6-9 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 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 <65

All other scales <60

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.

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 In the MMPI: A new selection on personality measurement. Minneapolis: University of Minnesota Press.

Only seven of the items making up Scale 6 are unique to this scale, a fact pointed out by Wiener and Harmon, (1948). The remaining items are contained in other scales. It is difficult to know from only seven items how the Paranoia Scale is capable of determining 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. 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.

Scale(s) 9 (Ma)

T-score ≥ 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 are excitable, high-energy people. They enter social situations with ease. They probably do not need as much sleep as most people. They work with enthusiasm. Their movements are rapid, coordinated, and they can sustain physical effort for long periods. They speak more rapidly than most others do. They like to be in control of their activities. They are organized, efficient, and manage their affairs effortlessly. They like the excitement of new experiences. They will try anything. They thrive in the company of other people. These contacts stimulate them. The more intense the interactions, the more they enjoy the coming together. Partying, dancing, drinking, loud music and concerted muscular activities provide them with the heightening of sensations they crave and cherish.

Mood Disorder

Hypomania
And
Mania

DSM-IV-TR (2000) lists the following criteria for Bi-polar Disorder, Hypomania, and Mania: A distinct period of abnormality and persistently elevated, expansive, or irritable mood for at least: 4 days of hypomania; or one week for mania.

At **least three (or more)** of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree during the period of mood disturbance: inflated self-esteem or grandiosity; decreased need for sleep (e.g., the person feels rested after only three hours of sleep; more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are racing; distractibility (i.e., the person's attention is too easily drawn to unimportant or irrelevant external stimuli; increase in goal directed activity (either socially, at work or school, or sexually) or psychomotor activity; excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestricted buying sprees, sexual indiscretions, or foolish business investments).

Hypomania: The episode is associated with an unequivocal change in functioning that is not characteristic of the person when they are not symptomatic. Others observe the disturbance in mood and the change in functioning. There is an absence of marked impairment in social or occupational functioning. Hospitalization is not indicated. Symptoms are not due to direct physiological effects of substance (e.g., drug abuse, medication, or other medical conditions).

Mania: Mania severe enough to cause marked impairment in occupational activities, or relationships, or necessitated hospitalization to prevent harm to self and others, or there are psychotic features. Symptoms are not due to direct physiological effects of substance (drug abuse, medication) or general medical condition (e.g., hyperthyroidism).

The lifetime base rate for mood disorders associated with elevated mood worldwide is approximately one percent (DSM-IV-TR, 2000).

Substance abuse is common (Strakowski and Del Bello, 2000).

Strakowski, S. M., & Del Bello, M. P., (2000). The occurrence of bipolar and substance use disorders. Clinical Psychology Review, 20(2): 191-206.

Bipolar manic persons who are also diagnosed with co-occurring personality disorders, have much poorer treatment outcomes 12 months after hospitalization (Dunayevich et al., (2000).

Dunayevich, E. et al., (2000). Twelve-month outcome in bipolar patients with and without personality disorders. Journal of Clinical Psychiatry 61(2): 134-139.

Bipolar disorder is several disorders rolled into one diagnosis. **Bipolar I Disorder** includes psychosis, paranoia, rapid mood cycling, recurrent schizophrenia-like symptoms, recurrent depression, mania, bizarre behavior, substance abuse, and/or self-medication. **Bipolar II Disorder** includes personality disturbance or disorder of temperament (borderline-like), seasonal depression, alcohol and/or substance abuse, rapid mood cycling, premenstrual dysphoria; premenstrual mood disturbance, impulse difficulties, interpersonal sensitivity, intermittent viciousness, backbiting, slander, manipulativeness, acts of bad-faith, recurrent depression, mood instability (Zerbe, 1999).

Zerbe, K. J., (1999). “Women’s’ mental health in primary care”. (p. 57). Philadelphia: W. B. Saunders.

Unipolar Depressive Disorders: The age of onset is usually between the ages of 40 to 44 years of age. Women are affected twice as often, as are men. Unstable ties to parents and families are frequently encountered. The divorce rate is no higher than for the population in general. Symptoms encountered during the depression include prominent guilt feelings, unresolved autonomy issues, increased motor activity, insomnia, and health concerns.

