1-0 Pattern

Clinical Scale Elevations

Scale 1 (Hs)

Elevations of this magnitude for these Scale(s), considering race, gender, and age for this group's data, indicate these clinical features could be present in this person's behavior and history:

Their bodily sensations frighten them. They often misinterpret what their bodily sensations signify. Their self-centered behavior shapes the responses others make to their personal health concerns. They demand that their problems to be solved by other people. The more help they receive, the more helpless they become. They let others know when they are under stress what they want by complaining and lamenting their fate.
They cannot be satisfied no matter what other people do for them. They thwart all attempts at assistance. Nothing changes. Helpers end-up feeling miserable.

Hypochondriasis

Hypochondriasis is an intense non-delusional preoccupation with the fear of having an unknown disease. This anxiety exerts a powerful influence upon a person. The individual interprets the origin of the anxiety in different ways. Physical symptoms arise out of the physiological induced stress produced by the anxiety. Alexander (1950) described the anxieties associated **with medical conditions,** i.e., bronchial asthma, ulcerative colitis, thyrotoxicosis, essential hypertension, rheumatoid arthritis, neurodermatitis, and peptic ulcer.

Alexander, Franz (1950) Psychosomatic Medicine: Its Principles and Applications. New York: W.W. Norton & Company.

The DSM-IV-TR term somatoform disorder was a development following on Alexander's work. The Diagnosis of a Somatoform disorder follows **when objective findings of physical disease are not in evidence.** Somatization is the expression of psychological stress through the development of physical symptoms.

The DSM-IV-TR criteria for somatoform disorders are: **Somatization Disorder**. History of many physical complaints beginning before 30 years of age, occurring over a period of years and resulting in impairment in social, occupational, or other important areas of functioning. Complaints **must** include all of the following: History of pain in at least **four** different sites or

functions; history of at least **two** gastrointestinal symptoms other than pain; history of at least **one** sexual or reproductive symptom; history of at least **one** symptom defined as or suggesting a neurological disorder. **Conversion Disorder**. This is the development of one or more symptoms or deficit suggesting a neurologic disorder (blindness, deafness, loss of touch) or general medical condition. Psychological factors are associated with the symptom or deficit. Psychological stressors initiate or exacerbate the symptoms. The symptoms are not due to malingering or factitious disorder and not culturally sanctioned. General medical condition or effects of a substance cannot explain them. They symptoms cause impairment in social or occupational functioning as well as cause marked distress, or requires medical attention**. Hypochondriasis. This is a preoccupation** with fears of having, or the ideas that one has, a serious disease. Preoccupation persists despite appropriate medical tests and reassurances. Rule out other diseases (i.e., somatic delusional disorders). Preoccupation causes significant impairment in social or occupational functioning or causes marked distress. **Pain Disorder**. Pain in one or more anatomical sites is a major part of the clinical picture. Pain causes significant impairment in occupational or social functioning or causes marked distress. Psychological factors are thought to cause onset, severity, or exacerbation. Pain associated with psychological factors; the symptoms are not intentionally produces or feigned. If medical condition present, it plays a minor role in accounting for pain. Pain maybe associated with a psychological and/or medical condition. Both factors are important in onset, severity, exacerbation, and maintenance of pain. **Body Dysmorphic Disorder**. Preoccupation with some imagined defect in appearance. If the defect is present, concern is excessive. Preoccupation causes significant impairment in social or occupational functioning or causes marked distress. The preoccupation is not accounted for by another mental disorder.

DSM-IV-TR (2000). Diagnostic and statistical manual of mental disorders (4th ed., test revision). Washington, D.C.: American Psychiatric Association.

Scale 1 (Hs)

Scale 1 (Hs) measures the number of bodily complaints endorsed by a patient. Hathaway and McKinley (1940) studied a group of 50 (the criterion group) inpatients with pure Hypochondriasis. Demographic information for the criterion group is not available.

