1-4 Pattern

Scale 1 (Hs)

Elevations on these Scales taking race, gender, age, education, marital and employment statue into consideration for this group's data, indicate these clinical features could be present in this person's behavior and history:

They are frightened of their own bodily sensations. They often misinterpret what their bodily sensations signify**.** Their self-centered behavior shapes 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.

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 symptom. It is not due to malingering or factitious disorder and not culturally sanctioned. It *c*annot be explained by general medical condition or effects of a substance.

The symptoms cause impairment in social or occupational functioning. Causes marked distress, or requires medical attention**. Hypochondriasis. Preoccupation** is a fear 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 thought to cause onset, severity, or exacerbation. Pain associated with psychological factors. Pain 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 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. Lair and Trapp (1962) wrote, "…the…pronounced overlap of individual scores sharply limits the usefulness of the test in a general medical setting as an instrument differentiating 'normal' organic from functional disorders". They go on to say, "The MMPI profile does not appear to be a practical test for making differential diagnoses among neurotics, psychophysiological reactions, and the physically ill. This partially explained by the fact that neurotics do get bodily diseases while injury and physical illness can produce somatic anxiety. Rarely…do somatogenic and psychogenic disturbances act independently of the other".

Lain, C.V., & Trapp, E.P. (1962) The differential diagnostic value of MMPI with somatically disturbed patients. Journal of Clinical Psychology, 18, 146-147.

Scale 4 (Pd)

Elevations on the present Scale(s), taking race, gender, age, education, marital and employment status into consideration for this group's data, indicate these clinical features could be present in this person's behavior or history:

> They resent authority. They do not conform their behavior to customary social conventions and expectations. A history of poor job performance, frequent changes in employment and inadequate total income is present. Misdemeant and felony histories mar their records. They do not maintain close personal ties with others. Loyalty is not a top-priority to them. They are hard-bitten individuals who have little of the milk of human kindness flowing in their veins.

Persons with elevated scores on these scales 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 [hem 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, n222j). Unsuspected illnesses are frequently discovered in the often-unlikely event that neurologically compromised and chronically mentally ill persons receive thorough medical evaluations. [N333).

Personality Disorders

The DSM-IV-TR (American Psychiatric Association 2000) definition for a Personality Disorder is:

1. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. The pattern is manifested in two (or more) of the following areas:

   Cognition (i.e., ways of perceiving and interpreting self, other people, and events).

   Affect (i.e., range, intensity, lability, and appropriateness of emotional response).

   Interpersonal functioning.

   Impulse Control.

2. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

3. The enduring pattern leads to clinically significant distress or impairment with social, occupational, or other important areas of functioning.

4. The pattern is stable and of long duration, and its onset can be traced Back at least to adolescence or early adulthood.

5. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

6. The enduring pattern is not due to direct physiological effects of a Substance (i.e., a drug of abuse, a medication) or a general medical condition (i.e., head trauma).

Diagnostic & Statistical manual of mental disorders (4th ed. –TR) 2000, Washington, D.C.: American Psychiatric Association.

Frosch (1983) defines psychopathy as a deviant developmental disturbance characterized by an inordinate amount of instinctual aggression and the absence of an object relational capacity to bond.

Frosch, J. (1983). The Psychotic Process. New York: International Universities Press.

Meloy (1992) adds, "… a fundamental *disidentification* with humanity".

Meloy, J.R. (1992). The psychopathic mind: origins, dynamics, and treatment. North Vale, N.J.: Jason Aronson, Inc.

Pinel (1801) described a group of persons who were impulsive and self-destructive, but without defects in reasoning.

Pinel, P. (1801). *Traite medico-philosophique sur l'alienation mentale. Paris: Richard, Caille et Ravier.*

Prichard (1835) coined the term "moral insanity" implying the damage to social relations observed in histories of persons diagnosed with Personality Disorders.

Prichard, J.C. (1835). A Treatise on Insanity. New York: Hafner.

