4-6 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 conceal the sensitive and sentimental side to their personality.

Scale 4 (Pd)

Tscore ≥ 74

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 dependent 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 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 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. Rationalization is a way of life for the psychopath (Wallace 2001). The gulf between the emotions that psychopaths 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 to participate in the creation of ideational mirrors reflecting the pleasure and pain associated with 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 .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.

Clinical Scale Elevations

Scale(s) 6 (Pa)

T-score ≥ 65

All other scales <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 exquisitely sensitive to the moods and emotions of others. They are adept at responding in tandem to the 'whatever' the other person, with whom they are speaking, says or does, following each changing nuisance as if it was a fleeting shadow dogging the conversation. Their skillful maneuvering conceals their artful control of the other person's initiatives. They keep their opinions, plans, and goals to themselves. They carry many secrets. They deflect any inquiries into their private lives with élan and sly misdirection. They are exceptionally private individuals. They conceal many secrets.

Scale(s) 6 (Pa)

T-score ≥ 70

They are chronically doing a slow burn. The cause of their anger is indecipherable. They twist what others do and say in the telling of their experiences until the truth is unrecognizable. They take their own perceptions and feelings seriously. They have convinced themselves that others will act with ill will towards them. People shy away from them due to their touchy, rigid, and stubborn natures. They develop long-standing feuds with people closest to them. They are demanding, critical, and controlling when involved in intimate relationships. They are convinced they are being or soon will be unfairly treated.

Paranoia

Ayd (1995) defines paranoia as a term employed by Kraepelin to describe, "…a group of patients with extensive delusional systems associated with suspiciousness and the belief that one is unfairly treated, harassed, and persecuted. Pervasive distrust underlies paranoid phenomenon."

Ayd, F. J., (1995). "Lexicon of Psychiatry, Neurology, and the Neurosciences". Baltimore: Williams & Wilkins.

Fenigstein and Vanable (1992) identified public self-consciousness as a general factor consistently and significantly correlated with a heightened sense of being observed.

Fenigstein, A., & Vanable, P. A. , (1992). “Paranoia and self-consciousness”. Journal of Personal and Social Psychology 62 (1): 129-138.

MMPI Scale 6 (Pa) items reflect sensitivity to the presence of others, self-righteousness, and a suspicious nature (Greene, 1991, p. 159).

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

The authors of Scale 6 (Pa) did not specify the parameters of the individuals included in the Paranoia group (Hathaway 1980, pp. 65-75).

Hathaway, S. R., (1980). “Scale 5 (Masculinity-Femininity), 6 (Paranoia), and 8 (Schizophrenia”. In G. S. Welsh and G. W. Dahlstrom (Eds.), Basic readings On the MMPI: A new selection on personality measurement. Minneapolis: University of Minnesota Press.

Wiener and Harmon (1948) point out the fact that only seven of the items making up Scale 6 (Pa) are unique to this scale. The remaining items are contained in other scales. It is difficult to know from only seven items how Paranoia Scale specifies such a complex condition as paranoia.

Wiener, D. N., (1948). “Subtle and obvious keys for the MMPI”. Journal of Consulting Psychology 12, 164-170.

Nichols and Greene (1995) view Scale 6 (Pa) as, “…the most general measure of projection and is sensitive to both implicit and explicit operations to place or locate motives, responsibility, and other, especially undesirable attributes outside the self.” (p. 36). This occurs without the presence of collaborative evidence involved in forming a conclusion.

Nichols, D. S., & Greene, R. L., (1995). MMPI-2 structural summary: Interpretive manual. Odessa, FL: Psychological Assessment Resources.

Romney (1987) thinks the paranoid process is insidious, growing slowly into it final forms. A sequence of stages evolves, beginning with a hostile attitude and culminating in delusions of influence. The intensity of the paranoia process defines the end diagnosis, i.e., paranoia, paranoid personality, and paranoid schizophrenia.

Romney, D. M., (1987). A simplex model of the paranoid process: Implications for diagnosis and prognosis. Acta Psychiatria Scandinavia 1987 Jun; 75(6): 651-655.

