

1-8 Pattern

Scale 1 (Hs)

Elevations on these Scales 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 and history:

Their bodily sensations frighten them. They often misinterpret what their bodily sensations signify. Their self-centered behaviors shape the responses others make to their personal health concerns. **They want the problems they encounter in life solved by other people. The more help they receive, the more helpless they become.** They let others know when they are under stress what they want by complaining and lamenting their fate. They cannot be satisfied no matter what other people do for them. All attempts at assistance are thwarted. 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 stressors initiate or exacerbate the symptoms. It is not due to malingering or factitious disorder and not culturally sanctioned. A general medical condition or effects of a substance cannot explain the symptoms. The symptoms cause impairment in social or occupational functioning. Causes marked distress, or requires medical attention. **Hypochondriasis**. **This is a preoccupation** is 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). 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. Symptoms are not intentionally produced or feigned. If medical condition present, it plays a minor role in accounting for pain. Pain may be 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 presence of another mental disorder does not account for the preoccupation.

DSM-IV-TR (2000) Diagnostic and statistical manual of mental disorders (4th ed., text 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.

Scale(s) 8 (Sc)

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 get little satisfaction from the company of others. They prefer to live in a fantasy world of their own creation. Fantasy provides them with the satisfactions they cannot get from living in a world most people occupy. Their thinking can be original, but when expressed makes others just a little uncomfortable. They find it hard to get people to understand them. Their thinking decompensates when they find themselves under pressure to perform tasks, which they find, are beyond their ability to deal with effectively. They exist with a compromised capacity to meet social and economic demands. They live isolated, lonely lives. They find solace and comfort in alcohol and drugs of pleasure.

Persons with the 1-8 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. Illnesses are can be discovered in the often-unlikely event that neurologically compromised and chronically mentally ill persons receive thorough medical evaluations [n 333).

Schizophrenia

Wallace (2001) describes schizophrenia in all of its manifestations, as the most prominent or obvious feature of schizophrenic disturbance is incoherent, illogical, or inappropriate abstract thinking. Incoherent thinking involves a disruption in the sequence of thoughts so that one thought does not flow continuously and coherently from another. They lose track of what they are saying. They may express a series of loosely related ideas that is difficult to follow.

Schizophrenics report they feel misunderstood, punished for no reason they can remember, and plotted against by persons who do not have their best interests at heart. They pull back from any person or situation they see as challenging them personally. They

have few or no friends. Their social skills are not well developed. They relate in a clumsy and rigid way to others. They have little flexibility responding to others wishes, needs, or expectations. They are easily frightened. Nichols and Greene (1995) note the schizophrenics' emotional disengagement reveals, "...pathological disengagement from life that discounts future interests, prospects, and engagement to the extent that they can no longer serve as incentives for continuing to live" (p. 29).

Nichols, D.S., & Greene, R.L. (1995) MMPI-2 structural summary: Interpretive manual. Odessa, FL.: Psychological Assessment Resources.

Schizophrenics tell of their difficulties thinking straight. Their problems with attention, concentration, remembering, plague them and prevent them from arriving at correct solutions to problems. They cannot formulate reasonable goals. They lack the intellectual energy required to plan, direct, correct processing errors, and rousing themselves to meet the occasions reflected in their goals.

Schizophrenics fear they will lose their minds. They cower at the prospect of suddenly finding they do not know who they are, the dying of their own self. They are at times restless, thin-skinned, and ultra sensitive to anything they construe as a reference to themselves. They can react violently to a perceived slight, threat, or insult.

Illogical thinking consists of reaching unreasonable conclusions based upon circumstantial evidence. Thinking at inappropriate levels of abstraction, is characteristic of a person with schizophrenia. Schizophrenic people use words in an overly concrete or literal manner.

Perceptual distortions result in poor judgment. They cannot assess their experience realistically. They act in odd or queer ways. The lives of schizophrenic people are dotted with such instances of poor judgment, which stems from unrealistic assessment of a situation, of themselves, or of the consequences of their actions. The disordered thinking and inaccurate perception of schizophrenic people often cause them to overlook or misjudge the feelings, motives, and actions of others.

They behave in ways that others find insensitive, self-centered, contentious, presumptuous, and suspicious or in some other way objectionable. Their poor social skills make it difficult for them to make or keep friends, even when they try. They frequently withdraw physically and become social isolates in their both work and recreation. They avoid situations that can bring them into close contact with others.

