5-0 Pattern

Clinical Scale Elevations

Scale(s) 5 (Mf)

Males T-score 60-79

Females T-score #45

Elevations on the present Scale(s), 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 are inquisitive and curious. They are sensitive and imaginative. They take pains to have art and literature in their lives. They are inclined to pursue higher education when the opportunity presents itself. They do not usually enjoy the rough and tumble for it-self alone. They can be adventurous. They seek out the novel, unusual and unexpected. They seek out the companionship of like-minded persons. 8. They tend to look for energetic, take control persons. They do not particularly object to being a follower.

Scale(s) 5 (Mf)

Males T-score $80

Females T-score #45

They are self-effacing. They prefer to influence others employing indirect means. They are concerned for the welfare and happiness of others. They are frightened of expressing their genuine felling and emotions to others. They are drawn to bold, assertive, out-going, domineering partners. They have mastered the art of placating angry people. They are yielding collaborators given the opportunity. They are interested in the management of a domicile, decoration, fashion, art, music, and cultural pursuits. They are capable of taking on other person’s burdens as their own. They go out of their way to maintain contacts with people who they consider need them in their lives. Their exertions may not be reciprocated in many instances. They find they attract people who are not willing or capable of returning their kindness, sensitivity, and generosity.

Scale(s) 5 (Mf)

Male T-score #45

He is practical, easy-going, earthy, and interested in sports, hunting, fishing technical employment. His attitudes are typically masculine in nature. He admires physical strength and agility. His humor is basic, course and often vulgar. He keeps a lid of his humorous impulses and is mindful of the company in which he finds himself.

Scale 5 (Mf)

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

Terman, L. M., & Miles, C. C., (1930). Sex and Personality (2nd Ed.). New York: McGraw-Hill.

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

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

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

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

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

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

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

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

The bipolar construction of Scale 5 (Mf) was investigated by Foerstner (1946) in a series of extensive examinations of large psychiatric in- and outpatient populations. The MMPI subtests developed by Harris and Lingoes, (1955), Serkownek’s (1975) in Schwerger (1987), Weiner (1948), and Wiggins (1966) were factor analyzed. Friedman, et al., (2001) commented, “It is clear from the data reported in Foerstner’s (1984) study that Scale 5 (Mf) (and Scale Sie (0) is multifactorial in nature; therefore, its composition is not limited to masculine-feminine factors. Scale (5) Mf scores, whether high or low, may be achieved by item endorsements of any of the combination of at least 6 factors”. (Wong 1984).

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

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

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

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

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

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

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

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

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

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

Wallace (2001) suggests the psychiatric male population with high Scale 4 combined with low Scale 5 scores are seen a vigorously seeking out opportunities for narcissistic masculine self-indulgence. These men use other people to satisfy their urges. They are indifferent to the impact their behavior has upon others. Female psychiatric populations who have high Scale 4 and low Scale 5 scores suggest angry hostile females who are provocative troublemakers. They twist what is said to them to the point that the original message is unrecognizable. This maneuver puts the recipient of her retorts off balance and more easily confused and manipulated. They use guilt to dominate those relationships they find useful to achieving their own interests and goals. They have little to no capacity for empathy.

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

Twenty-three of the Scale 5 (Mf) items are from the item pool of Terman and Miles work Sex and Personality, (1936). Thirty-seven items are from the MMPI pool. The MMPI-2 has 56 items for Scale 5 (Mf). Scale 5 (Mf) measures masculinity/femininity attitudes wherein high Scale 5 (Mf) scores reflect more feminine attitudes in males and low Scale 5 (Mf) scores indicate attitudes that are more feminine with females. Twenty-five of the MMPI-2 Scale 5 (Mf) items are scored in the true direction and 31 are scored in the false direction for men. Twenty-three of Scale 5 (Mf) items are scored in the true direction for females and 33 items are scored in the false direction. Scale 5 (Mf) norms are formed from linear Tscores instead of the Uniform Tscores utilized in the norming of the MMPI-2. Test-retest correlations on Scale 5 (Mf) run from 0.79 to 0.83 for 1 to 2 day intervals with psychiatric patients, 0.79 to 0.79 for a 1 to 2 week interval for psychiatric patients and 0.72 for 1 to 2 week intervals with college students (Dahlstrom 1975). Item overlap is: **L (1), F (2), K (3), 1 (0), 2 (2), 3 (4), 4 (3), 6 (2), 7 (1), 8 (4), 9 (3), Sie (9).**

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

Scale(s) 0 (Sie)

T-score >70

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 start a conversation even with people they know well. They dress conservatively. They do not like to attract attention to themselves.