Bipolar Disorder: The age of onset is between 19 to 30 years of age. It is equally prevalent in women and men. A higher rate of divorce and marital conflict occurs. The need for independence, control of others and being the center of attention is central to this disorder. A significant increase in the drive for success and prestige occurs.

Symptoms associated with the depressed phase of this illness are psychomotor retardation, increased sleep-intervals, few health concerns, and little anxiety or concern for self or others. A high frequency of relapse is associated with bipolar disorder as compared with (Unipolar) major depressive disorder (Varcarolis, 2002).

Varcarolis, E. M., (2002). “Foundation of Psychiatric Mental Health Nursing” (pp. 445-446). Philadelphia: W. B. Saunders Company.

Ethanol ingestion aggravates affective disorders. This combined with brain damage can lead to aggressive and violent behavior (Sweet, et al 1969). The level of sensitivity to the effects alcohol has upon a person is associated with a diagnosis of “pathological intoxication” or ‘*manie* à potú in combination with head injury. A person evidences the pathological effects of alcohol with much smaller levels of alcohol in their blood. They behave violently while under the influence of alcohol, recalling nothing of the events surrounding their intoxication. There is ongoing controversy concerning this diagnosis.

Sweet, W. H., Ervin, F., & Mark, V. H., (1969). “The relationship of violent behavior to focal cerebral disease”. In Aggressive Behaviour: Proceedings of international symposium on the Biology of Aggressive Behaviour, Garattini, S. &, Sigg, E. B. Eds. Exerpta Medica: Amsterdam (81, 82, 189).

Manic stupor can lead to elation and ecstasy. The patients’ report their mind fills to overflowing with ideas. They are unable to react to anything around them (Abrams and Taylor 1976).

Abrams, R., & Taylor, M. A., (1976). “Catatonia: a prospective clinical study”, Archives of General Psychiatry 33, 579-581.

Schukla et al., (1987) reported on 20 cases of the development of mania following head injury. There were no family histories of bipolar disorder. Epilepsy developed in one half of the cases. Irritable mood was more frequent than euphoria. Assaultive behavior often occurred. Fourteen of the patients had episodes of mania without depression.

Schukla, S., Cook, B. L., Mukherjee, S., Goodwin, C., & Miller, M. G., (1987). “Mania following head trauma”. American Journal of Psychiatry 144, 93-96.

Starkstein et al., (1988) studied 12 patients who developed mania from brain lesions (tumors, strokes, and brain injuries). None has histories of affective disorders. Right hemisphere lesions were more common than those of the left hemisphere. Lesions of the orbitofrontal cortex were strongly associated with mania. Two patients had repeated manic episodes and another developed mania along with a marked change of personality two years after a head injury.

Starkstein, S. E., Boston, J .D. 7 Robinson, R. G., (1988). “Mechanisms of mania after brain injury. Twelve case reports and review of the literature”. Journal of Nervous and Mental Disease, 176, (87-100).

Logsdail and Toone (1988) report twice as many tight hemisphere loci which is similar to those reported by Starkstein et al., (1988).

Logsdail, S. J., & Toone, B. K., (1988). “Post-ictal psychoses. A clinical and phenomenological description”. British Journal of Psychiatry 152, 246-252.

Scale 9 has 46 items. Item overlap is **L (12), F (1), K (5), 3 (6), 4 (7), 5 (3), 6 (3), 7 (6), and 8 (11).** Thirty-five items are keyed in the true direction. Scale 8 has one fourth of its items in common with Scale 9. The reading comprehension level for Scale 9 is the highest (ninth grade reading level) of all of the MMPI scales Paolo et al., (1991). The average reading level is the eighth grade in the US. Scale 9 test scores may need to be verified if the subject gives evidence of reading comprehension difficulties. Test-retest correlations for the standardization sample (Butcher, et al 1989) are 0.68 for females and 0.83 for males.

Paolo, A.M., Ryan, J. J., & Smith, A. J., (1991). “Reading difficulty of MMPI-2 subscales”. Journal of Clinical Psychology 47(4), 529-532

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 9 (Ma) presumably measures mood elevations. Scale 9 (hypomania) reflects heightened motor activity levels. Associated features are grandiosity, Green-Spanian irrational exuberance, and decreased need for sleep, suspiciousness, and a hot temper.

