1-9 Pattern

Clinical Scale Elevations

Scale 1 (Hs)

Elevations on these Scales taking race, gender, age, education, marital and employment statue into consideration for this group's data, indicate these clinical features could be present in this person's behavior and history:

Their bodily sensations are frightened to them. They often misinterpret what their bodily sensations signify. Their self-centered behavior shapes by the responses others make to their personal health concerns. They want others to solve their problems. The more help they receive, the more helpless they become. They let others know when they are under stress what they want by complaining and lamenting their fate. They cannot be satisfied no matter what other people do for them. They thwart all attempts at assistance. Nothing changes. Helpers end-up feeling miserable.

Hypochondriasis is an intense non-delusional preoccupation with the fear of having an unknown disease. This anxiety exerts a powerful influence upon a person. The individual interprets the origin of the anxiety in different ways. Physical symptoms arise out of the physiological induced stress produced by the anxiety. Alexander (1950) described the anxieties associated **with medical conditions,** i.e., bronchial asthma, ulcerative colitis, thyrotoxicosis, essential hypertension, rheumatoid arthritis, neurodermatitis, and peptic ulcer.

Alexander, Franz, (1950). Psychosomatic Medicine: Its Principles and Applications. New York: W.W. Norton & Company.

The DSM-IV-TR term somatoform disorder was a development following on Alexander's work. The Diagnosis of a Somatoform disorder follows **when objective findings of physical disease are not in evidence.** Somatization is the expression of psychological stress through the development of physical symptoms.

The DSM-IV-TR criteria for somatoform disorders are **Somatization Disorder**. History of many physical complaints beginning before 30 years of age, occurring over a period of years and resulting in impairment in social, occupational, or other important areas of functioning. Complaints **must** include all of the following: History of pain in at least **four** different sites or functions; history of at least **two** gastrointestinal symptoms other than pain; history of at least **one** sexual or reproductive symptom; history of at least **one** symptom defined as or suggesting a neurological disorder. **Conversion Disorder**. This is development of one or more symptoms or

deficit suggesting a neurologic disorder (blindness, deafness, loss of touch) or general medical condition. Psychological factors are associated with the symptom or deficit. Psychological stressors initiate or exacerbate the symptoms. The symptoms are not due to malingering or factitious disorder and not culturally sanctioned. General medical condition or effects of a substance cannot explain them. The symptoms cause impairment in social or occupational functioning. Causes marked distress, or requires medical attention**. Hypochondriasis.** This is a preoccupation with fears of having, or the ideas that one has, a serious disease. Preoccupation persists despite appropriate medical tests and reassurances. Rule out other diseases (i.e., somatic delusional disorders). The preoccupation causes significant impairment in social or occupational functioning or causes marked distress. **Pain Disorder**. Pain in one or more anatomical sites is a major part of the clinical picture. Pain causes significant impairment in occupational or social functioning or causes marked distress. Psychological factors thought to cause onset, severity, or exacerbation. Pain associated with psychological factors. The symptoms are not intentionally produce or feigned. If medical condition present, it plays a minor role in accounting for pain. Pain maybe associated with a psychological and/or medical condition. Both factors are important in onset, severity, exacerbation, and maintenance of pain. **Body Dysmorphic Disorder**. Preoccupation with some imagined defect in appearance. If the defect is present, concern is excessive. Preoccupation causes significant impairment in social or occupational functioning or causes marked distress. The preoccupation is not accounted for by another mental disorder.

DSM-IV-TR (2000) Diagnostic and statistical manual of mental disorders (4th ed., test revision). Washington, D.C.: American Psychiatric Association.

Hypochondriasis

Scale 1 (Hs)

Scale 1 (Hs) measures the number of bodily complaints endorsed by a patient. Hathaway and McKinley (1940) studied a group of 50 (the criterion group) inpatients with pure Hypochondriasis. Demographic information for the criterion group is not available.