Freud (1916) viewed psychopaths as, "…those who commit crimes without any sense of guilt, who have developed no moral inhibitions or who, in their conflict with society, consider themselves justified in their actions".

Freud, S. (1916). Some character types met with in psychoanalytic work. Standard Edition 14: 309-333. London: Hogarth Press, 1957.

Cleckley (1976) theorized, …a selective defect…prevents important components of normal (emotional) experience from being integrated into…human interactions." The vacuum or non-existence of genuine emotions may be the biological and psychodynamic hallmark of the psychopath's existence.

Living without an "echo chamber of the emotions" eliminates the reflected emotional reverberations, which form the guiding support and "glue" of conceptual activities. The absence of this emotional background activity, or disruptions and distortions in it, produce strained, approximate, situationally bound reasoning to fill the gap. Sensations alone demand fulfillment. Intellect directs the individual's efforts to satisfy the sensation seeking demands. The object chosen are frequently other

people, substances, fast vehicles, or any other means of intensifying pleasurable sensations.

Rationalization is a way of life for the psychopath. (Wallace 2003). The gulf between the emotions that psychopaths experience and those of other people with whom the psychopath interacts, remains an unbridgeable chasm. A healthy person sees the psychopath as “ just not getting it”, i.e., the sense of the emotions involved in interactions.

Meloy focuses on the psychopath’s *“disidentification with humanity”,* which takes on many forms. Most of these forms fall short of those found in full-blown psychopathy. Character disordered individuals, broadly conceived, may experience temporary emptiness of emotional sensations. This emptiness is plastic, expanding and contracting in turn. Cognitive efficiency deteriorates into flawed thinking and acting as the emotional depletion intensifies.

The absence of the fuel of emotions robs cognition of its energy and capacity to guide the formation of an idea. The dynamic force of the emotions’ capacity to direct cognition’s ability to participate in the creation of ideational auto-correcting mirrors reflecting the pleasure and pain, which could result from future acts, does not exist. An avalanche of interpersonal failures buries the development of empathy, compassion, and caring essential to all successful human acts.

Hare (1993) portrays “…*the crux of the issue (*pertaining to the psychopath): *Psychopaths do not feel they have psychological or emotional problems, and they see no reason to change their behavior to conform to societal standards with which they do not agree”. (p. 95).* Hare continues saying that psychopaths are satisfied with themselves the way they are. They find their behavior brings them those rewards they seek. They have no regrets or concerns for the future. “They perceive themselves as superior human beings in a hostile, dog-eat-dog world in which others are competitors for power and resources.” (p. 195). Psychopaths are convinced it is their right to get what they want using any and all means available to them. Hare shares the conviction that psychopaths enjoy a “rock-solid” personality structure that is resilient and unchangeable.

Hare, R.D. (1993). Without Conscience. New York: The Guilford Press.

Personality Disorders present with common features. Their response to stress is inflexible. They do not seem able to solve the situation leading up to the stress. Their inability to experience satisfaction in work and loving relationships is usually more evident when compared to other peoples’ lives. Their inability to share emotions with others and grasp the salient features of the emotions other people experience because of interacting with them eventuates in misunderstanding and emotional upheavals all around. They have an unusually well developed ability to get under the skin of other people. They know how to make other people feel miserable, upset, and angry. The other person feels they have done something

wrong but cannot figure out why. They cannot put their finger on exactly why they feel the way they do after an encounter with a psychopath. The personality-disordered individual leaves a trail of emotional wreckage behind them. This is the hallmark of their journey through life.

The DSM-IV-TR (2000) divides the personality disorders into three groups:

Cluster A. Odd or Eccentric

Paranoid Personality Disorder. This is a pervasive distrust of others. Theiy interpret others' motives as malevolent, beginning by early adulthood and present in a variety of contexts. The estimated base rate in the general population is 0.5 to 2.5 percent.

Schizoid Personality Disorder. A pervasive pattern of detachment from social relationships and a restricted range of (emotional) expression in interpersonal settings, beginning by early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 7.5 percent.

