3-4 Pattern

Clinical Scale Elevations

Scale 3 (Hy)

T-score 3 >_75
T-score 9 ≤ 60

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 self-satisfied and immature. They are suggestible. They go with the flow. Their many aches and pains reflect much dissatisfaction. They attract attention to themselves through thespian displays whenever they feel distressed.

Tscore ≥ 76

> Giving the right appearance is important to them. They go to considerable pains to make the right impression. They do not tolerate anything that is unpleasant, ugly, or the thought of failure or the impact of being thwarted. They have an abiding dread and intolerance of emotional discomfort, pain, or any type of suffering. Giving the right appearance is important to them. They go to considerable pains to make the right impression. They do not tolerate the prospect of being thwarted. They have an abiding dread and intolerance of emotional discomfort, pain, or any type of suffering.

Scale 3 (Hy)

General Overview

> Elevations on Scale 3 (Hy) indicate the presence of multiple temperaments and traits:
>
> > A profound fear of emotional and physical pain is at the core of the hysterics existence. Thinking is easily overwhelmed by emotion. Emotions are not portrayed or analyzed in words. They have no words available to them upon which to anchor their feelings. Visual rather than verbal awareness dominates their mental life. They cannot accurately put their feelings and ideas into words easily. This inability to tell others what is bothering them forces other people to guess what the matter is. Most attempts to do so meet with failure and puzzlement. Words associated

with painful experiences are banished from awareness reflexively. Stress is registered in the musculature. This is experienced as pain. The capacity for intimacy and mutuality is limited. Self-examination is poorly tolerated or not at all. They are self-centered. They are relatively immature. They are not particularly sensitive to the feelings of other people. Their social interactions are superficial. They have limited interests. They are vulnerable to demands made upon them. Personal appearance and appearances in general are of major importance to them. Making just the right impression on others assumes a major part of their planning and behavior with others. They want, desire, and depend upon the approval of others in order to maintain their sense of social acceptability. They employ petty cunning to get their way. They have an eye for attaining and maintaining social advantage, often at the expense of others. Wealth and power entice them.

Hysteria

Paul Lerner (1998) said hysterics depict "the emotional way of life." Their lives are emotional reactions to their involvement with others. Lerner cites Easser and Lesser (1966) who describe the hysterics emotionality, "as a jewel to be exhibited, fondled and cherished. Any attempt to move beyond it or remove it is viewed as an attack and is defended against with the total personality.

Lerner, P. M., (1998). Psychoanalytic perspectives on the Rorschach. London: The Psychoanalytic Press, pp. 53-54.

Easser, R., & Lesser, S., (1966). Transference resistance in hysterical character neurosis-technical considerations. Developments in Psychoanalysis at Columbia University. New York: Columbia University Press, pp. 69-80.

Hysterics remain anchored in the emotionality of their own childhood. Feelings dominate and often overrule their thinking. They need is to be appreciated, valued, recognized and loved. This is their "prime directive".

Freud (1915) in his article "The Unconscious" said, "…repression is essentially a process affecting ideas on the border between the Ucs and Pcs."

Freud, S., (1915) The unconscious. Standard Edition, 14,159-216. London: Hogarth Press 1957. p. 180

Levine and Spivak (1964) theorize repression inhibits cognitive processes.

Levin, M., & Spivak, C., (1964) The Rorschach Index of Repressive Style. Springfield, IL: Thomas.

Repression blocks entrance to awareness of ideas containing painful emotions. Hysterics welcome pleasurable emotions with open arms. The inability to integrate both painful and pleasurable emotions results in the failure to use all available information upon which to base reactions to the circumstances in which the hysterics find themselves. So long as the hysteric receives adulation, they are happy. Disappointment, criticism, or rejection depresses them.

The hysteric repairs their injured sense of self by planting subtle suggestions upon which others are to act to supply them with those pleasant experiences they crave simultaneously avoiding any hint of plethora of approval (Easser and Lesser (1965).

