3-9 Pattern

Clinical Scale Elevations

Scale 3 (Hy)

T-score 3 $\geq$ 75
T-score 9 $\leq$ 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. They have many aches and pains, which reflect much dissatisfaction. They attract attention to themselves through thespian displays whenever they feel distressed.

Scale 3 (Hy)

T-score $\geq$ 75

> 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.

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” to themselves and others.

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 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.

Scale(s) 9 (Ma)

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
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.

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 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.

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 is filled 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) reports on 20 cases of the development of 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 twice as many tight hemisphere loci, which are 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 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 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 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). They said, “It is the best that we could derive from the patients seen over a 5-year period” (p. 57).

Individuals who are in the throes of a genuine manic episode will render invalid 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 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 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 Sunk 7 Sept 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 (Ma) descriptors of healthy persons include the terms friendly, expansive, active, enthusiastic, talkative, and involved (Kunce and Anderson (1976); 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.

Research Findings: 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 in a private metropolitan swinging club with the MMPI who engaged in high-risk sexual activity. 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 an 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, J. & Giurintano, L .P., (1974). “Changes in the MMPI as a function of thalamotomy”. Journal of Clinical Psychology 30(4), 569-570.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 3-9 Pattern on the MMPI-A are 0.70 percent and on the MMPI 0.60 percent. Base rates for adolescent females with the 3-9 Pattern are 0.80 percent and 2.10 percent respectively (Archer, 1997).

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

The 3-9 adolescent Pattern is rarely encountered. No descriptors are listed.

Kelly and King (1979) report college females with the 3-9 Pattern, experience conflicts with sexual attraction to their instructors. Disturbed thought processes were observed. They were superficial, open, and socially ostentatious.

Kelly, C. K., & King, G. D. (1979). “Behavioral correlates of infrequent two-point MMPI code types at a university mental health center”. Journal of Clinical Psychology 35, 576-585.

Greene (2000) described the 3-9 Pattern adults as gregarious, outgoing, and dramatic. Stress is expressed in physical symptoms.

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

They are seen as talkative, extroverted, self-aware, and physically active. They are tuned-in to others' moods, attitudes, and easily pickup on interpersonal cues. Not at all like some attorneys. They do not like to upset others, unlike some attorneys.

Marks write that patients with this profile are generally seen as energetic, optimistic, and "sunny." They have high energy, high drive and a strong need to perform and achieve. They have difficulty focusing on their feelings for fear of facing negative emotions, and are constantly planning new activities and opportunities to achieve.

Typically they are unaware of their anger, tending to over-control and deny it though showing infrequent angry outbursts, usually directed toward a specific person. They are hypothesized to fear failure, which could lead them to being rejected by others, and try to avoid it by constantly performing and achieving. During childhood they were frequently raised by domineering parents who demanded achievement as a prerequisite for approval but provided only irregular rewards. Their central conflict is in needing approval on the one hand and resenting the control they perceive from those who provide it on the other hand.

These patients typically suffer from fear of psychological or emotional pain. They need to be liked and 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, and 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.

They have difficulty remembering painful events. Techniques that 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, and often 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 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 doe their success for which the child was given only partial or 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 need help to distinguish between their own needs and what they want in order to please others.

Therapy should help them distinguish between their own wants and what they think they should want in order to gain the approval of others.
They need help to learn how to reward themselves for what they achieve rather than to constantly drive themselves to produce even more. They also need to learn how to recognize their negative feelings and express them in order to prevent "explosions," and deal with their ambivalence towards their parents whose values they share in themselves.

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

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).

Marks, P. A. (1987). The Marks MMPI Adolescent Report and Manual. Wakefield, RI: Applied Innovations.

The base rates derived from a clinical sample of 15,316 from 52 JCAHO accredited psychiatric and substance abuse outpatient, partial hospitalization, and inpatient facilities are:

	Base Rate
Aggregate	0.12
White Adult Males	0.09
White Adolescent Males	0.15
White Adult Females	0.22

White Adolescent Females	0.23
African American Males	0.07
African American Adolescent Males	0.00
African American Adult Females	1.27

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

81. Somatization Disorder
4. Dysthymic Disorder
11. Conversion Disorder
1. Panic Disorder Without Agoraphobia
34. Intermittent Explosive Disorder
40. Bipolar I Disorder, Most Recent Episode Hypomanic, Unspecified

Axis II

301.50 Histrionic Personality Disorder