4-9 Pattern

Clinical Scale Elevations

Scale(s) 4 (Pd)

T-scores 74-79

All other scale scores 60

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

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

Tscore 74

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 .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) 9 (Ma)

T-score 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 are excitable, high-energy people. They enter social situations with ease. They probably do not need as much sleep as most people. They work with enthusiasm. Their movements are rapid, coordinated, and they can sustain physical effort for long periods. They speak more rapidly than most others do. They like to be in control of their activities. They are organized, efficient, and manage their affairs effortlessly. They like the excitement of new experiences. They will try anything. They thrive in the company of other people. These contacts stimulate them. The more intense the interactions, the more they enjoy the coming together. Partying, dancing, drinking, loud music and concerted muscular activities provide them with the heightening of sensations they crave and cherish.

Mood Disorder

Hypomania
And

Mania

DSM-IV-TR (2000) lists the following criteria for Bi-polar Disorder, Hypomania, and Mania: A distinct period of abnormality and persistently elevated, expansive, or irritable mood for at least: 4 days of hypomania; or one week for mania.

At **least three (or more)** of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree during the period of mood disturbance: inflated self-esteem or grandiosity; decreased need for sleep (e.g., the person feels rested after only three hours of sleep; more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are racing; distractibility (i.e., the person's attention is too easily drawn to unimportant or irrelevant external stimuli; increase in goal directed activity (either socially, at work or school, or sexually) or psychomotor activity; excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestricted buying sprees, sexual indiscretions, or foolish business investments).

Hypomania. The episode is associated with an unequivocal change in functioning that is not characteristic of the person when symptomatic. Others observe the disturbance in mood and the change in functioning. There is an absence of marked impairment in social or occupational functioning. Hospitalization is not indicated. Symptoms are not due to direct physiological effects of substance (e.g., drug abuse, medication, or other medical conditions).

Mania. Mania severe enough to cause marked impairment in occupational activities, or relationships, or necessitated hospitalization to prevent harm to self and others, or there are psychotic features. Symptoms are not due to direct physiological effects of substance (drug abuse, medication) or general medical condition (e.g., hyperthyroidism).

The lifetime base rate for mood disorders associated with elevated mood worldwide is approximately one percent (DSM-IV-TR 2000).

Substance abuse is common (Strakowski and Del Bello 2000).

Strakowski, S. M., & Del Bello, M. P., (2000). "The occurrence of bipolar and substance use disorders". Clinical Psychology Review, 20(2): 191-206.

Bipolar manic persons who are also diagnosed with co-occurring personality disorders, have much poorer treatment outcomes 12 months after hospitalization (Dunayevich, et al., (2000).

Dunayevich, E. et al., (2000). Twelve-month outcome in bipolar patients with and without personality disorders. Journal of Clinical Psychiatry 61(2): 134-139.

Bipolar disorder is several disorders rolled into one diagnosis. **Bipolar I Disorder** includes psychosis, paranoia, rapid mood cycling, recurrent schizophrenia-like symptoms, recurrent depression, mania, bizarre behavior, substance abuse, and/or self-medication. **Bipolar II Disorder** includes personality disturbance or disorder of temperament (borderline-like), seasonal depression, alcohol and/or substance abuse, rapid mood cycling, premenstrual dysphoria; premenstrual mood disturbance, impulse difficulties, interpersonal sensitivity, intermittent viciousness, backbiting, slander, manipulativeness, acts of bad-faith, recurrent depression, mood instability (Zerbe 1999).

Zerbe, K. J., (1999). “Women’s mental health in primary care”. (p. 57). Philadelphia: W. B. Saunders.

Unipolar Depressive Disorders. The age of onset is usually between the ages of 40 to 44 years of age. Women are affected twice as often, as are men. Unstable ties to parents and families are frequently encountered. The divorce rate is no higher than for the population in general. Symptoms encountered during the depression include prominent guilt feelings, unresolved autonomy issues, and increased motor activity, insomnia, and health concerns.

Bipolar Disorder. The age of onset is between 19 to 30 years of age. It is equally prevalent in women and men. A higher rate of divorce and marital conflict occurs. The need for independence, control of others and being the center of attention is central to this disorder. A significant increase in the drive for success and prestige occurs. Symptoms associated with the depressed phase of this illness are psychomotor retardation, increased sleep-intervals, few health concerns, and little anxiety or concern for self or others. A high frequency of relapse is associated with bipolar disorder as compared with (Unipolar) major depressive disorder (Varcarolis 2002).

Varcarolis, E. M., (2002). “Foundation of Psychiatric Mental Health Nursing”. (445-446). Philadelphia: W.B. Saunders Company.

