4-0 Pattern

Clinical Scale Elevations

Scale(s) 4 (Pd)

T-scores ≥ 74

All other scale scores # 60

Elevations on the present Scale(s), taking race, gender, age, education, marital and employment status into consideration for the corresponding group's data, indicate any or all of these clinical features could be present in this person's behavior and history:

They are good tempered, enthusiastic and fearless. They are frank, open, talkative, generous, and fair-minded. They look forward to “Happy Hour.” They do not object to having a social joint or two. They cover-up the sensitive, sentimental side to their personality.

Tscore ≥ 74

Elevations on the present Scale(s), taking race, gender, age, education, marital and employment status into consideration for this group's data, indicate these clinical features could be present in this person's behavior and history:

They resent authority. They do not conform to customary social conventions and 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 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: 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 than 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 0.74 with an interval of up to 1 year (McKinley and Hathaway 1944). Butcher et al. (1989) reports test-retest correlations of 0.80 with the MMPI-2 for an interval of one week with samples of healthy people.

McKinley, J. C., & Hathaway, S. R., (1944). The MMPI: V. Hysteria, hypomania, and psychopathic deviate. Journal of Applied Psychology 28, 153-174.

Butcher, J. N., Dahlstrom W. G., Graham, J. R., Tellegen, A., & Kaemmer, B. (1989) Minnesota Multiphasic Personality Inventory-2 (MMPI-2) Manual for administration and scoring. Minneapolis: University of Minnesota Press.

Clinical Scale Elevations

Scale(s) 0 (Sie)

T-score $70

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 prefer their own company to that of others. Confrontations with other people force them to withdraw. They are generally fearful of people they do not know well. Trust builds slowly, if at all, for them. They are shy people who do not seek out or like the limelight. They prefer to work alone. They will not go to public events or attend public meetings if given the opportunity. They are unusually quiet persons. They can stand long silences and may even like it. They find it hard to start a conversation even with people they know well. They dress conservatively. They do not like to attract attention to themselves.

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Social
Introversion
Extroversion

(Sie)

The Social Introversion scale is based upon the work of Evans and McConnel (1941) who authored the Minnesota T-S-E Inventory. The investigation centered about the dimensions of Thinking, Social, and Emotional aspects of behavior and their manifestations in either the introverted or the extroverted aspects of a person’s behavior.

Evans, C., & McConnell, T. R., (1941). “A new measure of introversion-extroversion”. Journal of Psychology 12, 111-124.

Drake (1946) based the Social Introversion (Sie) scale on Evans and McConnell's work with the Minnesota T-S-E Inventory's Social introversion items. Seventy items, which separated the top 65 percent from the lowest 35 percent of 100 female college students who served as test subjects, formed the Sie scale.

Drake, L. E., (1946). "A social I.E. scale for the Minnesota Multiphasic Personality Inventory". Journal of Applied Psychology 30, 51-54.

The Sie Scale criterion group is composed of healthy persons. Test norms for males were similar to the female norms; the two groups' combined results form the scale. The norms are composed of 350 female and 193 male college students. [An interesting aspect of this norming reflects the types of males in college during WW II. Those males capable of serving in the Armed Forces were not included or represented in this testing].

The 69 items (MMPI-2) composing the Social Introversion scale overlap with the other scales as follows: **L (0), F (0), K (9), 1 (1), 2 (8), 3 (8), 4 (11), 5f (11), 5m (9), 6 (5), 7 (9), 8 (6), and 9 (6).** 34 items are scored in the true direction, 35 in the false direction. Foerstner's (1986) studies reflect the multifactorial nature of the Sie scale.

Foerstner, S. B., (1986). "The factor structure and stability of selected Minnesota Multiphasic Personality Inventory (MMPI) subscales: Harris and Lingoes subscales, Wiggins's content scales, Wiener subscales, and Serkownet subscales". Unpublished dissertation, University of Akron, Ohio.

The Sie scale indicates the degree of comfort a person experiences when they are in the company of other people. Lewak et al., (1990) writes concerning high Sie scale scores, a person had "…a childhood characterized by an absence of warmth and physical contact from others. Elevated scores suggest that these people have extinguished their feeling response to physical touch and affection. They suffer from "affect hunger" and yet, they feel conflicted about close, intimate relationships." (p. 273). Low scores on the other hand suggest an intense need for stimulation afforded by the close proximity of other peoples' energetic activities.

Lewak, R. W., Marks, P.A., & Nelson, G. E., (1990). Therapist's Guide to the MMPI and MMPI-2: Providing feedback and treatment. Muncie, IN.: Accelerated Development.

The Sie scale also measures a person's willingness to be in the proximity of others. It includes a person's readiness to engage with others in social and work settings. Introverted people do not have social poise, engage in ready repartee, or involve themselves in quick witted, jocular, give-and-take. They ask themselves, "Why didn't I think of that" as a belated rejoinder to intentionally cutting comments. All those missed opportunities! They are usually not an insider; they are not even familiar with the current in-group's slang or the intimate references used by the in-group.

