4-7 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. The sensitive and sentimental side of their own personality is hidden from others.

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 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 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 pleasure and pain, which result from 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) 7 (Pt)

T-score 60-69

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 have a low threshold for anxiety. They are methodical, punctual, and organized. They are productive, hard working persons. They are sensitive to the moods and feelings of others. They do not wish to give offense. They follow the rules. They drive at or very near the speed limit. They may not be particularly original in their approach to problems, but once they have mastered a task, they perform it without errors or complaints. They prefer routine, changeless futures, and the predictable. They have a high tolerance for boredom.

Scale(s) 7 (Pt)

T-score ≥70

They are dissatisfied with their social relationships. .They are not confident in themselves or about what to expect from others much less themselves. They are rigid, habit bound, and self-critical. They cannot stop themselves from thinking unpleasant and frightening thoughts. They sweat the small things. They often overlook the most important parts of the “Big Picture.” They often overlook salient features of a problem or social situation. They can feel “dumb” when they realize what they had missed or left out. They are meticulous about their work and person. They drive themselves hard to reach personally import goals. They are unusually persistent. Their rigid approach to life may intensify should they become ill, suffer accidents or injuries. They ruminate about their problems.

They go over and over their problems in their minds, but rarely find satisfactory solutions for them. They feel miserable most of the time. They suffer from chronic tension. They sometimes find themselves so tied up in their own thoughts that they cannot make decision or attend adequately to everyday duties. They bear a heavy sense of responsibility, which is not called for by the objective facts of the situations in which they find themselves. They get little to no joy or satisfaction out of life. They are long suffering, as are their partners. They are not considered "The Life of the Party." They find it hard to laugh. Life is too serious for them to bear the thought of anything racy, erotic, or improper. They are good, if not, inspiring neighbors. They are dependable. Their sense of morality demands exceptionally high standards, for both themselves and others. They are straight laced. Most people would probably not want to go to lunch with them, unless job or social demands required it. They freeze when suddenly confronted with off colored jokes. They panic when faced with an insensitive "move" is placed upon them.

Psychasthenia

Pierre Janet (1903) defined psychasthenia as "…the lack of psychological strength associated with a narrowing of consciousness. (Ellenberger, 1970, p. (375).

Ellenberger, H. F., (1970). The Discovery of the Unconscious: the history and evolution of dynamic psychiatry. New York: Basic Books, Inc., Publishers.

Janet distinguishes "…two types of psychasthenia crises, fits of anxiety, and all kinds of conspicuous manifestations related to fixed ideas". "…Those fixed ideas were conscious in the form of obsessions and phobias". (Ellenberger, 1970 p. (376).

Janet (1930) wrote, "In my description of the symptoms of the psychasthenic neurosis (Janet 1903), I stressed particularly the pathological feelings (*sentiments pathologiques*), which I designated at the time as feelings of inadequacy (*sentiments d'incomplétude*) and which have become in my last book a part of the feelings of emptiness (*sentiments du vide*)". Janet includes the symptom of "…the maladies of doubt".

Janet, Pierre, (1903). *Les obsessions et la psychasthenia*, 2 volumes (Paris: Alcan). Vol. I by Pierre Janet, Vol. II by F. Raymond, and P. Janet.

Neurotic disorders were the preferred designation of all anxiety related mental disorders prior to the development of the Diagnostic and Statistical Manuals classifications, which now lists them as anxiety disorders. The DSM-IV-TR (2000) classifies anxiety disorders into nine categories.

Panic Disorder is the recurrent episodes of panic attacks. At least one month (or more) has followed one of the attacks of the following: Persistent concern about having additional attacks. Worry about the consequences of an attack, i.e., “I’m going crazy”, having a heart attack, and loosing self-control. Significant changes in behavior are feared. Panic disorder with and without agoraphobia and additional diagnoses with panic disorder is also a possible diagnosis.

