2-4 Pattern

Clinical Scale Elevations

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:

Scale 2 (Dep)

They are depressed, pessimistic, and deeply worried. They feel unworthy and inadequate. They could be silently angry and unable to admit it to themselves. A reactive depression could be present.

Depressive Disorders

Mood is a pervasive, sustained emotion operating in the background of mental life that colors the person's outlook on the world (APA 2000).

American Psychiatric Association (2000). Practice guidelines for the treatment of psychiatric disorders. Washington, D.C.: American Psychiatric Press.

The predominant feature in depressive disorders is a disturbance of mood manifested by a loss of interest in personally valued activities in all cases. The loss of pleasure when the individual anticipated and engaged in these activities eventuates in the collapse of this emotional background. A sense of pain pervades the person's life and all of the activities in which they engage. They cannot adequately put the pain they feel into words.

Physically they loose or gain weight; have sleep disturbances, either sleeping less or more than usual; feel too tired to do engage in everyday activities, and have less of an appetite for intimacy. They feel guilty for no good reason. Thoughts of dying, death and of to taking their own lives come to plague them. Many may have attempted to kill themselves.

Ninety seven percent of all cases report a loss of energy. Anxiety occurs in 60 percent of the cases (Zajecka (1995).

Zajecka, J. (1995). Treatment strategies to treating depressions complicated by anxiety disorder. Presented at the U.S. Psychiatric and Mental Health Congress. New York, November 16, 1995.

Thinking, concentration, and memory are impacted. They view themselves as

failures in life. They recount their faults and flaws, but do not see their strengths and virtues. They say and say they are terrible persons. A sense of guilt, that has no realistic basis fills their days. They feel worthless and helpless to change things around in their lives.

They pace about endlessly. They get no rest even when they do nothing at all. They have headaches, backaches, the blahs, constipation, and an all-pervasive sense of discomfort. Activities, which once gave them pleasure no longer do so. All looks black to them.

Their health deteriorates. Complicated physical conditions arise. Their ability to work is impaired. Social activities are no longer important to them. A general decline in life activities takes place.

The community base rate for major depression in the United States is 3 to 5 percent. The lifetime risk for depression is 5 to 12 percent for men and 10 to 25 percent for women (Diagnostic and Statistical Manual for Mental Disorders, 4th edition, text revision 2000). Unipolar depression is twice as common I women as in men (Dubovsky and Buzan 1999).

Dubovsky, S. L., and Buzan, R. (1999) Mood Disorders in Hales, R. E., Yudofsky, S.C., & Talbott, J. A. (Eds.) Textbook of psychiatry (pp. 479-566) Washington, D.C.: American Psychiatric Press.

Postpartum depression occurs in 10 percent of mothers. The rates for reported depression in preadolescents is 18 percent (Dubovsky and Buzan 1999). Young people between the ages of 9 to 17 yield a 6 percent rate of depression (Varcaroles, E.M. (1999).

Varcaroles, E. M. (1999). The invisible disease: Depression. National Institute of Mental Health. Washington, D.C.

Depression rates for the elderly living in the community is 3.5 percent; 16 percent for medically hospitalized elderly; 15 to 20 percent for our elderly living in nursing homes; and as high as 40 percent in selected groups of elderly (Dubovsky and Buzan 1999).

Dubovsky, S. L., and Buzan, R. (1999) Mood Disorders in Hales, R. E., Yudofsky, S.C., & Talbott, J. A. (Eds.) Textbook of psychiatry (pp. 479-566) Washington, D.C.: American Psychiatric Press.

Depression is associated with general medical conditions, substance-induced mood disorders following the use of recreational and misuse of prescription drugs, bereavement and reaching the end-of-live.

Medical conditions and syndromes associated with Mood Disorders:

System	Diagnoses
Neurologic	Dementias
	Hydrocephalus
	Huntington's Chorea
	Infections, i.e., HIV, neurosyphilis
	Migraines
	Multiple Sclerosis
	Myasthenia Gravis
	Parkinson's Disease
	Seizure Disorders
	Stroke
	Trauma
	Tumors
	Vasculitis
	Wilson's Disease
Endocrine	Addison' Disease
	Cushing's Syndrome
	Diabetes Mellitus
	Hyperpapathyroidism
	Hypothyroidism
	Menses-related Depression
	Postpartum Depression
Metabolic/Nutritional	Folate Deficiency
	Hypercalcemia
	Hypocalcaemia
	Hyponatremia
	Pellagra
	Porphyria
	Uremia
	Vitamin B12 Deficiency
Infections/Inflammatory	Influenza
	Hepatitis
	Mononucleosis
	Pneumonia
	Rheumatoid Arthritis

	Sjoegren's Disease
	Systematic Lupus Erythematosus
	Tuberculosis
Mixed	Anemia
	Cardiopulmonary Disease
	Neoplasms
	Sleep Apnea

Mulner, K. K., Florence, T., & Clark, R. R. (1999). Mood and anxiety syndromes in emergency psychiatry. Psychiatric Clinics of North America, 22 (4): 761.

