1-7 Pattern

Clinical Scale Elevations

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 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.

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 condition is not due to malingering or factitious disorder and not culturally sanctioned. General medical condition or effects of a substance cannot explain the disorder. The disorder causes impairment in social or occupational functioning. Causes 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 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 cannot be 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.

Psychasthenia

Pierre Janet (1903) defined psychasthenia as “…the lack of psychological strength associated with a narrowing of consciousness”. (Ellenberger 1970 p. 375).

Ellenberger, H.F. (1970). The Discovery of the Unconscious: the history and evolution of dynamic psychiatry. New York: Basic Books, Inc., Publishers.

Janet distinguishes "…two types of psychasthenia crises, fits of anxiety, and all kinds of conspicuous manifestations related to fixed ideas". "…Those fixed ideas were conscious in the form of obsessions and phobias". (Ellenberger 1970 p. 376).

Janet (1930) wrote, "In my description of the symptoms of the psychasthenic neurosis (Janet 1903), I stressed particularly the pathological feelings (*sentiments pathologiques*), which I designated at the time as feelings of inadequacy (*sentiments d'incomplétude*) and which have become in my last book a part of the feelings of emptiness (*sentiments du vide*)". Janet includes the symptom of "…the maladies of doubt".

Janet, Pierre (1903). *Les obsessions et la psychasthenia*, 2 volumes (Paris: Alcan). Vol. I by Pierre Janet, Vol. II by F. Raymond, and P. Janet.

Neurotic disorders were the preferred designation of all anxiety related mental disorders prior to the development of the Diagnostic and Statistical Manuals classifications, which now lists them as anxiety disorders. The DSM-IV-TR (2000) classifies anxiety disorders into nine categories.

Panic Disorder is the recurrent episodes of panic attacks. At least one of the attacks is followed by one month (or more) of the following: Persistent concern about having additional attacks. Worry about the consequences of an attack, i.e., "I'm going crazy", having a heart attack, and loosing self-control. Patients fear significant changes in their behavior. Panic disorder with and without agoraphobia and additional diagnoses with panic disorder is also a possible diagnosis.

Phobic Disorder is an irrational fear of an object or situation that persists although the person recognizes the fear is irrational. These specific phobias are Agoraphobia, the fear of being alone in an open or public area where escape might be difficult. The person is often terrified of leaving their home or residence; Social Phobia, the fear of situations where one might be seen and embarrassed or criticized. Speaking to person in authority, speaking in public or performing before an audience are avoided; Specific Phobia, a fear of a specific object, activity, or situation, i.e., fear of flying (Jong's Syndrome), snakes, mice, and closed places, amongst others.

Common Phobias

Feared Object Or Situation	Clinical Name
Animal	Zoophobia
Being Alone	Monophobia
Blood	Hematophobia
Fire	Pyrophobia
Closed Places	Claustrophobia
Darkness	Nyctophobia
Electrical Storms	Astrophobia
Germs/Dirt	Mysophobia
Heights	Acrophobia
Open Spaces	Agoraphobia
Strangers	Xenophobia
Talking	Glossophobia
Water	Hydrophobia

Obsessive-Compulsive Disorder (OCD) defines a preoccupation with persistent intrusive thoughts, impulses, or images. Compulsions are repetitive behaviors or mental acts that the person feels driven to perform in order to reduce distress or prevent a dreaded event or situation. The person knows the obsessions/compulsions are excessive and unreasonable. The obsession/compulsion is time consuming and can cause distress.

Generalizes Anxiety Disorder (GAD) is defined as excessive worry and anxiety more days than not over a period of the preceding six months. The person cannot control their worrying. The anxiety and worry is associated with three or more of these six symptoms: Restlessness, feeling keyed-up, easy fatigue ability, difficulty concentrating, irritability, muscular tension, and sleep disturbances. The anxiety and worry as well as physical symptoms, which follow on the anxiety and worry cause significant impairment in social, occupational, or other areas of important functioning.

Clinical Presentation of Anxiety Disorders

Panic Disorder. A panic attack is the sudden appearance of intense fear or dread, which may announce impending doom. Terror paralyzes its victim. Terror shakes the individual's hold on the elements of reality. They can neither see nor think clearly. They may think they are loosing their minds. Physical sensations including palpitations, chest pain, suffocation, nausea, chills and hot flashes erupt unexpectedly. The abrupt onset of these attacks last a number of minutes and then subside.

Panic Disorder and Agoraphobia characterizes recurring panic attacks, which combine with agoraphobia.

Phobias are persistent, irrational fears of specific objects or situations, which an individual avoids. High levels of anxiety and distress arise from contact with objects or situations, which most people find innocuous, i.e., the sight of blood, looking down from heights, thunder and lightening, viewing open expanses over water, enclosed spaces, among many others.

Social Phobias involve fear and anxiety arising from engagement in social situations or situations in which a performance is expected of the person. Afflicted persons fear they will say something foolish, which would expose them to ridicule or shame; not being able to answer a simple question, which would reveal they are stupid; forgetting their lines or saying them wrong in a play would expose them as inept are examples of social phobias.