Easser, R., & Lesser, S., (1965). Hysterical personality: A re-evaluation. Psychoanalytic Quarterly, 43, 390-405. p. 397.

The emphasis upon the emotional side of existence overshadows the cognitive side. Hysterics avoid engaging in the mundane, dull, drudgery involved in most everyday activities like balancing the check book, house work, grocery shopping, getting the car serviced to mention only a few. These duties fall upon the shoulder of those closest to them. They would rather do things that get them the recognition they want.

Scale 3 (Hy)

Scale 3 (Hy) has 60 items on both the MMPI and MMPI-2. Forty-seven items are scored in the false direction and 13 of the items are scored in the true direction. A false response set will elevate Scale 3 (Hy). The K scale has 10 items in common with Scale 3 (Hy), which represents a built-in K correction. Item overlap is: L (0), F (1), K (10), 1 (20), 2 (13), 4 (10), 5 (4), 6 (4), 7 (0), 8 (8), 9 (6), Sie (13). Test-retest correlations range from 0.66 to 0.80 for intervals of 1 to 2 weeks on the MMPI (Dahlstrom et al. 1972) and 0.72 to 0.75 for a one-week interval on the MMPI-1 (Butcher et al. 1989).

Dahlstrom, W. G. Welsh, G. S., & Dahlstrom, L. E., (1972). An MMPI handbook: Vol. 1. Clinical Interpretation (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.

Clinical Scale Elevations

Scale(s) 4 (Pd)

T-scores 74-79

All other scale scores – 60

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 good tempered, enthusiastic and fearless. They are frank, open, talkative, generous, and fair-minded. They look forward to “Happy Hour.” They do not object to having a social joint or two. They conceal the sensitive and sentimental side to their personality.

Tscore 74-79

They resent authority. They do not conform to customary social conventions or expectations. A history of poor job performance, frequent changes in employment and inadequate total income is present. They do not maintain close personal ties with others. Loyalty is not a top priority to them. They are hard-bitten individuals who have little of the milk of human kindness flowing in their veins.

They are self-seeking, self-infatuated, and self-indulgent. They are emotionally shallow and devoid of compassion. They habitually place the blame for all of the problems they experience on the backs of other people. They resent demands being placed upon them. They refuse to believe they have psychological or emotional problems. They are easily angered and frustrated. They simmer with resentment. They refuse to acknowledge criticism of themselves. They are slighted easily. Self-control is dependant upon high-intelligence along with a fear of the retaliatory power of their environment. They use intimidation and threats to induce fear in others in order to get what they want out of them. Lies and manipulation are the lingua francae of their way of life for them. Pain, punishment, injuries, and threats do not deter them. They do no learn from past mistakes. Narcissism is a core feature of their personality. There may be a history of involvement with the criminal justice system. They are contemptuous of people who follow the rules, hold steady employment, and engage in religious observations. They consider such people to be naïve and “easy pickings”. They engage in risky behaviors. They like the physical high such activities produce. They are easily bored. They do not tolerate having time on their hands. They do not like being alone for any period. They use alcohol and drugs intemperately. They are hard on other people.

Personality Disorders

The DSM-IV-TR (American Psychiatric Association 2000) definition for a Personality Disorder is:

1. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. The pattern manifests itself in two (or more) of the following areas:

Cognition (i.e., ways of perceiving and interpreting self, other people, and events).

Affect (i.e., range, intensity, lability, and appropriateness of emotional response).

Interpersonal functioning.

Impulse Control.

2. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

3. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

4. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

5. The enduring pattern is no better accounted for as a manifestation or consequence of another mental disorder.

6. The enduring pattern is not due to direct physiological effects of a substance (i.e., a drug of abuse, a medication) or a general medical condition (i.e., head trauma).

Diagnostic & Statistical manual of mental disorders (4th ed. –TR) 2000, Washington, D.C.: American Psychiatric Association.

