2-0 Pattern

Elevations of this magnitude for this Scale considering this group's data indicate these clinical features could be present in this person's behavior and history:

They are sad and unhappy most of the time. They look at the future through wistful eyes, and out of their reach. They are easily discouraged and quickly put off from initiating important plans and activities. They are sad and unhappy most of the time. They look at the future through wistful eyes, and out of their reach. They are easily discouraged and quickly put off from initiating important plans and activities. They are depressed, pessimistic, and deeply worried. They feel unworthy and inadequate. They could be silently angry and unable to admit it to themselves. A reactive depression could be present. They are severely depressed, tired, and indifferent to everyday human contacts. Mental retardation and lethargy interfere with everyday activities.
Case review may indicate their need for medication referral.

Depressive Disorders

Mood is a pervasive, sustained emotion operating in the background of mental life that colors the person's outlook on the world (APA 2000).

American Psychiatric Association (2000). Practice guidelines for the treatment of psychiatric disorders. Washington, D.C.: American Psychiatric Press.

The predominant feature in depressive disorders is a disturbance of mood manifested by a loss of interest in personally valued activities in all cases. The loss of pleasure when the individual anticipated and engaged in these activities eventuates in the collapse of this emotional background. A sense of pain pervades the person's life and all of the activities in which they engage. They cannot adequately put the pain they feel into words.

Physically they loose or gain weight; have sleep disturbances, either sleeping less or more than usual; feel too tired to do engage in everyday activities, and have less of an appetite for intimacy. They feel guilty for no good reason. Thoughts of dying, death and of taking their own lives come to plague them. Many may have attempted to kill themselves.

Sleep abnormalities occur in ninety percent of persons hospitalized for treatment of major depressions (APA 2000). People treated in outpatient settings have a 40 to 60 percent chance of experiencing sleep disturbances. Sleep abnormalities persist after recovery from a depressive episode (Thase 1999).

Thase, M. E., (1999) Mood disorders in Neurobiology. In H. I. Kaplan and B. J. Sadock (Eds.), Comprehensive textbook of psychiatry (7th ed., pp. 1318-1327), Vol. I. Philadelphia: Lippincott, Williams & Wilkins.

Ninety seven percent of all cases report a loss of energy. Anxiety occurs in 60 percent of the cases (Zajecka (1995).

Zajecka, J., (1995). Treatment strategies to treating depressions complicated by anxiety disorder. Presented at the U.S. Psychiatric and Mental Health Congress. New York: November 16, 1995.

Thinking, concentration, and memory are impacted. They view themselves as failures in life. They recount their faults and flaws, but do not see their strengths and virtues. They say and say they are terrible persons. A sense of guilt, that has no realistic basis, fills their days. They feel worthless and helpless to change things around in their lives.

They pace about endlessly. They get no rest even when they do nothing at all. They have headaches, backaches, the blahs, constipation, and an all-pervasive sense of discomfort. Activities, which once gave them pleasure no longer, do so. All looks black to them.

Their health deteriorates. Complicated physical conditions arise. Their ability to work is impaired. Social activities are no longer important to them. A general decline in life activities takes place.

The community base rate for major depression in the United States is 3 to 5 percent. The lifetime risk for depression is 5 to 12 percent for men and 10 to 25 percent for women (Diagnostic and Statistical Manual for Mental Disorders, 4th edition, text revision 2000). Unipolar depression is twice as common I women as in men (Dubovsky and Buzan 1999).

Dubovsky, S. L., and Buzan, R., (1999). Mood Disorders in Hales, R. E., Yudofsky, S. C., & Talbott, J. A. (Eds.) Textbook of psychiatry (pp. 479-566) Washington, D.C.: American Psychiatric Press.

Postpartum depression occurs in 10 percent of mothers. The rates for reported depression in preadolescents is 18 percent (Dubovsky and Buzan 1999). Young people between the ages of 9 to 17 yield a 6 percent rate of depression (Varcaroles, E. M. (1999).

Varcaroles, E. M., (1999). The invisible disease: Depression. National Institute of Mental Health. Washington, D.C.

Depression rates for the elderly living in the community is 3.5 percent; 16 percent for medically hospitalized elderly; 15 to 20 percent for our elderly living in nursing homes; and as high as 40 percent in selected groups of elderly (Dubovsky and Buzan 1999).

Depression is associated with general medical conditions, substance-induced mood disorders following the use of recreational and misuse of prescription drugs, bereavement and reaching the end-of-live.

