1-2 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 behavior shapes the responses others make to their personal health concerns. They want other 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.

Persons with scores in this range 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, n222]. Unsuspected Illnesses are frequently uncovered in the unlikely event that neurologically impaired and chronically mentally ill persons receive thorough medical evaluations [n333].

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**. The symptoms reflect the development of one or more symptoms or deficits 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 symptoms are not due to malingering or factitious disorder and not culturally sanctioned. General medical condition or effects of a substance cannot explain them. They cause 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. The preoccupation persists despite appropriate medical tests and reassurances. Rule out all 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. Symptoms not intentionally produce or feigned. If medical condition present, it plays a minor role in accounting for pain. Pain maybe associated with a psychological and/or medical condition. Both factors are important in onset, severity, exacerbation, and maintenance of pain. **Body Dysmorphic Disorder**. Preoccupation with some imagined defect in appearance. If the defect is present, concern is excessive. Preoccupation causes significant impairment in social or occupational functioning or causes marked distress. The preoccupation is not 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.

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Scale 2 (Dep)

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.

Persons with scores in this range are typically preoccupied and focused upon physical symptoms and complaints. Often health care professionals who see **these** patients as having imagined illnesses dismiss them. Even when actually ill, they may exaggerate their conditions and use [hem to manipulate or control family members or others. They can be quick to complain, and often end up blaming those who try (but fail) to render help to them [n111, n222j). Unsuspected illnesses discovered in the often-unlikely event that neurologically compromised and chronically mentally ill persons receive thorough medical evaluation come as surprises [n333).

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 to 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: 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.

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”. Washington, DC: National Institute of Mental Health.

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 Hyperpapathyroidism Hypothyroidism Menses-related Depression Postpartum Depression
Metabolic/Nutritional	Folate Deficiency

	Hypercalcemia
	Hypocalcaemia
	Hyponatremia
	Pellagra
	Porphyria
	Uremia
	Vitamin B12 Deficiency
Infections/Inflammatory	Influenza
	Hepatitis
	Mononucleosis
	Pneumonia
	Rheumatoid Arthritis
	Sjoegren's Disease
	Systematic Lupus Erythematosus
	Tuberculosis
Mixed	Anemia
	Cardiopulmonary Disease
	Neoplasms
	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).

Prescription medications associated with Mood Disorders:

Systems	Medication/Substance
Neurologic/Psychiatric	Amantadine
	Anticholinesterases
	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)

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 there is 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 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 in groups sorted based on their self-reported depression. These data suggest that depression have 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 in patients passing symptom validity tests". Archives of Clinical Neuropsychology 17(3), 205-222.

Scale 2 (Dep)

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 for 74 Scale 2 (Dep) studies was reported. Butcher et al. (1989) reported Scale 2 (Dep) test-retest correlation 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.

Profile Characteristics

Base rates for adolescent males with the 1-2 Pattern on the MMPI-A are 0.90 percent and on the MMPI 1.40 percent. Base rates for adolescent females with the 1-2 Pattern are 2.20* percent and 3.40 percent respectively (Archer, 1997).

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

These adolescents are temperate, thoughtful, performance oriented individuals. They hold the goals they wish to reach firmly in mind while taking into account problems as they

arise. They are perfectionists. They are hard on themselves if these initiatives do not meet their expectations. The opinions of others are important to them, sometimes too important. They can be deflected from accomplishing what they want. The majority of these adolescents come from broken homes. Therapists see these young people as being grossly depressed. They are slow of speech. They are tired most of the time. They are socially isolated. They have few or no friends at all (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.

Archer (1997) writes these adolescents complain of fatigue and weakness. They are concerned about their physical health. They are easily upset, tense, nervous, and socially ill at ease. They seek out the approval of others. They want the backing of stronger, more accomplished individuals to bolster their strivings for achievement and independence.

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

Adults with the 1-2 Pattern are depressed because they see themselves as being physically ill. They are deluged with sensations of malaise and pain, unexpected twinges, and spasms, migraine, head and back aches, cramps and stinging, tenderness and skin sensitivities, odontalgia and otalgia, colic, gnawing of the bowels and angina, among other things. They can not define their sensations and feelings clearly Duckworth and Anderson (1995).

Duckworth, J.C., & Anderson, W. P., (1995). MMPI & MMPI-2: Interpretation Manual for Counselors and Clinicians (4th ed.). Bristol, PA: Accelerated Development.

Caldwell (1974) thinks the adult 1-2 Pattern is associated with the fear of death.

Caldwell, A., (1974). “Characteristics of MMPI pattern types”. Los Angeles: Ninth Annual Symposium on the MMPI.

They often comfort themselves with alcohol, sometimes too much alcohol. College students with the 1-2 Pattern are inner directed, self-conscious, unsure of themselves, and afraid to initiate intimacy. College women are irresolute, easily embarrassed, seeking approval and affirmation, and tentative. They are paralyzed with fear when confronted with tests (Friedman et al., 2001).

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

Marks said that patients with this profile represent a stereotype of the disgruntled medical patient who is angry and complaining about the unfairness of an illness or injury. The profile reflects a blocked mourning process. The anger is being discharged through a

focus on physical symptoms with associated resentments that the person has not been well taken care of by others and that their body has let them down.

These patients crave personal care. Caregivers give massive attention tot heir constant needs for reassurance and various physical requirements. They may chronically perpetuate a fear of bodily harm, physical illness, pain, and death. Typically, an early illness in the patient or patient's family, or an early experience of physical abuse, conditioned various overprotective behaviors that shielded the client from physical injury by reducing both the rate and incidence of motor activity. Their awareness focuses on maintaining physical integrity and the availability of medical help.

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 of further needing or "wanting”. They find themselves 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.

The focus in therapy should be to encourage the client to express anger and sadness about past losses without blaming themselves or others (Marks, P.A., 1987).

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

The recommendations for the psychiatric treatment of Somatoform disorders were as follows: brief dynamic psychotherapy, family therapy, and excellent medical consultation are the basis for the treatment of hypochondriasis. Limited long-term supportive psychotherapy and good medical consultation are important in somatization disorder. Symptom relief, psychotherapeutic support, and meticulous collaboration with physicians are the keys to managing psychogenic pain disorder. Physiotherapy to improve physical functioning and patient education to facilitate the distinction between normal symptoms and abnormal illness behaviors are important in all three conditions. Neither the Benzodiazepines nor behavior therapy appears to be of use in these conditions. Treatment outlines for the management of the Somatoform disorders (The Quality Assurance Project. Australia.1985 Dec 19(4. 4): 397-407).

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	2.26
White Adult Males	2.60
White Adolescent Males	3.41
White Adult Females	1.14
White Adolescent Females	4.11
African American Males	2.44
African American Adolescent Males	5.43
African American Adult Females	0.40

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

300.7 Hypochondriasis
300.81 Somatization Disorder
80. Pain Disorder Associated with Psychological Factors
81. 305.00 Alcohol Abuse
303.90 Alcohol Dependence
296.30 Major Depressive Disorder, Recurrent Episode, Unspecified
300.4 Dysthymic Disorder
309.0 Adjustment Disorder with Depressed Mood
302.70 Sexual Dysfunction NOS

Axis II

301.22 Schizoid Personality Disorder
301.6 Dependant Personality Disorder
301.82 Avoidant Personality Disorder