Frosch (1983) defines psychopathy as a deviant developmental disturbance characterized by an inordinate amount of instinctual aggression and the absence of an object relational capacity to bond.

Frosch, J., (1983). The Psychotic Process. New York: International Universities Press.

Meloy (1992) adds, "… a fundamental disidentification with humanity".

Meloy, J. R., (1992). The psychopathic mind: origins, dynamics, and treatment. North Vale, N.J.: Jason Aronson, Inc.

Pinel (1801) described a group of persons who were impulsive and self-destructive, but without defects in reasoning.

Pinel, P., (1801). Traite medico-philosophique sur l'alienation mentale. Paris: Richard, Caille et Ravier.

Prichard (1835) coined the term "moral insanity" implying the damage to social relations observed in histories of persons diagnosed with Personality Disorders.

Prichard, J.C., (1835). A Treatise on Insanity. New York: Hafner.

Freud (1916) viewed psychopaths as, "…those who commit crimes without any sense of guilt, who have developed no moral inhibitions or who, in their conflict with society, consider themselves justified in their actions".

Freud, S., (1916). Some character types met with in psychoanalytic work. Standard Edition 14: 309-333. London: Hogarth Press, 1957.

Cleckley (1976) theorized …a selective defect…prevents important components of normal (emotional) experience from being integrated into…human interactions." The vacuum or absence of genuine emotions may be the biological and psychodynamic hallmark of the psychopath's existence.

Cleckley, H., (1976). Mask of Sanity. St. Louis: C. V. Mosby.

Living without an "echo chamber of the emotions" eliminates the reflected emotional reverberations, which form the guiding support and "glue" of conceptual activities. The absence of this emotional background activity, or disruptions and distortions in it, produce strained, approximate, situationally bound responses and reasoning to fill the gap. Sensations alone demand fulfillment. Intellect directs the individual's efforts to satisfy the sensation seeking demands. The object chosen are frequently other people, substances, fast vehicles, or any other means of increasing pleasurable sensations. They are all equally of the same value to the psychopath. Rationalization is a way of life for the psychopath (Wallace 2001). The gulf between the emotions that psychopaths may or may not experience and those of other people, with whom the psychopath interacts, remains an unbridgeable chasm. A healthy person sees the psychopath as "Just not getting it", i.e., the sense of the emotions involved in interactions.

Wallace, J. L., (2001). A Clinicians Guide to Minnesota Multiphasic Personality Inventory Interpretation. Ex Libris.

Meloy focuses on the psychopath's "disidentification with humanity", which takes on many forms. Most of these forms fall short of those found in full-blown psychopathy. Character disordered individuals, broadly conceived, may experience temporary emptiness of emotional sensations. This emptiness is plastic, expanding and contracting in turn. Cognitive efficiency deteriorates into flawed thinking as the emotional depletion intensifies.

Meloy, J. R., (1992). They Psychopathic Mind: Origins, Dynamics, and Treatment. North Dale, NJ: Jason Aronson.

The absence of the fuel of emotions robs cognition of its energy and capacity to guide the formation of an idea. The dynamic force of the emotions' capacity to direct cognition's ability, which could result from future acts, to participate in the creation of ideational mirrors that reflect pleasure and pain does not exist. An avalanche of interpersonal failures buries the development of empathy, compassion, and caring essential to all successful human acts.

Hare (1993) portrays "…the crux of the issue (pertaining to the psychopath): Psychopaths do not feel they have psychological or emotional problems, and they see no reason to change their behavior to conform to societal standards with which they do not agree". (p. 95). Hare continues saying that psychopaths are satisfied with themselves the way they are. They find their behavior brings them those rewards they seek. They have no regrets or concerns for the future. "They perceive themselves as superior human beings in a hostile, dog-eat-dog world in which others are competitors for power and resources." (p. 195). Psychopaths are convinced it is their right to get what they want using any and all means available to them. Hare shares the conviction that psychopaths enjoy a "rock-solid" personality structure that is resilient and unchangeable.