Medical conditions and syndromes associated with Mood Disorders:

System	Diagnoses
Neurologic	Dementias
	Hydrocephalus
	Huntington's Chorea
	Infections, i.e., HIV, neurosyphilis
	Migraines
	Multiple Sclerosis
	Myasthenia Gravis
	Parkinson's Disease
	Seizure Disorders
	Stroke
	Trauma
	Tumors
	Vasculitis
	Wilson's Disease
Endocrine	Addison' Disease
	Cushing's Syndrome
	Diabetes Mellitus
	Hyperparathyroidism
	Hypothyroidism
	Menses-related Depression
	Postpartum Depression
Metabolic/Nutritional	Foliate Deficiency
	Hypercalcemia
	Hypocalcaemia
	Hyponatremia
	Pellagra
	Porphyria
	Uremia
	Vitamin B12 Deficiency
Infections/Inflammatory	Influenza
	Hepatitis
	Mononucleosis
	Pneumonia
	Rheumatoid Arthritis
	Sjogren's Disease
	Systematic Lupus Erythematosus
	Tuberculosis

Mixed	Anemia
	Cardiopulmonary Disease
	Neoplasm
	Sleep Apnea

Mulner, K. K., Florence, T., & Clark, R. R., (1999). Mood and anxiety syndromes in emergency psychiatry. Psychiatric Clinics of North America, 22 (4): 761.

Depressions recur. Sixty percent of those people who have suffered on depressive episode can expect a second episode; seventy percent can expect a third episode; and ninety percent can expect three or more episodes (APA 2000).

American Psychiatric Association (2000). Practice guidelines for the treatment of psychiatric disorders. Washington, D.C.: American Psychiatric Press

Prescription medications associated with Mood Disorders:

Systems	Medication/Substance
Neurologic/Psychiatric	Amantadine
	Anticholinesterase
	Antipsychotics
	Baclofen
	Barbiturates
	Benzodiazepines
	Bromocriptine
	Carbamazepine
	Disulfiram
	Ethosuximide
	Levodopa
	Phenytoin
Antibacterical/Antifungals	Corticosteroids
	Grieseofulvin
	Metronidazole
	Nalidix Acid
	Trimethoprim
Anti-inflammatory/Analgesic	Corticosteroids
	Indomethacin
	Opiates
	Sulindac
Antineoplastic	Aspariginase
	Azothioprine
	Bleomycine

	Hexamethylamine
	Vincristine
	Vinblastine
Cardiovascular	Clonidine
	Digitalis
	Guanethidine
	Methyldopa
	Propranolol
	Resperine
Gastrointestinal	Cimetidine
	Ranitidine
Mixed	Alcohol
	Anxiolitics
	Cocaine
	Heroin
	Marijuana

(Mulner, et al 1999).

Mulner, K. K., Florence, T., & Glick, R. L., (1999). Mood and anxiety syndromes in emergency psychiatry. Psychiatric Clinics of North America, 22(4): 761.

Research studies. Franklin et al. (2002) using Taxometric analyses tested directly whether the MMPI-2 depression scales could differentiate 2000 psychiatric patients with depressive symptoms from patients with other disorders. Taxometric analyses did **not** find a MMPI-2 Depression scale cut point that categorizes patients with depressive symptoms form other patients. The findings support the assumption that the MMPI measures an underlying dimensionality of depression.

Franklin, C. L., Strong, D. R., & Greene, R. L., (2002) A Taxometric analysis of the MMPI-2 Depression Scales. Journal of Personality Assessment, August 79(1), 110-121.

Rohling et al. (2002) examined the effect of depression on neurocognitive performance in patients who passed symptom validity testing. No differences occurred on objective cognitive and psychomotor measures with groups sorted based on their self-reported depression. These data suggest that depression has no impact on objective neurocognitive functioning.

Rohling, M. L., Green, Paul, Allen, L. M. III, & Iverson, G. L., (2002). Depressive Symptoms and neurocognitive test scores with patients passing symptom validity tests. Archives of Clinical Neuropsychology. 17(3), 205-222.