Hathaway, S. R., & McKinley, J.C., (1940). A Multiphasic personality schedule (Minnesota): I. Construction of the schedule. Journal of Psychology. 10, 249-254.

Two groups of visitors to the University of Minnesota Hospitals and a group of freshmen at the University of Minnesota Testing Bureau form the normal group for which demographic information is available.

The MMPI has 33 items. The MMPI-2 has 32 items. These items identify endorsement of items relating to poor physical health and gastrointestinal difficulties. Scale 1 (Hs) on the MMPI-2 has 11 items scored in the true direction and 22 items scored in the false direction. A false response set elevates this scale. Scale 1 (Hs) items overlap with other scales as follows: **L (0), F (0), K (0), 2 (10), 3 (20), 4 (1), 5 (0), 6 (1), 7 (2), 8 (4), 9 (0), and Sie (1).** An elevated score on Scale 3 (Hy) can elevate Scale 1 (Hs).

The diagnostic efficiency of the MMPI Scale 1 (Hs) is low. Schwartz et al., (1972) demonstrates base rates for 178 medical patients who generated 1-3 or 3-1 MMPI profiles. Organic diagnoses base rate is 39 percent, functional diagnoses base rate is 34 percent, and mixed organic/ functional base rate is 29 percent. Sixty two percent of the 1-3 profiles had a medical condition as a principle consideration in establishing a diagnosis.

Schwartz, M. S., Osborne, K., & Krupp, N.C., (1972). Moderating effects of age and sex on the association of medical diagnoses and the 1-3/3-1 MMPI profiles. Journal of Clinical Psychology. 28, 502-505.

Schwartz and Krupp (1971) established base rates for the 1-3 MMPI profiles with 50,000 medical admissions to the Mayo Clinic for the years 1963 through 1965. Female admission MMPIs yielded 1-3 profiles in 6.3 percent of the cases, 3-1 profiles in 2.0 percent of the cases; males yielded 1-3 profiles in 6.3 percent of the cases and 3-1 profiles in 1.9 percent of the cases.

Schwartz, M. S., & Krupp, M. E., (1971). “Conversion V” among 50,000 medical patients. A study of incidence, criteria, and profile elevation. Journal of Clinical Psychology. 28, 89-95.

Scale 9 (Ma)

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

They are excitable, high-energy people. They enter into social situations with ease. They probably do not sleep as much 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, and 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.

During the period of mood disturbance, 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: 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 not symptomatic. Others observe the disturbance in mood and the change in functioning. A marked impairment in social or occupational functioning is absent. Hospitalization is not indicated. Symptoms are not due to direct physiological effects of substance (e.g., drug abuse, medication, or other medical conditions).

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 diagnosed with unipolar depressions are affected twice as often, as are men. Unstable ties to parents and family is 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, 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.

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. (eds.). Garattini, S. & Sigg, E. B. 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, et al., (1987) report 20 cases, which 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, 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 that Interictal psychoses associated with complex partial seizures, along with an absence of family histories of affective disorders, are associated with the development of mania. Right hemisphere locus of the seizures is similar to that 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 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 has one fourth of its items in common with Scale 9. The reading comprehension level for Scale 9 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 .68 for females and .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 numbered 24 (Dahlstrom and Dahlstrom 1980). They pointed out the small number of cases used in the construction of Scale 9. “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 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 Sept 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 own thinking and feeling is addressed by a focus upon externalities. This is a focus, which rushes in to fill the void left in the wake of their 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 Sept 2003. Re: MMPI-2/Rorschach follow-up. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Scale 9 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. Northwestern University. Chicago, IL.

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 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 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 (1997) 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. (1997) MMPI-A: Assessing Adolescent Psychopathology (2^{nd} ed.). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Research findings. Silerud 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. November, 44(6), 847-853.

Duckworth and Levitt (1985) evaluated 30 swingers from a private metropolitan swinging club with the MMPI. One half had significant clinical scale elevations, most of on Scale 9 (Ma). Two thirds of the group were 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. Summer, 4(4), 199-207.