The empirical foundation for Scale 6 is weak. Researchers have found paranoid states over the entire range of scores on Scale 6. Low, medium, and high elevations have at one time or another indicated the presence of paranoia. The clinician alone

must make the determination of the presence of absence of paranoia base upon information other than that provided by MMPI itself (Greene 2000).

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

Duckworth (1995) is of the opinion that Scale 6 measures sensitivity to the behavior and opinions of others, the possibility that suspiciousness is present, and the unshakable conviction that others plan to harm them. (p. 213).

Duckworth, J. C., & Anderson, W. P., (1995). MMPI & MMPI-2: Interpretive manual for counselors and clinicians. 4th ed. Bristol, PA: Accelerated Development.

Duckworth and Anderson (1995) say paranoid individuals are difficult to work with. They are confrontational. They question the credentials of any person who appears to be a person in authority. They feel they have the right to make judgments of others' behavior and character based upon their own idiosyncratic ideas of right and wrong.

They believe they are always in the right. Added to this is a burning desire to know what is really going on around them. They question everything. Their thinking is precise, sharp, and penetrating. They see features in situations that remain overlooked by other people. They see more deeply into the world and it's workings than most (Kunce & Anderson, 1984).

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Kunce, J., & Anderson, W., (1984). "Perspectives on the MMPI in non-psychiatric settings. In P. McReynolds & G. J. Chelune (Eds.), Advances in psychological assessment". San Francisco: Jossey-Bass.

Scale 6 (Pa) scores may reflect a fear of physical attack. They anticipate being on the receiving end of severe and unfair judgments (Caldwell 1985).

Caldwell, A., (1985). "MMPI clinical interpretation". Los Angeles: Advanced Psychological Studies Institute.

Hovey and Lewis (1967) think Scale 6 (Pa) reflect long-standing resentment towards relatives, exceptional sensitivity to the opinions held about themselves by others, a touchy nature, and the willingness to blame others for their problems.

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

Carson (1969) views paranoid individuals as registering and remembering any hint of criticism of their person. All rejections, slights, and snubs are stored in perpetuity. They will seek vengeance at an appropriate time and place in the future at the offended parties choosing. They have histories of throwing monkey wrenches into

employers' business operations in order to get even with perceived slights and injustices. Going "postal" is a modern day phenomenon. This is a tragic and exceptionally dangerous phenomenon, to say the least. They do not expose information about themselves. They are tight lipped. They are guarded. They defend themselves against any possible threat. They do not open up in treatment. They distrust therapists. A colleague of this writer was shot by a paranoid character many years ago.

Carson, R., (1969). "Interpretive manual to the MMPI in J. Butcher (Ed.). MMPI: Research developments and clinical applications (pp. 279-296)".
New York: McGraw-Hill.

Lewak (1993) reports a case of a police officer that gave a within-normal-limits MMPI profile with an exceptionally low Scale 6 score. This man has now served many years in prison. Extremely low Scale 6 scores are usually associated with a presumed paranoid condition.

Lewak, R., (1993). "Low scores on Scale 6: A case history". Paper presented at the annual convention of the Society of Personality Assessment, San Francisco.

Medical conditions can lead to paranoid presentations. The classic picture of an acute paranoid illness virtually indistinguishable from paranoid schizophrenia is particularly common after an injection of methyl- amphetamine (Lishman 1998, p. 617).

Cocaine psychosis represents an end on the progression to extreme paranoia, which begins with suspiciousness, ideas of reference, and verbal hallucinations (Lishman 1998, p. 619).

General paresis, associated with syphilitic disease, may eventuate in paranoid delusions (Lishman 1998, p. 341).

Migraine suffers report complex visual and auditory hallucinations with a distinct paranoid component. A paranoid psychosis may result from an acute exacerbation of a migraine attack (Lishman 1998, p. 405-406).

Lishman, W. A., (1998). "Organic Psychiatry. The psychological consequences of cerebral disorder". 3rd ed. Malden, MA: Blackwell Science, Inc.

Toxic cannabis psychosis occurred in a group of 100 black South Africans, wherein one fourth of the cases were diagnosed with paranoia. (Solomons et al., 1990, pp. 476-481).

Solomon, K., Neppe, V. M., & Kuyl, J. M., (1990). Toxic cannabis psychosis is a valid entity. South African Medical Journal 20; 78(8): 476-481.

