

3-8 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)

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)

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 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 shoulders 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) 8 (Sc)

T-score >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:

They get little satisfaction from the company of others. They prefer to live in a fantasy world of their own creation. Fantasy provides them with the satisfactions they cannot get from living in a world most people occupy. Their thinking can be original, but when expressed makes others just a little uncomfortable. They find it hard to get people to understand them. Their thinking rapidly becomes disorganized and fragmented when they find themselves under pressure to perform tasks, which they find, are beyond their ability to deal with effectively. They exist with a compromised capacity to meet social and economic demands. They live isolated, lonely lives. They find solace and comfort in alcohol and drugs of pleasure.

Schizophrenia

Wallace (2001) describes the most prominent or obvious feature of schizophrenic disturbance is incoherent, illogical, or inappropriate abstract thinking. Incoherent thinking involves a disruption in the sequence of thoughts so that one thought does not flow continuously, coherently, and meaningfully from another. They lose track of what they are saying. They may express a series of loosely related ideas that is difficult to follow.

Wallace, J. L., (2001). "A Clinicians Guide to Minnesota Multiphasic Personality Inventory Interpretation". Ex Libris.

Schizophrenics, report they feel misunderstood, punished for no reason they can remember, and plotted against by persons who do not have their best interests at heart. They pull back from any person or situation they see as challenging them personally. They have few or no friends. Their social skills are not well developed. They relate in a clumsy and rigid way to others. They have little flexibility responding to others wishes, needs, or expectations. They are easily frightened. Nichols and Greene (1995) note the schizophrenics' emotional disengagement reveals, "...pathological disengagement from life that discounts future interests, prospects, and engagement to the extent that they can no longer serve as incentives for continuing to live" (p. 29).

Nichols, D. S., & Greene, R. L. (1995). "MMPI-2 structural summary: Interpretive manual". Odessa, FL.: Psychological Assessment Resources.

Schizophrenics tell of their difficulties thinking straight. Schizophrenics are plagued with problems of attention, concentration, remembering, and arriving at a correct solution. They cannot formulate reasonable goals. They lack the intellectual energy required to plan, direct, correct processing errors, and rousing themselves to meet the occasions reflected in their goals.

Schizophrenics fear they will lose their minds. They cower at the prospect of suddenly finding they do not know who they are, the dying of their own self. They are at times restless, thin-skinned, and ultra sensitive to any think they construe as a reference to themselves. They can react violently to a perceived slight, threat, or insult.

Illogical thinking consists of reaching unreasonable conclusions based upon circumstantial evidence. Thinking at inappropriate levels of abstraction, is characteristic of person with schizophrenia. Schizophrenic people use words in an overly concrete or literal manner.

Perceptual distortions result in poor judgment. They cannot assess their experience realistically. They act in odd or queer ways. The lives of schizophrenic people are dotted with such instances of poor judgment, which stems from unrealistic assessment of a situation, and of themselves, or of the consequences of their actions. The disordered thinking and inaccurate perception of schizophrenic people often cause them to overlook or misjudge the feelings, motives, and actions of others.

They behave in ways that others find insensitive, self-centered, contentious, presumptuous, and suspicious or in some other way objectionable. Their poor social skills make it difficult for them to make or keep friends, even when they try. They frequently withdraw physically and become social isolates in their both work and recreation. They avoid situations that can bring them into close contact with others.

Many withdraw emotionally while placing themselves physically in close proximity to others. Public events sometimes help schizophrenics preserve the fiction that they are meaningfully involved with others. Even when mingling with other people, they maintain a psychological distance by keeping their thoughts and feelings to themselves and interacting only on a formal, impersonal level.

Schizophrenic persons are frequently unable to prevent anxiety-provoking and socially unacceptable ideas from occupying their minds. Uncontrollable aggressive and sexual fantasies and constant concern about terrible events they might cause or suffer from are particularly likely to make the schizophrenics existence a waking nightmare.