Depressions recur. Sixty percent of those people who have suffered on depressive episode can expect a second episode; seventy percent can expect a third episode; and ninety percent can expect three or more episodes (APA 2000).

Prescription medications associated with Mood Disorders:

Systems	Medication/Substance
Neurologic/Psychiatric	Amantadine
	Anticholinesterases
	Antipsychotics
	Baclofen
	Barbiturates
	Benzodiazepines
	Bromocriptine
	Carbamazepine
	Disulfiram
	Ethosuximide
	Levodopa
	Phenytoin
Antibacterical/Antifungals	Corticosteroids
	Grieseofulvin
	Metronidazole
	Nalidix Acid
	Trimethoprim
Anti-inflammatory/Analgesic	Corticosteroids
	Indomethacin
	Opiates
	Sulindac

Antineoplastic	Asparaginase Azothioprine Bleomycine Hexamethylamine Vincristine Vinblastine
Cardiovascular	Clonidine Digitalis Guanethidine Methyldopa Propanolol Resperine
Gastrointestinal	Cimetidine Ranitidine
Mixed	Alcohol Anxiolytics Cocaine Heroin Marijuana

Mulner, K. K., Florence, T., & Clark, R. R. (1999). Mood and anxiety syndromes in emergency psychiatry. Psychiatric Clinics of North America, 22 (4): 761.

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:

Scale 4 (Pd)

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 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 easily feel slighted. 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. 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 is manifested 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. It is pervasive across a broad range of personal and social situations.

3. The enduring pattern leads to clinically significant distress or impairment of 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 accounted for as a manifestation, of or a 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. Living without an "echo chamber of the emotions" eliminates the reflected emotional reverberations, which form the guiding support 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. 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.

The psychopath's "disidentification with humanity" (Meloy) 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.

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, which could 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. A pervasive distrust of others such that others motive is interpreted as malevolent, beginning by early adulthood and present in a variety of contexts. The estimated base rate in the general population is 0.5 to 2.5 percent.

Schizoid Personality Disorder. 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. 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 develop schizophrenia.

Cluster B. Dramatic, Emotional, Erratic.

Antisocial Personality Disorder. A pervasive pattern of disregard for and violation of the rights of others occur 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. 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. 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. 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. 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. 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. 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 than in females.

DSM-IV-TR (2000). Diagnostic and statistical manual of mental disorders (4th ed., test revision). Washington, D.C.: American Psychiatric Association.

Profile Characteristics

Base rates for adolescent males with the 2-4 Pattern on the MMPI-A are 5.00 percent and on the MMPI 3.70 percent. Base rates for adolescent females with the 2-4 Pattern are 3.30 percent and 6.90 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) pointed out these 2-4 Pattern young people did not feel close to either of their parents. They had no one with whom they could talk about the events in their lives. They said they couldn't find people upon whom they could rely or depend. Many 2-4 Pattern adolescents get in trouble with the law. They turn to drugs and alcohol to escape the pain of punishing home situations. Girls get pregnant, run away from home and are truants from school. They are elopement risks while hospitalized (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 2-4 Pattern feel depressed and frustrated. They feel they are failures. They are down on themselves. They cannot decide whom to blame for the way they feel; themselves or others. They are their own worst enemies.

They are angry at the world and then themselves in turn. They don not know what to do with themselves. They switch goals, jobs, and relationships impulsively. Their thoughtless, emotionally driven impulsivity results in confrontations with others. The backlash is painful. They rarely accept responsibility for their acts. They feel no guilt for the damage they do. This behavior is continuous.

2-4 Pattern adults do not want any demands placed upon them. They will act aggressively when the opposition is weak. Strong opposition sends them into a sneaky mode. They sabotage that which offends them. This often includes them in the process. They use alcohol to sooth their hurt feelings. Heavy alcohol and substance abuse is associated with the 2-4 Pattern (Shroeder & Piercy 1979).

Shroeder, D. J., & Piercy, D. C. (1979). A comparison of MMPI two point codes in four alcoholism treatment facilities. Journal of Clinical Psychology, 35, 656-663.

Adults with the 2-4 Pattern are often identified as being alcoholics. Twenty-one percent of a sample of 1.009 white male alcoholics generated a 2-4 Pattern (Hodo and Fowler, 1976).

Hodo, G. L., & Fowler, R. D. (1976). Frequency of MMPI two-point codes in a large alcoholic sample. Journal of Clinical Psychology, 32, 487-489.

Greene and Gavin (1988) found a base rate of 15.3 percent with alcoholic males and a base rate of 14.8 percent with alcoholic females in their meta-analysis of the MMPI literature.

