## 9-0 Pattern

### Clinical Scale Elevations

### Scale(s) 9 (Ma)

### T-score ≥ 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 are excitable, high-energy people. They enter social situations with ease. They probably do not need as much sleep as most people. They work with enthusiasm. Their movements are rapid, coordinated, and they can sustain physical effort for long periods. They speak more rapidly than most others do. They like to be in control of their activities. They are organized, efficient, and manage their affairs effortlessly. They like the excitement of new experiences. They will try anything. They thrive in the company of other people. These contacts stimulate them. The more intense the interactions, the more they enjoy the coming together. Partying, dancing, drinking, loud music and concerted muscular activities provide them with the heightening of sensations they crave and cherish.

### Mood Disorder

### Hypomania<br>And<br>Mania

DSM-IV-TR, (2000) lists the following criteria for Bi-polar Disorder, Hypomania, and Mania: A distinct period of abnormality and persistently elevated, expansive, or irritable mood for at least: 4 days of hypomania; or one week for mania.

At **least three (or more)** of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree during the period of mood disturbance: inflated self-esteem or grandiosity; decreased need for sleep (e.g., the person feels rested after only three hours of sleep; more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are racing; distractibility (i.e., the person’s attention is too easily drawn to unimportant or irrelevant external stimuli; increase in goal directed activity (either socially, at work or school, or sexually) or psychomotor activity; excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestricted buying sprees, sexual indiscretions, or foolish business investments).

**Hypomania.** The episode is associated with an unequivocal change in functioning that is not characteristic of the person when they are not symptomatic. Others observe the

disturbance in mood and the change in functioning. There is an absence of marked impairment in social or occupational functioning. Hospitalization is not indicated. Symptoms are not due to direct physiological effects of substance (e.g., drug abuse, medication, or other medical conditions).

**Mania.** Mania severe enough to cause marked impairment in occupational activities, or relationships, or necessitated hospitalization to prevent harm to self and others, or there are psychotic features. Symptoms are not due to direct physiological effects of substance (drug abuse, medication) or general medical condition (e.g., hyperthyroidism).

The lifetime base rate for mood disorders associated with elevated mood worldwide is approximately one percent (DSM-IV-TR 2000).

Substance abuse is common (Strakowski and Del Bello, 2000).

Strakowski, S. M., & Del Bello, M. P., (2000). “The occurrence of bipolar and substance use disorders”. Clinical Psychology Review 20(2): (191-206).

Bipolar manic persons who are also diagnosed with co-occurring personality disorders, have much poorer treatment outcomes 12 months after hospitalization (Dunayevich et al., (2000).

Dunayevich, E. et al., (2000). “Twelve-month outcome in bipolar patients with and without personality disorders”. Journal of Clinical Psychiatry 61 (2): 134-139.

Bipolar disorder is several disorders rolled into one diagnosis. **Bipolar I Disorder** includes psychosis, paranoia, rapid mood cycling, recurrent schizophrenia-like symptoms, recurrent depression, mania, bizarre behavior, substance abuse, and/or self-medication. **Bipolar II Disorder** includes personality disturbance or disorder of temperament (borderline-like), seasonal depression, alcohol and/or substance abuse, rapid mood cycling, premenstrual dysphoria; premenstrual mood disturbance, impulse difficulties, interpersonal sensitivity, intermittent viciousness, backbiting, slander, manipulativeness, acts of bad-faith, recurrent depression, mood instability (Zerbe, 1999).

Zerbe, K. J., (1999). “Women’s mental health in primary care”. (p. 57). Philadelphia: W. B. Saunders.

**Unipolar Depressive Disorders.** The age of onset is usually between the ages of 40 to 44 years of age. Women are affected twice as often, as are men. Unstable ties to parents and families are frequently encountered. The divorce rate is no higher than for the population in general. Symptoms encountered during the depression include prominent guilt feelings, unresolved autonomy issues, and increased motor activity, insomnia, and health concerns.