Mendez, et al. (1990) reported the results of a retrospective chart review with 217 patients diagnosed with Alzheimer's disease wherein 35 percent of the cases presented with suspiciousness and paranoia.

Mendez, M. F., Martin, R. J., Smyth, K. A., & Whitehouse, P. J., (1990). "Psychiatric symptoms associated with Alzheimer's disease". Journal of Neuropsychiatry & Clinical Neuroscience 2(1): 28-33.

Maier (1994) wrote that Paranoid Personality Disorders occur much more frequently in relatives with histories of major depression than in control subjects.

Maier, W., Lichermann, D., Minges, J., & Heun, R., (1994). "Personality Disorders among the relatives of schizophrenia patients". Schizophrenia Bulletin, 20(3): 481-493.

The DSM-IV-TR (2000) defines the Paranoid Personality Disorder as a pervasive distrust of others such that their motives are malevolent, beginning by early adulthood and present in a variety of settings. [The estimated base rate for the general population is 0.5 to 2.5 percent]. Individuals with this disorder believe other people will exploit, harm, or deceive them even though there is no evidence upon which to base such judgments. They expect others will plot against them and attack them from ambush. They are convinced others have irreparably damaged them. They doubt the trustworthiness and loyalty of family members, friends, and co-workers. They scan and survey in excruciating detail any hint of hostile intentions of the people around them. Their limited perspectives and narrow understanding of people in general facilitates their erroneous justifications of disloyalty. They do not let others get close to them. They do not share personal information. They fear attack if a personal weak spot is revealed. They read hidden meanings into benign remarks, which they see as reflecting threat or demeaning attitudes towards them. They bear grudges. They do not forgive other people mistakes or insults. Hostile feelings are their hallmark. They are always on their guard. They can be extremely jealous. They accuse partners and spouses of being unfaithful. They are control freaks. They insist on a complete accounting of their whereabouts, activities, and associates.

The DSM-IV-TR (2000) notes the essential feature of the Paranoid Type of Schizophrenia is the presence of prominent delusions or auditory hallucinations in the context of a relative sparing of cognitive functioning and affect. Delusions are typically persecutory or grandiose, and can include both. Delusions with other themes (e.g., jealousy, religiosity, or Somatization) may also occur. The delusions may be multiple and organized around coherent themes. Hallucinations relate to the content of the delusional themes. Associated features include anxiety, anger, aloofness, and argumentativeness. Extreme intensity in interpersonal relations is prominent. Grandiose delusions with anger predispose the individual to violence. These individuals may be post office employees. They evidence little or no impairment on neuropsychological or cognitive testing.

Scale 6 (Pa)

Scale 6 (Pa) has 40 items in both the MMPI and MMPI-2. Twenty-five of the items are scored in the true direction. Fifteen items are scored in the false direction. An "all true" response set will elevate the Scale 6 (Pa) profile. Item overlap is: **L (0), F (9), K (2), 1 (4), 2 (10), 3 (8), 4 (10), 5 (2), 7 (4), 8 (13), 9 (6), Sie (5).** Test-retest correlations range from .61 to .71 for an interval of 1 to 2 days for psychiatric patients and between .59 to .65 for and interval of one year for psychiatric patients (Dahlstrom et al. 1975). Butcher et al. (1989) reported similar test-retest correlations for the MMPI-2 norm group.

Dahlstrom, W. G., Welsh, G. S., & Dahlstrom, L. E., (1975). "An MMPI handbook: Vol. II. Research applications (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.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 4-6 Pattern on the MMPI-A are 6.20 percent and on the MMPI 5.60 percent. Base rates for adolescent females with the 4-6 Pattern are 4.00 percent and 4.50 percent respectively (Archer, 1997).

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

Marks et al., 1974 describes the 4-6 Pattern adolescent as irritable, aggressive, egocentric, and self-indulgent. Their therapists said they are evasive, resentful, and argumentative. They are rebellious. They put down people in authority. They are furthermore said to be immature and manipulative. Alcohol and drug abuse is commonly encountered.