Hathaway, S. R., & McKinley, J.C., (1940) A Multiphasic personality schedule (Minnesota): I. Construction of the schedule. Journal of Psychology. 10, 249-254.

Two groups of visitors to the University of Minnesota Hospitals and a group of freshmen at the University of Minnesota Testing Bureau form the normal group for which demographic information is available.

The MMPI has 33 items. The MMPI-2 has 32 items. These items identify endorsement of items relating to poor physical health and gastrointestinal difficulties. Scale 1 (Hs) on the MMPI-2 has 11 items scored in the true direction and 22 items scored in the false direction. A false response set elevates this scale. Scale 1 (Hs) items overlap with other scales as follows: **L (0), F (0), K (0), 2 (10), 3 (20), 4 (1), 5 (0), 6 (1), 7 (2), 8 (4), 9 (0), and Sie (1).** An elevated score on Scale 3 (Hy) can elevate Scale 1 (Hs).

The diagnostic efficiency of the MMPI Scale 1 (Hs) is low. Schwartz et al. (1972) demonstrates base rates for 178 medical patients who generated 1-3 or 3-1 MMPI profiles. Organic diagnoses base rate is 39 percent, functional diagnoses base rate is 34 percent, and mixed organic/functional base rate is 29 percent. Sixty two percent of the 1-3 profiles had a medical condition as a principle consideration in establishing a diagnosis.

Schwartz, M. S., Osborne, K., & Krupp, N.C., (1972) Moderating effects of age and sex on the association of medical diagnoses and the 1-3/3-1 MMPI profiles. Journal of Clinical Psychology. 28, 502-505.

Schwartz and Krupp (1971) established base rates for the 1-3 MMPI profiles with 50,000 medical admissions to the Mayo Clinic for the years 1963 through 1965. Female admission MMPIs yielded 1-3 profiles in 6.3 percent of the cases, 3-1 profiles in 2.0 percent of the cases; males yielded 1-3 profiles in 6.3 percent of the cases and 3-1 profiles in 1.9 percent of the cases.

Schwartz, M. S., & Krupp, M. E., (1971) “Conversion V” among 50,000 medical patients. A study of incidence, criteria, and profile elevation. Journal of Clinical Psychology. 28, 89-95.

> Elevations of this magnitude for these Scale(s), considering race, gender, and age for this group’s data, indicate these clinical features could be present in this person’s behavior and history:
>
> Scale(s) 0 (Sie)
>
> 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 startup a conversation even with people they know well. They dress conservatively. They do not like to attract attention to themselves.

Social Introversion and Extroversion (Sie)

The Social Introversion scale is based upon the work of Evans and McConnel (1941), who authored the Minnesota T-S-E Inventory. The investigation centered about the dimensions of Thinking, Social, and Emotional aspects of behavior and their manifestations in either the introverted or the extroverted aspects of a persons behavior.

Evans, C., & McConnell, T.R., (1941) A new measure of introversion-extroversion. Journal of Psychology. 12, 111-124.

Drake (1946) based the Social Introversion (Sie) scale on Evans and McConnell's work with the Minnesota T-S-E Inventory's Social introversion items. Seventy items, which separated the top 65 percent and lowest 35 percent of 100 female college students who served as test subjects, formed the Sie scale.

Drake, L. E., (1946) A social I.E. scale for the Minnesota Multiphasic Personality Inventory. Journal of Applied Psychology. 30, 51-54.

The Sie Scale criterion group is composed of healthy persons. Test norms for males were similar to the female norms; the two groups' combined results form the scale. The norms are composed of 350 female and 193 male college students. [An interesting aspect of this norming reflects the types of males in college during WW II. Those males capable of serving in the Armed Forces were not included or represented in this testing].

The 69 items (MMPI-2) composing the Social Introversion scale overlap with the other scales as follows: **L (0), F (0), K (9), 1 (1), 2 (8), 3 (8), 4 (11), 5f (11), 5m (9), 6 (5), 7 (9), 8 (6), and 9 (6).** 34 items are scored in the true direction, 35 in the false direction. Foerstner's (1986) studies reflect the multifactorial nature of the Sie scale.

