Clinical Scale Elevations

Scale(s) 7 (Pt)

T-score 60-69

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 have a low threshold for anxiety. They are methodical, punctual, and organized. They are productive, hard working persons. They are sensitive to the moods and feelings of others. They do not wish to give offense. They follow the rules. They drive at or very near the speed limit. They may not be particularly original in their approach to problems, but once they have mastered a task, they perform it without errors or complaints. They prefer routine, changeless futures, and the predictable. They have a high tolerance for boredom.

Scale(s) 7 (Pt)

T-score 70-84

They are dissatisfied with their social relationships. 2.They are not confident about what to expect from others much less themselves. They are rigid, habit bound, and self-critical. They cannot stop themselves from thinking unpleasant and frightening thoughts. They sweat the small things. They often overlook the most important parts of the “Big Picture.” They often overlook salient features of a problem or social situation. They can feel “dumb” when they realize what they had missed or left out. They are meticulous about their work and person. They drive themselves hard to reach personally import goals. They are unusually persistent. Their rigid approach to life may intensify should they become ill, suffer accidents or injuries.

Scale(s) 7 (Pt)

T-score $ 85

They ruminate about their problems. They go over and over their problems, but rarely find satisfactory solutions for them. They feel miserable most of the time. They suffer from chronic tension. They sometimes find themselves so tied up in their own thoughts that they cannot make decision or attend adequately to everyday duties. They bear a heavy sense of responsibility, which is not called for by the objective facts of the situations in which they find themselves. They get little to no joy or satisfaction out of life. They are long suffering, as are their partners. They are not considered ”The Life of the Party.” They find it hard to laugh. Life is too serious for them to bear the thought of anything racy, erotic, or improper. They are good, if not, inspiring neighbors. They are dependable. Their sense of morality demands exceptionally high standards, for both

themselves and others. They are straight laced. Most people would probably not want to go to lunch with them, unless job or social demands required it. They freeze when suddenly confronted with off colored jokes. They panic when faced with an insensitive "move" is placed upon them.

Psychasthenia

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

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

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

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

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

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

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

Phobic Disorder is an irrational fear of an object or situation that persists although the person recognizes the fear is irrational. These specific phobias are **Agoraphobia**, the fear of being alone in an open or public area where escape might be difficult. The person is often terrified of leaving their home or residence; **Social Phobia**, the fear of situations where one might be seen and embarrassed

or criticized. Speaking to person in authority, speaking in public or performing before an audience are avoided; **Specific Phobia**, a fear of a specific object, activity, or situation, i.e., fear of flying (Jong's Syndrome), snakes, mice, and closed places, amongst others.

Common Phobias

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

Obsessive-Compulsive Disorder (OCD) defines a preoccupation with persistent intrusive thoughts, impulses, or images. **Compulsions** are repetitive behaviors or mental acts that the person feels driven to perform in order to reduce distress or prevent a dreaded event or situation.

The person knows the obsessions/compulsions are excessive and unreasonable. The obsession/compulsion is time consuming and can cause distress.

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

Clinical Presentation of Anxiety Disorders

Panic Disorder: A panic attack is the sudden appearance of intense fear or dread, which may announce impending doom. Terror paralyzes its victim. Terror shakes the individual's hold on the elements of reality. They can neither see nor

think clearly. They may think they are losing their minds. Physical sensations including palpitations, chest pain, suffocation, nausea, chills and hot flashes erupt unexpectedly. The abrupt onset of these attacks last a number of minutes and then subsides.

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

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

Social Phobias involve fear and anxiety arising from engagement in social situations or situations in which a performance is expected of the person. Afflicted persons fear they will say something foolish, which would expose them to ridicule or shame; not being able to answer a simple question, which would reveal they are stupid; forgetting their lines or saying them wrong in a play would expose them as inept are examples of social phobias. Fear of speaking in public is a common social fear. The life of persons living with social phobias becomes more and more constricted as they avoid more and more objects and situations which cause them to be paralyzed with fear. Alcohol and drugs reduce the distress they experience.

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

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

Generalized Anxiety Disorder is overweening worry and anxiety, which has persisted over the foregoing six months and is present along with sleeplessness, tension, irritability, poor concentration, tiredness, and fidgeting. The person worries about letting people down, not being able to earn enough money, illness with family members, doing poorly at work with a fear of being fired, and feeling they are not up to the task of effective living. They spend their nights going over the

day's failures, seeking means to make things come out right and solving problems in their heads. They continuously review past mistakes, problems and fret over future developments. They fear making mistakes of even the simplest sorts. They view their own decisions as inadequate and problematical.

