1-5 Pattern

Male

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:

> 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 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 symptoms. They are not due to malingering or factitious disorder and not culturally sanctioned. General medical condition or effects of a substance cannot explain them. The symptoms cause impairment in social or occupational functioning. Causes marked distress, or requires medical attention**. Hypochondriasis. This preoccupation** is 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 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 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 can be explained partially 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.

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:

Scale 5 (Mf)

> They are self-effacing. They prefer to influence others employing indirect means. They are concerned for the welfare and happiness of others. They are frightened of expressing their genuine felling and emotions to others. They like to bold, assertive, out-going, domineering partners. They have mastered the art of placating angry people. They are yielding collaborators given the opportunity. They are interested in the management of a domicile, decorating, art, and

cultural pursuits. They are capable of taking on other person's burdens as their own. They go out of their way to maintain contacts with people who they consider need them in their lives. Others do not reciprocated in many instances. They find they attract people who are not capable of returning the sensitivity, and generosity. They display a fussy, complaining, and sometimes cynical, defeatist life-style. Somatic complaints are frequently the focus of their complaints.

Persons with the 1-5 Pattern 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, n222j. Unsuspected illnesses appear in the often-unlikely event that neurologically compromised and chronically mentally ill persons should receive thorough medical evaluations, [n333].

Scale 5 (Mf)

The Terman and Miles (1936) investigations, which commenced in 1922, into the masculine and feminine interest patterns of intellectually superior children, form the basis of the Masculinity/Femininity Scale of the MMPI and MMPI-2. A series of masculinity and femininity tests (M-F test) were developed. "…the scores tended to be correlated with general masculinity and femininity behavior and to reveal an important line of cleavage in personality and temperament." (p. 13).

Terman, L.M., & Miles, C.C. (19360. Sex and Personality. (2nd ed.). New York, McGraw-Hill.

Terman observed, "In modern Occidental culture, at least, the typical woman is believed to differ from the typical man in the greater richness and variety of her emotional life and in the extent to which her everyday behavior is emotionally determined. In particular, who is believed to experience in greater degree than the average man the tender emotions, including sympathy, pity, and parental love; to be more given to cherishing and protective behavior of all kinds. Compared to men she is more timid and more readily overcome by fear. She is more religious and at the same time more prone to jealousy, suspicion, and injured feelings. Sexually she is by nature less promiscuous that men, is coy rather than aggressive, and her feelings are less specifically localized in her body. Submissiveness, docility, inferior steadfastness of purpose, and a general lack of aggressiveness reflect her weaker conative tendencies (the ability to stick with a complex and demanding task and see it through to a successful completion). Her moral life is shaped less by principles that by personal relationships, but thanks to her lack of adventurousness she is much less subject than men are are to most types of criminal behavior. Her sentiments are more complex than man's and dispose her personality to refinement, gentility, and pre-occupation with the artistic and cultural." (p. 2).

Volentine (1981) investigated femininity interest items on the Bem Sex Role Inventory and Scale 5 of the MMPI. The correlations supported the conclusion that Scale 5 more clearly reflects feminine rather that masculine interest patterns.

Volentine, S.Z. (1981). The assessment of masculinity and femininity: Scale 5 of the MMPI compared with the BSRI and PAQ. Journal of Clinical Psychology, 37, 367-374.

Hathaway and McKinley (1940) developed Scale 5 to identify homosexuals. Items from the Terman and Miles Attitude-Interest Analysis Test (1936) were incorporated into Scale 5 after the data had already been collected from the original normative sample. Dahlstrom (1972) said, “Scale 5 was designed to identify the personality features related to the **disorder** of male sexual inversion”. “Persons with the personality pattern often engage in homoerotic practices as part of their feminine emotional makeup; however, many of these men are too inhibited or full of conflict to make any overt expression of their sexual preference. (p. 201).

Hathaway, S.R. (1956). Scales 5 (Masculinity/Femininity), 6 (Paranoia), and 8 (Schizophrenia). In G.S. Welsh & W.G. Dahlstrom (Eds.), Basic readings on the MMPI in psychology and medicine (pp. 104-111). Minneapolis: University of Minnesota Press.