Scale 2 (Dep) measures the presence of clinical depression (Dahlstrom et al. 1972). The MMPI has 60 items. The MMPI-2 has 57 items. Thirty-seven of these items are scored in the false direction, 20 in the true direction. A false response set will elevate Scale 2 (Dep), along with Scale 1 (Hs) and Scale 3 (Hy). Item overlap is: **L (2), F (2), K (8), 1 (10), 3 (13), 4 (7), 5 (2), 6 (2), 7 (13), 8 (10), 9 (5), Sie (8).**

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

Hunsley et al. (1988) provided meta-analytic derived test-retest data for retest intervals of 1 day to 2 years. An average interval consistency of 0.87 was reported for 74 Scale 2 (Dep) studies. Butcher et al. (1989) reported Scale 2 (Dep) test-retest correlations in the 0.79 ranges for the MMPI-2.

Hunsley, J., Hanson, R. K., & Parker, C.H.K., (1988) A summary of the reliability and stability of MMPI Scales. Journal of Clinical Psychology. 44, 44-46.

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.

Clinical Scale Elevations

Scale 0 (Sie)

T-score >70

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

They prefer their own company to that of others. Confrontations with other people force them to withdraw. They are generally fearful of people they do not know well. Trust builds slowly, if at all, for them. They are shy people who do not seek out or like the limelight. They prefer to work alone. They will not go to public events or attend public meetings if given the opportunity. They are unusually quiet persons. They can stand long silences and may even like it. They find it hard to startup a conversation even with people they know well. They dress conservatively. They do not like to attract attention to themselves.

Social
Introversion
Extroversion

The Social Introversion scale is based upon the work of Evans and McConnel (1941) who authored the Minnesota T-S-E Inventory. The investigation centered about the dimensions of Thinking, Social, and Emotional aspects of behavior and their manifestations in either the introverted or the extroverted aspects of a persons behavior.

Evans, C., & McConnell, T. R., (1941) A new measure of introversion-extroversion. Journal of Psychology. 12, 111-124.

Drake (1946) based the Social Introversion (Sie) scale on Evans and McConnell's work with the Minnesota T-S-E Inventory's Social introversion items. Seventy items, which separated the top 65 percent and lowest 35 percent of 100 female college students who served as test subjects, formed the Sie scale.

Drake, L. E., (1946). A social I.E. scale for the Minnesota Multiphasic Personality Inventory. Journal of Applied Psychology. 30, 51-54.

The Sie Scale criterion group is composed of healthy persons. Test norms for males were similar to the female norms; the two groups' combined results form the scale. The norms are composed of 350 female and 193 male college students. [An interesting aspect of this norming reflects the types of males in college during WW II. Those males capable of serving in the Armed Forces were not included or represented in this testing].

The 69 items (MMPI-2) composing the Social Introversion scale overlap with the other scales as follows: **L (0), F (0), K (9), 1 (1), 2 (8), 3 (8), 4 (11), 5f (11), 5m (9), 6 (5), 7 (9), 8 (6), and 9 (6).** 34 items are scored in the true direction, 35 in the false direction. Foerstner's (1986) studies reflect the multifactorial nature of the Sie scale.

Foerstner, S. B., (1986). The factor structure and stability of selected Minnesota Multiphasic Personality Inventory (MMPI) subscales: Harris and Lingoes subscales, Wiggins's content scales, Wiener subscales, and Serkownet subscales. Unpublished dissertation, University of Akron, Ohio.

The Sie scale indicates the degree of comfort a person experiences when they are in the company of other people. Lewak et al. (1990) writes concerning high Sie scale scores, a person had "…a childhood characterized by an absence of warmth and physical contact from others. Elevated scores suggest that these people have extinguished their feeling response to physical touch and affection. They suffer from "affect hunger" and yet, they feel conflicted about close, intimate relationships." (p. 273). Low scores on the other hand suggest an intense need for stimulation afforded by the close proximity of other peoples' energetic activities.

Lewak, R. W., Marks, P.A., & Nelson, G. E., (1990). Therapist's guide to the MMPI and MMPI-2: Providing feedback and treatment. Muncie, IN.: Accelerated Development.

The Sie scale also measures a person's willingness to be in the proximity of others. It includes a person's readiness to engage with others in social and work settings. Introverted people do not have social poise, engage in ready repartee, or involve themselves in quick witted, jocular, give-and-take. They ask themselves, "Why didn't I think of that" as a belated rejoinder to intentionally cutting comments. All those missed opportunities! They are usually not an insider, They are not even familiar with the current in-group's slang or the intimate references used by the in-group.

Introverted people isolate themselves when they feel under pressure. This could be due to the experiences of past disappointments and emotional injuries. They go it alone for lack of any other supportive options.