Many withdraw emotionally while placing themselves physically in close proximity to others. Public events sometimes help schizophrenics preserve the fiction that they are meaningfully involved with others. Even when mingling with other people, they maintain a psychological distance by keeping their thoughts and feelings to themselves and interacting only on a formal, impersonal level.

Schizophrenic persons are frequently unable to prevent anxiety-provoking and socially unacceptable ideas from occupying their minds. Uncontrollable aggressive and sexual

fantasies and constant concern about terrible events they might cause or suffer from are particularly likely to make the schizophrenics existence a waking nightmare.

Schizophrenics are consequently subject to severe bouts of anxiety and self-disgust. They have difficulty distinguishing between their dreams and waking reality. Schizophrenics also suffer from poor integration of their feelings and thoughts. They may show blunted affect with little or no emotional response to any situations, or such inappropriate affect as giggling while relating a violently aggressive fantasy or crying while describing how good they feel.

Schizophrenics may be unable to prevent and control their aggressive and sexual ideas. When several of these impairments occur together and persist over any length of time, schizophrenia is present.

A prominent mood disorder coexists along side a schizophrenia is present in schizoaffective disorders. Subtypes include affective bipolar and depressive types.

Schizophrenia, which exists along with grossly disorganized behavior, incoherence, marked loosening of associations; flat emotionally and grossly inappropriate affect is associated with disorganized schizophrenia.

Schizophrenia exists along with a preoccupation with systemized delusions, auditory hallucinations, argumentativeness, and possibility for violence and over-wearing suspiciousness is associated with paranoid schizophrenia.

Schizophrenia manifested by many or all of its variations including prominent delusions, hallucinations, incoherence, and grossly disorganized behaviors is associated with undifferentiated schizophrenia.

The DSM-IV-TR (2000) list the diagnostic criteria for schizophrenia as:

Characteristic Symptoms. Two or more of the following during a one-month period (or less if successfully treated): **Delusions, hallucinations**, and disorganized speech (loosening of associations), grossly disorganized behavior or catatonic (with extreme motor retardation or extreme motor agitation), negative symptoms (e.g., emotional blunting, loss of interest in things and activities, inability to experience happiness).

If bizarre delusions or auditory hallucinations **and** a. voices keep a running commentary about the person's thoughts and behaviors **or** b. two or more voices converse with each other **then** only one criterion is needed.

A. **Social/Occupational Dysfunction.** **If** one or more major areas of the person's life are markedly below premorbid functioning (work, interpersonal relations or self-care) **or if** childhood or adolescence failure to achieve expected levels of interpersonal, academic, or occupational achievement **then meets** the **B** criteria.

B. **Duration.** Continuous signs persist for at least six months with at least one month that meets the **A** criteria (Active Phase) and may include prodromal (early warning signs) or residual symptoms.

D. Rule out all other mental diseases (e.g., schizoaffective/mood disorders). **All other medical conditions** (substance use/medications or general medical conditions) have been ruled out. **If a history of pervasive developmental disorders exists** then prominent, hallucinations or delusions must be present for one month to make the diagnosis of schizophrenia.

Diagnostic and Statistical Manual of Mental Disorders, Text Revision, Fourth edition. (2000). American Psychiatric Association.

Schizophrenia is (DSM-IV-TR 2000, p. 297) a psychotic disorder, which encompasses delusions, hallucinations, and disorganized behavior and speech.

The symptoms of schizophrenia are classified further as positive, negative, cognitive, and disorganized. **Positive** symptoms are delusions, hallucinations, paranoia, and bizarre behavior. These symptoms have been historically the major focus of treatment. **Negative** symptoms are apathy, loss of pleasure, disordered thought, and the loss of interest in engaging in vital life activities. These negative symptoms are the most crippling. **Cognitive** symptoms refer to deficits in attention, concentration, memory, decision-making, and problem solving. Anderson et al. (1998) think cognitive symptoms are the principle disabilities associated with schizophrenia. **Disorganized** symptoms signify the degree of disorganization of affect or behavior.

Anderson, C., Chakos, M., Mailman, R., & Lieberman, J. (1998) Emerging roles for novel antipsychotic medications in the treatment of schizophrenia. *Psychiatric Clinics of North America*, 21(1), 151-179.

