6-7 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 do, 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 élan and sly misdirection. They are exceptionally private individuals. They conceal many secrets.

Clinical Scale Elevations

Scale(s) 6 (Pa)

T-score 60-69

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(s) 6 (Pa)

T-score 70-79

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.

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 it is possible for the Paranoia Scale responses to determine the presence of 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 (1995) is of the opinion that Scale 6 (Pa) measures sensitivity to the opinions others may be entertaining, also the possibility that the individual may be of a suspicious bent, as well as 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. Their question everything. Their thinking is precise, sharp, and penetrating. They see features in situations that remain overlooked by other people. They see more deeply into the world and it's workings than most (Kunce & Anderson, 1984).

Kunce, J., & Anderson, W., (1984). “Perspectives on the MMPI in non-psychiatric settings”. In P. McReynolds & G.J. Chelune (Eds.) Advances in psychological assessment San Francisco: Jossey-Bass.

Scale 6 (Pa) scores may reflect a fear of physical attack. They anticipate being on the receiving end of severe and unfair judgments. (Caldwell, 1985).

Caldwell, A., (1985). “MMPI clinical interpretation. Los Angeles”: Advanced Psychological Studies Institute.

Hovey and Lewis (1967) think Scale 6 (Pa) reflect long-standing resentment towards relatives, exceptional sensitivity to the opinions held about themselves by others, a touchy nature, and the willingness to blame others for their problems.

Hovey, H., & Lewis, E., (1967). “Semi-automated interpretation of the MMPI”. Journal of Clinical Psychology 23, 123-124.

Carson (1969) views paranoid individuals as registering and remembering any hint of criticism of their person. All rejections, slights, and snubs are stored in perpetuity. They will seek vengeance at an appropriate time and place in the future at the offended parties choosing. They have histories of throwing monkey wrenches into 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. This writer (Wallace) had a colleague shot by a paranoid character many years ago.

Carson, R., (1969). “Interpretive manual to the MMPI”. In J. Butcher (Ed.) MMPI: Research developments and clinical applications (pp. 279-296).
New York: McGraw-Hill.

Lewak (1993) reports a case of a police officer that gave a within normal limits MMPI profile with an exceptionally low Scale 6 score. This man has now served many years in prison. Extremely low Scale 6 scores are usually associated with a presumed paranoid condition.

Lewak, R., (1993). “Low scores on Scale 6: A case history”. Paper presented at the annual convention of the Society of Personality Assessment, San Francisco.

Medical conditions can lead to paranoid presentations. The classic picture of an acute paranoid illness virtually indistinguishable from paranoid schizophrenia is particularly common after an injection of methyl- amphetamine (Lishman, 1998, p. 617).

Cocaine psychosis represents an end on the progression to extreme paranoia, which begins with suspiciousness, ideas of reference, and verbal hallucinations (Lishman, 1998, p. 619).

General paresis, associated with syphilitic disease, may eventuate in paranoid delusions (Lishman, 1998, p. 341).

Migraine suffers report complex visual and auditory hallucinations with a distinct paranoid component. A paranoid psychosis may result from an acute exacerbation of a migraine attack (Lishman, 1998, p. 405-406).

Lishman, W. A., (1998). “Organic Psychiatry. The psychological consequences of cerebral disorder”. 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.

Clinical Scale Elevations

Scale(s) 7 (Pt)

T-score 60-69

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 have a low threshold for anxiety. They are methodical, punctual, and organized. They are productive, hard working persons. They are sensitive to the moods and feelings of others. They do not wish to give offense. They follow the rules. They drive at or very near the speed limit. They may not be particularly original in their approach to problems, but once they have mastered a task, they perform it without errors or complaints. They prefer routine, changeless futures, and the predictable. They have a high tolerance for boredom.

Scale(s) 7 (Pt)

T-score 70-84

They are dissatisfied with their social relationships. They are not confident about what to expect from others much less themselves. They are rigid, habit bound, and self-critical. They cannot stop themselves from thinking unpleasant and frightening thoughts. They sweat the small things. They often overlook the most important parts of the “Big Picture.” They often overlook salient features of a problem or social situation. They can feel “dumb” when they realize what they had missed or left out. They are meticulous about their work and person. They drive themselves hard to reach personally import goals. They are unusually persistent. Their rigid approach to life may intensify should they become ill, suffer accidents or injuries.