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

Feelings of emptiness, the loss of the capacity to respond emotionally, being distant and unavailable to others, the incapacity to connect and a hopeless sense of detachment lead to the conviction life must be lived in a vacuous isolation. Exaggerated startle responses, an all-pervasive guardedness, heightened vigilance, and a sense of an irremediable loss and death of essential portions of their emotional lives form barriers to full and productive lives. Self-medication, chemical abuse, re-fighting the traumas in real time with real people, as well as physical abuse of family members, and brushes with the law complicate social, economic, and civic behaviors.

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

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

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

Anxiety Disorder	Base Rate	Comorbid Diagnosis
Generalized Anxiety Agoraphobia Disorder	4-5	Major Depression Panic Disorder Somatoform Disorder

Panic Disorder	1-3.5	
Agoraphobia	30-40	
		Major Depression
Phobias		
Major Depression	21.3%	
		Agoraphobia
2.8-5.3%		
		Anxiety Disorder
Alcohol and Substance		
		Abuse
Social Phobia	7.9-13	
Alcohol and Substance		
		Abuse
Obsessive-Compulsive		
Disorder	2-2.5	
Major Depressions		
		Panic Disorder
		Phobias
Posttraumatic Stress		
Disorder	1.0	
General Population		
	2.0	
Panic Attacks		

Substance Abuse

Depression
Somatization

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

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

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

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

This Demoralization Scale is composed of only 24 items drawn from clinical Scale 2 (Depression) and Scale 7 (Psychasthenia). The Demoralization Scale reflects overall emotional discomfort, which combines feelings of demoralization, discouragement, insecurity, pessimism, and poor self-esteem. A sense of failure pervades a person’s evaluations of their life’s achievements. The individual feels helpless, overwhelmed, and unable to make things turn out satisfactorily.

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

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

Scale 7 (Pt) has 47 items in both the MMPI and MMPI-2. Thirty-nine items are scored in the true direction and nine are scored in the false direction. A K correction multiplier of 1.0 is added to the Scale 7 (Pt) raw score. Item overlap is: **L (0), F (1), K (2), 1 (2), 2 (13), 3 (7), 4 (6), 5 (1), 6 (4), 8 (17), 9 (3), Sie (9).** Scale 7 (Pt) and Scale 8 (Sc) have many items in common. Elevations on Scale 7 (Pt) will raise the score and Scale 8 (Sc). High scores may measure any of a variety of subjective difficulties ranging from concentration problems to frank psychoses (Comrey 1958). Test-retest correlations on Scale 7 (Pt) range from 0.83 to 0.86 in a 1 to 2 day interval for psychiatric patients and from to 0.49 to 0.58 for a one year interval, also for psychiatric patients (Dahlstrom et al. 1975). Butcher et al. (1989) reported similar results with the MMPI-2 with normals for intervals of 1 to 2 days.

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

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

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

Scale(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) 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 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 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 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 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 7-0 Pattern on the MMPI-A are 1.30 percent and on the MMPI 0.40 percent. Base rates for adolescent females with the 7-0 Pattern are 1.20 percent and 0.30 percent respectively (Archer, 1997).

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

The 7-0 adolescent is referred to treatment because of their shyness and vulnerability for becoming easily frightened, hurt, and offended. There are family histories of psychiatric problems in nearly half of the cases studied. They have academic and intellectual interests. They are ambitious scholastically. They are aware of their own psychological moments, understand themselves well, and blame themselves rather than others when things go wrong. They are fundamentally insecure. They long for affection. Their therapists see them as thoughtful, sincere, cooperative, and obliging (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

Adults with the 7-0 Pattern are dissatisfied with their lives. They are reserved. People frighten them. They are isolated, lonely people (Greene, 2000).

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

College students with the 7-0 Pattern are shy. They don’t talk much. They worry a lot. They get rattled easily. They are awkward around others. They don’t sleep well (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.

Marks has written additional clinical characteristics of this profile include a profound fear of unpredictable frightening events. It is likely that this type of patients were at an early age teased and humiliated, or experienced some unpredictable and catastrophic event which led them to over-protect against unanticipated future events by thinking ahead and worrying.

Worrying is seen as trying to predict the future by thinking ahead of all possible eventualities.

These patients are amenable to almost any form of therapy. Implosion techniques in conjunction with insight therapy can be particularly useful as can desensitization to the originally unpredictable and frightening experiences.

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 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).

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	0.03
White Adult Males	0.00
White Adolescent Males	0.00
White Adult Females	0.00
White Adolescent Females	0.00
African American Males	0.00
African American Adolescent Males	0.00
African American Adult Females	0.00

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

22. Agoraphobia Without History Of Panic Disorder

Axis II

799.9 Diagnosis Deferred on Axis II