Introverted people isolate themselves when they feel under pressure. This could be due to the experiences of past disappointments and emotional injuries. They go it alone for lack of any other supportive options.

Extroverted people have learned to welcome the enjoyment they gain from the stimulation other people offer them. They are socially skilled. They give and take on an equal footing. They turn to others in times of difficulties, using these contacts as sources of emotional support and sources of solution to the problems facing them.
They learn from others more easily than they do when attempting to learn new information and skills by themselves. They do not like being alone.

Kunce and Anderson (1984) propose autonomy as the principal force under girding the Social Introversion scale. One can either function as a resourceful, self-directed, independent individual or withdraw into them-selves leaving the world of people behind.

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

Research Findings. Steyaert et al., (1994) investigated the higher incidence of psychiatric morbidity in **female fragile X carriers** (fragile X syndrome, also known as the Martin-Bell syndrome, after the British investigators who first reported it in 1943). The tip of the X chromosome tends to break off in many of those affected. Hence, the name Fragile X. Female carriers have more disorders that are schizophrenia-like. The sample mean MMPI scale scores fell within the normal range for a group of 11 females of normal intelligence. Low scores on the Sie scale reflected extraversion, not introversion, as expected.

Steyaert, J., Decruyenaere, M., Borghraef, M., & Fryns, J. P., (1994). “Personality profile in adult female fragile X carriers: assessed with the Minnesota Multiphasic Personality Inventory (MMPI)”. American Journal of Medical Genetics 51(4), 370-373.

Meehl (1989) proposed a research model opposing biological **vs.** psychological **causation in the genesis of schizophrenia.** Meehl hypothesizes those given unfavorable polygenic potentiators (e.g., introversion, hypohedonia, and anxiety) and adverse life experiences (e.g., childhood trauma or adult misfortune), 10 percent of such individuals so afflicted develop schizophrenia. Meehl concludes, “Taxometric statistics are appropriate to testing a major locus model”.

Meehl, P. E., (1989). “Schizotaxia revisited”. Archives of General Psychiatry 46(10), 935-944.

Gauci et al. (1993) used the MMPI to study women with allergic rhinitis. Twenty-two female suffers of perennial **allergic rhinitis** (inflammation of the nasal mucosa initiated by botanical airborne substances) and an 18 non-allergic female control group. Allergic sufferers scored significantly higher scores on the Sie scale along with high score on Scale

1 (Hs). Skin reactivity to house dust mite and grass pollen allergens correlated positively with scores on the Sie scale.

Gauci, M., King, M. G., Saxarra, H., Tulloch, B. J., & Husband, A. J., (1993). “A Minnesota Multiphasic Personality Inventory profile of women with allergic rhinitis”. Psychosomatic Medicine 55(6), 533-540.

Fals and Schafer (1993) examined the relationship between **compliance with a behavioral therapy program** and MMPI profiles of obsessive-compulsive disorder (OCD) outpatients. Compliance referred to the number of scheduled therapy sessions cancelled or missed. High scores on scales Sie, 2 (D), and 8 (Sc) predicted lower compliance with treatment for OCD patients engaged in behavioral therapy.

Fals, W. W., & Schafer, J., (1993). “MMPI correlates of psychotherapy compliance among obsessive-compulsives”. Psychopathology 26(1), 1-15.

Danjou et al., (1991) screened 62 young healthy volunteers with the MMPI for **eligibility to participate in psychopharmacology studies**. The most striking differences occurred on the Sie scale, which was lower than even the controls Sie scores, but significantly higher than controls on Scales 4 (Pd), 9 (Ma), and 8 (Sc). The low Sie scale scores were significant at the .0001 levels. Bias is possible in the selection of psychopharmacology research volunteer subjects. Drug seeking may be an important factor urging young healthy males to volunteer.

Danjou, P., Warot, D., Weiller, E., Lacomblez, L., & Puech, A. J., (1991). “Personality of healthy volunteers. Normality and paradox”. Therapie 46(2), 125-129.

Siegler et al., (1997) utilized the MMPI to study 796 women and 3,630 men enrolled in the University of North Carolina Heart Study to test the predictive power of personality on **adult exercise behavior**. Lower scores on Scales 0 (Sie), 2 (D), and 4 (Pd) are predictive of an increased probability of exercising in mid life for both women and men.

Siegler, H. D., Blumenthal, J. A., Barefoot, J. C., Peterson, B. L., Saunders, W. B., Dahlstrom, W. G., Costa, P. T., Suarez, E. C., Helms, M., Maynard, K. D., & Williams, R. B., (1997). “Personality factors differentially predict exercise behavior in men and women”. Women’s 3(1.1), 61-70.