The original clinical group of inpatients who served as criterion subjects in the construction of Scale 9 numbered 24 (Dahlstrom and Dahlstrom, 1980). They pointed out the small number of cases used in the construction of Scale 9. “It is the best (data) that we could derive from the patients seen over a 5-year period” (p. 57).

Individuals who are in the throes of a genuine manic episode will render invalid MMPI results. Distractibility, ideational flooding, and increased motor activity levels are the cause.

Dahlstrom, W. G., & Dahlstrom, L. E., (Eds.) (1980). “Basic readings on the MMPI: A new selection on personality measurement”. Minneapolis: University of Minnesota Press.

Langer, (2003) defines Scale 9 (Ma) as a focus on achievement. Self-worth rests upon career success, material acquisition, and fame. Ready response to stimuli is a core feature. Tension is high between aspiration and accomplishment.

Langer, F., (2003) frank.langer@ALIENS.Com Wednesday 3 Sept 2003. Re: MMPI-2/ Rorschach Confusion. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Increased motor behavior follows the anticipation of failure. “If they see a looming catastrophe, they pull out all stops to do everything possible to avert it” (Langer 2003). The relative vacuum of insight into their own thinking and feeling is addressed by a focus upon externalities. This is a focus, which rushes in to fill the void left in the wake of the flight away from the threat of the recognition of their weaknesses, anxieties, incompetence, and fear for the future. Grim determination and “…sticking to one’s guns in the face of an unbending environment…” addresses the roadblocks facing them. Achievement supplants the quality and extent of connectedness with others.

Langer, F., (2003). frank.langer@ALIENS.COM Sunday 7 Sept 2003. Re: MMPI-2/ Rorschach follow-up. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Scale 9 (Ma) may also reflect a fear of frustrations to come, which displaces the enjoyment of the present moment (Caldwell, 1984).

Caldwell, A. B., (1984). “Clinical decision making with the MMPI”. Advanced Psychological Institute. Chicago, IL: Northwestern University.

Duckworth and Anderson (1995) say that Scale 9 (Ma) “…is a measure of psychic energy,” upon which the person “…feels compelled to act…” (p. 267).

The number of thoughts a person experiences also increases during hypomanic episodes. Scale 9 (Ma) is the most common scale elevation with college students.

Duckworth, J.C., & Anderson, W. P., (1995). MMPI and MMPI-2: Interpretation Manual for Counselors and Clinicians. Fourth Ed. Bristol, PA: Accelerated Development.

Scale 9 descriptors of healthy persons include the terms friendly, expansive, active, enthusiastic, talkative, and involved. Kunce and Anderson, (1976) and Hovey and Lewis ,(1967).

Kunce, J., & Anderson, W., (1976). “Normalizing the MMPI”. Journal of Clinical Psychology 32, 776-780.

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

Scale 9(Ma) may also measure sensation seeking, self-confidence, a sense of being indestructible and disdain for others’ weaknesses (Lachar, 1974).

Lachar, D., (1974). The MMPI: Clinical Assessment and Automated Interpretation. Los Angeles, CA: Western Psychological Services.

Research findings. Siblerud et al., (1998) examined the effect of dental amalgam mercury removal with nine patients on manic depression and related symptoms. The Scale 2 (Dep) and Scale 9(Ma) score showed significant improvement for the amalgam removal group. The amalgam removal group reported a 42% decrease in the number of somatic health problems after amalgam removal.

Silerud, R. L., Motl, J., & Kinholz, E., (1998). “Psychometric evidence that dental amalgam mercury may be an etiological factor in manic depression”. Journal of Orthomolecular Medicine 13(1, 31-40.

Comrey (1958 studied the factor content of Scale 9 (Ma). He concluded that this scale has the most content diversity of all of the MMPI scales. Scale 9 (Ma) does not possess the needed factor homogeneity needed to establish statistical and logical relationships.

Comrey, A. L., (1958). “A factor analysis of items on the MMPI Hypomania scale.” Educational & Psychological Measurement 18, 313-323.

Kalichman (1988) collected demographic information and Minnesota Multiphasic Personality Inventory profiles with 16 adult women convicted of murdering their (domestic) partners and 20 adult men convicted of murdering strangers during the course of the crime. The men convicted of murdering strangers had higher elevations on the Hypomania scale than men who murdered (domestic) partners. Women who murdered (domestic) partners had higher elevations on Scale 6 (Pa) and Scale 0 (Sie).