Schizotypal Personality Disorder. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relations as well as by cognitive or perceptual distortions and eccentricities of behavior; beginning by early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 3 percent. One forth of those persons so diagnosed develop schizophrenia.

Cluster B. Dramatic, Emotional, Erratic.

Antisocial Personality Disorder. A pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15 is present. The estimated base rate in the general population is 1 percent for females and 3 percent for males.

Borderline Personality Disorder. A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 2 percent.

Histrionic Personality Disorder. A pervasive pattern of excessive emotionality and attention seeking, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 2 to 3 percent.

Narcissistic Personality Disorder. A pervasive pattern of grandiosity (in fantasy and behavior), need for admiration, and lack of empathy, beginning in early adulthood and present in a variety of contexts is present. The base rate in the general population is 1 percent.

Cluster C. Anxious and Fearful

Avoidant Personality Disorder. A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 0.5 to 1 percent.

Dependant Personality Disorder. A pervasive pattern and need to be taken care of that leads to submissive and clinging behavior and fear of separation, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is among the most frequently encountered in the Personality Disordered group.

Obsessive-Compulsive Personality Disorder. A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 1 percent and is twice as common in males than in females.

Scale 4 (Pd)

Scale 4 (Pd) has 50 items in both the MMPI and MMPI-2. Twenty-four of the items are scored in the true direction. Twenty-six of the items are scored in the false direction. A K correction of 0.4 (K raw score multiplied by 0.4) is added to the Scale 4 (Pd) raw score. Item overlap is: **L. (0), F (4), K (8), 1 (1), 2 (7), 3 (10), 5 (3), 6 (8), 7 (6), 8 (10), 9 (7), Sie (11).** Scales 3, 8 and Sie have many items in common with Scale 4 (Pd). Test-retest correlations for Scale 4 (Pd) are .74 with an interval of up to 1 year (McKinley and Hathaway 1944). Butcher et al. (1989) reports test-retest correlations of .80 with the MMPI-2 for an interval of one week with samples of healthy people.

McKinley, J.C., & Hathaway, S.R. (1944) The MMPI: V. Hysteria, hypomania, and psychopathic deviate. Journal of Applied Psychology, 28, 153-174.

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 and their needs for repeated re-assurance from caregivers, who subsequently give 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. Their awareness focuses on maintaining their own physical integrity and the ready availability of medical help.

They chronically experience profound fear of being unwanted or abandoned. They fear becoming emotionally invested in relationships with others and in establishing long-term goals. Typically, during periods of stress in childhood they had no one to turn to. They suppress and “numb out” their feelings.

They now will appear aloof, distant, and hard to engage in meaningful relationships although some of them are superficially charming. Chronic anger and hostility enter all of their behaviors and relationships. They employ deceit, dissimulation, and underhanded means to astutely control the people around them.

Treatment is stormy. They require constant involvement with the therapeutic relationship just to keep them involved. They often feel that the therapist cannot be trusted. Frequently, this is a projection of their own view of the world as a "dog eat dog" place where people play games and do not really care about anyone but themselves.

Among therapeutic approaches most likely, to succeed would be techniques of forcing the client to engage ongoing feelings in "real life" situations. Dealing with transference on a regular basis is also important. Patients with this profile may also show a positive response if they can re-engage the painful experience of feeling unwanted or emotionally abandoned as children, and thereby reactivate their "numbed out" feelings (Marks, P.A., 1987).

Some patients with this profile may present as stereotypical, disgruntled medical patients who are angry and complaining about the unfairness of a fate, which burdened them with an illness or injury (Marks, 1991). The diagnoses rendered frequently include the Axis I Somatoform Disorders (DSM-IV) whose aggregate base rate is 1.74 percent for the 1-4 Profile Pattern from a clinical sample of 15,316 patients from 52 JCAHO accredited hospitals.