> Persons with the 1-9 Pattern are typically preoccupied and focused upon physical symptoms and complaints. Often health care professionals who see these patients as having imagined illnesses dismiss them. Even when actually ill, they may exaggerate their conditions and use them to manipulate or control family members or others. They can be quick to complain, and often end up blaming those who try (but fail) to render help to them [n111, n222j. Unsuspected illnesses, in the often-unlikely event that neurologically compromised and chronically mentally ill persons receive thorough medical evaluations, come as an unwelcome surprise [n333].

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 1-9 Pattern on the MMPI-A are 0.90 percent and on the MMPI 1.30 percent. Base rates for adolescent females with the 1-9 Pattern are 0.80 percent and 1.60 percent respectively (Archer, 1997).

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

> Neither Marks et al., (1974) nor Archer (1997) have descriptive statements for the adolescent 1-9 Pattern.

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

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

Adults with the 1-9 Pattern are intensely frustrated because they cannot do what they feel they should be able to accomplish. They invest enormous effort in

activities they consider important. Few concrete results are forthcoming. They experience but deny diminishing personal strength, vitality, and mental capacities as a reaction to prolonged stress (Wallace, 2001). Their high-energy expenditure serves to mask the despair of failure. They reach out for support and comfort. They find none. They are seekers who find no surcease.

Adults with the 1-9 Pattern are described as angry, "shook up", jumpy, and a handful with which to deal. The 1-9 Pattern adults view themselves as independent, cheerful, and without a trouble in the world (Greene, 2000).

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

Caldwell (1972) writes the 1-9 Pattern adult is vulnerable to heart attacks,

Caldwell, A., (1972). Families of MMPI patterns. Mexico City: Seventh Annual Symposium on the MMPI.

The 1-9 Pattern adult is prone to cardiovascular disorders (Caldwell, 1974).

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

The adult 1-9 Pattern is in some cases associated with endocrinological disorders expressed behaviorally in excessive energy levels. These people are described as driven, ambitious, uncertain about whether or not they will have what it takes to succeed, and afraid of relying upon others who have the potential of letting them down (Friedman et al., 2001).

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

Marks said these patients appear to long for personal care and their needs for reassurance, acceptance, and continuous support. Massive amounts of attention to their physical requirements are required. They may chronically perpetuate a fear of bodily harm, physical illness, pain, and death.

It is possible that an early illness in the patient or patient's family, or an early experience of physical abuse, conditioned various overprotective behaviors that shielded the client from physical injury by reducing both the rate and incidence of motor activity. Their awareness focuses on maintaining physical integrity and the availability of medical help.

These patients have a chronic pattern of protecting themselves against the frustration and unhappiness associated with failure. Their parents had high

expectations of success for the child who, unfortunately, gave only partial or only periodic rewards for their efforts. The parents constantly pushed the child to achieve difficult goals. At the same time, they controlled the resulting surges of impulsive energy the child invested in reaching these goals. The parent withheld regular rewards from the child who needed rewards to meet their needs. This increased the child's drive state. This increased the child's output of energy, which became uncontrollable by the child.

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 in the here-and-now. This assures the patients do not focus on attempting to deal with events of the past or anticipated events in the future (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	0.40
White Adult Males	0.33
White Adolescent Males	0.44
White Adult Females	0.15
White Adolescent Females	0.46
African American Males	0.57
African American Adolescent Males	1.26
African American Adult Females	0.58

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

305.00 Alcohol Dependence
305.0 Sedative, Hypnotic, Or Anxiolytic Dependence
304.80 Polysubstance Dependence
301.13 Cyclothymic Disorder
312.30 Impulse Control Disorder
294.9 Cognitive Disorder NOS
296.40 Bipolar Disorder I, Most Recent Episode Hypomanic
309.81 Posttraumatic Stress Disorder
293.89 Anxiety Disorder Due to …(existing medical condition)
302.83 Sexual Masochism

Axis II

301.6 Dependant Personality Disorder
301.7 Antisocial Personality Disorder