Clinical Scale Elevations

Scale(s) 7 (Pt)

T-score ≥ 85

They ruminate about their problems. They go over and over their problems, but rarely find satisfactory solutions for them. They feel miserable most of the time. They suffer from chronic tension. They sometimes find themselves so tied up in their own thoughts that they cannot make decision or attend adequately to everyday duties. They bear a heavy sense of responsibility, which is not called for by the objective facts of the situations in which they find themselves. They get little to no joy or satisfaction out of life. They are long suffering, as are their partners. They are not considered”The Life of the Party.” They find it hard to laugh. Life is too serious for them to bear the thought of anything racy, erotic, or improper. They are good, if not, inspiring neighbors. They are dependable. Their sense of morality demands exceptionally high standards, for both themselves and others. They are straight laced. Most people would probably not want to go to lunch with them, unless job or social demands required it. They freeze when

suddenly confronted with off colored jokes. They panic when faced with an insensitive "move" is placed upon them.

Psychasthenia

Pierre Janet (1903) defined psychasthenia as "…the lack of psychological strength associated with a narrowing of consciousness (Ellenberger, 1970, p. 375).

Ellenberger, H. F., (1970). The Discovery of the Unconscious: the history and evolution of dynamic psychiatry. New York: Basic Books, Inc., Publishers.

Janet distinguishes "…two types of psychasthenia crises, fits of anxiety, and all kinds of conspicuous manifestations related to fixed ideas". "…Those fixed ideas were conscious in the form of obsessions and phobias", (Ellenberger, 1970 p. 376).

Janet (1930) wrote, "In my description of the symptoms of the psychasthenic neurosis (Janet 1903), I stressed particularly the pathological feelings (*sentiments pathologiques*), which I designated at the time as feelings of inadequacy (*sentiments d'incomplétude*) and which have become in my last book a part of the feelings of emptiness (*sentiments du vide*)". Janet includes the symptom of "…the maladies of doubt".

Janet, P., (1903). *Les obsessions et la psychasthenia*, 2 volumes (Paris: Alcan). Vol. I by Pierre Janet, Vol. II by F. Raymond, and P. Janet.

Neurotic disorders were the preferred designation of all anxiety related mental disorders prior to the development of the Diagnostic and Statistical Manuals classifications, which now lists them as anxiety disorders. The DSM-IV-TR, (2000) classifies anxiety disorders into nine categories.

Panic Disorder is the recurrent episodes of panic attacks. At least one month (or more) has followed one of the attacks of the following: Persistent concern about having additional attacks. Worry about the consequences of an attack, i.e., "I'm going crazy", having a heart attack, and loosing self-control. Significant changes in behavior are feared. Panic disorder with and without agoraphobia and additional diagnoses with panic disorder is also a possible diagnosis.

Phobic Disorder is an irrational fear of an object or situation that persists although the person recognizes the fear is irrational. These specific phobias are **Agoraphobia**, the fear of being alone in an open or public area where escape might be difficult. The person is often terrified of leaving their home or residence; **Social Phobia**, the fear of situations where one might be seen and embarrassed or criticized. Speaking to person in authority, speaking in public or performing before an

audience are avoided; **Specific Phobia**, a fear of a specific object, activity, or situation, i.e., fear of flying (Jong's Syndrome), snakes, mice, and closed places, amongst others.

Common Phobias

Feared Object Or Situation	Clinical Name
Animal	Zoophobia
Being Alone	Monophobia
Blood	Hematophobia
Closed Places	Claustrophobia
Darkness	Nyctophobia
Electrical Storms	Astrophobia
Fire	Pyrophobia
Germs/Dirt	Mysophobia
Heights	Acrophobia
Open Spaces	Agoraphobia
Strangers	Xenophobia
Talking	Glossophobia
Water	Hydrophobia

Obsessive-Compulsive Disorder (OCD) defines a preoccupation with persistent intrusive thoughts, impulses, or images. **Compulsions** are repetitive behaviors or mental acts that the person feels driven to perform in order to reduce distress or prevent a dreaded event or situation. The person knows the obsessions/ compulsions are excessive and unreasonable. The obsession/compulsion is time consuming and can cause distress.

Generalizes Anxiety Disorder (GAD) is defined as excessive worry and anxiety more days than not over a period of the preceding six months. The person cannot control their worrying. The anxiety and worry is associated with three or more of these six symptoms: Restlessness, feeling keyed-up, easy fatigue ability, difficulty concentrating, irritability, muscular tension, and sleep disturbances. The anxiety, worry, as well as physical symptoms following on the anxiety and worry, cause significant impairment in other areas of important functioning.

Clinical Presentation of Anxiety Disorders

Panic Disorder: A panic attack is the sudden appearance of intense fear or dread, which may announce impending doom. Terror paralyzes its victim. Terror shakes the

individual's hold on the elements of reality. They can neither see, nor think clearly. They may think they are losing their minds. Physical sensations including palpitations, chest pain, suffocation, nausea, chills and hot flashes erupt unexpectedly. The abrupt onset of these attacks last a number of minutes and then subsides.