Extroverted people have learned to welcome the enjoyment they gain from the stimulation other people offer them. They are socially skilled. They give and take on an equal footing. They turn to others in times of difficulties, using these contacts as sources of emotional support and sources of solution to the problems facing them.
They learn from others more easily than they do when attempting to learn new information and skills by themselves. They do not like being alone.

Kunce and Anderson (1984) propose autonomy as the principal force under girding the Social Introversion scale. One can either function as a resourceful, self-directed, independent individual or withdraw into them-selves leaving the world of people behind.

Kunce, J., & Anderson, W., (1984). Perspectives on uses of the MMPI in non-psychiatric settings. In P. McReynolds & C. J. Chelune (Eds.) Advances in psychological assessment. San Francisco: Jossey-Bass.

Research studies with the Sie scale. Steyaert et al. (1994) investigated the higher incidence of psychiatric morbidity in **female fragile X carriers** (fragile X syndrome, also know as the Martin-Bell syndrome, after the British investigators who first reported it in 1943). The tip of the X chromosome tends to break off in many of those affected. Hence, the name Fragile X. Female carriers have more disorders that are schizophrenia-like. The sample mean MMPI scale scores fell within the normal range for a group of 11 females of normal intelligence. Low scores on the Sie scale reflected extraversion, not introversion, as expected.

Steyaert. J., Decruyenaere, M., Borghraef, M., & Fryns, J.P., (1994) Personality profile in adult female fragile X carriers: assessed with the Minnesota Multiphasic Personality Inventory (MMPI). American Journal of Medical Genetics. 51(4), 370-373.

Meehl (1989) proposed a research model opposing biological **vs.** psychological **causation in the genesis of schizophrenia.** Meehl hypothesizes those given unfavorable polygenic potentiators (e.g., introversion, hypohedonia, and anxiety) and adverse life experiences (e.g., childhood trauma or adult misfortune), 10 percent of such individuals so afflicted develop schizophrenia. Meehl concludes, "Taxometric statistics are appropriate to testing a major locus model".

Meehl, P. E., (1989). Schizotaxia revisited. Archives of General Psychiatry, 46(10), 935-944.

Gauci et al., (1993) used the MMPI to study women with allergic rhinitis. Twenty-two female suffers of perennial **allergic rhinitis** (inflammation of the nasal mucosa initiated by botanical airborne substances) and an 18 non-allergic female control group. Allergic sufferers scored significantly higher scores on the Sie scale along with high score on Scale 1 (Hs). Skin reactivity to house dust mite and grass pollen allergens correlated positively with scores on the Sie scale.

Gauci, M., King, M. G., Saxarra, H., Tulloch, B. J., & Husband, A. J., (1993). A Minnesota Multiphasic Personality Inventory profile of women with allergic rhinitis. Psychosomatic Medicine. 55(6), 533-540.

Fals and Schafer (1993) examined the relationship between **compliance with a behavioral therapy program** and MMPI profiles of obsessive-compulsive disorder (OCD) outpatients. Compliance referred to the number of scheduled therapy sessions cancelled or missed. High scores on scales Sie, 2 (D), and 8 (Sc) predicted lower compliance with treatment for OCD patients engaged in behavioral therapy.

Fals, W. W., & Schafer, J., (1993). MMPI correlates of psychotherapy compliance among obsessive-compulsives. Psychopathology. 26(1), 1-15.

Danjou et al. (1991) screened 62 young healthy volunteers with the MMPI for **eligibility to participate in psychopharmacology studies**. The most striking differences occurred on the Sie scale, which was lower than even the controls Sie scores, but significantly higher than controls on Scales 4 (Pd), 9 (Ma), and 8 (Sc). The low Sie scale scores were significant at the .0001 levels. Bias is possible in the selection of psychopharmacology research volunteer subjects. Drug seeking may be an important factor urging young healthy males to volunteer.

Danjou, P., Warot, D., Weiller, E., Lacomblez, L., & Puech, A. J., (1991). Personality of healthy volunteers. Normality and paradox. Therapie. 46(2), 125-129.

Siegler et al. (1997) utilized the MMPI to study 796 women and 3,630 men enrolled in the University of North Carolina Heart Study to test the predictive power of personality on **adult exercise behavior**. Lower scores on Scales 0 (Sie), 2 (D), and 4 (Pd) are predictive of an increased probability of exercising in mid life for both women and men.

