think normal men who have high Scale 5 scores entertain many interests and are tolerant of diversity. Low Scale 5 score in normal men may reflect assertiveness, a need for physical activity, competitiveness, enthusiasm for sports, and little interest in revealing much about themselves. Normal females who score high on Scale 5 may be seen as confident, energetic, and in control of their lives. Low Scale 5 scores for normal females suggest an acceptance of the attitudes and interests of a typically feminine person as defined by the current cultural milieu.

Kunce, J., & Anderson, W., (1984). “Perspectives on uses of the MMPI in psychiatric settings” In P. McReynolds & G. T. Chelvne (Eds.) Advances in psychological assessment (Vol.6, pp. 41-76.

Wallace (2001) suggests the psychiatric male population with high Scale 4 combined with low Scale 5 scores are seen a vigorously seeking out opportunities for narcissistic masculine self-indulgence. These men use other people to satisfy their urges. They are indifferent to the impact their behavior has upon others. Female psychiatric populations who have high Scale 4 and low Scale 5 scores suggest angry hostile females who are provocative troublemakers. They twist what is said to them to the point that the original message is unrecognizable. This maneuver puts the recipient of her retorts off balance and more easily confused and manipulated. They use guilt to dominate those relationships they find useful to achieving their own interests and goals. They have little to no capacity for empathy.

Wallace, J. L. (2001). “A Clinician’s Guide to Minnesota Multiphasic Personality Inventory Interpretation” Ex Libris.

Twenty-three of the Scale 5 (Mf) items are from the item pool of Terman and Miles work Sex and Personality (1936). Thirty-seven items are from the MMPI pool. The MMPI-2 has 56 items for Scale 5 (Mf). Scale 5 (Mf) measures masculinity/femininity attitudes. High Scale 5 (Mf) scores reflect feminine attitudes in males. Low Scale 5 (Mf) scores indicate feminine attitudes with females. Twenty-five of the MMPI-2 Scale 5 (Mf) items are scored in the true direction and 31 are scored in the false direction for men. Twenty-three of Scale 5 (Mf) items are scored in the true direction for females and 33 items are scored in the false direction. Scale 5 (Mf) norms are formed from linear Tscores instead of the Uniform Tscores utilized in the norming of the MMPI-2. Test-retest correlations on Scale 5 (Mf) run from 0.79 to 0.83 for 1 to 2 day intervals with psychiatric patients, 0.79 to 0.79 for a 1 to 2 week interval for psychiatric patients and 0.72 for 1 to 2 week intervals with college students (Dahlstrom 1975). Item overlap is: L (1), F (2), K (3), 1 (0), 2 (2), 3 (4), 4 (3), 6 (2), 7 (1), 8 (4), 9 (3), Sie (9).

Dahlstrom, W. G., Welsh, G. S., & Dahlstrom, L. E., (1975). “An MMPI Handbook”: Vol. II. Research applications. (Rev. Ed.) Minneapolis: University of Minnesota Press.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 3-5 Pattern on the MMPI-A are 1.00 percent and on the MMPI 3.30* percent. Base rates for adolescent females with the 3-5 Pattern are 3.00* percent and 0.70 percent respectively (Archer, 1997).

Marks found males predominated in the 3-5 adolescent Pattern. They came from morally rigid homes where punishment for even minor infractions was predictable. Therapists noted their depressions, emotional shallowness, sincerity, idealism, and "queerness". Therapists also see them as shy, insecure, and in need of affirmation. The 3-5 Pattern adolescent engage in a lot of daydreaming and fantasy. They control their impulses. The majority does not use drugs. Some did, however. Their suicide attempts were unsuccessful. Nearly half had problems with maintaining a correct weight. A few of the 3-5 Pattern adolescents' behavior could only be described as bizarre (Marks et al., 1974).

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

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

The 3-5 Pattern for adults is rarely found in both female and male populations. Nelson and Marks (1985) studied a non-clinical group of 726 volunteer subjects engaged in a career evaluation program. Ninety-two percent were college graduates. Twenty-three subjects generated a 3-5 Pattern. They describe themselves as getting along well with others. They liked to go to movies, concerts and other forms of entertainment alone. They viewed themselves as pleasant, sparkling, yet hard-hearted. They saw themselves as straight forward, but not approachable. They chose to be inner-directed isolated people, distant, and are often ill mannered. They are inclined to be officious and authoritative.

Nelson, L. D., & Marks, P. A., (1985). "Empirical Correlates of Infrequently Occurring MMPI Code Types". Journal of Clinical Psychology 41, 477-482.

Tanner (1990) reports on 10 3-5 Pattern cases in psychotherapy. They started therapy by being pleasant and positive, but quickly became demanding, immature, and manipulative. They complained of low back pain, headaches, impotency (8males), and job dissatisfaction. They also had outstanding job connected disability claims.

Tanner, B. A., (1990). "Composite descriptions associated with rare MMPI two-point code types: Codes that involve Scale 5". Journal of Clinical Psychology 46, 425-431.

Marks commented on treatment for female 3-5 Pattern patients that they typically suffer from fear of psychological or emotional pain. They need to be liked. They 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. They 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.

Female patients with this profile complain of fatigue and exhaustion. They 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.

It is likely that these patients are experiencing disturbances in role functioning such as gender identity issues and not one's sexual preference. The stronger the role dissatisfaction, the more the individual identifies with values, interests and behaviors stereotypic of the opposite sex.

For women, this suggests a close girl-father (or male surrogate) childhood relationship, with the girl playing with boys, being a "tomboy," and participating in activities traditionally confined mostly to boys. The girl-mother (or female surrogate) relationship in this instance is assumed to have been less close, present or intense. There may also be a genetic component to this type of role scenario.

Women with this type of profile tend to have been independent, practical and adventuresome as girls.

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

Marks write that male patients also typically suffer from fear of psychological or emotional pain. They need to be liked. They 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. They 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. They 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.

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It is likely that these patients are experiencing disturbances in role functioning such as gender identity issues and not one's sexual preference. The stronger the role dissatisfaction, the more the individual identifies with values, interests and behaviors stereotypic of the opposite sex. For men, this may suggest a close boy-mother (or female surrogate) childhood relationship in which the mother would confide in the boy and discourage displays of "masculine" aggression.

The boy-father (or male surrogate) relationship is assumed to have been less close, intense or present. There may also be a genetic component to such role instability. Male patients tend to have been non-aggressive and sensitive as boys.

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

Marks, P.. (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	0.33
White Adolescent Males	0.00
White Adult Females	0.81
White Adolescent Females	0.00
African American Males	0.23
African American Adolescent Males	0.00
African American Adult Females	0.17

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

9. Diagnosis Deferred

Axis II

799.9 Diagnosis Deferred