Panic Disorder and Agoraphobia characterizes recurring panic attacks, which combine with agoraphobia.

Phobias are persistent, irrational fears of specific objects or situations, which an individual avoids. High levels of anxiety and distress arise from contact with objects or situations, which most people find innocuous, i.e., the sight of blood, looking down from heights, thunder and lightning, viewing open expanses over water, enclosed spaces, among many others.

Social Phobias involve fear and anxiety arising from engagement in social situations or situations in which a performance is expected of the person. Afflicted persons fear they will say something foolish, which would expose them to ridicule or shame; not being able to answer a simple question, which would reveal they are stupid; forgetting their lines or saying them wrong in a play would expose them as inept are examples of social phobias. Fear of speaking in public is a common social fear. The life of persons living with social phobias becomes more and more constricted as they avoid more and more objects and situations which cause them to be paralyzed with fear. Alcohol and drugs reduce the distress they experience.

Obsessive-Compulsive Disorder: Obsessions are experienced as thoughts or images that keep recurring without let-up. They are meaningless in and of themselves. They occur within a matrix of persistent intense anxiety.

Compulsions are procedures adopted and followed rigorously, to control the experience of anxiety and reduce the intensity of the anxiety. These procedures lead to temporary relief. A tune repeated repeatedly is one's head is such an example. Repeated questioning such as, "Did I turn off the stove," "Did I turn off the lights," and " Did I lock the door?" drive the person to check their activities many times over and often lead to self-dissatisfaction. Crippling doubts centering on violence, illness or death, contamination, and sexuality cause the individual to feel humiliated, shamed, and disgusted with him or herself. The demand-performances, procedures, and rituals involved in compulsions interfere with accomplishing necessary everyday activities and the fulfillment of obligations to other people.

Generalized Anxiety Disorder is overweening worry and anxiety, which has persisted over the foregoing six months and is present along with sleeplessness, tension, irritability, poor concentration, tiredness, and fidgeting. The person worries about letting people down, not being able to earn enough money, illness with family members, doing poorly at work with a fear of being fired, and feeling they are not up to the task of effective living. They spend their nights going over the day's failures,

seeking means to make things come out right and solving problems in their heads. They continuously review past mistakes, problems and fret over future developments. They fear making mistakes of even the simplest sorts. They view their own decisions as inadequate and problematical.

Posttraumatic Stress Disorder is intense fear, helplessness, and terror associated with the repeatedly re-experiencing memories of traumatic events where threatened or actual injury or death has occurred. Intrusive recall of these events in flashbacks, dreams, or incidental everyday experiences bring the recollected trauma backs to life in full force. The person refrains from reawakening memories of the trauma.

Feelings of emptiness, the loss of the capacity to respond emotionally, being distant and unavailable to others, the incapacity to connect and a hopeless sense of detachment lead to the conviction life must be lived in a vacuous isolation. Exaggerated startle responses, an all-pervasive guardedness, heightened vigilance, and a sense of an irremediable loss and death of essential portions of their emotional lives form barriers to full and productive lives. Self-medication, chemical abuse, re-fighting the traumas in real time with real people, as well as physical abuse of family members, and brushes with the law complicate social, economic, and civic behaviors.

Acute Stress Disorder is the reaction to an immediate stressor, which abates when the issues involved in causing the stress cease.

The Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Test-Revised, (DSM-IV-TR, APA 2000) lists a mixed anxiety-depressive disorder wherein a dysphoric mood has lasted for a least one month; the dysphoric mood is associated with four or more of the following symptoms.

Difficulty concentrating, the mind goes blank, difficulty falling asleep or staying asleep or unsatisfying sleep, fatigue and low energy, irritability, worry, easily moved to tears, heightened vigilance, anticipating the worst, catastrophizing, hopelessness, all encompassing pessimism, a bleak outlook on the future, low self-esteem and a sense of being worthless. Additional comorbid disorders include substance abuse, Somatization, and physical disorders.

Anxiety Disorder	Base Rate %	Comorbid Diagnosis
Generalized Anxiety Disorder	4-5	Agoraphobia Major Depression Panic Disorder Somatoform Disorder
Panic Disorder	1-3.5	Agoraphobia (30-

		40 %) Major Depression
Phobias		Major Depression (21.3%) Agoraphobia (2.8-5.3%) Anxiety Disorder Alcohol and Substance Abuse
Social Phobia	7.9-13	Alcohol and Substance Abuse
Obsessive-Compulsive Disorder	2-2.5	Major Depressions Panic Disorder Phobias
Posttraumatic Stress Disorder	1.0	General Population
	20	Traumatized Persons Panic Attacks Substance Abuse Depression Somatization

(Welkowitz, et al., 2000, and Horworth and Weisman, 2000).