Siegler, H. D., Blumenthal, J. A., Barefoot, J. C., Peterson, B. L., Saunders, W. B., Dahlstrom, W. G., Costa, P. T., Suarez, E. C., Helms, M., Maynard, K. D., & Williams, R. B., (1997). Personality factors differentially predict exercise behavior in men and women. Women's 3(1.1), 61-70.

Richman (1983) used the MMPI to study 30 **adolescents with cleft lips and palates**. Heightened social introversion was associated with increased self- consciousness centering on their cleft lips and palates when the adolescents found themselves in social situations.

Richman, L. C., (1983). Self-reported social, speech, and facial concerns and personality adjustment of adolescents with cleft lip and palate. Cleft 20(20), 108-112.

Peterson and Knudson (1983) cross-validated several measures of anhedonia and the MMPI Sie scale. The results of multiple statistical measures lead to the conclusion, "**The high degree of relationship between anhedonia and introversion**, long suggested by clinicians, is confirmed".

Peterson, C. A., & Knudson, R. M., (1983). Anhedonia; a construct validation approach. Journal of Personality. 47(5), 539-555.

Kling et al., (1978) studied the scoring norms **on adolescent psychiatric drug users and non-users MMPI profiles**. Sie scale scores differentiated the users from non-user profiles. Low Sie scores were more frequently associated with drug use.

Klinge, V, Lachar, D., Grisell, J., & Berman, W., (1978). Effects of scoring norms on adolescent psychiatric drug users and non-users MMPI profiles. Adolescence 13(49), 1-11.

Ansseau et al., (1986) investigated the relationship between MMPI scale scores and **dexamethasone suppression tests** (DST) with42 patients diagnosed with **major depression**. The Sie scale scores correlated positively with depression and negatively with Scale 9 (Ma) scale scores.

Ansseau, M., Frenckell, R., Frank, G., Geenen, V., & Legros, J. J., (1986). Dexamethasone suppression test and MMPI scales. Neuropsychobiology. 16(2-3), 68-71.

Nocita et al. (1986) used the MMPI to investigate the relationship between the **MMPI Sie scale** and the experience 83 **introverted clients** had in **counseling sessions**. Clients with higher Sie scale scores rated their sessions as uncomfortable, unpleasant, tense, rough, and difficult. They rated their post-session mood as unfriendly, uncertain, sad, angry, and afraid.

Nocita, A., & Stiles, W.B., (1986). Client introversion and counseling session impact. Journal of Counseling Psychology. 33(3), 235-241.

Yen and Shirley (2003) investigated the MMPI subscales ability to differentiate male **suicide completers, clinically depressed men, and a control group of men who died of medical causes**. Suicide completers have significantly higher Sie scores when compared to depressed and deceased controls.

Yen, S., & Shirley, I. C., (2003). Self-blame, social introversion and male suicides: Prospective data from a longitudinal study. Archives of Suicide Research. 7(1), 17-27.

Craig and Bivens (2000) examined the relationship between **psychological needs** of 198 non-clinical subjects using the Adjective Check List **and the MMPI. Scale O (Sie) scale** scores were positively associated with need for receiving support, showing deference to others, and a preference for being a follower rather than a leader. The same scores were negatively associated with needs for achievement, dominance, autonomy, and exhibitionism.

Craig, R. J., & Bivens, A., (2000). Psychological needs associated with MMPI-2 scales in a non-clinical sample. Journal of Personality Assessment. 74(3), 439-446.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 2-0 Pattern on the MMPI-A are 1.80 percent and on the MMPI 0.90 percent. Base rates for adolescent females with the 2-0 Pattern are 3.80 percent and 1.80 percent respectively (Archer, 1997).

Archer, R. P., (1997). MMPI-A: Assessing Adolescent Psychopathology (2nd ed.). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Adolescents with the 2-0 Pattern are described as conforming, quiet, and law abiding. Social skills are usually not well developed. The 2-0 Pattern adolescent is referred to treatment because of tension, anxiety, exquisite emotional sensitivity, and fear of involvement with others. They are meek, isolated, lonely, obedient, and have few friends. They do not use alcohol or drugs. They do not think they are attractive. They feel they are not as good as others are. They say they are awkward, uncoordinated, not athletic, uninteresting, sad, and not courageous (Marks et al., 1974).