Schizophrenics are consequently subject to severe bouts of anxiety and self-disgust. They have difficulty distinguishing between their dreams and waking reality. Schizophrenics also suffer from poor integration of their feelings and thoughts. They may show blunted affect with little or no emotional response to any situations, or such inappropriate affect as giggling while relating a violently aggressive fantasy or crying while describing how good they feel.

Schizophrenics may be unable to prevent and control their aggressive and sexual ideas. When several of these impairments occur together and persist over any length of time, schizophrenia is present.

A prominent mood disorder coexists alongside a schizophrenia is present in schizoaffective disorders. Subtypes include affective bipolar and depressive types.

Schizophrenia, which exists along with grossly disorganized behavior, incoherence, marked loosening of associations; flat emotionally and grossly inappropriate affect is associated with disorganized schizophrenia.

Schizophrenia exists along with a preoccupation with systemized delusions, auditory hallucinations, argumentativeness, and possibility for violence and over-wearing suspiciousness is associated with paranoid schizophrenia.

Schizophrenia manifested by many or all of its variations including prominent delusions, hallucinations, incoherence, and grossly disorganized behaviors is associated with undifferentiated schizophrenia.

The DSM-IV-TR (2000) list the diagnostic criteria for schizophrenia as:

- A. **Characteristic Symptoms.** Two or more of the following during a one-month period (or less if successfully treated): **Delusions, hallucinations,** and disorganized speech (loosening of associations), grossly disorganized behavior or catatonic (with extreme motor retardation or extreme motor agitation), negative symptoms (e.g., emotional blunting, loss of interest in things and activities, inability to experience happiness).
If bizarre delusions or auditory hallucinations **and** a. voices keep a running commentary about the person's thoughts and behaviors **or** b. two or more voices converse with each other **then** only one criterion is needed.
- B. **Social/Occupational Dysfunction.** **If** one or more major areas of the person's life are markedly below premorbid functioning (work, interpersonal relations or self-care) **or if** childhood or adolescence failure to achieve expected levels of interpersonal, academic, or occupational achievement **then meets** the **B** criteria.
- C. **Duration.** Continuous signs persist for at least six months with at least one month that meets the **A** criteria (Active Phase) and may include prodromal (early warning signs) or residual symptoms.
- D. **Rule out all other mental diseases** (e.g., schizoaffective/mood disorders) **All other medical conditions** (substance use/medications or general medical conditions) have been ruled out. **If a history of pervasive developmental disorders exists** then prominent, hallucinations or delusions for one month are needed to make the diagnosis of schizophrenia.

Diagnostic and Statistical Manual of Mental Disorders, Text Revision (2000) (4th Ed): American Psychiatric Association.

Schizophrenia is a psychotic disorder, which encompasses delusions, hallucinations, and disorganized behavior and speech (DSM-IV-TR 2000, p. 297).

The symptoms of schizophrenia are classified further as positive, negative, cognitive, and disorganized. **Positive** symptoms are delusions, hallucinations, paranoia, and bizarre behavior. These symptoms have been historically the major focus of treatment. **Negative** symptoms are apathy, loss of pleasure, disordered thought, and the loss of

interest in engaging in vital life activities. These negative symptoms are the most crippling. **Cognitive** symptoms refer to deficits in attention, concentration, memory, decision-making, and problem solving. Anderson et al. (1998) think cognitive symptoms are the principle disabilities associated with schizophrenia. **Disorganized** symptoms signify the degree of disorganization of affect or behavior.

Anderson, C., Chakos, M., Mailman, R., & Lieberman, J. (1998) Emerging roles for novel antipsychotic medications in the treatment of schizophrenia. *Psychiatric Clinics of North America* 21(1), 151-179.

Lishman (1998) writes, "The acute organic reactions are called forth by a great number of different pathological processes affecting the brain..." (p. 9). A host of misfortunes follow-on brain insults, i.e., fragmentation of attention, thinking, and purposive reality based action, diminution of the powers of memory, and failures of judgment (p. 9-13).

