6-0 Pattern

Clinical Scale Elevations

Scale(s) 6 (Pa)

T-score # 65

All other scales # 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 exquisitely sensitive to the moods and emotions of others. They are adept at responding in tandem to the 'whatever' the other person, with whom they are speaking, says or does, following each changing nuisance as if it was a fleeting shadow dogging the conversation. Their skillful maneuvering conceals their artful control of the other person's initiatives. They keep their opinions, plans, and goals to themselves. They carry many secrets. They deflect any inquiries into their private lives with elan and sly misdirection. They are exceptionally private individuals. They conceal many secrets.

Scale(s) 6 (Pa)

T-score ≥ 66-75

They are cold, 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.

Scale 6 (Pa)

T-score 76-79

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 unfairly treated.

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.

Research Findings. Fenigstein and Vanable (1992) identified public self-consciousness as a general factor consistently and significantly correlated with a heightened sense of being observed.

Fenigstein, A., & Vanable, P. A., (1992). "Paranoia and self-consciousness". Journal of Personal and Social Psychology 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., (2000). The MMPI-2 /MMPI: An Interpretive Manual (2nd Ed.). Boston: Allyn and Bacon.

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

Hathaway, S. R., (1980). "Scale 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 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, 2000).

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

Duckworth and Anderson (1995) is of the opinion that Scale 6 measures sensitivity to the behavior and opinions of others, the possibility that suspiciousness is present, and the unshakable 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. 4th 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. They 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 employers’ business operations 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. A colleague of the writer was shot in their office by a paranoid character many years ago. The colleague survived.

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”. 3rd 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 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. An "all true" response set will elevate the Scale 6 (Pa) profile. Item overlap is: **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 0.61 to 0.71 for an interval of 1 to 2 days for psychiatric patients and between 0.59 to 0.65 for and interval of one year for psychiatric patients (Dahlstrom et al. 1975). Butcher et al., (1989) reported similar test-retest correlations for the MMPI-2 norm group.

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

Scale(s) 0 (Sie)

T-score >70

They prefer their own company to that of others. Confrontations with other people force them to withdraw. They are generally fearful of people they do not know well. Trust builds slowly, if at all, for them. They are shy people who do not seek out or like the limelight. They prefer to work alone. They will not go to public events or attend public meetings if given the opportunity. They are unusually quiet persons. They can stand long silences and may even like it. They find it hard to start a conversation even with

people they know well. They dress conservatively. They do not like to attract attention to themselves.

Base rates for adolescent males with the 6-0 Pattern on the MMPI-A are 0.30 percent and on the MMPI 0.10 percent. Base rates for adolescent females with the 6-0 Pattern are 0.30 percent and 0.10 percent respectively (Archer, 1997).

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

Neither Archer, (1997) nor Marks et al., (1974) list descriptors for the adolescent 6-0 Pattern.

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

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

Adults with the 6-0 Pattern are shy, bashful, and quick to be embarrassed. They are not aggressive, avoid confrontations, and keep a low profile socially. They are pleasant people (Greene, 2000).

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

Tanner (1990) reports on seven women treated in a psychiatric setting who generated a 6-0 Pattern. They describe themselves as helpless underdogs who had done nothing to deserve their fate. Their anger repelled people.

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.

Elevated 6-0 Pattern profiles suggest the presence of unreasonable jealousy, the unverifiable conviction that people are talking about them behind their backs, and accusing people of entertaining thoughts, feelings, and urges that are in fact those of the accuser. They give silly soundings excuses for their attitudes and beliefs. They do not change their tunes, ever. Their thinking is rigid, inflexible, and unchangeable by anyone.

Marks write that these patients may exhibit a history of fear of attack on one's abilities and beliefs, and domination over one's will. In reality, they indeed may have been subjected to varying degrees of attack, criticism, and judgment. It is assumed that the more significant the clinical characteristics of this 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 their 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 and engaging their rage at having been criticized and humiliated unfairly also are useful.

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.

Clinical studies indicate that introvert tendencies tend to be fairly stable over long periods of time. People who were shy and socially uncomfortable as children often remain so as adults. Some elements may have been determined genetically, but this type of profile also reflects a childhood characterized by an absence of outward human warmth and physical contact.

The socially extroverted adolescent who has trouble studying because of frequent socializing and social drifting, often become the adult who is constantly trying to be in the middle of social events. This possibly suggests a person whose increased need for social stimulation may be driven by a significant degree of insecurity rather than a need for more intense social experiences.

Therapy for these patients should concentrate on helping them find ways to accept and enjoy their shyness rather than trying to change through desensitization and possibly expose themselves to what they may feel as degrading experiences.

For those patients who are more socially mobile, therapeutic interventions should concentrate on helping them accept, reinforce and enhance their self-confidence and structure their socializing so that it doesn't interfere with their responsibilities (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	0.03
White Adult Males	0.00
White Adolescent Males	0.00
White Adult Females	0.18

White Adolescent Females	0.00
African American Males	0.00
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

1.	Delusional Disorder
80.	Polysubstance Dependence
90.	Other (Or Unknown) Substance Abuse
30.	Schizophrenia, Paranoid Type
300.	Anxiety Disorder NOS
4.	Dysthymic Disorder
90.	Mood Disorder NOS
83.	Mood Disorder Due To (existing medical condition)

Axis II

301.	Paranoid Personality Disorder
301.82	Avoidant Personality Disorder