3-7 Pattern

Clinical Scale Elevations

Scale 3 (Hy)

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

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

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

Scale 3 (Hy)

T-score $\geq$ 75

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

Scale 3 (Hy)

General Overview

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

> They have a profound fear of emotional and physical pain. Emotions easily overwhelm their thinking easily. They cannot portray or analyze their emotions in words. They have no words available to them upon which to anchor their feelings. Visual rather than verbal awareness dominates their mental life. They cannot accurately put their feelings and ideas into words easily. This inability to tell others what is bothering them forces other people to guess what the matter is. 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 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.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 3-7 Pattern on the MMPI-A are 0.00 percent and on the MMPI * percent. Base rates for adolescent females with the 3-7 Pattern are 0.40 percent and * percent respectively (Archer, 1997).

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

The adolescent 3-7 Pattern is rarely encountered. No descriptors are listed.

The adult 3-7 Pattern reflects tension, anxiety, and the development of physical symptoms. Depression, insomnia, phobias, and fear are also noted (Greene, 2000).

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

These people are not psychologically minded. They fail to integrate other peoples’ opinions about how they think and feel. They are troubled over their need to rely upon stronger persons to provide them to approve of them. These people fear they will drive away people with the concealed anger they harbor. They employ clever ploys to get others to treat them they way they want. They shun confrontations. They are pleasers. They are not self-starters or bold entrepreneurs.

Marks write that patients with this profile at upper elevations are "worriers" who think ahead to all possible eventualities and try to anticipate them. If they have a number of responsibilities then they are quick to feel guilty unless all responsibilities are taken care of well in advance. They also wish to be liked, to avoid people being angry with them, and to have others approve of them. They dislike confrontation and will deny anger or resentment towards others, rather than risk the discomfort of their own negative feelings.

They are prone to developing somatic symptoms under stress. Their responsibilities are most important to them and precipitating circumstances of referral often will center on some anticipated angry confrontations, or a threat to their emotional or financial security. It is likely that their fear of anger and unpredictable events stems from a childhood in which one of their parents, or a sibling or peer, was periodically explosive and rejecting towards them. The unforeseeable anger was so frightening that they learned to over-protect against it by thinking ahead for possible eventualities in order to anticipate and avoid them.

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.

They 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.

Additional clinical characteristics of this profile include a profound fear of unpredictable frightening events. It is likely that this type of patients were at an early age teased and humiliated, or experienced some unpredictable and catastrophic event which led them to over-protect against unanticipated future events by thinking ahead and worrying. Worrying is seen as trying to predict the future by thinking ahead of all possible eventualities.

These clients are very amenable to standard behavioral therapy procedures. Relaxation and thought stopping are particularly useful. Assertiveness training, and helping the patient role-play being assertive and express anger would also be useful. Implosion techniques in conjunction with insight therapy can be particularly useful as can desensitization to the originally unpredictable and frightening experiences.

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, 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	0.70
White Adult Males	0.09
White Adolescent Males	0.15
White Adult Females	0.07
White Adolescent Females	0.00
African American Males	0.07
African American Adolescent Males	0.00
African American Adult Females	0.00

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

2. Generalized Anxiety Disorder
81. Somatization Disorder
6. Depersonalization Disorder

Axis II

799.9 Diagnosis Deferred on Axis II