Lishman (1998) writes, "The acute organic reactions are called forth by a great number of different pathological processes affecting the brain..." (p. 9). A host of misfortunes follow-on brain insults, i.e., fragmentation of attention, thinking, and purposive reality based action, diminution of the powers of memory, and failures of judgment (p. 9-13).

Acute and chronic central nervous system conditions lead to psychotic reactions. Schizophrenia is one diagnostic possibility, which present with manifold symptoms. Head injuries at times lead to schizophrenic conditions. "All forms of schizophrenia have been reported after head injury..." (p. 190). "Paranoid forms are reported to be especially common..." (p. 190). Achte et al. (1969) followed 3552 head injured Finnish WW II soldiers for over 20 years. Ninety-two of these cases developed schizophrenic like symptoms (2.6 percent).

Achte, K.A., Hillbom, E., & Aalberg, V. (1969) Psychoses following war brain injuries. *Acta Psychiatrica Scandinavica* 45, 1-18.

Achté found that mild brain injuries produced schizophrenia more frequently than did severe brain injuries. Whether or not other precipitating factors, such as familial histories of schizophrenia, added to the vulnerability to develop schizophrenia after head injuries is not clear. Lishman (1998), p. 190, writes, "... the early onset of the psychosis (is) related to (the) severity of diffuse brain injury, and a possible special association with temporal lobe damage". Achté reported 2.1 percent of the group of brain injured Finnish WW II soldiers he studied were diagnoses with paranoid conditions.

Tumors of the temporal lobe are associated with schizophrenia. This is a rare occurrence, but greater than the occurrence in the general population. Pituitary tumors are also associated with the development of schizophrenia (Davison and Bagley (1969).

Davison, K., & Bagley, C.R. (1969) Schizophrenia-like psychoses associated with organic disorders of the central nervous system: a review of the literature In Current Problems in Neuropsychiatry. Herrington, R.N. (Ed.) British Journal of Psychiatry Special Publication No.4. Headly Brothers: Ashford, Kent.

Mendez et al. (1993) reports the excessive occurrence of schizophrenia with epilepsy. Interictal schizophrenia disorders occurred in 9.25 percent of 1611 epileptic patients. Complex partial seizures are associated with epilepsy and simultaneously occurring schizophrenia.

Mendez, M.F., Grau, R., Doss, R.C., & Taylor, J.L. ((1993) Schizophrenia in epilepsy: seizure and psychoses variables. *Neurology*, 43,1073-1077.

Slater, et al. (1963) systematically collected 69 patients with unequivocal evidence of epilepsy that subsequently developed schizophrenia. The majority of these patients, 80 percent, experienced an insidious onset of symptoms with delusions as the first manifestation. Paranoid symptoms were present in the majority of the cases. Delusions were present in nearly all cases. Auditory hallucinations occurred in nearly half of the cases. Visual hallucinations were present in 16 percent of the cases. Thought disorders occurred in half of the patients.

Slater interpreted the changes observed in the epileptic schizophrenia patients as organic personality changes manifested by lack of spontaneity, dullness, (mental) retardation, concrete thinking, and memory deficits. The epileptic foci were in the temporal lobe in 2/3rds of the cases.

Slater, E., Beard, A.W., & Glithero, E. (1963). The schizophrenic-like disorders of epilepsy. *British Journal of Psychiatry*, 109, 95-150.

Schizophrenic-like disorders are also associated with cannabis intoxication, general paresis, Huntington's disease, hyperthyroidism, hypothyroidism, narcolepsy, systemic lupus erythematosus, Wilson's disease, Korsakoff's Syndrome, multiple sclerosis, stroke, uremia, among other physical conditions Lishman (1998).

The causes of schizophrenia are unclear. Schizophrenia has multiple interrelated etiologies, i.e., biological, genetic, and developmental abnormalities of the brain (Varcarolis 2002, p. 525).

Varcarolis, E.M. (2002) Foundations of psychiatric mental health nursing: a clinical approach. Fourth edition. Philadelphia: W.B. Saunders Company.

A long list of chemical neurotransmitters, which are involved in the production of schizophrenic disorders, has been identified. Dopamine, norepinephrine, serotonin, glutamate, GABA, and neuropeptides are among the many biochemical substances associated with the development of schizophrenia.

Genetic investigations with identical twins reveal a 45 percent chance of one twin developing a schizophrenic disorder if the other twin is so affected. If one twin has an autistic spectrum disorder, the other twin stands a 60 percent chance of developing impairments of communication and deficits in social interaction, i.e., Asperger's Syndrome. Some twins do not develop these disorders, however. Genetic causation is only a partial answer to the conundrum of the causation of the schizophrenic disorders (Hyman 2003, p. 99).