Foerstner, S. B., (1986). The factor structure and stability of selected Minnesota Multiphasic Personality Inventory (MMPI) subscales: Harris

and Lingoes subscales, Wiggins's content scales, Wiener subscales, and Serkownet subscales. Unpublished dissertation, University of Akron, Ohio.

The Sie scale indicates the degree of comfort a person xperiences when they are in the company of other people. Lewak et al. (1990) writes concerning high Sie scale scores, a person had "…a childhood characterized by an absence of warmth and physical contact from others. Elevated scores suggest that these people have extinguished their feeling response to physical touch and affection. They suffer from "affect hunger" and yet, they feel conflicted about close, intimate relationships." (p. 273). Low scores on the other hand suggest an intense need for stimulation afforded by the close proximity of other peoples' energetic activities.

Lewak, R.W., Marks, P.A., & Nelson, G. E., (1990) Therapist guide to the MMPI and MMPI-2: Providing feedback and treatment. Muncie, IN: Accelerated Development.

The Sie scale also measures a person's willingness to be in the proximity of others. It includes a person's readiness to engage with others in social and work settings. Introverted people do not have social poise, engage in ready repartee, or involve themselves in quick witted, jocular, give-and-take. They ask themselves, "Why didn't I think of that" as a belated rejoinder to intentionally cutting comments. All those missed opportunities! They are usually not an insider or even familiar with the current in-group's slang or the intimate references used by the in-group.

Introverted people isolate themselves when they feel under pressure. This could be due to the experiences of past disappointments and emotional injuries. They go it alone for lack of any other supportive options.

Extroverted people have learned to welcome the enjoyment they gain from the stimulation other people offer them. They are socially skilled and they give-and-take on an equal footing. They turn to others in times of difficulties, using these contacts as sources of emotional support and sources of solution to the problems facing them. They learn from others more easily than they do when attempting to learn new information and skills by themselves. They do not like being alone.

Kunce and Anderson (1984) propose autonomy as the principal force under girding the Social Introversion scale. One can either function as

a resourceful, self-directed, independent individual or withdraw into them-selves leaving the world of people behind.

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

Research studies with the Sie scale. Steyaert et al., (1994) investigated the higher incidence of psychiatric morbidity in **female fragile X carriers** (fragile X syndrome, also know as the Martin-Bell syndrome, after the British investigators who first reported it in 1943). The tip of the X chromosome tends to break off in many of those affected. Hence, the name Fragile X. Female carriers have more disorders that are schizophrenia-like. The sample mean MMPI scale scores fell within the normal range for a group of 11 females of normal intelligence. Low scores on the Sie scale reflected extraversion, not introversion, as expected.

Steyaert. J., Decruyenaere, M., Borghraef, M., & Fryns, J.P. (1994) Personality profile in adult female fragile X carriers: assessed with the Minnesota Multiphasic Personality Inventory (MMPI). American Journal of Medical Genetics. 51(4), 370-373.

Meehl (1989) proposed a research model opposing biological **vs.** psychological **causation in the genesis of schizophrenia.** Meehl hypothesizes those given unfavorable polygenic potentiators (e.g., introversion, hypohedonia, and anxiety) and adverse life experiences (e.g., childhood trauma or adult misfortune), 10 percent of such individuals so afflicted develop schizophrenia. Meehl concludes, “Taxometric statistics are appropriate to testing a major locus model”.

Meehl, P. E., (1989) Schizotaxia revisited. Archives of General Psychiatry. 46(10), 935-944.

Gauci et al., (1993) used the MMPI to study women with allergic rhinitis. Twenty-two female suffers of perennial **allergic rhinitis** (inflammation of the nasal mucosa initiated by botanical airborne substances) and an 18 non-allergic female control group. Allergic sufferers scored significantly higher scores on the Sie scale along with high score on Scale 1 (Hs). Skin reactivity to house dust mite and grass pollen allergens correlated positively with scores on the Sie scale.