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

Terman and Miles (1936) concluded,” It (the M-F test) does not measure homosexuality, as that term is commonly used, but it does measure, roughly, (the) degree of inversion of the sex temperament …” (p. 467). “ … a serious limitation to the present usefulness of the (M-F) test lies in the fact that as yet too little is known about the behavior correlated with high and low scores”. (p. 9). This appears to by true to this day. “Most empathic warning is necessary against the assumption that an extremely feminine score for males or an extremely masculine score for females can serve as an adequate basis for the diagnosis of homosexuality, either overt or latent”. (p. 9). “…probably a majority of subjects who test as variates in the direction of the opposite sex are capable of making a perfectly normal heterosexual adjustment.” (p. 9).

Hathaway and McKinley (1956) concluded that Scale 5 did not identify homosexuals. Wong (1984) stated that subsequent attempts to construct independent scales to identify homosexuals have met a similar fate.

Foerstner (1946) investigated the bipolar construction of Scale 5 (Mf) in a series of extensive examinations of large psychiatric in- and out-patient populations. The MMPI subtests developed by Harris and Lingoes (1955), Serkownek’s 1975 in Schwerger (1987), Weiner (1948), and Wiggins (1966) were factor analyzed. Friedman, et al, (2001) commented, “It is clear from the data reported in Foerstner’s (1984) study that Scale 5 (and Scale 0) is multifactorial in nature; therefore, its composition is not limited

to masculine-feminine factors. Scale 5 scores, whether high or low, may be achieved by item endorsements of any of the combination of at least 6 factors". (Wong,1984).

Foerstner, S.B. (1984). The factor structure and stability of selected Minnesota Multiphasic Personality Inventory subscales: Harris and Lingoes subscales, Wiggins's content scales, Weiner subscales, and Serkownek subscales. Doctoral dissertation. University of Akron, Ohio.

Harris, R.E., & Lingoes, J.C. (1955). Subscales for the MMPI: An aide to profile interpretation. Department of Psychiatry. University of California.

Serkownek, K. (1975). Subscales for Scales 5 and 0 of the MMPI. Unpublished manuscript.

Schwerger, J.M., Foerstner, S.B., Serkownek, K., & Ritz, G. (1987). History and validities of the Serkownek subscales for MMPI Scales 5 and 0. Psychological Reports, 61, 227-235.

Weiner, J.S. (1948). Subtle and obvious keys for the MMPI. Journal of Consulting Psychology, 12, 164-170.

Wiggins, J.S. (1966). Substantive dimensions of self-report in the MMPI item pool. Psychological Monographs, (80), (22, Whole No. 630).

Wong, M.R. (1984). MMPI Scale 5 meaning or lack thereof. Journal of Personality Assessment, 48, 279-284.

Friedman, A.F., Lewak, R., Nichols, D.S., & Webb, J.T. (2001). Psychological Assessment with the MMPI-2. Mahwah, N.J.: Lawrence Erlbaum Associates, Publishers.

Kunce and Anderson (1984) think normal men who have high Scale 5 scores entertain many interests and are tolerant of diversity. Low Scale 5 score in normal men may reflect assertiveness, a need for physical activity, competitiveness, enthusiasm for sports, and little interest in revealing much about themselves. Normal females who score high on Scale 5 (Mf) are confident, energetic, and in control of their lives. Low Scale 5 scores for normal females suggest an acceptance of the attitudes and interests of a typically feminine person as defined by the current cultural milieu.

Kunce, J., & Anderson, W. (1984). Perspectives on uses of the MMPI in psychiatric settings In P. McReynolds & G.T. Chelvne (Eds.). Advances in psychological assessment (Vol.6, pp. 41-76.

Wallace (2001) suggests the psychiatric male population with high Scale 4 (Pd) combined with low Scale 5 (Mf) scores are seen a vigorously seeking out opportunities for narcissistic masculine self-indulgence. These men use other people to satisfy their

urges. They are indifferent to the impact their behavior has upon others. Female psychiatric populations who have high Scale 4 and low Scale 5 scores suggest angry hostile females who are provocative troublemakers. They twist what is said to them to the point the original message is unrecognizable. This maneuver puts the recipient of her retorts off balance and more easily confused and manipulated. They use guilt to dominate those relationships they find useful to achieving their own interests and goals. They have little to no capacity for empathy.