Social
Introversion
Extroversion

(Sie)

The Social Introversion scale is based upon the work of Evans and McConnel (1941) that 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 person’s 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 from 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 known 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 level of confidence. 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 led 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 CheckList **and the MMPI. Scale (Sie)** Tscores 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 5-0 Pattern on the MMPI-A are 0.30 percent and on the MMPI 0.40 percent. Base rates for adolescent females with the 5-0 Pattern are 1.10 percent and 0.00 percent respectively (Archer, 1997).

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

Their therapists view adolescents with the 5-0 Pattern as awkward, shy, timid, and cautious. They are anxious, some severely so. They are inner directed and aware of what is transpiring inside of them. They are self-conscious about their erotic impulses. They are afraid of acting aggressively. Like Cassias, they think too much. Their thoughts are likely to be unique. They gain satisfaction for fantasy (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.

Greene (2000) sees the 5-0 Pattern adult as socially introverted and easily embarrassed.

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

Tanner (1990) found three 5-9 Pattern patients in a psychiatric group. All were females. They were described as anxious, immature, and unconcerned about their grooming. They were unwed welfare mothers.

Tanner, B. A., (1990). “Composite descriptions associated with rare MMPI two-point code types: Codes that involve Scale 5”. Journal of Clinical Psychology 46, 425-431.

Men with the 5-0 Pattern are introverted and isolated. They are cautious, think too much, and are filled with self-doubt. Women with the 5-0 Pattern are not generally well educated. They are not confident of themselves or assertive (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 has written that it is likely that these **female** patients are experiencing disturbances in role functioning such as gender identity issues and not one's sexual preference. The stronger the role dissatisfaction, the more the individual identifies with values, interests and behaviors stereotypic of the opposite sex.

For women, this suggests a close girl-father (or male surrogate) childhood relationship, with the girl playing with boys, being a "tomboy," and participating in activities traditionally confined mostly to boys. The girl-mother (or female surrogate) relationship in this instance is assumed to have been less close, present or intense. There may also be a genetic component to this type of role scenario.

Women with this type of profile tend to have been independent, practical and adventuresome as girls.

Clinical studies indicate that introvert tendencies tend to be fairly stable over long periods of time. 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 frequent socializing and social drifting, often become 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 trying to change through desensitization and possibly expose themselves to what they may feel as degrading experiences.

For those patients who are more socially mobile, 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 writes for **men** it is likely that these patients are experiencing disturbances in role functioning such as gender identity issues and not one's sexual reference. The stronger the role dissatisfaction, the more the individual identifies with values, interests and behaviors stereotypic of the opposite sex. For men, this may suggest a close boy-mother (or female surrogate) childhood relationship in which the mother would confide in the boy and discourage displays of "masculine" aggression.

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

Clinical studies indicate that introvert tendencies tend to be fairly stable over long periods of time. 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 frequent socializing and social drifting, often become 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 trying to change through desensitization and possibly exposes them to what they may feel are degrading experiences.

For those patients who are more socially mobile, 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, P. A. (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	0.04
White Adult Males	0.09
White Adolescent Males	0.00
White Adult Females	0.04
White Adolescent Females	0.00
African American Males	0.00
African American Adolescent Males	0.00
African American Adult Females	0.29

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

928. Adjustment Disorder With Mixed Anxiety and Depressed Mood
90. Mood Disorder NOS
300. Anxiety Disorder NOS
30. Obsessive-Compulsive Disorder
8. Brief Psychotic Disorder
1. Delusional Disorder
40. Schizophreniform Disorder
83. Mood Disorder Due To (existing medical condition)

Axis II

20. Schizoid Personality Disorder
301.82 Avoidant Personality Disorder