**Bipolar Disorder.** The age of onset is between 19 to 30 years of age. It is equally prevalent in women and men. A higher rate of divorce and marital conflict occurs. The need for independence, control of others and being the center of attention is central to this disorder. A significant increase in the drive for success and prestige occurs. Symptoms associated with the depressed phase of this illness are: psychomotor retardation, increased sleep-intervals, few health concerns, and little anxiety or concern for self or others. A high frequency of relapse is associated with bipolar disorder as compared with (Unipolar) major depressive disorder (Varcarolis, 2002).

Varcarolis, E. M., (2002). “Foundation of Psychiatric Mental Health Nursing”, (pp. 445-446). Philadelphia: W.B. Saunders Company.

**Research Findings.** Ethanol ingestion aggravates affective disorders. This combined with brain damage can lead to aggressive and violent behavior (Sweet, et al., 1969). The level of sensitivity to the effects alcohol has upon a person is associated with a diagnosis of “pathological intoxication” or ‘*manie* à potú in combination with head injury. A person evidences the pathological effects of alcohol with much smaller levels of alcohol in their blood. They behave violently while under the influence of alcohol, recalling nothing of the events surrounding their intoxication. There is ongoing controversy concerning this diagnosis.

Sweet, W.H., Ervin, F., & Mark, V.H., (1969). “The relationship of violent behavior to focal cerebral disease. In Aggressive Behaviour, Proceedings of international symposium on the Biology of Aggressive Behaviour”. Garattini, S. & Sigg, E.B. (Eds.) Exerpta Medica: Amsterdam (81, 82, 189).

Manic stupor can lead to elation and ecstasy. The patients’ report their mind fills to overflowing with ideas. They are unable to react to anything around them (Abrams and Taylor, 1976).

Abrams, R., & Taylor, M. A., (1976). “Catatonia: a prospective clinical study”, Archives of General Psychiatry 33, 579-581.

Schukla reports on 20 patients who developed mania following head injury. There were no family histories of bipolar disorder. Epilepsy developed in one half of the cases. Irritable mood was more frequent than euphoria. Assaultive behavior often occurred. Fourteen of the patients had episodes of mania without depression Schukla et al., (1987).

Schukla, S., Cook, B. L., Mukherjee, S., Goodwin, C., & Miller, M. G., (1987). “Mania following head trauma”. American Journal of Psychiatry 144, 93-96.

Starkstein et al., (1988) studied 12 patients who developed mania from brain lesions (tumors, strokes, and brain injuries). None has histories of affective disorders. Right hemisphere lesions were more common that those of the left hemisphere. Lesions of the orbitofrontal cortex were strongly associated with mania. Two patients had repeated

manic episodes and another developed mania along with a marked change of personality two years after a head injury.

Starkstein, S. E., Boston, J .D., 7 Robinson, R. G., (1988). “Mechanisms of mania after brain injury. Twelve case reports and review of the literature. Journal of Nervous and Mental Disease 176, (87-100”.

Logsdail and Toone, (1988) report twice as many tight hemisphere loci, which is similar to those, reported by Starkstein, et al., (1988).

Logsdail, S. J., & Toone, B. K., (1988). “Post-ictal psychoses. A clinical and phenomenological description”. British Journal of Psychiatry 152, 246-252.

Scale 9(Ma) has 46 items. Item overlap is **L (12), F (1), K (5), 3 (6), 4 (7), 5 (3), 6 (3), 7 (6), and 8 (11).** Thirty-five items are keyed in the true direction. Scale 8 (Sc) has one fourth of its items in common with Scale 9 (Ma). The reading comprehension level for Scale 9 (Ma) is the highest (ninth grade reading level) of all of the MMPI scales Paolo et al (1991). The average reading level is the eighth grade in the US. Scale 9 (Ma) test scores may need to be verified if the subject gives evidence of reading comprehension difficulties. Test-retest correlations for the standardization sample (Butcher, et al 1989) are 0.68 for females and 0.83 for males.

Paolo, A.M., Ryan, J.J., & Smith, A.J., (1991). “Reading difficulty of MMPI-2 subscales”. Journal of Clinical Psychology July 47 (4), 529-532

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 9 (Ma) presumably measures mood elevations. Scale 9 (hypomania) reflects heightened motor activity levels. Associated features are grandiosity, Green-Spanian irrational exuberance, and decreased need for sleep, suspiciousness, and a hot temper.

