MMPI 1-3 Pattern

Clinical Scale Elevations

Scale 1 (Hs)

Elevations of this magnitude for these Scales, 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 shape by the responses others make to their personal health concerns. They want others to solve their problems. 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. Giving the right appearance is important to them. They go to considerable pains to make the right impression. They do not tolerate anything that is unpleasant or ugly. They reject the very thought of failure or the impact of being thwarted as unacceptable. They have an abiding dread and intolerance of emotional discomfort, physical pain, or any type of suffering. They are self-satisfied and somewhat immature. They are suggestible. They go with the flow. They experience dissatisfactions as aches and physical pains. They attract attention to themselves through thespian displays whenever they feel distressed.

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**. The development of one or more symptoms or deficit suggesting a neurologic disorder (blindness, deafness, loss of touch) or general medical condition is present. Psychological factors are associated with the symptom or deficit. The symptoms are initiated or exacerbated by psychological stressors. The condition is not due to malingering or factitious disorder and not culturally sanctioned. A general medical condition or effects of a substance cannot explain the condition. The condition causes impairment in social or occupational functioning. Causes marked distress, or requires medical attention**. Hypochondriasis. A preoccupation** with fears of having, or the ideas that one has, a serious disease persists despite appropriate medical tests and reassurances. Other diseases have been ruled out (i.e., somatic delusional disorders). The 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 thought to cause onset, severity, or exacerbation. Pain associated with psychological factors. The symptoms are not intentionally produced 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 better 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.

Hypochondriasis

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.

Scale 3 (Hy)

Elevations on Scale 3 (Hy) indicate the presence of multiple temperaments and traits:

> They have a profound fear of emotional and physical pain. Emotions easily overwhelm their thinking easily. They cannot portray or analyze their emotions in words. They have no words available to them upon which to anchor their feelings.
>
> Visual rather than verbal awareness dominates their mental life. They cannot accurately put their feelings and ideas into words easily. This inability to tell others what is bothering them forces other people to guess what is the matter. Most attempts to do so meet with failure and puzzlement. Words associated with painful experiences are banished from awareness reflexively. Stress registers as pain in the musculature. The capacity for intimacy and mutuality is limited. Self-examination is poorly tolerated or not at all. They are self-centered. They are relatively immature. They are not particularly sensitive to the feelings of other people. Their social interactions are superficial. They have limited interests. They are vulnerable to demands made upon them. Personal appearance and appearances in general are of major importance to them. Making just the right impression on others assumes a major part of their planning and behavior with others. They want, desire, and depend upon the approval of others in order to maintain their sense of social acceptability. They employ petty cunning to get their way. They have an eye for attaining and maintaining social advantage, often at the expense of others. Wealth and power entice them.

Hysteria

Paul Lerner (1998) said hysterics depict “the emotional way of life”. Their lives are emotional reactions to their involvement with others. Lerner cites Easser and Lesser (1966), who describe the hysterics emotionality, “as a jewel to be exhibited, fondled and cherished. Hysterics view any attempt to move beyond it or remove is an attack, which is defended against with their total personality.

Lerner, P.M. (1998). Psychoanalytic perspectives on the Rorschach. London: The Psychoanalytic Press, pp. 53-54.

Easser, R., & Lesser, S. (1966) Transference resistance in hysterical character neurosis-technical considerations. Developments in Psychoanalysis at Columbia University. New York: Columbia University Press, pp. 69-80.

Hysterics remain anchored in the emotionality of their own childhoods. Feelings dominate and often overrule their thinking. They need is to be appreciated, valued, recognized and loved. This is their “prime directive”.

Freud (1915) in his article “The Unconscious” said, “…repression is essentially a process affecting ideas on the border between the Ucs and Pcs”.

Freud, S. (1915). The unconscious. Standard Edition, 14:159-216. London: Hogarth Press 1957. p. 180

Levine and Spivak (1964) theorize repression inhibits cognitive processes.

Levin, M., & Spivak, C. (1964). The Rorschach Index of Repressive Style. Springfield, IL: Thomas.

Repression blocks entrance to awareness of ideas containing painful emotions. Hysterics welcome pleasurable emotions with open arms. The inability to integrate both painful and pleasurable emotions results in the failure to use all available information upon which to base reactions to the circumstances in which the hysteric finds themselves. So long as the hysteric receives adulation, they are happy. Disappointment, criticism, or rejection depresses them.