Phobic Disorder is an irrational fear of an object or situation that persists although the person recognizes the fear is irrational. These specific phobias are **Agoraphobia**, the fear of being alone in an open or public area where escape might be difficult. The person is often terrified of leaving their home or residence; **Social Phobia**, the fear of situations where one might be seen and embarrassed or criticized. Speaking to person in authority, speaking in public or performing before an audience are avoided; **Specific Phobia**, a fear of a specific object, activity, or situation, i.e., fear of flying (Jong’s Syndrome), snakes, mice, and closed places, amongst others.

Common Phobias

Feared Object Or Situation	Clinical Name
Animal	Zoophobia
Being Alone	Monophobia
Blood	Hematophobia
Closed Places	Claustrophobia
Darkness	Nyctophobia
Electrical Storms	Astrophobia
Fire	Pyrophobia
Germs/Dirt	Mysophobia
Heights	Acrophobia
Open Spaces	Agoraphobia
Strangers	Xenophobia
Talking	Glossophobia
Water	Hydrophobia

Obsessive-Compulsive Disorder (OCD) defines a preoccupation with persistent intrusive thoughts, impulses, or images. **Compulsions** are repetitive behaviors or mental acts that the person feels driven to perform in order to reduce distress or prevent a dreaded event or situation.

The person knows the obsessions/compulsions are excessive and unreasonable. The obsession/compulsion is time consuming and can cause distress.

Generalizes Anxiety Disorder (GAD) is defined as excessive worry and anxiety more days than not over a period of the preceding six months. The person cannot control their worrying. The anxiety and worry is associated with three or more of these six symptoms: Restlessness, feeling keyed-up, easy fatigue ability, difficulty concentrating, irritability, muscular tension, and sleep disturbances. The anxiety and worry as well as physical symptoms, which follow on the anxiety and worry, cause significant impairment in other areas of important functioning.

Clinical Presentation of Anxiety Disorders

Panic Disorder: A panic attack is the sudden appearance of intense fear or dread, which may announce impending doom. Terror paralyzes its victim. Terror shakes the individual's hold on the elements of reality. They can neither see nor think clearly. They may think they are loosing their minds. Physical sensations including palpitations, chest pain, suffocation, nausea, chills and hot flashes erupt unexpectedly. The abrupt onset of these attacks last a number of minutes and then subsides.

Panic Disorder and Agoraphobia characterizes recurring panic attacks, which combine with agoraphobia.

Phobias are persistent, irrational fears of specific objects or situations, which an individual avoids. High levels of anxiety and distress arise from contact with objects or situations, which most people find innocuous, i.e., the sight of blood, looking down from heights, thunder and lightening, viewing open expanses over water, enclosed spaces, among many others.

Social Phobias involve fear and anxiety arising from engagement in social situations or situations in which a performance is expected of the person. Afflicted persons fear they will say something foolish, which would expose them to ridicule or shame; not being able to answer a simple question, which would reveal they are stupid; forgetting their lines or saying them wrong in a play would expose them as inept are examples of social phobias. Fear of speaking in public is a common social fear. The life of persons living with social phobias becomes more and more constricted as they avoid more and more objects and situations which cause them to be paralyzed with fear. Alcohol and drugs reduce the distress they experience.

Obsessive-Compulsive Disorder: Obsessions are experienced as thoughts or images that keep recurring without let-up. They are meaningless in and of themselves. They occur within a matrix of persistent intense anxiety.

Compulsions are procedures adopted and followed rigorously, to control the experience of anxiety and reduce the intensity of the anxiety. These

procedures lead to temporary relief. A tune repeated repeatedly is one's head is such an example. Repeated questioning such as, "Did I turn off the stove", "Did I turn off the lights", or Did I lock the door?" drive the person to check their activities many times over and often lead to self-dissatisfaction. Crippling doubts centering on violence, illness or death, contamination, and sexuality cause the individual to feel humiliated, shamed, and disgusted with him or her self. The demand-performances, procedures, and rituals involved in compulsions interfere with accomplishing necessary everyday activities and the fulfillment of obligations to other people.