Hare, R. D., (1993). Without Conscience. New York: The Guilford Press.

Personality Disorders present with common features. Their response to stress is inflexible. They do not seem able to solve the situation leading up to the stress. Their inability to experience satisfaction in work and loving relationships is usually more evident when compared to other peoples' lives. Their inability to share emotions with others and grasp the salient features of the emotions other people experience because of interacting with them eventuates in misunderstanding and emotional upheavals all around. They have an unusually well developed ability to get under the skin of other people. They know how to make other people feel miserable, upset, and angry. The other person feels they have done something wrong but cannot figure out why. They cannot put their finger on exactly why they feel the way they do after an encounter with a psychopath. The personality-disordered individual leaves a trail of emotional wreckage behind them. This is the hallmark of their journey through life.

The DSM-IV-TR (2000) divides the personality disorders into three groups:

Cluster A. Odd or Eccentric

Paranoid Personality Disorder: This is a pervasive distrust of others beginning by early adulthood where others' motives are interpreted as malevolent. The estimated base rate in the general population is 0.5 to 2.5 percent.

Schizoid Personality Disorder: This is a pervasive pattern of detachment from social relationships and a restricted range of (emotional) expression in interpersonal settings; beginning by early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 7.5 percent.

Schizotypal Personality Disorder: This is a pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relations as well as by cognitive or perceptual distortions and eccentricities of behavior; beginning by early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 3 percent. One forth of those persons so diagnosed develops schizophrenia.

Cluster B. Dramatic, Emotional, Erratic.

Antisocial Personality Disorder: This is a pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15 is present. The estimated base rate in the general population is 1 percent for females and 3 percent for males.

Borderline Personality Disorder: This is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 2 percent.

Histrionic Personality Disorder: This is a pervasive pattern of excessive emotionality and attention seeking, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 2 to 3 percent.

Narcissistic Personality Disorder: This is a pervasive pattern of grandiosity (in fantasy and behavior), need for admiration, and lack of empathy, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 1 percent.

Cluster C. Anxious and Fearful

Avoidant Personality Disorder: This is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 0.5 to 1 percent.

Dependant Personality Disorder: This is a pervasive pattern and need to be taken care of that lead to submissive and clinging behavior and fear of separation, beginning in early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is among the most frequently encountered in the Personality Disordered group.

Obsessive-Compulsive Personality Disorder: This is a pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency; beginning by early adulthood and present in a variety of contexts is present. The estimated base rate in the general population is 1 percent and is twice as common in males as in females.

Scale 4 (Pd)

Scale 4 (Pd) has 50 items in both the MMPI and MMPI-2. Twenty-four of the items are scored in the true direction. Twenty-six of the items are scored in the false direction. A K correction of 0.4 (K raw score multiplied by 0.4) is added to the Scale 4 (Pd) raw score. Item overlap is: L. (0), F (4), K (8), 1 (1), 2 (7), 3 (10), 5 (3), 6 (8), 7 (6), 8 (10), 9 (7), Sie (11). Scales 3, 8 and Sie have many items in common with Scale 4 (Pd). Test-retest correlations for Scale 4 (Pd) are 0.74 with an interval of up to 1 year (McKinley and Hathaway 1944). Butcher et al. (1989) reports test-retest correlations of 0.80 with the MMPI-2 for an interval of one week with samples of healthy people.

McKinley, J. C., & Hathaway, S. R. (1944). The MMPI: V. Hysteria, hypomania, and psychopathic deviate. Journal of Applied Psychology, 28, 153-174.

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

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 3-5 Pattern on the MMPI-A are 4.90 percent and on the MMPI 4.00 percent. Base rates for adolescent females with the 3-5 Pattern are 3.60 percent and 2.70 percent respectively (Archer, 1997).