Hyman, S.E. (2003) Diagnosing disorders. Special issue: Better Brains. September 2003. Scientific American, 289(3), 96-103.

Jones and Cannon (1998) noted if one parent were schizophrenic, 12 percent of the children would become schizophrenic. If both parents are schizophrenic, 46 percent of the children will be also.

Jones, P., & Cannon, M. (1998). The new epidemiology of schizophrenia. Psychiatric Clinics of North America, 12(1): 1-25.

Neuroimaging studies of individuals diagnosed with schizophrenia provide evidence of enlargement of the lateral ventricles, atrophy of the frontal lobes and the cortex in general as well as atrophy of the cerebellum, enlargement of the third ventricle and asymmetry of one or both ventricles (Kaplan and Shadock 1995).

Kaplan, H.I., & Shadock, B.J. (1995) Synopsis of psychiatry, 6th ed. Baltimore: Williams & Wilkins.

Thompson et al. (2001) found significant anatomical changes in brains of schizophrenic adolescents between the ages of 13 and 18 with a marked loss of gray matter in the cerebral cortex. This loss increased as the cellular losses progressed, spreading to other areas of the brain. These anatomical abnormalities were synchronous with the severity of the development of the psychotic symptoms and impairments produced by these diseases.

Thompson, P.M., Vidal, C., Giedd, J.N., Gochman, P., Blumenthal, J., Nicolson, R., Toga, A., & Rapoport, J.L. (2001) *Proceedings of the National Academy of Sciences USA*, 98(20), 11650-11655.

Scale 8 on the MMPI and MMPI-2 contains 78 items. These Scale 8 items overlap with 11 other scales: **F (15), K (1), 1 (2), 2 (10), 3 (8), 4 (6), 5 (4), 6 (13), 7 (17), 9 (11), and Scale 0 (6)**. It is not readily apparent with elevations on Scale 8 just which symptoms would be observed in any one patient who may or may not be diagnosed with schizophrenia. All of the K scale items answered in the deviant direction are added to the Scale 8 raw score. Any 20 Scale 8 items endorsed in the deviant direction are needed to produce a Tscore of 65 when the client has an average score on the K scale. (Greene 1991, p. 169).

The development of the K scale improved the hit rate of Scale 8 (Dahlstrom and Dahlstrom 1980). This results in the increase in the Scale 8 relative to the standardization group. This piggy backing on the norms group's data permitted the criterion group's data to mounted above the normative group's score elevations in order to make Scale 8 elevations more prominent. Cross validation, studies were able to correctly identify no more than 60 percent of the total number of schizophrenics studied. Hathaway (1980) reported that a considerable number of cases in 91 cross validation studies scored below a Tscore of 61 on Scale 8. Friedman et al. (2001) concluded, "A diagnostic conclusion of schizophrenia cannot be made solely on the basis of a Scale 8 elevation" (p. 132). Butcher and Williams (1992) are of the opinion that Scale 8 clinical elevations can be due to severe depression, severe personality disorders, a 'rebel without a cause' attitude, sensory deficits, or a "cry-for-help". Anderson and Kuncze (1984) found high scoring Scale 8 college students, who suffered from social isolation, loneliness, and the inability to engage with others, were not schizophrenic.

Psychiatric settings yielding similar MMPI scores lead to different interpretations than those gotten in non-psychiatric settings. Greene (2000) investigated MMPI data collected on psychiatric inpatients and out patients. The most frequent code pattern for men was 86, for women the 48, 84, and 86 code patterns were prominent. Psychiatric diagnoses were wide ranging. There is no assurance that Scale 8 elevations are associated exclusively with schizophrenic disorders.

Hathaway, S.R. (1980) Scales 5 (Masculinity-Femininity), 6 (Paranoia), and * (Schizophrenia). In W.G. Dahlstrom & L. Dahlstrom (Eds.), (1980). *Basic reading in the MMPI: A new selection on personality measurement* (pp. 65-75). Minneapolis. University of Minnesota Press.

Greene, R.L. (1991) *The MMPI-MMPI-2: An interpretive manual*. Boston: Allyn & Bacon.

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

Butcher, J.N., & Williams, C.L. (1992) *Essentials of MMPI-2 and MMPI-A interpretation*. Minneapolis: University of Minnesota Press.