It is sometimes characteristic of an individual preoccupied with fears of having, or the idea that one has a serious disease, all of which is a misinterpretation of one or more bodily sensations or symptoms. Their preoccupations may be with bodily functions, minor physical abnormalities, or with vague and ambiguous physical sensations (Ettari, 2001). The patient may focus on these symptoms or signs of the suspected disease(s) and

become deeply concerned with their meaning, authenticity, and etiology (DSM-IV) The concerns may involve several functional systems simultaneously or at alternating intervals. There may be preoccupations with a specific organ or a single disease. Repeated utilization of a variety of healthcare resources ranging from multiple private practitioners and a series of admissions to different hospitals is a possibility. The results of treatments are often questionable and meet progressively with diminished effectiveness. "Doctor-shopping" is common as well as deterioration in the doctor-patient relationships over time. Frustration and anger on both sides is commonly the outcome (Wallace, 2001).

Individuals with this disorder often believe that they are not getting proper medical care. They may strenuously resist referral to mental health settings. Complications may arise from repeated diagnostic procedures, which carry their own risks and are costs. However, because these individuals have a history of multiple complaints, which are without a clear-cut physical basis, they may eventually begin to receive cursory evaluations. Failed diagnoses general medical condition occurs (Nims, 2002).

Their preoccupation with their perceived conditions strains social relationships. These individuals expect and demand from family member's special treatment and consideration. Family life may become disturbed, as it focuses upon assuring this individual's physical welfare and happiness.

If the individual limits their hypochondriacal preoccupations to the time they send after work, there may be no effect on their functioning at work. More often, the preoccupation interferes with performance and causes the person to miss time from work. In more severe cases, the individual with this type of profile may deteriorate to a level of invalidism (Christopher, 2001). Serious clinical consideration should he given to the possibility that the early stages of neurological conditions (e.g., multiple sclerosis or myasthenia gravis. endocrine conditions (e.g., thyroid or parathyroid disease), diseases thin affect multiple body systems (e.g.. systemic lupus erythematosus), and occult malignancies, is yet to be diagnosed (Addario, 1999).

These individuals usually describe their complaints in colorful, exaggerated terms, but specific, information is often lacking. They are often-inconsistent historians. A checklist approach to diagnostic interviewing may be effective. A thorough review of documented medical treatments and hospitalizations can reveal patterns of frequent somatic complaints (DSM-IV).

They often seek treatment from several physicians concurrently, which may lead to complicated and sometimes hazardous combinations of treatments. Prominent anxiety symptoms and depressed mood are common and may lead to their admission in mental health settings. There may be histories of impulsive and antisocial behavior, suicide threats and attempts, and marital discord.

These patients crave personal care and the caregivers focusing their attention on the patient's physical concerns and complaints meet their constant needs for reassurance. They may chronically perpetuate a fear of bodily harm, physical illness, pain, and death. Typically, an illness early in the patient's life or patient's family or an early experience of

physical abuse resulted in the conditioned overprotective behaviors intended to shield the client from physical injury by reducing both the rate and incidence of motor activity, is encountered. Their awareness focuses on maintaining physical integrity and the availability of medical help (Nims, 2002).

The most frequently rendered diagnosis is for Hypochondriasis; the second most frequently rendered diagnosis is for Somatoform Disorder. This profile type is frequently characteristic of alcohol abuse, and alcohol dependence.

The Axis II diagnoses of Antisocial Personality Disorder, Paranoid Personality Disorder, and Avoidant Personality Disorder are often associated with a 1-4 Pattern. Depression with somatization, agitation, and paranoid thinking is present in the 1-4 Pattern. Homosexuality is rare and when it is, it is part of the paranoid thinking disorder. Psychotic decompensation may occur (Wallace, 2001).

Another significant feature of this profile type may be a pattern of avoidance of work, social, or academic activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection. Career advancement opportunities may be missed or declined because the patient's belief that new responsibilities might result in criticism from co-workers. These individuals avoid making new friends. They want assurances from others that they are without criticism accepted before they will take initiatives to make new friends (Blount, 1998). They think other people are critical and disapproving of them until they pass stringent tests to the contrary. Individuals with this type of profile will not join in-group activities unless there are repeated and generous offers of support and nurturance. Interpersonal intimacy is difficult for them, although they may able to establish intimate relationships when there is assurance of acceptance and nurturing (Wallace, 2001).