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 (1997) notes these adolescents make impossible demands upon others but resent any demand being placed upon them. They have a suspicious bent. They form only superficial relationships with others. They are clueless concerning their own thoughts, emotions, or motives. They create excuses for their problems. They blame others for their bad behavior. They refuse to accept responsibility for anything they do. They are provocative. They act before they think.

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

Adults with the 4-6 Pattern are described in much the same way as adults with the same pattern, i.e., resentful, argumentative, angry, prone to violent outbursts, suspicious, and unable to get along with others. Adults have long histories of social maladjustment and uneven work records (Greene, 2000).

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

The 4-6 Pattern in adults is associated with **litigiousness and the initiation of law suits** (Carson, 1969).

Carson, R., (1969). “Interpretive manual to the MMPI”. In J. Butcher (Ed.), MMPI: Research developments and clinical applications (pp. 279-296)”. New York: McGraw-Hill.
Women with the 4-6 Pattern are described as self-centered, hostile, tense, irritable, and always on their guard. They do not want to deal with their problems (Duckworth and Anderson, 1995).

Duckworth, J.C., & Anderson, W. P., (1995). MMPI & MMPI-2: Interpretation Manual for Counselors and Clinicians (4th Ed.). Bristol, PA: Accelerated Development.

These people feel others will break relations with them, criticize then unfairly with malicious intent, hurt them or neglect to respond their needs. They are quick to place blame and jump to conclusions without adequate justification. Extremely unstable adjustment in their close relationships is typical. **Borderline diagnoses** are frequently tendered. They have no idea why they act as they do, neither do they have any interest in finding out.

Marks write patients that with this profile at upper elevations feel angry, alienated and resentful. They are suspicious and are vigilant of being exploited and let down by others. They anticipate anger and often provoke it with a argumentative style. It is likely that as children their parents were arbitrary and critical and would use humiliation of the child as a way of disciplining the child. They developed a hyper-vigilance of fairness and distrust of authority, and a tendency to argue as if all communication was a "battle" for control. Because they are so wary of attacks on their "will" they are quick to accuse and feel accused in return.

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 own view of the world as a "dog-eat-dog" place where people play games and don't really care about anyone but themselves.

These patients may exhibit a history of fear of attack on their abilities and beliefs, and domination over one's will. In reality, they indeed may have been subjected to varying degrees of attack, criticism, and judgment. It is assumed that the more significant the clinical characteristics of this profile are, the more they reflect the more extreme, the more will-breaking, and the more humiliating history of such attacks.

When engaging in a therapeutic alliance, these patients need to trust that their therapist will not humiliate or control them. They are usually very perceptive and have a "sixth sense" as to whether a person is frightened or intimidated by them, or is not telling them the truth. Many techniques can be effective with them once basic trust is established. Giving them permission to be angry and empathizing with their sensitivity to humiliation would be vital in the initial stages of therapy. Encouraging insight and engaging their rage at having been criticized and humiliated unfairly also are useful.

Typically, these patients were not allowed to retaliate against criticism with anger for fear that it would lead to further attacks and criticism. They now need to learn how to "fight for themselves" before their anger leads to overwhelming negative consequences.

Therapy should concentrate initially on building trust. It is important, in order to maintain the relationships, to deal with transference and give them permission to be angry. These clients will expect the therapist to abandon them if they express anger, and if this doesn't occur, then they can develop the trust that was lacking in their early parental relationships. Help them find ways to express their intense inner rage, and their wants and hurts directly rather than storing them up until they feel justified in expressing them by which time they are resentful.

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	2.23

White Adult Males	1.21
White Adolescent Males	0.59
White Adult Females	4.33
White Adolescent Females	1.83
African American Males	1.07
African American Adolescent Males	1.51
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
305.90 Other (Or Unknown) Substance Abuse
1. Delusional Disorder
3. Schizophrenia, Paranoid Type
81. Somatization Disorder
3. Obsessive-Compulsive Disorder
300. Anxiety Disorder NOS
312.30 Impulse-Control Disorder NOS
4. Dysthymic Disorder
312.34 Intermittent Explosive Disorder

Axis II

301. Paranoid Personality Disorder
22. Schizotypal Personality Disorder
7. Antisocial Personality Disorder
301.83 Borderline Personality Disorder