4-5 Pattern

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 cover-up the sensitive, sentimental side to their personality.

Scale 4 (Pd)

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 a 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 of time. 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 not 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 reasoning to fill the gap. Sensations alone demand satisfaction. 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. Rationalization is a way of life for the psychopath (Wallace 2001). The gulf between the emotions that the psychopath experiences, and the emotion other people with whom the psychopath interacts have, 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). The 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 the cognitive ability to participate in the creation of ideational mirrors reflecting the pleasure and pain arising out of future acts, 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, and 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 .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.

Research Findings. Nelson and Marks (1985) studied a non-clinical group of 726 volunteer subjects engaged in a career evaluation program. Ninety-two percent were college graduates. Twenty-seven subjects generated a 4-5 Pattern. They described themselves as business-like, devious, calculating, and silent types. They say they are looked upon as being “swell headed”. They are self-conscious about their appearances. They are also quick studies.

Nelson, L. D., & Marks, P. A., (1985). “Empirical Correlates of Infrequently Occurring MMPI Code Types”. Journal of Clinical Psychology 41, 477-482.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 4-9 Pattern on the MMPI-A are 1.60 percent and on the MMPI 3.60 percent. Base rates for adolescent females with the 4-9 Pattern are 3.80 percent and 1.10 percent respectively (Archer, 1997).

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

Adolescents with the 4-5 Pattern are gregarious and extroverted. They are better adjusted than their peers who have higher Scale 4 (Pd) Tscores. Half of these adolescents were rated as having a good prognosis. Those teenagers with higher Scale 4 (Pd) Tscores were prone to substance abuse, high rates of delinquent behaviors as well as temper tantrums and physical violence. School adjustments for these young people were problematical (Marks et al., 1974).

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

Adults with the 4-5 Pattern are satisfied with themselves. They are reluctant to bear their souls. They are clear thinking and have a good grasp on their inner lives. Males are unconventional. They dislike and challenge rules of conventional conduct (Greene, 2000).

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

Twenty-three percent of women convicted of murder had 4-5 Pattern MMPI results (Suther et al., 1981).

Suther, P. B., Archer, R. P., & Kilpatrick, D. G., (1981). “Sociopathy and antisocial behavior: Theory and Treatment” In S. M. Turner, K. S. Calhoun, & H. E. Adams (Eds.) Handbook of Clinical Behavior Therapy (pp. 665-712). New York: Wiley.

Interpretation of the 4-5 Pattern is dependent upon the person’s age, gender, and education. Adolescents are prone to temper tantrums and outbursts of violence. These adolescents do not abide rules. They are truant from school, steal, and abuse alcohol and drugs. They are generally well liked by their peers. A higher Scale 5 (Mf) Tscore is associated with unconventional behavior. They dress in fashions that are outrageous, at least to their elders. They challenge rules and regulations.

Adults with the 4-5 Pattern who have less than two years of college are viewed as narcissistic. They act in unconventional ways. Males with more than two years of

college are likely to be Democrats. The want to promote social change. They are probably ‘tree huggers’. Adult women with the 4-5 Pattern focus on practical pursuits, action-oriented occupations, and social activities requiring self-assertiveness.

Marks write that **female** patients with this type of profile 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.

They will require constant working 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.

It is likely that these patients are experiencing disturbances in role functioning such as gender identity issues and not one's sexual preference. The stronger the role dissatisfaction, the more the individual identifies with values, interests and behaviors stereotypic of the opposite sex.

For women, this suggests a close girl-father (or male surrogate) childhood relationship, with the girl playing with boys, being a "tomboy," and participating in activities traditionally confined mostly to boys. The girl-mother (or female surrogate) relationship in this instance is assumed to have been less close, present or intense. There may also be a genetic component to this type of role scenario.

Women with this type of profile tend to have been independent, practical and adventuresome as girls.

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 (Marks, P.A., 1987).

Marks write that **male** patients with this type of profile 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.

They will require constant working 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.

It is likely that these patients are experiencing disturbances in role functioning such as gender identity issues and not one's sexual preference. The stronger the role dissatisfaction, the more the individual identifies with values, interests and behaviors stereotypic of the opposite sex. For men, this may suggest a close boy-mother (or female surrogate) childhood relationship in which the mother would confide in the boy and discourage displays of "masculine" aggression.

The boy-father (or male surrogate) relationship is assumed to have been less close, intense or present. There may also be a genetic component to such role instability. Male patients tend to have been non-aggressive and sensitive as boys.

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 (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	1.25
White Adult Males	1.65
White Adolescent Males	2.81
White Adult Females	0.92
White Adolescent Females	0.00
African American Males	1.57
African American Adolescent Males	0.25
African American Adult Females	4.62

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

50. Opioid Abuse
90. Other (Or Unknown) Substance Abuse
8. Conduct Disorder
4. Adjustment Disorder With Mixed Disturbance of Emotion and Conduct
89. Anxiety Disorder Due To (existing medical condition)
300. Anxiety Disorder NOS
30. Impulse Control Disorder NOS
4. Dysthymic Disorder
6. Gender Identity Disorder NOS
9. Sexual Disorder NOS

Axis II

81. Narcissistic Personality Disorder
7. Antisocial Personality Disorder
301.6 Dependent Personality Disorder