They may act with restraint, have difficulty talking about their feelings, and withhold intimate feelings for fear of exposure, ridiculed, or shamed (Marks, 1996). Attempts to reassure these patients about their health and focus them on their psychological problems only increase their fear that they will be overwhelmed by pain with nobody to turn to. A more effective approach would be to use desensitization techniques. Have the patient retell their frightening earlier experiences, which lead to their pain and fear of death. This could diffuse the emotional charge that led the client to overprotect against bodily harm and loss of bodily function. The focus in therapy should lie to encourage the client to "… express anger and sadness about past losses without blaming themselves or others (Nims, 1998).

Frequent use of medications may lead to side effects and Substance-Related Disorders. The diagnosis of Alcohol Abuse, Alcohol Dependence, and Alcohol Intoxication (DSM-IV) is frequently present with the 1-4 Profile Pattern, which is derived from a clinical sample of 15,316 patients hospitalized in 52 JCAHO installations. The mean number of inpatient episodes for this group is two; the mean number of outpatient episodes is one. The mean number of years for alcohol use is 6.5. The mean number of years of drug use is 4.2. Clearly, alcohol and drug use and abuse enter the person's life to a significant degree. Self-comforting and self-soothing is present in the vast majority of cases where the patient

has met with little or no success in resolving their medical and psychological problems. Problems in living are a constant source of dissatisfaction, disappointment, and pain. The patients grasp for any means available to them, legal or illegal, for surcease for their pain and disillusionment. Antisocial Personality Disorder diagnoses are rendered frequently, along with diagnoses of Dependant Personality Disorder, Avoidant Personality Disorder, and Schizotypal Personality Disorder. In summary, it seems fair to say the 1-4 Profile Patterns contains within it many possible sets of problems in living. The most striking features relate to fear of illness and depression. They often seek treatment from several physicians concurrently, which may lead to complicated and sometimes hazardous combinations of treatments. Prominent anxiety symptoms and depressed mood are common. This leads to their admission to mental health settings. There may be histories of impulsive and antisocial behavior, suicide threats and attempts, and marital discord. Additional characteristics may include feelings of inadequacy, generalized loss of interest or pleasure, social withdrawal feelings of guilt, brooding about the past, subjective feelings of irritability or excessive anger, low self-esteem, feelings of hopelessness, diminished mental activities, poor appetite or overrating, poor concentration, difficulty making decisions, low energy, insomnia or hypersomnia fatigue and decreased physical activity, effectiveness, or productivity (DSM-IV). The lives of these individuals, particularly, those with associated Personality Disorders are often as chaotic and complicated as their medical histories (Millon, 1998). Frequent use of medications may lead to side effects and Substance-Related Disorders. These individuals commonly undergo numerous medical examinations, diagnostic procedures, surgeries, and hospitalizations, which expose the person to an increased risk of morbidity associated with these procedures. These patients crave personal care and the caregivers focusing their attention on the patient’s physical concerns and complaints meet their constant needs for reassurance. 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, resulted in the conditioning of various overprotective behaviors that shielded the client from physical injury by reducing both the rate and incidence of motor activity. Their awareness focuses on maintaining physical integrity and the availability of medical resources (Nims, 2002).

The base rate for the 1-4 Pattern in the total aggregate population of 15,361 cases, which were drawn from 52 JACHO accredited-hospitals is 1.74 percent.

DSM-IV diagnoses rendered for the1-4 Pattern are: Axis I: 300.7 Hypochondriasis 300.81 Somatization Disorder 305.00 Alcohol Abuse 303.90 Alcohol Dependence 300.3 Social Phobia 296.30 Mood disorder NOS Axis II: 301.7 Antisocial Personality Disorder 301.0 Paranoid Personality Disorder 301.82 Avoidant Personality Disorder.