Welkowitz, L. A., Strvening, E. L., Pittman, J., Guardino, M., and Welkowoitz, J., (2000). “Obsessive-compulsive disorder and comorbid anxiety problems in a national anxiety-screening sample”. Journal of Anxiety Disorders, 14(5): 471-482.

Horworth, E., and Weissman, N. M., (2000). “The epidemiology and cross-national presentation of obsessive-compulsive disorder”. Psychiatric Clinics of North America, 23(3): 493-507.

Tellegen, et al., (2003) created the MMPI-2 Restructured Clinical (RC) Scales as a response to the need to clarify the saturation of the MMPI scales with a common, emotionally saturated factor, which can be broadly specified as generalized anxiety. This emotional factor colors all emotional life. The negative manifestations are termed Demoralization.

This Demoralization Scale is composed of only 24 items drawn from clinical Scale 2 (Depression) and Scale 7 (Psychasthenia). The Demoralization Scale reflects overall emotional discomfort, which combines feelings of demoralization, discouragement, insecurity, pessimism, and poor self-esteem. A sense of failure

pervades a person's evaluations of their life's achievements. The individual feels helpless, overwhelmed, and unable to make things turn out satisfactorily.

The RC factor corresponds well with Janet's descriptions of his patients who suffered from Psychasthenia. Statistical confirmation of a century old clinical phenomenon is a hopeful sign.

Tellegen, A., Ben-Porath, Y. S., McNulty, J. L., Arbisi, P. A., Graham, J. R., and Kaemmer, B., (2003). The MMPI-2 Restructured Clinical Scales: Development, validation, and interpretation. Minneapolis, MN: University of Minnesota Press.

Scale 7 (Pt) has 47 items in both the MMPI and MMPI-2. Thirty-nine items are scored in the true direction and nine are scored in the false direction. A K correction multiplier of 1.0 is added to the Scale 7 (Pt) raw score. Item overlap is: **L (0), F (1), K (2), 1 (2), 2 (13), 3 (7), 4 (6), 5 (1), 6 (4), 8 (17), 9 (3), Sie (9).** Scale 7 (Pt) and Scale 8 (Sc) have many items in common. Elevations on Scale 7 (Pt) will raise the score and Scale 8 (Sc). High scores may measure any of a variety of subjective difficulties ranging from concentration problems to frank psychoses (Comrey 1958). Test-retest correlations on Scale 7 (Pt) range from 0.83 to 0.86 in a 1 to 2 day interval for psychiatric patients and from 0.49 to 0.58 for a one year interval, also for psychiatric patients (Dahlstrom et al. 1975). Butcher et al. (1989) reported similar results with the MMPI-2 with normals for intervals of 1 to 2 days.

Comrey, A. L., (1958). "A factor analysis of items on the MMPI Psychasthenia scale". Educational and Psychological Measurement 18, 293-300.

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.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 6-7 Pattern on the MMPI-A are 1.40 percent and on the MMPI 1.50 percent. Base rates for adolescent females with the 6-7 Pattern are 0.50 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.

The adolescent 6-7 Pattern is rarely encountered. No descriptors are listed.

The 6-7 Pattern adult is not likely to be diagnoses as paranoid. They present as suspicious, rigid, stubborn, and thin-skinned (Greene, 2000).

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

Among college women the 6-7 Pattern mirrors inferiority feelings, rigidity, genito-urinary complaints, and being subject to crying spells. No consistent pattern of distress is evident with the 6-7 Pattern (Kelly and King, 1979).

Kelly, C. K., & King, G. D., (1979). “Behavioral correlates of infrequent two-point MMPI code types at a university mental health center”. Journal of Clinical Psychology 35, 576-585.

The 6-7 Pattern reflects resentment and dark brooding. These people are stung by any sort of criticism no matter how true it may be. They guard themselves with vigilance against all possible personal insults. They shrink from confrontations, which hold the possibility for them to be judged and according to them, wronged. Their social relations follow a rocky course.

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. The more significant the clinical characteristics of this profile become, it is assumed that 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.

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 patients are amenable to almost any form of therapy. Implosion techniques in conjunction with insight therapy can be particularly useful as can desensitization to the originally unpredictable and frightening experiences
(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	0.20
White Adolescent Males	0.00
White Adult Females	0.29
White Adolescent Females	0.00
African American Males	0.60
African American Adolescent Males	0.50
African American Adult Females	0.12

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
23. Social Phobia
2. Anxiety Reactions
90. Mood Disorder NOS
40. Bipolar I Disorder, Most Recent Episode Manic, Unspecified

Axis II

82. Avoidant Personality Disorder
301.4 Obsessive-Compulsive Personality Disorder