Gauci, M., King, M. G., Saxarra, H., Tulloch, B. J., & Husband, A. J., (1993) A Minnesota Multiphasic Personality Inventory profile of

women with allergic rhinitis. Psychosomatic Medicine. 55(6), 533-540.

Fals and Schafer (1993) examined the relationship between **compliance with a behavioral therapy program** and MMPI profiles of obsessive-compulsive disorder (OCD) outpatients. Compliance referred to the number of scheduled therapy sessions cancelled or missed. High scores on scales Sie, 2 (D), and 8 (Sc) predicted lower compliance with treatment for OCD patients engaged in behavioral therapy.

Fals, W. W., & Schafer, J., (1993). MMPI correlates of psychotherapy compliance among obsessive-compulsives. Psychopathology. 26(1), 1-15.

Danjou et al., (1991) screened 62 young healthy volunteers with the MMPI for **eligibility to participate in psychopharmacology studies**. The most striking differences occurred on the Sie scale, which was lower than even the controls Sie scores, but significantly higher than controls on Scales 4 (Pd), 9 (Ma), and 8 (Sc). The low Sie scale scores were significant at the .0001 levels. Bias is possible in the selection of psychopharmacology research volunteer subjects. Drug seeking may be an important factor urging young healthy males to volunteer.

Danjou, P., Warot, D., Weiller, E., Lacomblez, L., & Puech, A.J., (1991) Personality of healthy volunteers. Normality and paradox. Therapie,.46(2), 125-129.

Siegler et al., (1997) utilized the MMPI to study 796 women and 3,630 men enrolled in the University of North Carolina Heart Study to test the predictive power of personality on **adult exercise behavior**. Lower scores on scales Sie, 2 (D), and 4 (Pd) are predictive of an increased probability of exercising in mid life for both women and men.

Siegler, H. D., Blumenthal, J.A., Barefoot, J.C., Peterson, B.L., Saunders, W.B., Dahlstrom, W.G., Costa, P., & Richman, L. C., (1983) used the MMPI to study 30 **adolescents with cleft lips and palates**. Heightened social introversion was associated with increased self-consciousness centering on their cleft lips and palates when the adolescents found themselves in social situations.

Richman, L. C., (1983) Self-reported social, speech, and facial concerns and personality adjustment of adolescents with cleft lip and

palate. Cleft. 20(20), 108-112.

Peterson and Knudson (1983) cross-validated several measures of anhedonia and the MMPI Sie scale. The results of multiple statistical measures lead to the conclusion, "**The high degree of relationship between anhedonia and introversion**, long suggested by clinicians, is confirmed".

Peterson, C. A., & Knudson, R. M., (1983) Anhedonia; a construct validation approach. Journal of Personality. 47(5), 539-555.

Kling et al., (1978) studied the scoring norms **on adolescent psychiatric drug users and non-users MMPI profiles**. Sie scale scores differentiated the users from non-user profiles. Low Sie scores were more frequently associated with drug use.

Klinge, V, Lachar, D., Grisell, J., & Berman, W., (1978)/ Effects of scoring norms on adolescent psychiatric drug users and non-users MMPI profiles. Adolescence. 13(49), 1-11.

Ansseau et al. (1986) investigated the relationship between MMPI scale scores and **dexamethasone suppression tests** (DST) with42 patients diagnosed with **major depression**. The Sie scale scores correlated positively with depression and negatively with Scale 9 (Ma) scale scores.

Ansseau, M., Frenckell, R., Frank, G., Geenen, V., & Legros, J. J., (1986) Dexamethasone suppression test and MMPI scales. Neuropsychobiology. 16(2-3), 68-71.

Nocita et al., (1986) used the MMPI to investigate the relationship between the **MMPI Sie scale** and the experience 83 **introverted clients** had in **counseling sessions**. Clients with higher Sie scale scores rated their sessions as uncomfortable, unpleasant, tense, rough, and difficult. They rated their post-session mood as unfriendly, uncertain, sad, angry, and afraid.