Ethanol ingestion aggravates affective disorders. This combined with brain damage can lead to aggressive and violent behavior (Sweet, et al., 1969).
The level of sensitivity to the effects alcohol has upon a person is associated with a diagnosis of “pathological intoxication” or ‘*manie* à potú in combination with head injury. A person evidences the pathological effects of alcohol with much smaller levels of alcohol in their blood. They behave violently while under the influence of alcohol, recalling nothing of the events surrounding their intoxication. There is ongoing controversy concerning this diagnosis.

Sweet, W.H., Ervin, F., & Mark, V.H., (1969). “The relationship of violent behavior to focal cerebral disease” In Aggressive Behaviour, Proceedings of international

symposium on the Biology of Aggressive Behaviour. Garattini, S. & Sigg, E.B. (Eds.) Exerpta Medica: Amsterdam (81, 82, 189).

Manic stupor can lead to elation and ecstasy. The patients' report their mind is filled to overflowing with ideas. They are unable to react to anything around them (Abrams and Taylor 1976).

Abrams, R., & Taylor, M. A., (1976). "Catatonia: a prospective clinical study", Archives of General Psychiatry 33, 579-581.

Schukla, et al., (1987) reports on 20 cases of the development of mania following head injury. There were no family histories of bipolar disorder. Epilepsy developed in one half of the cases. Irritable mood was more frequent than euphoria. Assaultive behavior often occurred. Fourteen of the patients had episodes of mania without depression.

Schukla, S., Cook, B. L., Mukherjee, S., Goodwin, C., & Miller, M. G., (1987). "Mania following head trauma". American Journal of Psychiatry 144, 93-96.

Starkstein, et al., (1988) studied 12 patients who developed mania from brain lesions (tumors, strokes, and brain injuries). None has histories of affective disorders. Right hemisphere lesions were more common that those of the left hemisphere. Lesions of the orbitofrontal cortex were strongly associated with mania. Two patients had repeated manic episodes and another developed mania along with a marked change of personality two years after a head injury.

Starkstein, S. E., Boston, J .D., 7 Robinson, R. G., (1988). "Mechanisms of mania after brain injury. Twelve case reports and review of the literature". Journal of Nervous and Mental Disease 176, 87-100.

Logsdail and Toone (1988) report twice as many right hemisphere loci, which is similar to those reported by Starkstein, et al., (1988).

Logsdail, S. J., & Toone, B. K., (1988). "Post-ictal psychoses. A clinical and phenomenological description". British Journal of Psychiatry 152, 246-252.

Scale 9 has 46 items. Item overlap is **L (12), F (1), K (5), 3 (6), 4 (7), 5 (3), 6 (3), 7 (6), and 8 (11).** Thirty-five items are keyed in the true direction. Scale 8 has one fourth of its items in common with Scale 9. The reading comprehension level for Scale 9 is the highest (ninth grade reading level) of all of the MMPI scales Paolo et al (1991). The average reading level is the eighth grade in the US. Scale 9 test scores may need to be verified if the subject gives evidence of reading comprehension difficulties. Test-retest correlations for the standardization sample (Butcher, et al 1989) are 0.68 for females and 0.83 for males.

Paolo, A.M., Ryan, J.J., & Smith, A.J., (1991). Reading difficulty of MMPI-2 subscales. Journal of Clinical Psychology July 47(4), 529-532

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.

Scale 9 (Ma) presumably measures mood elevations. Scale 9 (hypomania) reflects heightened motor activity levels. Associated features are grandiosity, Green-Spanian irrational exuberance, and decreased need for sleep, suspiciousness, and a hot temper.

The original clinical group of inpatients who served as criterion subjects in the construction of Scale 9 (Ma) numbered 24 (Dahlstrom and Dahlstrom 1980). They pointed out the small number of cases used in the construction of Scale 9. “It is the best that we could derive from the patients seen over a 5-year period” (p. 57).

Individuals who are in the throws of a genuine manic episode will render invalid MMPI results. Distractibility, ideational flooding, and increased motor activity levels are the cause.

Dahlstrom, W. G., & Dahlstrom, L. E. (Eds.), (1980). “Basic readings on the MMPI: A new selection on personality measurement”. Minneapolis: University of Minnesota Press.

Langer (2003) defines Scale 9 as a focus on achievement. Self-worth rests upon career success, material acquisition, and fame. Ready response to stimuli is a core feature. Tension is high between aspiration and accomplishment.