The hysteric repairs their injured sense of self by planting subtle suggestions upon which others are to act to supply them with those pleasant experiences they crave simultaneously avoiding any hint of plethora of approval (Easser and Lesser (1965).

Easser, R., & Lesser, S. (1965) Hysterical personality: A re-evaluation. Psychoanalytic Quarterly, 43:390-405. p. 397.

The emphasis upon the emotional side of existence overshadows the cognitive side. Hysterics avoid engaging in the mundane, dull, drudgery involved in most everyday activities like balancing the check book, house work, grocery shopping, getting the car serviced to mention only a few. These duties fall upon the shoulder of those closest to them. They would rather do things that get them the recognition they want.

Scale 3 (Hy)

Scale 3 (Hy) has 60 items on both the MMPI and MMPI-2. Forty-seven items are scored in the false direction and 13 of the items are scored in the true direction. A false response set will elevate Scale 3 (Hy). The K scale has 10 items in common with Scale 3 (Hy), which represents a built-in K correction. Item overlap is: **L (0),**
F (1), K (10), 1 (20), 2 (13), 4 (10), 5 (4), 6 (4), 7 (0), 8 (8), 9 (6), Sie (13). Test-retest correlations range from .66 to .80 for intervals of 1 to 2 weeks on the MMPI (Dahlstrom et al. 1972) and .72 to .75 for a one-week interval on the MMPI-1 (Butcher et al. 1989).

Dahlstrom, W.G. Welsh, G.S., & Dahlstrom, L.E. (1972) An MMPI handbook: Vol. 1. Clinical Interpretation (Rev. ed.). Minneapolis: University of Minnesota Press.

Butcher, J.N., Dahlstrom, W.G., Graham, J.R., Tellegen, A., & Kaemmer, B. (1989) Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring. Minneapolis: University of Minnesota Press.

PROFILE CHARACTERISTICS

Marks said these patients crave personal care. Caregivers must meet their continuous needs for reassurance with massive attention to their physical requirements. They may chronically perpetuate a fear of bodily harm, physical illness, pain, and death. Typically, 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 by reducing both the rate and incidence of motor activity. They focus on maintaining physical integrity and the ready availability of medical help.

These patients also typically suffer from fear of psychological or emotional pain. They need others to like them and they to avoid conflict. It is important for them that others see them as psychologically healthy. They will seek reassurance that they are likable and will try to elicit it from others by flattering and complimenting them.

They are positive in the face of adversity, anger, and hostility. They develop somatic symptoms when faced with stress and conflict situations. Often Gestalt implosion and systematic desensitization will help them face painful situations and unblock the anger and sadness related to frightening past events. It is helpful to look for what they explicitly deny because that is often at the center of their conflict.

These patients have difficulty remembering painful events. Techniques to elicit catharsis are often helpful in extinguishing the strong fears that painful feelings will overpower them.

Patients with this profile complain of fatigue and exhaustion. They are "difficult" cases. Their ambivalence toward therapy reflects their fear that their therapists look upon them "bad" patients and reject them as a result. Seeking out physicians for help with their physical symptom acts as a source of reality testing. They become frightened, however, when the physician or therapist confronts them with non-organic diagnoses or psychological issues. They may therefore resist it.

They typically block the anger and sadness aspects of the mourning process. They often cry, but not about painful losses. They may also get angry, but not about past painful events, or the person seen as responsible for the painful events. Their response to pain is to deny it, to look at the bright side of things and to develop increasingly more severe physical symptoms. Insight therapies might focus on the early frightening experiences as a way of helping them work through the mourning process. Assertiveness training is useful to help deal with confrontations in the present.

Catharsis and systematic desensitization might help relieve the stored up feelings, which prevent them from engaging pain, and relaxation is useful to help relieve some of their physical symptoms (Marks, P.A., 1987).

The base rate for the 1-3 Pattern in the total aggregate population of 15,361 cases drawn from 52 JACHO accredited hospitals is 1.34 percent.

DSM-IV diagnoses rendered for the 1-3 Pattern are:

Axis I	300.7	Hypochondriasis
	300.81	Somatization Disorder
	307.80	Pain Disorder Associated with Psychological Factors
	301.01	Pain Disorder without Agoraphobia
	300.11	Conversion Disorder
	307.50	Eating Disorder NOS
	295.40	Schizophreniform Disorder
	300.2	General Anxiety Disorder
	V65.20	Malingering
Axis II	301.22	Schizotypal Personality Disorder
	301.50	Histrionic Personality Disorder
	301.6	Dependant Personality Disorder