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

The 3-4 Pattern adolescent is a “rough-neck”. They are referred because of sleep problems. Most fight a lot. They are hostile and aggressive. They like school, passing most of their classes. They make friends easily. Therapists note that many of the 3-4 Pattern adolescents show signs of depression. Some are suspicious. Others make suicide attempts, use drugs heavily, run away from home, steal, and get into trouble because of their impulsivity (Marks et al., 1974).

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

Archer points to the common features present in the 3-4 Pattern adolescent of impulsive behavior, histories of theft, truancy from school, and running away from home. Many females with the 3-4 Pattern are sexually promiscuous. They elope from hospitals after being admitted (Archer 1997).

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

Adult patients with the 3-4 Pattern keep vital personal information to themselves. They deny having even obvious problems. Others describe these people as immature and narcissistic. They can be sneaky. They take out their pique and anger in underhanded dealings with others. They may lie a lot in circumstances, which are of little moment or importance. They do it just for the heck of it. In circumstances where their welfare, comfort, and freedom are at stack, they can be counted upon to lie, prevaricate, and dissimulate. Poorly controlled anger and outbursts of aggression that they experience as a feeling of euphoria, and sense of being in control, is characteristic of the 3-4 Pattern. High rates of attempted suicide are recorded in clinical populations. Alcoholism and drug abuse is the frequent single problem in this Pattern (Gilberstadt and Duker, 1965).

Gilberstadt, H., & Duker, J., (1965). A Handbook for Clinical and Actuarial MMPI Interpretation. Lantham, MD: University Press of America

Scale 3 (Hy) elevations are an indirect indication of the amount of control these individuals have available to moderate the expression of their hostility relative to the elevations of Scale 4 (Pd).

Gutherie (1952) noted that females in an internal medicine group exhibit a shallow outlook on life. They are unable to acknowledge the short comings in their friends or themselves. These women expressed self-justified anger and hostility toward their families.

Gutherie, G. M., (1952). Common characteristics associated with frequent MMPI profile types. Journal of Clinical Psychology. 8, 141-145.

Female college mental health center clients had marital problems. They said they had many physical problems as well as problems with their sexual experiences. They harbored hostile feelings, which were expressed in irrational outbursts of rage (Kelly and King, 1979).

Kelly, G. D., & Kelly, C. K., (1979). Behavioral Correlates for spike 4, spike 9, and 4-9/9-4 MMPI profiles in students in a university mental health clinic. Journal of Clinical Psychology. 33, 718-724.

Marital adjustment is problematic with the 3-4 Pattern. Infidelity is frequently encountered. Wives express resentment directed at their husbands through subtle encouragement of their child to act out in ways that are guaranteed to infuriate their husbands.

The 3-4 Pattern reflect the person's habit of bottling up their anger for long periods until they reach a point where frustration unleashes outburst of rage. This is particularly true when they abuse alcohol and drugs. Serious assaults occur upon family members and the law enforcement officers who respond to calls for assistance.

The 3-4 Pattern is associated with persons who have developed acting skills, which allow them to pose as whatever character will get them what they desire. They appear to follow the rules of socially approved activities while surreptitiously undercutting others in the nicest possible ways. Their needs for approval and support are strong. They value their independence more, however. This situation eventuates in conflicts that cannot easily be resolved. The pressure resulting from the inevitable stress arising from the conflicts they get themselves into often ends in outburst of aggression and rage.

Marks write patients with this profile elevations are often exceptionally sensitive to criticism, rejection, and being discounted by others. They project their sensitivity onto others and so have difficulty giving face-to-face criticism to anyone else. When confronted with difficult face-to-face situations, they will say whatever is expedient to avoid negativity, and are unaware of how they distort reality by lying or selectively reporting. They typically over-control their anger and are often out of touch with their motives and feelings.

They may present a good front, but periodically will act-out their anger in unpredictable outbursts. It is likely that as children they were subjected to parental discounts and rejections. It is also likely that they dealt with rejection by trying to deny it, to "positivize it," or to look on the "bright side" and at the same time shutting-off caring towards their parents to protect themselves against letdown. They sought the correct social role to play in order to avoid rejection and anger from their parents. They also learned to over-control their anger and deny it.