The original clinical group of inpatients who served as criterion subjects in the construction of Scale 9(Ma) numbered 24 (Dahlstrom and Dahlstrom, 1980). They pointed out the small number of cases used in the construction of Scale 9 (Ma). “It is the best that we could derive from the patients seen over a 5-year period” (p. 57).

Individuals who are in the throws of a genuine manic episode will render valid MMPI results. Distractibility, ideational flooding, and increased motor activity levels are the cause.

Dahlstrom, W. G., & Dahlstrom, L. E., (Eds.) (1980). “Basic readings on the MMPI: A new selection on personality measurement”. Minneapolis: University of Minnesota Press.

Langer (2003) defines Scale 9 (Ma) as a focus on achievement. Self-worth rests upon career success, material acquisition, and fame. Ready response to stimuli is a core feature. Tension is high between aspiration and accomplishment.

Langer, F., (2003) frank.langer@ALIENS.Com Wednesday 3 September (2003). Re: MMPI-2/Rorschach Confusion. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Increased motor behavior follows the anticipation of failure. “If they see a looming catastrophe, they pull out all stops to do everything possible to avert it” (Langer 2003). The relative vacuum of insight into their thinking and feeling is addressed by a focus upon externalities This focus rushes in to fill the void left in the wake of the flight away from the threat of the recognition of their own weaknesses, anxieties, incompetence, and fear for the future. Grim determination and “…sticking to one’s guns in the face of an unbending environment…” addresses the roadblocks facing them. Achievement supplants the quality and extent of connectedness with others.

Langer, F., (2003). frank.langer@ALIENS.COM Sunday 7 September (2003). Re: MMPI-2/Rorschach follow-up. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Scale 9 (Ma) may also reflect a fear of frustrations to come, which displaces the enjoyment of the present moment (Caldwell, 1984).

Caldwell, A. B., (1984). “Clinical decision making with the MMPI”. Advanced Psychological Institute. Chicago, IL: Northwestern University.

Duckworth and Anderson (1995) say that Scale 9 (Ma) “…is a measure of psychic energy,” upon which the person “…feels compelled to act…” (p. 267).

They think the number of thoughts a person experiences also increases during hypomanic episodes. Scale 9 (Ma) is the most common scale elevation with college students.

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

Scale 9 descriptors of healthy persons include the terms friendly, expansive, active, enthusiastic, talkative, and involved. Kunce and Anderson, (1976) and Hovey and Lewis, (1967).

Kunce, J., & Anderson, W., (1976). “Normalizing the MMPI”. Journal of Clinical Psychology 32, (776-780).

Hovey, H., & Lewis, E., (1967). “Semi-automated interpretation of the MMPI”. Journal of Clinical Psychology 23, (123-124).

Scale 9 (Ma) may also measure sensation seeking, self-confidence, a sense of being indestructible and disdain for others' weaknesses (Lachar, 1974).

Lachar, D., (1974). The MMPI: Clinical Assessment and Automated Interpretation. Los Angeles, CA: Western Psychological Services.

Archer (1992) lists the following Scale 9 features applying to adolescents:
Increased personal tempo with increased activity occurs. Action is preferred over thought and contemplation. Impulsivity, restlessness, and distractibility are present. Unrealistic aspirations and goal setting is a problem, which guarantees failure for them. They are extroverted, gregarious, talkative, and filled with energy. They are narcissistic, self-involved, self-infatuated, insensitive to others feelings and ideas as well as prone to rule breaking.

Archer, R. P., (1992). MMPI-A: Assessing Adolescent Psychopathology. Hillsdale, NJ: Lawrence Erlbaum Associates Publishers.

Siblerud et al., (1998) examined the effect of dental amalgam mercury removal with nine patients on manic depression and related symptoms. The Scale 2 (Dep) and Scale 9(Ma) score showed significant improvement for the amalgam removal group. The amalgam removal group reported a 42% decrease in the number of somatic health problems after amalgam removal.

Silerud, R. L., Motl, J., & Kinholz, E., (1998). "Psychometric evidence that dental amalgam mercury may be an etiological factor in manic depression". Journal of Orthomolecular Medicine 13(1), (31-40).