Nocita, A., & Stiles, W.B., (1986) Client introversion and counseling session impact. Journal of Counseling Psychology. 33(3), 235-241.

Yen and Shirley (2003) investigated the MMPI subscales ability to differentiate male **suicide completers, clinically depressed men, and a control group of men who died of medical causes**. Suicide completers have significantly higher Sie scores when compared to depressed and deceased controls.

Yen, S., & Shirley, I. C., (2003). Self-blame, social introversion and male suicides: Prospective data from a longitudinal study. Archives of Suicide Research. 7(1), 17-27.

Craig and Bivens (2000) examined the relationship between **psychological needs** of 198 non-clinical subjects using the Adjective Check List **and the MMPI. Sie scale** scores were positively associated with need for receiving support, showing deference to others, and a preference for being a follower rather than a leader. The same scores were negatively associated with needs for achievement, dominance, autonomy, and exhibitionism.

Craig, R. J., & Bivens, A., (2000) Psychological needs associated with MMPI-2 scales in a non-clinical sample. Journal of Personality Assessment. 74(3), 439-446.

Profile Characteristics

Base rates for adolescent males with the 1-0 Pattern on the MMPI-A are 0.70 percent and on the MMPI 0.40 percent. Base rates for adolescent females with the 1-0 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 Marks et al. (1974) nor Archer (1997) list descriptors of the adolescent 1-0 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 1-0 Pattern are shy, insecure people who report a surprisingly limited number of aches, pains, and illnesses (Greene, 1991).

Green, R.L., (1991) The MMPI-2/MMPI: An interpretive manual. Boston: Allyn and Bacon.

They do not complain of emotional distress and deny having psychological problems. They lead conventional lives. They do not burden others with personal problems. They expect little. They demand little. They accept their fate (Wallace 2001).

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

Their parents were distant and unresponsive; more shadow than substance. They grew up underexposed to the social graces. They do not rapidly notice social cues. They are not adept at socializing. They are not responders.

Marks said these patients appear to long for personal care. They demand that massive attention and reassurance by given to their personal care and physical requirements, usually by family members. They are invariably fearful of bodily harm, physical illness, pain, and death. It is possible that an early illness in the patient or patient's family, or an early experience of physical abuse, conditioned various overprotective behaviors that shielded the client from physical injury, which reduced both the rate and incidence of motor activity. They focus on maintaining their own physical integrity and the availability of medical help.

Clinical studies indicate that introvert tendencies tend to be stable over long periods. 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 becomes the adult who is constantly trying to be in the middle of social events. A significant degree of insecurity drives this person to increase his or her own social stimulation.

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

For those patients who are more socially mobile, effective therapeutic interventions should concentrate on helping them accept, reinforce and enhance their self-confidence. They structure their socializing so that it does not interfere with their responsibilities. (Marks, P.A., 1987).

Marks, PA. (1987). The Marks MMPI Adolescent Report and Manual. Wakefield, RI: Applied Innovations.

Persons with scores in this range are typically preoccupied and focused upon physical symptoms and complaints. Often health care professionals who see these patients as having imagined illnesses dismiss them. Even when

actually ill, they may exaggerate their conditions and use them to manipulate or control family members or others. They can be quick to complain, and often end up blaming those who try, but fail, to render help to them [n111, n222]. Unsuspected Illnesses are in the unlikely event that neurologically impaired and chronically mentally ill persons receive thorough medical evaluations uncovered [n333].

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	0.30
White Adult Males	0.20
White Adolescent Males	0.00
White Adult Females	0.11
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	300.81	Somatization Disorder
	300.7	Hypochondrias
	305.0	Alcohol Dependence
	291.8	Alcohol-Induced Mood Disorder
	300.22	Agoraphobia Without History of Panic Disorder
Axis II	301.0	Paranoid Personality Disorder
		Avoidant Personality Disorder