Generalized Anxiety Disorder is overweening worry and anxiety, which has persisted over the foregoing six months and is present along with sleeplessness, tension, irritability, poor concentration, tiredness, and fidgeting. The person worries about letting people down, not being able to earn enough money, illness with family members, doing poorly at work with a fear of being fired, and feeling they are not up to the task of effective living. They spend their nights going over the day's failures, seeking means to make things come out right and solving problems in their heads. They continuously review past mistakes, problems and fret over future developments. They fear making mistakes of even the simplest sorts. They view their own decisions as inadequate and problematical.

Posttraumatic Stress Disorder is intense fear, helplessness, and terror associated with the repeatedly re-experiencing memories of traumatic events where threatened or actual injury or death has occurred. Intrusive recall of these events in flashbacks, dreams, or incidental everyday experiences bring the recollected trauma backs to life in full force. The person refrains from reawakening memories of the trauma.

Feelings of emptiness, the loss of the capacity to respond emotionally, being distant and unavailable to others, the incapacity to connect and a hopeless sense of detachment lead to the conviction life must be lived in a vacuous isolation. Exaggerated startle responses, an all-pervasive guardedness, heightened vigilance, and a sense of an irremediable loss and death of essential portions of their emotional lives form barriers to full and productive lives. Self-medication, chemical abuse, re-fighting the traumas in real time with real people, physically abusing family members, and brushes with the law complicate social, economic, and civic behaviors.

Acute Stress Disorder is the reaction to an immediate stressor, which abates when the issues involved in causing the stress cease.

The Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition Test-Revised, (DSM-IV-TR APA 2000) lists a mixed anxiety-depressive disorder wherein a dysphoric mood has lasted for a least one month; the dysphoric mood is associated with four or more of the following symptoms.

Difficulty concentrating, the mind goes blank, difficulty falling asleep or staying asleep or unsatisfying sleep, fatigue and low energy, irritability, worry, easily moved to tears, heightened vigilance, anticipating the worst, catastrophizing, hopelessness, all encompassing pessimism, a bleak out look on the future, low self-esteem and a sense of being worthless. Additional comorbid disorders include substance abuse, Somatization, and physical disorders.

Anxiety Disorder	Base Rate %	Comorbid Diagnosis
Generalized Anxiety Disorder	4-5	Agoraphobia Major Depression Panic Disorder Somatoform Disorder
Panic Disorder	1-3.5	Agoraphobia (30-40 %) Major Depression
Phobias		Major Depression (21.3%) Agoraphobia (2.8-5.3%) Anxiety Disorder Alcohol and Substance Abuse
Social Phobia	7.9-13	Alcohol and Substance Abuse
Obsessive-Compulsive Disorder	2-2.5	Major Depressions Panic Disorder Phobias
Posttraumatic Stress Disorder	1-2.0	General Population Traumatized Persons Panic Attacks Substance Abuse Depression Somatization

(Welkowitz, et al., 2000, and Horworth and Weisman, 2000).

Welkowitz, L. A., Strvening, E. L., Pittman, J., Guardino, M., and Welkowoitz, J., (2000). “Obsessive-compulsive disorder and comorbid anxiety problems in a national anxiety-screening sample”. Journal of Anxiety Disorders 14(5): 471-482.

Horworth, E., and Weissman, N. M., (2000). “The epidemiology and cross-national presentation of obsessive-compulsive disorder”. Psychiatric Clinics of North America, 23(3): 493-507.

Research Findings: Tellegen, et al., (2003) created the MMPI-2 Restructured Clinical (RC) Scales as a response to the need to clarify the saturation of the MMPI scales with a common, emotionally saturated factor, which can be broadly specified as generalized anxiety. This emotional factor colors all emotional life. The negative manifestations are termed Demoralization.

This Demoralization Scale is composed of only 24 items drawn from clinical Scale 2 (Depression) and Scale 7 (Psychasthenia). The Demoralization Scale reflects overall emotional discomfort, which combines feelings of demoralization, discouragement, insecurity, pessimism, and poor self-esteem. A sense of failure pervades a person’s evaluations of their life’s achievements. The individual feels helpless, overwhelmed, and unable to make things turn out satisfactorily.