Fear of speaking in public is a common social fear. The life of persons living with social phobias becomes more and more constricted as they avoid more and more objects and situations which cause them to be paralyzed with fear. Alcohol and drugs reduce the distress they experience.

Obsessive-Compulsive Disorder. Obsessions are experienced as thoughts or images that keep recurring without let-up. They are meaningless in and of themselves. They occur within a matrix of persistent intense anxiety.

Compulsions are procedures adopted and followed rigorously, to control the experience of anxiety and reduce the intensity of the anxiety. These procedures lead to temporary relief. A tune repeated repeatedly is one's head is such an example. Repeated questioning such as, "Did I turn off the stove?" "Did I turn off the lights?" Did I lock the door?" drive the person to check their activities many times over and often lead to self-dissatisfaction. Crippling doubts centering on violence, illness or death, contaminations, and sexuality cause the individual to feel humiliated, shamed, and disgusted with him or herself. The demand-performances, procedures, and rituals involved in compulsions interfere with accomplishing necessary everyday activities and the fulfillment of obligations to other people.

Generalized Anxiety Disorder is overweening worry and anxiety, which has persisted over the foregoing six months and is present along with sleeplessness, tension, irritability, poor concentration, tiredness, and fidgeting. The person worries about letting people down, not being able to earn enough money, illness with family members, doing poorly at work with a fear of being fired, and feeling they are not up to the task of effective living. They spend their nights going over the day's failures seeking means to make things come out right and solving problems in their heads. They continuously review past mistakes, problems and fret over future developments. They fear making mistakes of even the simplest sorts. They view their own decisions as inadequate and problematical.

Posttraumatic Stress Disorder is intense fear, helplessness, and terror associated with the repeatedly re-experiencing memories of traumatic events where threatened or actual injury or death has occurred. Intrusive recall of these events in flashbacks, dreams, or incidental everyday experiences bring the recollected trauma backs to life in full force. The person refrains from reawakening memories of the trauma.

Feelings of emptiness, the loss of the capacity to respond emotionally, being distant and unavailable to others, the incapacity to connect and a hopeless sense of detachment lead to the conviction life must be lived in a vacuous isolation.

Exaggerated startle responses, an all-pervasive guardness, heightened vigilance, and, a sense of an irremediable loss and death of essential portions of their emotional lives form barriers to full and productive lives. Self-medication, chemical abuse, re-fighting the traumas in real time with real people, physical abuse of family members, brushes with the law complicate social, economic, and civic behaviors.

Acute Stress Disorder is the reaction to an immediate stressor, which abates when the issues involved in causing the stress cease.

The Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Test-Revised (DSM-IV-TR, APA 2000) lists a mixed anxiety-depressive disorder wherein a dysphoric mood has lasted for a least one month; the dysphoric mood is associated with four or more of the following symptoms.

Difficulty concentrating, the mind goes blank, difficulty falling asleep or staying asleep or unsatisfying sleep, fatigue and low energy, irritability, worry, easily moved to tears, heightened vigilance, anticipating the worst, catastrophizing, hopelessness, all encompassing pessimism, a bleak out look on the future, low self-esteem and a sense of being worthless. Additional comorbid disorders include substance abuse, Somatization, and physical disorders.

Anxiety Disorder	Base Rate %	Comorbid Diagnosis
Generalized Anxiety Disorder	4-5	Agoraphobia Major Depression Panic Disorder Somatoform Disorder
Panic Disorder	1-3.5	Agoraphobia (30- 40%)
Major Depression	21.3	

Phobia		Agoraphobia (2.8-5.3%)
		Anxiety Disorder
		Alcohol and Substance Abuse
Social Phobia	7.9-13	Alcohol and Substance Abuse
Obsessive-Compulsive Disorder	2-2.5	Major Depressions
		Panic Disorder
		Phobias
Posttraumatic Stress Disorder	1.0	General Population
	2.0	Traumatized Persons
		Panic Attacks
		Substance Abuse
		Depression
		Somatization

(Welkowitz, et al. 2000, and Horworth and Weisman 2000)

Welkowitz, L.A., Strvening, E.L., Pittman, J., Guardino, M., and Welkowoitz, J. (2000). Obsessive-compulsive disorder and comorbid anxiety problems in a national anxiety-screening sample. Journal of Anxiety Disorders, 14(5): 471-482.

Horworth, E., and Weissman, N.M. (2000). The epidemiology and cross-national presentation of obsessive-compulsive disorder. Psychiatric Clinics of North America, 23(3): 493-507.

Tellegen, et al (2003) created the MMPI-2 Restructured Clinical (RC) Scales as a response to the need to clarify the saturation of the MMPI scales with a common, emotionally saturated factor, which can be broadly specified as generalized anxiety. This emotional factor colors all emotional life. The negative manifestations are termed Demoralization.