Marks, P. A., Seeman, W., & Haller, D. L., (1974). The Actuarial Use of the MMPI with Adolescents and Adults. New York: Oxford University Press

The 2-0 Pattern bespeaks of a sad introverted person. People with the 2-0 Pattern are shy, ill at ease in social situations, quiet, unhappy, and restrained. Their depressions are deeply ingrained (Greene 2000).

Greene, R. L., (2000). The MMPI-2/MMPI: An Interpretive Manual (2nd ed.). Boston: Allyn and Bacon.

Kelly and King (1979) found the 2-0 Pattern showed indecisiveness and indecision.

Kelly, C. K., & King, G. D., (1979). Behavioral correlates of infrequent two-point MMPI code types at a university mental health center. Journal of Clinical Psychology. 35, 576-585.

Insomnia is often present. They have few friends. They become social-wallpaper at gatherings. They avoid the limelight (Wallace 2001).

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

Marks writes that these patients are often unhappy, withdrawn, guilty, and shy. They feel isolated, lack self-confidence and have limited tolerance for social and emotional relationships. It is likely that as children they received very little physical warmth, affection and contact. Usually the parents were not outwardly cruel and hostile but rather were withdrawn, socially inept or retiring and limited in their ability to receive or give physical warmth and comfort themselves.

In some instances the parent's viewed the outward display of emotion as a weakness and the child learned how to control feelings and stop emotional wanting. These patients typically have difficulty touching, holding, caressing, or kissing. The profile reflects a stable personality pattern, which is quite resistant to therapeutic exploration.

Patients with this profile often experience fear of irretrievable loss of some highly valued physical or emotional object. They tend to respond to this loss by blocking of further needing or "wanting." They are locked in the "despair" phase of the mourning process and are afraid to cry and feel angry. 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 any positive feelings or events that happen to them in the present.

Attempts to reassure these patients about their health and focus them on their psychological problems only increases their fear that they will be overwhelmed by pain with nobody to turn to. A more effective approach would be through desensitization by the patient re-telling the frightening earlier experiences relating to pain and fear of death and thereby diffusing the emotional charge that led the client to overprotect against bodily harm and loss of bodily function.

Clinical studies indicate that introvert tendencies tend to be stable over long periods. People who were shy and socially uncomfortable as children often remain so as adults. Some elements may have been determined genetically, but this type of profile also reflects a childhood characterized by an absence of outward human warmth and physical contact.

The socially extroverted adolescent, who has trouble studying because of their frequent socializing and social drifting, often becomes the adult who is constantly trying to be in the middle of social events. This possibly suggests a person whose increased need for

social stimulation may be driven by a significant degree of insecurity rather than a need for more intense social experiences.

Therapy for these patients should concentrate on helping them find ways to accept and enjoy their shyness rather than their trying to change their shyness through desensitization and thereby possibly exposing themselves to what they may feel as degrading experiences. Therapy could help the client learn the importance of physical contact and, through the developing of social skills, how to be more assertive and comfortable with others. They need help to feel comfortable with their own feelings.

For those patients who are more socially mobile, effective therapeutic interventions should concentrate on helping them accept, reinforce and enhance their self-confidence and structure their socializing so that it doesn't interfere with their responsibilities (Marks, P.A., 1987）.

Marks, PA. (1987). The Marks MMPI Adolescent Report and Manual. Wakefield, RI: Applied Innovations.

The base rates derived from a clinical sample of 15,316 from 52 JCAHO accredited psychiatric and substance abuse outpatient, partial hospitalization, and inpatient facilities are:

	Base Rate
Aggregate	1.14
White Adult Males	0.11
White Adolescent Males	0.00
White Adult Females	0.44
White Adolescent Females	0.00
African American Males	0.00
African American Adolescent Males	0.00
African American Adult Females	0.06

DSM-IV DIAGNOSTIC CONSIDERATIONS

The following spectrum of diagnostic considerations has been derived from a clinical sample of 15,316 patients from 52 JCAHO accredited psychiatric and substance abuse outpatient, partial hospitalization, and inpatient facilities. The numbers in parentheses

indicate ascending base rates of specific DSM-IV disorders diagnosed within this normative clinical population.

Axis I

20.	Major Depressive Disorder, Single Episode, Unspecified
50.	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
4.	Dysthymic disorder
13.	Cyclothymic Disorder
30.	Mood Disorder NOS
300.	Anxiety Disorder NOS

Axis II

20.	Schizoid Personality Disorder
301.82	Avoidant Personality Disorder