Green, R.L., & Gavin, R. D. (1988). Substance abuse/dependence. In R. L. Greene (Ed.), The MMPI: Use in specific populations (pp. 159-197). San Antonio: Grune & Stratton.

The 2-4 Pattern adult is immature, narcissistic, and engages in self-pity while they blame other s for causing their problems. These for the elements of a long standing pattern. These people are not good treatment candidates.

Referral for testing with the 2-4 Pattern adults frequently occurs within the context of a criminal investigation. These people present as depressed as a consequence of being incarcerated. Their freedom of movement is severely curtailed. Other rather unsympathetic individuals control them. They respond with anger and sadness. They ask for medications to sooth their fevered brows. The depression evaporates immediately upon release from captivity. The intelligent 2-4 Pattern are often accomplished at drawing. They tell their therapist of their deep understanding of their thinking, feelings and motivations as well as their inner psychological moments. They can be impressive and persuasive. They promise in the strongest possible terms to mend their ways. They have the strangest memories. They forget all of their promises upon release from imprisonment. Their deep psychological understanding of their inner moments is put on hold until they meet another therapist. They do not change their ways (Greene 2000).

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

The 2-4 Pattern adult is often seen as self-defeating and emotionally changeable. They have been known to attempt suicide in order to shame and punish those persons they feel wronged them by preventing them from achieving goals, which were important to them. MMPI-2 items 140, 506, 520, and 524 should be checked for suicide potential.

Marks said these types of patients often feel hopelessly trapped in an intolerable situation. Their anger will oscillate between rage at the world for "placing" them in their present predicament and anger with themselves for having allowed it to happen.

They frequently tend to be self-defeating and self-destructive, especially with alcohol or drugs. Their propensity for impulsive suicide attempts is high. It is possible that as children they never learned basic trust. They felt unable to turn to adults for help because adults were either unavailable or would somehow make their situation worse. Consequently, they turned to their own resources and developed a distrust of emotional relationships. The precipitating circumstances for their present contact with therapy is usually an event, which has left them feeling trapped, angry and alienated.

Patients with this profile often experience fear of irretrievable loss
of some highly valued physical or emotional object. They tend to respond to this loss by blocking of further needing or "wanting". The "despair" phases of the mourning, process blocks them in. They are afraid to cry and feel angry. They will need to

express anger and "rage at fate" in order to finish the grieving process. Frequently these patients will discuss past losses and present feelings of hopelessness about ever being happy, and they ignore any positive feelings or events that happen to them in the present.

Attempts to reassure them about their health and focus them on their own psychological problems only increases their fear that pain will overwhelm them when they find there is nobody to turn to. A more effective approach would be through desensitization by the patient re-telling the frightening earlier experiences relating to pain and fear of death and thereby diffusing the emotional charge that led the client to overprotect against bodily harm and loss of bodily function.

They experience a profound, chronic fear of being unwanted and abandoned. They fear becoming emotionally invested in relationships with others and in establishing long-term goals. They suppressed and "numbed" out their feelings. Numbness is a defense against periods of stress, which developed during their childhood when loneliness overwhelmed them. They now will appear aloof, distant, and hard to engage in meaningful relationships although some of them are superficially charming.

The focus in therapy should be to encourage the client to express anger and sadness about past losses without blaming themselves or others. 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 do not really care about anyone but himself or herself.

Therapy should begin by helping them develop a bond with someone they can trust. Next, help them to "rage against" the loses they have experienced and unlock their anger at these losses implicit in the mourning process.

It is important that they have a series of goals to work on a weekly or perhaps even daily basis. Therapy can then concentrate on why the goals were or were not achieved. Progress is best made and experienced by accomplishing specific small goals within a prescribed period.

Consideration should given to the fact that they have a tendency to give up before giving themselves a chance to succeed, and that they can draw the therapist, who must be on their guard, into expressing the anger and frustration that they themselves feel. 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).

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:

Aggregate	5.80	Percent
White Adult Male	7.27	Percent
Adolescent Males	2.22	Percent
White Adult Females	5.34	Percent

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	305.00	Alcohol Abuse
	301.70	Alcohol-Related Disorder NOS
	305.90	Psychoactive Substance Abuse NOS
	312.30	Impulse Control Disorder NOS
	300.3	Obsessive-Compulsive Disorder
	309.3	Adjustment Disorder with Disturbance of Conduct
	300.40	Dysthymic Disorder
	295.90	Schizophrenia, Undifferentiated Type
	296.30	Major Depressive Disorder, Recurrent Episode, Unspecified
Axis II	301.22	Schizotypal Personality Disorder
	301.0	Paranoid Personality Disorder
	301.50	Histrionic Personality Disorder
	301.82	Antisocial Personality Disorder