Langer, F., (2003). frank.langer@ALIENS.com Wednesday 3 Sept 2003. Re: MMPI-2/Rorschach Confusion. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Increased motor behavior follows the anticipation of failure. “If they see a looming catastrophe, they pull out all stops to do everything possible to avert it” (Langer 2003). The relative vacuum of insight into their thinking and feeling is addressed by a focus upon externalities. This is a focus, which rushes in to fill the void left in the wake of the flight away from the threat of the recognition of their weaknesses, anxieties, incompetence, and fear for the future. Grim determination and “…sticking to one’s guns in the face of an unbending environment…” addresses the roadblocks facing them. Achievement supplants the quality and extent of connectedness with others.

Langer, F., (2003). frank.langer@ALIENS.COM Sunday 7 Sept 2003. Re: MMPI-2/ Rorschach follow-up. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Scale 9 (Ma) may also reflect a fear of frustrations to come, which displaces the enjoyment of the present moment (Caldwell 1984).

Caldwell, A. B., (1984). “Clinical decision making with the MMPI. Advanced Psychological Institute”. Chicago, IL: Northwestern University.

Duckworth and Anderson (1995) say that Scale 9 (Ma) “…is a measure of psychic energy,” upon which the person “…feels compelled to act…” (p. 267).

They think the number of thoughts a person experiences also increases during hypomanic episodes. Scale 9 is the most common scale elevation with college students.

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

Scale 9 descriptors of healthy persons include the terms friendly, expansive, active, enthusiastic, talkative, and involved. (Kunce and Anderson (1976); Hovey and Lewis (1967).

Kunce, J., & Anderson, W., (1976). “Normalizing the MMPI”. Journal of Clinical Psychology 32, 776-780.

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

Scale 9 (Ma) may also measure sensation seeking, self-confidence, a sense of being indestructible and disdain for others’ weaknesses (Lachar 1974).

Lachar, D., (1974). The MMPI: Clinical Assessment and Automated Interpretation. Los Angeles, CA: Western Psychological Services.

Archer (1992) lists the following Scale 9 features applying to adolescents: Increased personal tempo with increased activity occurs. Action is preferred over thought and contemplation. Impulsivity, restlessness, and distractibility are present. Unrealistic aspirations and goal setting is a problem, which guarantees failure for them. They are extroverted, gregarious, talkative, and filled with energy. They are narcissistic, self-involved, self-infatuated, insensitive to others feelings and ideas as well as prone to rule breaking.

Archer, R. P., (1992). MMPI-A: Assessing Adolescent Psychopathology. Hillsdale, NJ: Lawrence Erlbaum Associates Publishers.

Research findings. Siblerud et al. (1998) examined the effect of dental amalgam mercury removal with nine patients on manic depression and related symptoms. The Scale 2 (Dep) and Scale 9(Ma) score showed significant improvement for the amalgam removal group. The amalgam removal group reported a 42% decrease in the number of somatic health problems after amalgam removal.

Silerud, R. L., Motl, J., & Kinholz, E., (1998). “Psychometric evidence that dental amalgam mercury may be an etiological factor in manic depression”. Journal of Orthomolecular Medicine 13(1, 31-40.

Comrey (1958) studied the factor content of Scale 9 (Ma). He concluded that this scale has the most content diversity of all of the MMPI scales. Scale 9 (Ma) does not possess the needed factor homogeneity needed to establish statistical and logical relationships.

Comrey, A. L., (1958). “A factor analysis of items on the MMPI Hypomania scale”. Educational & Psychological Measurement 18, 313-323.

Kalichman (1988) collected demographic information and Minnesota Multiphasic Personality Inventory profiles with 16 adult women convicted of murdering their (domestic) partners and 20 adult men convicted of murdering strangers during the course of the crime. The men convicted of murdering strangers had higher elevations on the Hypomania scale than men who murdered (domestic) partners. Women who murdered (domestic) partners had higher elevations on Scale 6 (Pa) and Scale 0 (Sie).

Kalichman, S. C., (1988). “MMPI profiles of women and men convicted of domestic homicide”. Journal of Clinical Psychology 44(6), 847-853.

Duckworth and Levitt (1985) evaluated 30 swingers from a private metropolitan swinging club with the MMPI who engaged in high-risk sexual behaviors. One half had significant clinical scale elevations, most of on Scale 9 (Ma). Two thirds of the group were judged emotionally disturbed, however, they had sufficient ego resources to enable them to cope with their problems.

Duckworth, J., & Levitt, E. E., (1985). “Personality analysis of a swinger’s club”. Lifestyles, 8(1), 35-45.

Baetsen et al., (1985) examined personality characteristics and demographic factors of 23 pregnant women who intended to have and abortion and 23 women who planned to carry to term with the MMPI. Only the Hypomania scale differentiated between the groups, with the abortion group scoring significantly higher on Scale 9 (Ma).