Acute and chronic central nervous system conditions lead to psychotic reactions. Schizophrenia is one diagnostic possibility, which present with manifold symptoms. Head injuries at times lead to schizophrenic conditions. "All forms of schizophrenia have been reported after head injury..." (p. 190). "Paranoid forms are reported to be especially common..." (p. 190). Ach e et al. (1969) followed 3552 head injured Finnish WW II soldiers for over 20 years. Ninety-two of these cases developed schizophrenic-like symptoms (2.6 percent).

Ach e, K. A., Hillbom, E., & Aalberg, V. (1969). Psychoses following war brain injuries. *Acta Psychiatrica Scandinavica* 45, 1-18.

Ach e found that mild brain injuries produced schizophrenia more frequently than did severe brain injuries. Whether or not other precipitating factors, such as familial histories of schizophrenia, added to the vulnerability to develop schizophrenia after head injuries is not clear. Lishman (1998), p. 190, writes, "... the early onset of the psychosis (is) related to (the) severity of diffuse brain injury, and a possible special association with temporal lobe damage". Ach e reported 2.1 percent of the group of brain injured Finnish WW II soldiers he studied were diagnoses with paranoid conditions.

Tumors of the temporal lobe are associated with schizophrenia. This is a rare occurrence, but greater than the occurrence in the general population. Pituitary tumors are also associated with the development of schizophrenia (Davison and Bagley (1969).

Davison, K., & Bagley, C. R., (1969). "Schizophrenia-like psychoses associated with organic disorders of the central nervous system: a review of the literature" In *Current Problems in Neuropsychiatry*.

Herrington, R. N. (Ed.), (1958). *British Journal of Psychiatry Special Publication No.4: Headly Brothers: Ashford, Kent.*

Mendez et al., (1993) reports the excessive occurrence of schizophrenia with epilepsy. Interictal schizophrenia disorders occurred in 9.25 percent of 1611 epileptic patients. Complex partial seizures are associated with epilepsy and simultaneously occurring schizophrenia.

Mendez, M. F., Grau, R., Doss, R. C., & Taylor, J. L., ((1993). Schizophrenia in epilepsy: seizure and psychoses variables. *Neurology* 43, (1073-1077).

Slater et al., (1963) systematically collected 69 patients with unequivocal evidence of epilepsy that subsequently developed schizophrenia. The majority of these patients, 80 percent, experienced an insidious onset of symptoms with delusions as the first manifestation. Paranoid symptoms were present in the majority or the cases. Delusions were present in nearly all cases. Auditory hallucinations occurred in nearly half of the cases. Visual hallucinations were present in 16 percent of the cases. Thought disorders occurred in half of the patients.

Slater interpreted the changes observed in the epileptic schizophrenia patients as organic personality changes manifested by lack of spontaneity, dullness, (mental) retardation, concrete thinking, and memory deficits. The epileptic foci were in the temporal lobe in two-thirds of the cases.

Slater, E., Beard, A. W., & Glithero, E., (1963). "The schizophrenic-like disorders of epilepsy". *British Journal of Psychiatry* 109, 95-150.

Schizophrenic-like disorders are also associated with cannabis intoxication, general paresis, Huntington's disease, hyperthyroidism, hypothyroidism, narcolepsy, systemic lupus erythematosus, Wilson's disease, Korsakoff's Syndrome, multiple sclerosis, stroke, uremia, among other physical conditions Lishman (1998).

Lishman, W. A., (1998). *Organic Psychiatry: The Psychological Consequences of Cerebral Disorder*. London: Blackwell Science Ltd.

The causes of schizophrenia are unclear. Schizophrenia has multiple interrelated etiologies, i.e., biological, genetic, and developmental abnormalities of the brain (Varcarolis 2002, p. 525).

Varcarolis, E. M., (2002). "Foundations of psychiatric mental health nursing: a clinical approach" 4th edition. Philadelphia: W. B. Saunders Company.

A long list of chemical neurotransmitters has been identified, which are thought to be involved in the production of schizophrenic disorders. Dopamine, norepinephrine, serotonin, glutamate, GABA, and neuropeptides are among the many biochemical substances associated with the development of schizophrenia.