This Demoralization Scale is composed of only 24 items drawn from clinical Scale 2 (Depression) and Scale 7 (Psychasthenia). The Demoralization Scale reflects overall emotional discomfort, which combines feelings of demoralization, discouragement, insecurity, pessimism, and poor self-esteem.

A sense of failure pervades a person's evaluations of their life's achievements. The individual feels helpless, overwhelmed, and unable to make things turn out satisfactorily.

The RC factor corresponds well with Janet's descriptions of his patients who suffered from Psychasthenia. Statistical confirmation of a century old clinical phenomenon is a hopeful sign.

Tellegen, A., Ben-Porath, Y.S., McNulty, J.L., Arbisi, P.A., Graham, J.R., and Kaemmer, B. (2003). The MMPI-2 Restructured Clinical Scales: Development, validation, and interpretation. Minneapolis, MN: University of Minnesota Press.

Scale 7 (Pt) has 47 items in both the MMPI and MMPI-2. Thirty-nine items are scored in the true direction and nine are scored in the false direction. A K-correction multiplier of 1.0 is added to the Scale 7 (Pt) raw score. Item overlap is: **L (0), F (1), K (2), 1 (2), 2 (13), 3 (7), 4 (6), 5 (1), 6 (4), 8 (17), 9 (3), Sie (9).** Scale 7 (Pt) and Scale 8 (Sc) have many items in common. Elevations on Scale 7 (Pt) will raise the score and Scale 8 (Sc). High scores may measure any of a variety of subjective difficulties ranging from concentration problems to frank psychoses (Comrey 1958). Test-retest correlations on Scale 7 (Pt) range from .83 to .86 in a 1 t 2 day interval for psychiatric patients and from to .49 to .58 for a one year interval, also for psychiatric patients (Dahlstrom et al. 1975). Similar results were reported in Butcher et al. (1989) with the MMPI-2 with normals for intervals of 1 to 2 days.

Comrey, A.L. (1958). A factor analysis of items on the MMPI Psychasthenia scale. Educational and Psychological Measurement, 18, 293-300.

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

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

Scale 7 (Pt)

They are dissatisfied with their social relationships. They are not confident about what to expect from others much less themselves. They are rigid, habit bound, and self-critical. They cannot stop themselves from thinking unpleasant and frightening thoughts. They sweat the small things. They often overlook the most important parts of the “Big Picture”.

They often overlook salient features of a problem or social situation. They can feel “dumb” when they realize what they had missed or left out. They are meticulous about their work and person. They drive themselves hard to reach personally import goals. They are unusually persistent. Their rigid approach to life intensifies; should they become ill, suffer accidents or injuries.

Persons with the 1-7 Pattern are typically preoccupied and focused upon physical symptoms and complaints. Stress causes physical symptoms to come to the fore. Unsuspected Illnesses are frequently uncovered in the unlikely event that neurologically impaired and chronically mentally ill persons receive thorough medical evaluations [n333].

PROFILE CHARACTERISTICS

These patients long for personal care. Their demand reassurance, acceptance, and continuous support. These demands must be by massive attention to their physical requirements from caregivers. Additional clinical characteristics of this profile include a profound fear of unpredictable frightening events. They worry about trying to predict the future by thinking ahead of all possible eventualities.

These patients are amenable to almost any form of therapy. Implosion techniques in conjunction with insight therapy can be particularly useful as can desensitization to the originally unpredictable and frightening experiences (Marks, P.A., 1987). The use

of relaxation techniques and thought blocking training as well as supportive psychotherapy is helpful.

Prominent anxiety symptoms and depressed mood are common and may lead to their admission to mental health settings. Additional characteristics include feelings of inadequacy, generalized loss of interest or pleasure, and social withdrawal. Feelings of guilt, brooding about the past and subjective feelings of irritability or excessive anger exist.

Low self-esteem, feelings of hopelessness, and diminished mental activities, as well as poor appetite or overrating, poor concentration, and difficulty making decisions impair functioning. Low energy levels, insomnia, fatigue, and decreased physical activity decrease effectiveness and productivity. (DSM-IV)

These individuals may tend to avoid making new friends, unless they are certain others like and accept them without criticism (Blount, 1998). Individuals with this type of profile will not join group activities unless they receive support to do so. Interpersonal intimacy is often difficult for them, although they are able to establish intimate relationships when there is assurance of acceptance and nurturing (Wallace, 2000).

They may act with restraint, have difficulty talking about their lives, and withhold intimate feelings for fear they will be exposed, ridiculed, or shamed (Marks, 1996).

They lend to be shy, quiet, inhibited, and "invisible". The diagnoses rendered frequently include the Axis I Somatoform Disorders (DSM-IV) whose aggregate base rate is 1.71 percent for the 1-7 Profile Pattern from a clinical sample of 15,316 patients from 52 JCAHO accredited hospitals. The most frequently rendered diagnosis is for Somatization Disorder and the second most frequently rendered diagnosis is for Eating Disorder NOS. Axis II diagnoses include Obsessive-Compulsive Personality and Dependant Personality Disorder. These patients follow through with prescribed medical care. They are gratifying patients.