Comrey (1958 studied the factor content of Scale 9 (Ma). He concluded that this scale has the most content diversity of all of the MMPI scales. Scale 9 (Ma) does not possess the needed factor homogeneity needed to establish statistical and logical relationships.

Comrey, A. L., (1958). "A factor analysis of items on the MMPI Hypomania scale". Educational & Psychological Measurement 18, (313-323).

Kalichman (1988) collected demographic information and Minnesota Multiphasic Personality Inventory profiles with 16 adult women convicted of murdering their (domestic) partners and 20 adult men convicted of murdering strangers during the course of the crime. The men convicted of murdering strangers had higher elevations on the Hypomania scale than men who murdered (domestic) partners. Women who murdered (domestic) partners had higher elevations on Scale 6 (Pa) and Scale 0 (Sie).

Kalichman, S. C., (1988). ""MMPI profiles of women and men convicted of domestic homicide". Journal of Clinical Psychology 44(6), (847-853).

Duckworth and Levitt (1985) evaluated 30 swingers from a private metropolitan swinging club, who engaged in high-risk sexual behaviors, with the MMPI. One half had

significant clinical scale elevations, most of on Scale 9 (Ma). Two thirds of the group were judged emotionally disturbed, however, they had sufficient ego resources to enable them to cope with their problems.

Duckworth, J., & Levitt, E. E., (1985). “Personality analysis of a swinger’s club”. Lifestyles 8(1), (35-45).

Baetsen et al., (1985) examined personality characteristics and demographic factors of 23 pregnant women who intended to have and abortion and 23 women who planned to carry to term with the MMPI. Only the Hypomania scale differentiated between the groups, with the abortion group scoring significantly higher on Scale 9 (Ma).

Baetsen, K. L., Rankin, R.E., Fuller, G. B., & Stack, J. M., (1985). “A comparative MMPI study of abortion-seeking women and those who intend to carry their pregnancies to term”. Family Practice Research Journal 4(4), (199-207).

Jurko et al., (1974) administered the MMPI to eight patients who received a pre-thalamotomy. The only significant long-term change was a decrease in the elevation of Scale 9 (Ma).

Jurko, M. F., Andy, O. J., & Giurintano, L .P., (1974). “Changes in the MMPI as a function of thalamotomy”. Journal of Clinical Psychology 30(4),( 569-570).

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 startup 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) 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 Findings.** 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 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).

Base rates for adolescent males with the 9-0 Pattern on the MMPI-A are 0.60 percent and on the MMPI percent. Base rates for adolescent females with the 9-0 Pattern are percent and percent respectively (Archer, 1997).

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

Neither Marks et al., (1974) nor Archer, (1997) list descriptive statements for the adolescent 9-0 Pattern.

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

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 9-0 Pattern say they are healthy and happy. They have fair social skills, get along with others, but prefer their own company (Greene, 2000).

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

Marks has written that these patients have a chronic pattern of protecting themselves against the frustration and unhappiness associated with failure. It is very likely that they were raised by parents who had high expectations of success for which the child was given only partial or a periodic rewards. Thus, the parents were seen as constantly pushing the child to achieve while at the same time trying to control the resulting surges of energy and impulsivity. The child's needs for reward were then met by the parent's withholding of regular rewards, which increased the drive-state and, in effect, increased the manic tendencies.

The purpose of therapy should be to help the patient stop and enjoy the "here and now." These patients often are future oriented and fearful of the present where they would have to deal with the pain and disappointment of slowing down. They are afraid that if

they stop driving themselves they might achieve less in the future. They will need help to distinguish between their own needs and what they want in order to please others.

Gestalt techniques are usually effective in "forcing" them to express their feelings now, rather than trying to deal with events of the past or anticipated events in the future.

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, 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 | 0.03 |
| White Adult Males | 0.20 |
| 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 | 0.12 |

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

24. Adjustment Disorder With Anxiety
300. Anxiety Disorder NOS
30. Impulse-Control Disorder NOS
305. Alcohol Abuse
4. Dysthymic Disorder

Axis II

7. Antisocial Personality Disorder
301.81 Narcissistic Personality Disorder