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

Scale 5 (Mf)

Twenty-three of the Scale 5 (Mf) items are from the item pool of Terman and Miles work, Sex and Personality (1936). Thirty-seven items are from the MMPI pool. The MMPI-2 has 56 items for Scale 5 (Mf). Scale 5 (Mf) measures masculinity/femininity attitudes wherein high Scale 5 (Mf) scores reflect more feminine attitudes in males and low Scale 5 (Mf) scores indicate attitudes that are more feminine with females. Twenty-five of the MMPI-2 Scale 5 (Mf) items are scored in the true direction and 31 are scored in the false direction for men. Twenty-three of Scale 5 (Mf) items are scored in the true direction for females and 33 items are scored in the false direction. Scale 5 (Mf) norms are formed from linear Tscores instead of the Uniform Tscores utilized in the norming of the MMPI-2. Test-retest correlations on Scale 5 (Mf) run from .79 to .83 for 1 to 2 day intervals with psychiatric patients, .79 to .79 for a 1 to 2 week interval for psychiatric patients and .72 for 1 to 2 week intervals with college students (Dahlstrom 1975). Item overlap is: **L (1), F (2), K (3), 1 (0), 2 (2), 3 (4), 4 (3), 6 (2), 7 (1), 8 (4), 9 (3), Sie (9).**

Dahlstrom, W.G., Welsh, G.S., & Dahlstrom, L.E. (1975) An MMPI handbook: Vol. II. Research applications. (Rev. ed.). Minneapolis: University of Minnesota Press.

PROFILE CHARACTERISTICS

Marks said these patients crave personal care. Their demands that their perpetual needs for re-assurance be met by the constant attention of caregivers to their physical requirements. They 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 physical integrity and the availability of medical help in the future.

It is likely that these patients are experiencing disturbances in role functioning such as gender identity issues and not one's sexual preference. The stronger the role dissatisfaction, the more the individual identifies with values, interests, and behaviors

stereotypic of the opposite sex. For men, this may suggest a close boy-mother (or female surrogate) childhood relationship in which the mother would confide in the boy and discourage displays of "masculine" aggression.

The boy-father (or male surrogate) relationship was less close, intense or present. There may also be a genetic component to such role instability. Male patients tend to have been non-aggressive and sensitive as boys.

Assertiveness training may be of help for these men. Expressing the bottled up anger, which gave rise to the tensions expressed as somatic symptoms, may also give relief. (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 0.35 percent for the 1-5 Profile Pattern from a clinical sample of 15,316 patients from 52 JCAHO accredited hospitals.

It is sometimes characteristic that the fears they have of getting, or the idea that they have a serious disease, are based upon 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" occurs as well as deterioration in the doctor-patient relationships. 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. Professionals fail to diagnose general medical conditions (Nims, 2002).

Social relationships become strained due to the preoccupation with their perceived conditions. These individuals expect and demand from family members' special treatment and consideration. The focus upon assuring this individual's physical welfare and happiness disturbs family life.

Their health related pre-occupations might have no effect on their functioning at work, if the individual limits their hypochondriacal preoccupations to the time they send after 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) Clinical consideration should he given to the possibility that an underlying general medical condition is yet to be diagnosed. 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) may need to be ruled out.

The patient's responses may also reflect a mourning process, due to some real or imaginary loss that has been blocked from their awareness and which may have existed for a long period. Sadness, fear, and/or anger are being discharged through a fusion with physical symptoms. This person has resentments over has not having been well taken care of by others; that their body has let them down, are combined with the somatic features of their problems (Marks, 1998).

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 is recommended to 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 being seen in 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).

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 help (Nims, 2002).

Additionally, patients with this profile often experience fear of irretrievable loss of some highly valued physical or emotional object. As indicated, they tend to respond to this loss by blocking further needing or "wanting". They lock into the "despair" phase of the mourning process. They are afraid to cry, feel, or express anger. They will need to express anger and "rage at fate" in order to finish the grieving process. Frequently these patients will discuss past losses and present feelings of hopelessness about ever being happy, and they ignore now positive feelings or events that happen to them in the present.

The second most frequently rendered diagnosis is Dysthymic Disorder and the third most frequently rendered diagnosis is for Delusional Disorder, the fourth is Brief Psychotic Disorder, the fifth Schizophreniform Disorder and the sixth Sexual Dysfunction NOS. The Axis II diagnoses are Narcissistic Personality Disorder and Schizotypal Personality Disorder.

The base rate for the 1-5 Pattern in the total aggregate population of 15,361 cases, which are drawn from 52 JACHO, accredited hospitals is 0.35 percent.

DSM-IV diagnoses rendered for the 1-5 Pattern are: Axis I: 300.81 Somatization Disorder 300.4 Dysthymic disorder 297.1 Delusional Disorder 298.8 Brief Psychotic disorder 295.40 Schizophreniform Disorder 302.70 Sexual Dysfunction NOS Axis II: 301.81 Narcissistic Personality Disorder 301.22 Schizotypal Personality Disorder.