Genetic investigations with identical twins reveal a 45 percent chance of one twin developing a schizophrenic disorder if the other twin is so affected. If one twin has an

autistic spectrum disorder, the other twin stands a 60 percent chance of developing impairments of communication and deficits in social interaction, i.e., Asperger's Syndrome. Some twins do not develop these disorders, however. Genetic causation is only a partial answer to the conundrum of the causation of the schizophrenic disorders (Hyman 2003, p. 99).

Hyman, S. E., (2003). "Diagnosing disorders. Special issue: Better Brains". Scientific American 289(3), (96-103).

Jones and Cannon (1998) noted if one parent were schizophrenic, 12 percent of the children would become schizophrenic. If both parents are schizophrenic, 46 percent of the children will be also.

Jones, P., & Cannon, M., (1998). "The new epidemiology of schizophrenia". Psychiatric Clinics of North America 12(1): 1-25.

Neuroimaging studies of individuals diagnosed with schizophrenia provide evidence of enlargement of the lateral ventricles, atrophy of the frontal lobes and the cortex in general as well as atrophy of the cerebellum, enlargement of the third ventricle and asymmetry of one or both ventricles (Kaplan and Shadock 1995).

Kaplan, H. I., & Shadock, B. J., (1995). Synopsis of psychiatry, 6th ed. Baltimore: Williams & Wilkins.

Thompson et al., (2001) found significant anatomical changes in brains of schizophrenic adolescents between the ages of 13 and 18 where a marked loss of gray matter in the cerebral cortex was demonstrated. This loss increased as the cellular losses progressed, spreading to other areas of the brain. These anatomical abnormalities were synchronous with the severity of the development of the psychotic symptoms and impairments produced by these diseases.

Thompson, P. M., Vidal, C., Giedd, J. N., Gochman, P., Blumenthal, J., Nicolson, R., Toga, A., & Rapoport, J. L. (2001). Proceedings of the National Academy of Sciences USA 98(20), (11650-11655).

Scale 8 on the MMPI and MMPI-2 contains 78 items. These Scale 8 items overlap with 11 other scales: **F (15), K (1), 1 (2), 2 (10), 3 (8), 4 (6), 5 (4), 6 (13), 7 (17), 9 (11), and Scale 0 (6)**. It is not readily apparent with elevations on Scale 8 just which symptoms would be observed in any one patient who may or may not be diagnosed with schizophrenia. All of the K scale items answered in the deviant direction is added to the Scale 8 raw score. Any 20 Scale 8 items endorsed in the deviant direction are needed to produce a Tscore of 65 when the client has an average score on the K scale (Greene 2000).

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

The K scale was developed to improve the hit rate of Scale 8 (Dahlstrom and Dahlstrom 1980). This results in the increase in the Scale 8 relative to the standardization group. This piggy backing on the norms group's data permitted the criterion group's data to be mounted above the normative group's score elevations in order to make Scale 8 elevations more prominent. Cross validation, studies were able to correctly identify no more than 60 percent of the total number of schizophrenics studied. Hathaway (1980) reported that a considerable number of cases in 91 cross validation studies scored below a Tscore of 61 on Scale 8. Friedman et al. (2001) concluded, "A diagnostic conclusion of schizophrenia cannot be made solely on the basis of a Scale 8 elevation" (p. 132). Butcher and Williams (1992) are of the opinion that Scale 8 clinical elevations can be due to severe depression, severe personality disorders, a 'rebel without a cause' attitude, sensory deficits, or a "cry-for-help". Anderson and Kuncce (1984) found high scoring Scale 8 college students, who suffered from social isolation, loneliness, and the inability to engage with others, were not schizophrenic.