Kalichman, S. C., (1988). “MMPI profiles of women and men convicted of domestic homicide”. Journal of Clinical Psychology 44(6), 847-853.

Duckworth and Levitt (1985) evaluated 30 swingers from a private metropolitan swinging club with the MMPI who engaged in high-risk sexual behaviors. One half had significant clinical scale elevations, most of on Scale 9 (Ma). Two thirds of the group were judged emotionally disturbed, however, they had sufficient ego resources, which enabled them to cope with their problems and pay for club memberships.

Duckworth, J., & Levitt, E. E., (1985). “Personality analysis of a swinger’s club”. Lifestyles 8(1), 35-45.

Baetsen et al., (1985) examined personality characteristics and demographic factors of 23 pregnant women who intended to have an abortion and 23 women who planned to carry to term with the MMPI. Only the Hypomania scale differentiated between the groups, with the abortion group scoring significantly higher on Scale 9 (Ma).

Baetsen, K. L., Rankin, R. E., Fuller, G. B., & Stack, J. M., (1985). “A comparative MMPI study of abortion-seeking women and those who intend to carry their pregnancies to term”. Family Practice Research Journal 4(4), 199-207.

Jurko et al., (1974) administered the MMPI to eight patients who received a pre-thalamotomy. The only significant long-term change was a decrease in the elevation of Scale 9 (Ma).

Jurko, M. F., Andy, O. J., & Giurintano, L .P. (1974). “Changes in the MMPI as a function of thalamotomy”. Journal of Clinical Psychology 30(4), 569-570.

Base rates for adolescent males with the 6-9 Pattern on the MMPI-A are 2.10 percent and on the MMPI 2.10 percent. Base rates for adolescent females with the 6-9 Pattern are 1.60 percent and 2.30 percent respectively (Archer, 1997).

Archer (1992) lists the following Scale 9 features applying to adolescents:
Increased personal tempo with increased activity occurs. Action is preferred over thought and contemplation. Impulsivity, restlessness, and distractibility are present. Unrealistic aspirations and goal setting is a problem, which guarantees failure for them. They are extroverted, gregarious, talkative, and filled with energy. They are narcissistic, self-involved, self-infatuated, insensitive to others feelings and ideas as well as prone to rule breaking.

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

The adult 6-9 Pattern is most often encountered in impatient psychiatric settings. They are angry, filled with animosity, puffer up narcissists. Mood disorders predominate. Clinicians report them to be on edge most of the time. They are anxious. They react strongly to minor frustrations. They are unpredictable. They act without sufficient forethought. They are uncooperative. They distrust others. They feel other people are motivated to do them no good. Psychotic diagnoses are rendered in most cases (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

Adults with the 6-9 Pattern fear falling under the control of others. They will resist. They feel they are treated unfairly. They take the high road when conflicts arise. They judge others harshly. They are difficult people.

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.

These patients have a chronic pattern of protecting themselves against the frustration and unhappiness associated with failure. It is very likely that parents who had high expectations of success for raised them, which the child was given only partial or periodic rewards. Thus, the parents were seen as constantly pushing the child to achieve while at the same time trying to control the resulting surges of energy and impulsivity. The child's needs for reward were then met by the parent's withholding of regular rewards, which increased the drive-state and, in effect, increased the manic tendencies.

The purpose of therapy should be to help the patient stop and enjoy the "here and now." These patients often are future oriented and fearful of the present where they would have to deal with the pain and disappointment of slowing down. They are afraid that if they stop driving themselves they might achieve less in the future. They will need help to distinguish between their own needs and what they want in order to please others.

Gestalt techniques are usually effective in "forcing" them to express their feelings now, rather than trying to deal with events of the past or anticipated events in the future (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	0.38
White Adult Males	0.18
White Adolescent Males	0.00
White Adult Females	0.81
White Adolescent Females	0.00
African American Males	0.17

African American Adolescent Males	0.50
African American Adult Females	0.98

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
9. Cognitive Disorder NOS
30. Schizophrenia, Paranoid Type,
40. Bipolar I, Most Recent Episode Manic, Unspecified

Axis II

301.0 Paranoid Personality Disorder