Richman (1983) used the MMPI to study 30 **adolescents with cleft lips and palates**. Heightened social introversion was associated with increased self- consciousness centering on their cleft lips and palates when the adolescents found themselves in social situations.

Richman, L. C., (1983). “Self-reported social, speech, and facial concerns and personality adjustment of adolescents with cleft lip and palate”.
Cleft 20(20), (pp. 108-112).

Peterson and Knudson (1983) cross-validated several measures of anhedonia and the MMPI Sie scale. They conclude the results of multiple statistical measures lead to the conclusion, "**The high degree of relationship between anhedonia and introversion**, long suggested by clinicians, is confirmed".

Peterson, C. A., & Knudson, R. M., (1983). "Anhedonia; a construct validation approach". Journal of Personality 47(5), 539-555.

Kling et al., (1978) studied the scoring norms **on adolescent psychiatric drug users and non-users MMPI profiles**. Sie scale scores differentiated the users from non-user profiles. Low Sie scores were more frequently associated with drug use.

Klinge, V, Lachar, D., Grisell, J., & Berman, W., (1978). "Effects of scoring norms on adolescent psychiatric drug users and non-users MMPI profiles". Adolescence 13(49), 1-11.

Ansseau et al., (1986) investigated the relationship between MMPI scale scores and **dexamethasone suppression tests** (DST) with42 patients diagnosed with **major depression**. The Sie scale scores correlated positively with depression and negatively with Scale 9 (Ma) scale scores.

Ansseau, M., Frenckell, R., Frank, G., Geenen, V., & Legros, J. J., (1986). "Dexamethasone suppression test and MMPI scales: Neuropsychobiology 16(2-3), 68-71.

Nocita et al., (1986) used the MMPI to investigate the relationship between the **MMPI Sie scale** and the experience 83 **introverted clients** had in **counseling sessions**. Clients with higher Sie scale scores rated their sessions as uncomfortable, unpleasant, tense, rough, and difficult. They rated their post-session mood as unfriendly, uncertain, sad, angry, and afraid.

Nocita, A., & Stiles, W. B., (1986). "Client introversion and counseling session impact". Journal of Counseling Psychology 33(3), 235-241.

Yen and Shirley (2003) investigated MMPI subscales' ability to differentiate male **suicide completers, clinically depressed men, and a control group of men who died of medical causes**. Suicide completers have significantly higher Sie scores when compared to depressed and deceased controls.

Yen, S., & Shirley, I. C., (2003). "Self-blame, social introversion and male suicides: Prospective data from a longitudinal study". Archives of Suicide Research 7(1), 17-27.

Craig and Bivens (2000) examined the relationship between **psychological needs** of 198 non-clinical subjects using the Adjective CheckList **and the MMPI. Scale O (Sie) scale** scores were positively associated with need for receiving support, showing deference to others, and a preference for being a follower rather than a leader. The same scores were negatively associated with needs for achievement, dominance, autonomy, and exhibitionism.

Craig, R. J., & Bivens, A., (2000). “Psychological needs associated with MMPI-2 scales in a non-clinical sample”. Journal of Personality Assessment 74(3), 439-446.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 4-0 Pattern on the MMPI-A are 2.30 percent and on the MMPI 0.70 percent. Base rates for adolescent females with the 4-0 Pattern are 2.10 percent and 0.70 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) portray 4-0 Pattern adolescents as shy, uninvolved, neither friendly nor sociable. They are mistrustful. They fix the responsibility for the events they experience upon the shoulders of others. They hold themselves blameless when things go wrong. They rid themselves of stress and painful emotions through ill-considered acts. They carry resentments, argue a lot, and do not cater to persons in authority.

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

Greene, (2000) describes 4-0 Pattern adults as shy individuals who are conventional and law abiding.

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

Tanner (1990) studied nine cases, eight of which were female, in a psychiatric setting. These women were angry, hostile people who attributed their problems to the actions of others. They confronted those they felt had wronged them to purge themselves of stress and tension. They did not grasp relevant social cues. They were described as difficult to work with in treatment. Passive-aggressive diagnoses were frequently rendered.

Tanner, B. A., (1990). “Composite descriptions associated with rare MMPI two-point code types: Codes that involve scale 5”. Journal of Clinical Psychology, 46,425-431.

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	Base Rate
	0.03

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

1. Delusional Disorder
305. Alcohol Abuse
300. Anxiety Disorder NOS
89. Anxiety Disorder Due To (existing medical condition)
90. Mood Disorder NOS
83. Mood Disorder Due To (existing medical condition)
30. Impulse Control Disorder NOS
8. Conduct Disorder
34. Intermittent Explosive Disorder NOS

Axis II

301. Paranoid Personality Disorder
7. Antisocial Personality Disorder
301.82 Dependent Personality Disorder