Psychiatric settings yielding similar MMPI scores lead to different interpretations than those gotten in non-psychiatric settings. Greene (2000) investigated MMPI data collected on psychiatric inpatients and out patients. The most frequent code pattern for men was 8-6, for women the 4-8, 8-4, and 8-6 code patterns were prominent. Psychiatric diagnoses were wide ranging. There is no assurance that Scale 8 elevations are associated exclusively with schizophrenic disorders.

Hathaway, S. R., (1980). "Scale 5 (Masculinity-Femininity), 6 (Paranoia), and 8 (Schizophrenia)". In W. G. Dahlstrom & L. Dahlstrom (Eds.), (1980). *Basic reading in the MMPI: A new selection on personality measurement* (pp. 65-75). Minneapolis: University of Minnesota Press.

Greene, R. L. (1991). *The MMPI-MMPI-2: An interpretive manual*. Boston: Allyn & Bacon.

Friedman, A. F., Lewak, R., Nichols, D. S., & Webb, J., (2001). "Psychological Assessment with the MMPI-2", *Essentials of MMPI-2 and MMPI-A interpretation*. Minneapolis: University of Minnesota Press.

Anderson, W. P. & Kuncce, J. T., (1984). "Diagnostic implications of markedly elevated MMPI Sc (Scale 8) scores for non-hospitalized clients". *Journal of Clinical Psychology* 40, 925-930.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 3-8 Pattern on the MMPI-A are 0.10 percent and on the MMPI 0.00 percent. Base rates for adolescent females with the 3-8 Pattern are 0.70 percent and 0.50 percent respectively (Archer, 1997).

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

The 3-8 adolescent Pattern is rarely encountered. No descriptors are listed.

The 3-8 adult Pattern prefigures patients who are experiencing significant distress. They are viewed as strange and peculiar. Their social skills are not of the best. They often behave in an immature manner. They are angry and tense. They are displeased with their inability to think clearly. They often present with bizarre physical complaints. Depression is a prominent feature of the 3-8 Pattern. These people do not solve everyday problems easily. Therapists report they are evasive, unoriginal in their approach to problem solving, apathetic, uninvolved in social gatherings, and reluctant to respond to any sort of direction (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

The adult with the 3-8 Pattern finds it hard to carry on a conversation. Their distractibility leads to topical gaps in the conversation. These interruptions in continuity lose the meaning of the message. Misunderstandings follow. Confusions over missing the point of a conversation cause emotions to flare up, further disrupting communications. The 3-8 Pattern adult entertains peculiar preoccupations frequently involving religious and erotic themes. They also fear great many things.

Marks say 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.

It is likely that patients with this profile had a childhood characterized by being despised and rejected by a person upon whom life and security depended. Perhaps in some instances the child expressed some peculiar habit or eccentricities or was handicapped in some way, which led others to express anger, hatred and resentment towards the child. A child would self-protect by "shutting down" cognitively and emotionally which would lead in turn to impairments in cognitive and emotional functioning.

Therapy with these patients should concentrate on helping them feel comfortable at the moment. Moving into uncovering therapy too quickly is highly disorganizing to these patients, and change should be avoided. Achieving insight often leads these patients to feeling even more alien and defective. They are very sensitive to hostility and will require a consistent, warm, interactive and positive therapeutic relationship.

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. A. (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 | 0.27 | |
| White Adult Males | 0.13 | |
| White Adolescent Males | 0.15 | |
| White Adult Females | 0.55 | |
| White Adolescent Females | 0.00 | |
| African American Males | | 0.17 |
| 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

- 10. Schizophrenia, Disorganized Type
- 60. Schizophrenia, Residual Type
- 90. Schizophrenia, Undifferentiated Type
- 40. Bipolar I Disorder, Most Recent Episode Manic, Unspecified
- 14. Somatization Disorder
- 30. Major Depressive Disorder, Recurrent Episode, Unspecified
- 1. Delusional Disorder
- 3. Obsessive-Compulsive Disorder
- 90. Mood Disorder NOS
- 300. Anxiety Disorder NOS

Axis II

- 22. Schizotypal Personality Disorder
- 20. Schizoid Personality Disorder
- 301.82 Avoidant Personality Disorder