Anderson, W.P. & Kuncze, J.T. (1984) Diagnostic implications of markedly elevated MMPI Sc (Scale 8) scores for non-hospitalized clients. *Journal of Clinical Psychology*, 40, 925-930.

Eronen et al. (1996) investigated the relationship between schizophrenia and homicidal behavior with 93 homicide offenders with schizophrenia using the MMPI and WAIS-R. Calculations of the odds-ratios revealed that the risk of committing a homicide was about 10 times greater for schizophrenia offenders of both genders than it was for the general population. Schizophrenia without alcoholism increase the odds ration more that 7 times, schizophrenia with coexisting alcoholism increase the odds ration by more that 17 times in men.

Eronen, M., Tilhonen, J., & Hakola, P. (1996) Schizophrenia and homicidal behavior. *Schizophrenia Bulletin*, 22(1), 83-90.

Dalby et al. (1994) examined whether or not cognitive decline in schizophrenia predict by test results of the Wechsler Adult Intelligence Scale - Revised, the Wide Range Achievement, the MMPI-2, the Brief Psychiatric Rating Scale, the Scale for the Assessment of Positive Symptoms, and the Scale for the Assessment of Negative Symptoms. They conclude, "...cognitive decline is a separate clinical dimension **not** predictable from the variables measures".

Dalby, J.T., Williams, R., Dickson, R., & Yuen, O. (1994) *Journal of Psychiarty & Neuroscience*. November, 19(5), 381-382.

MacNiven and Finlayson ((1993) studied the relationship between the MMPI and the Halstead-Reitan Neuropsychological Test Battery Category Test with 59patients who had suffered closed head injuries. The results suggest that patients with better psychological functioning perform at a higher level and make a greater post-traumatic recovery on neurocognitive tests.

MacNiven, E., & Finlayson, M.A. (1993) *Brain Injury*, 7(3), 241-246.

PROFILE CHARACTERISTICS

Marks said an early illness in the patient or patient's family, or an early experience of physical abuse, conditioned various overprotective behaviors that shielded the patient from physical injury by reducing both the rate and incidence of motor activity. Their awareness focuses upon maintaining physical integrity and the availability of medical help.

These patients long for personal care. They want their caregivers to supply them with their needs for reassurance, acceptance, and continuous support by giving them massive attention to their physical requirements. They perpetuate a fear of bodily harm, physical illnesses, pain, and death. It is likely that patients with this profile had a childhoods characterized by being despised and rejected by a person upon whom life and security depended. Perhaps in some instances, the child expressed some peculiar habit or eccentricities or was handicapped in some way, which led others to express anger, hatred,

and resentment towards the child. A child would protect itself by "shutting down" cognitively and emotionally. This would lead in turn to impairments in cognitive and emotional functioning.

Therapy with these patients should concentrate on helping them feel comfortable now. Avoid moving into uncovering therapy too quickly is highly disorganizing to these patients and change. Achieving insight often leads these patients to feeling even more alienated and defective about themselves. They are sensitive to hostility in any form. They will require a steady, consistent, warm, interactive, and positive therapeutic relationship (Marks, P.A., 1987).

Others describe these patients as shy, retiring persons who avoid the limelight. They have had many disappointments in forming friendships. They are clumsy socially. They do not grasp relevant social clues and fail to respond appropriately to initiatives from others. They have become accustomed to isolation. They have few or no friends. Their affective prosody is monotonic. They are not spontaneous or interesting people.

Unhappiness pervades their lives. They do not laugh much. They have problems concentrating on economically and socially important tasks. Their thinking is garbled, fragmented, and ineffective. They are easily distracted and confused. They spend a lot of time in fantasy. Daydreaming gives them the illusion of satisfactions denied them in their daily lives.

Presenting complaints focus on physical illnesses. They may have had several illnesses in the past. They say they suffer from headaches and insomnia. Their somatic concerns may signal the vulnerability to the development of a psychotic episode.

The aggregate base rate for the 1-8 Pattern is 1.29 percent drawn from a clinical sample of 15,316 patients from 52 JACHO accredited hospitals.

Frequently rendered Axis I diagnoses are for Alcohol Abuse and Dependence, Hypochondrias, Generalized Anxiety Disorders, and Delusional Disorders.

Axis II diagnoses are Schizoid, Paranoid, Borderline, and Avoidant Personality Disorders.