The RC factor corresponds well with Janet’s descriptions of his patients who suffered from Psychasthenia. Statistical confirmation of a century old clinical phenomenon is a hopeful sign.

Tellegen, A., Ben-Porath, Y. S., McNulty, J. L., Arbisi, P. A., Graham, J. R., and Kaemmer, B., (2003). “The MMPI-2 Restructured Clinical Scales: Development, validation, and interpretation”. Minneapolis, MN: University of Minnesota Press.

Scale 7 (Pt) has 47 items in both the MMPI and MMPI-2. Thirty-nine items are scored in the true direction and nine are scored in the false direction. A K correction multiplier of 1.0 is added to the Scale 7 (Pt) raw score. Item overlap is: **L (0), F (1), K (2), 1 (2), 2 (13), 3 (7), 4 (6), 5 (1), 6 (4), 8 (17), 9 (3), and Sie (9).** Scale 7 (Pt) and Scale 8 (Sc) have many items in common. Elevations on Scale 7 (Pt) will raise the score and Scale 8 (Sc). High scores may measure any of a variety of subjective difficulties ranging from concentration problems to frank psychoses (Comrey 1958). Test-retest correlations on Scale 7 (Pt) range from 0.83 to 0.86 in a 1 to 2 day interval for psychiatric patients and from to 0.49 to 0.58 for a one year interval, also for psychiatric patients (Dahlstrom et al. 1975). Butcher et al. (1989) reported similar results with the MMPI-2 with normals for intervals of 1 to 2 days.

Comrey, A. L., (1958). A factor analysis of items on the MMPI Psychasthenia scale. Educational and Psychological Measurement 18, 293-300.

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 4-7 Pattern on the MMPI-A are 2.40 percent and on the MMPI 1.70 percent. Base rates for adolescent females with the 4-7 Pattern are 1.20 percent and 1.60 percent respectively (Archer, 1997).

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

Adolescents and adults with the 4-7 Pattern are described as acting without forethought. They do not take into consideration the possible consequences of their thoughtless behavior. They experience shame and guilt when they realized what they have done. Their behavior disregards social norms. They act in provocative ways as they confront others. They are viewed as frightened, anxious, and insecure (Archer, 1997).

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

Tension, nervousness, impetuousness, and substance abuse are also associated with the adolescent 4-7 Pattern (Williams and Butcher, (1989).

Williams, C. L., & Butcher, J. N., (1989). “An MMPI study of adolescents: II, Verification and limitations of code type classification”. Psychological Assessment 1, 260-265.

College students seen at a university mental health center are described as moody, less mature, and filled with self-doubt (Kelly and King, 1979).

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).

The behavior that is suggested by the 4-7 Pattern is cyclic in nature. The accumulations of the stresses in normal living produce tension and anxiety. These bottled-up frustrations are discharged through intemperate activities, which they experience as a euphoric sense of being in control of their lives. These 'highs' are narcissistically addicting. These discharges eventuate in embarrassing and/or illegal acts. Alcoholism, drug abuse, gambling, and compulsive sexuality as well as other forms of addiction are preferred means of tension reduction (Friedman, et al., 2000).

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

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	1.58
White Adult Males	2.03
White Adolescent Males	7.70
White Adult Females	1.10
White Adolescent Females	1.60
African American Males	1.57
African American Adolescent Males	3.53
African American Adult Females	10.29

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.	Alcohol Dependence
24.	Adjustment Disorder With Anxiety
8.	Brief Psychotic Disorder
40.	Schizophreniform Disorder
1.	Delusional Disorder
89.	Anxiety Disorder Due To (existing medical condition)

30. Impulse Control Disorder NOS
4. Dysthymic Disorder

Axis II

22. Schizotypal Personality Disorder
301.7 Antisocial Personality Disorder