These patients also typically suffer from fear of psychological or emotional pain. They need to be liked. They try to avoid conflict. It is important for them to be seen by

others as psychologically healthy. They will seek reassurance that they are likable and will try to elicit that by flattering and complimenting others.

They tend to be positive in the face of adversity, anger and hostility. They will develop somatic symptoms when faced with stress and conflict situations. Often gestalt implosion and systematic desensitization will help them face painful situations and unblock the anger and sadness related to frightening past events. It is helpful to look for what they explicitly deny because that is often at the center of their conflict.

These patients have difficulty remembering painful events. Techniques to elicit catharsis are often helpful in extinguishing the strong fears that painful feelings will overpower them.

Patients with this profile complain of fatigue and exhaustion. They are seen as "difficult" cases. Their ambivalence toward therapy may reflect their fear that they will somehow be seen as "bad" and rejected. Seeing physicians for their physical symptoms acts as a source of reality testing, and that confronting them with non-organic or psychological issues is frightening and they may therefore resist it.

They typically block the anger and sadness aspects of the mourning process. They often cry, but not about painful losses. They may also get angry, but not about past painful events, or the person seen as responsible for the painful events. Their response to pain is to deny it, to look at the bright side of things and to develop increasingly more severe physical symptoms. Insight therapies might focus on the early frightening experiences as a way of helping them work through the mourning process. Assertiveness training is useful to help deal with confrontations in the present.

They may chronically experience profound fear of being unwanted or abandoned. They are often afraid of becoming emotionally invested in relationships with others and in establishing long-term goals. Typically, during periods of stress in childhood they had no one to turn to and developed a defense in which their feelings were suppressed and "numbed" out.

They now will appear aloof, distant, and hard to engage in meaningful relationships although some of them are superficially charming.

Therapy should concentrate on developing trust and on recognizing and expressing angry and negative feelings. These clients assume that the therapist plays roles, which is a projection of their own role-playing and they have difficulty believing that they can express negative feelings without the therapist withdrawing from them. For trust to develop the therapist must actively engage in dealing with the transference on a regular basis. The client will need permission to express negative emotions or doubts about therapy. If the therapist does not withdraw from hearing such doubts or negative emotions then trust will slowly develop. The client may then be amenable to explore their painful childhood rejections.

They will require constant attention and work on the therapeutic relationship just to keep them involved. These patients often feel that the therapist cannot be trusted. Frequently, this is a projection of their view of the world as a "dog eat dog" place where people play games and don't really care about anyone but themselves.

Approaches most likely to succeed would include gestalt techniques of forcing the client to engage ongoing feelings in "real life" situations. Dealing with transference on a regular basis is also important. Patients with this profile may show a positive response too if they can re-engage, the painful experience of feeling unwanted or emotionally abandoned as children, and thereby reactivate their "numbed out" feelings.

Catharsis and systematic desensitization might help relieve the stored up feelings, which prevent them from engaging pain, and relaxation is useful to help relieve some of their physical symptoms (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	0.93
White Adult Males	0.92
White Adolescent Males	0.44
White Adult Females	1.91
White Adolescent Females	0.68
African American Males	0.04
African American Adolescent Males	0.00
African American Adult Females	0.87

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. Alcohol Abuse
90. Other (Or Unknown) Substance Abuse
1. Personality Change Due To Substance Abuse
4. Dysthymic Disorder
40. Bipolar I Disorder, Most Recent Episode Hypomanic, Unspecified
11. Conversion Disorder With Mixed Anxiety and Depressed Mood
V71.01 Adult Antisocial Behavior
34. Intermittent Explosive Disorder
90. Mood Disorder
300. Anxiety Disorder NOS

Axis II

50. Histrionic Personality Disorder
83. Borderline Personality Disorder
301.82 Avoidant Personality Disorder