Baetsen, K. L., Rankin, R.E., Fuller, G. B., & Stack, J. M., (1985). “A comparative MMPI study of abortion-seeking women and those who intend to carry their pregnancies to term”. Family Practice Research Journal 4(4), 199-207.

Jurko et al., (1974) administered the MMPI to eight patients who received a pre-thalamotomy. The only significant long-term change was a decrease in the elevation of Scale 9 (Ma).

Jurko, M. F., Andy, O. J., & Giurintano, L. P., (1974). “Changes in the MMPI as a function of thalamotomy”. Journal of Clinical Psychology 30(4), 569-570.

PROFILE CHARACTERISTICS

Base rates for adolescent males with the 4-9 Pattern on the MMPI-A are 10.10 percent and on the MMPI 7.90 percent. Base rates for adolescent females with the 4-9 Pattern are 4.00 percent and 8.60 percent respectively (Archer, 1997).

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

Adolescents with the 4-9 Pattern are described as defiant, disobedient, impulsive, mischievous, and school skippers. They lie as a matter of principle, run-away from home and school, and commit delinquent acts. They do not like school. They are not interested in intellectual pursuits. They drink alcohol excessively. They are gleeful Polysubstance connoisseurs. They do not experience anxiety. Their memory and intellect are intact and unimpaired. They are not depressed. They like themselves a lot. They do not suffer from guilty. They are indifferent to the pain and suffering others experience. They are surprisingly kind, generous, and supportive to little children should their fancy dictate (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.

Archer (1997) describes the 4-9 Pattern adolescent as egocentric, selfish, narcissistic, and self-indulgent. They blame others when things go wrong for them. They refuse to accept responsibility for their behavior. They are thrill seekers. They are easily bored. They are outgoing. They make a good first impression, which doesn’t last, for long. For those who have emotions, they are exceptionally shallow and superficial. Many have no emotions. They are manipulative. They exploit people and situations, and take advantage of any and all opportunities for their own profit (Archer 1997).

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

They are emotionally crippled, some more, some less (Gilberstadt and Duker, 1965). They do not have the capacity to love. They are deaf to the melody of affection. They are driven by the physiology imperative to respond to sensations. They relish excitement, which, when pursued to its ultimate ends, the let down leaves them with the sensation of a hollow painful emptiness. There is no lasting comfort for them. There is no respite from the pursuit for excitement. There is no end to the treadmill spinning wheel in the cage. They do not connect with other peoples' lives. No sparks ignite a joining. They are imprisoned in the chrysalis of their isolated needs, sensations, and thoughts. There is no possibility of mutual friendships, genuine collaborations, or loyalty.

Gilberstadt, H., & Duker, J., (1965). "A Handbook for Clinical and Actuarial MMPI Interpretation". Lantham, MD: University Press of America

An important confound is associated with the 4-9 Pattern. On the one hand the characteristic behavioral history of delinquency and later continuing antisocial behavior is the hallmark of the forensic 4-9 Pattern. On the other hand there are persons who present with the 4-9 Pattern who are not inclined to criminal behavior, but represent a similar personality construct (Marks et al., 1974). These people do not experience anxiety. They do not avoid situations, which have the potential to eventuate in catastrophe (a la Evil Kneivel). Pain, while unpleasant, has little or no meaning for them and they do not avoid situations, which have the potential for painful endings. They have no future. They live in the eternal present. They respond to the immediate, spontaneous, and most compelling features of the 'now'. They have no appreciation for the next oncoming 'now', or the next. Nothing is linked together. No corrections for past errors are ever made. The past errors go on and on and on.

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

The 4-9 Pattern echoes the need to maintain high levels of excitement (Duckworth and Anderson, 1995). The 4-9 Pattern adult will bear tales to get people in a group stirred up, excited, and in each other's faces. They enjoy the resulting uproar. They are truly troublemakers.

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

The 4-9 Pattern mirrors a hodgepodge of descriptors and diagnostic categories. Highly educated persons with the 4-9 Pattern control their behavior. Stock brokers with the 4-9 Pattern for example may defraud their clients, but are rarely called to account. These people are likely to be self-involved, selfish, controlling, power

seeking, and not inclined to commit to others for longer than their manipulations require for their maneuvering to be successful.

Marks has written that patients with this type of profile are self-centered, impulsive, excitement seeking and often lacking in conscience. They are usually in trouble with the law, with other authority figures, or with people in their close relationships. Superficially charming with an easygoing style, they quickly become impatient and belligerent when confronted or crossed. They are seen as skillful manipulators, who will verbalize their "dislike" of people who "lie" while at the same time themselves "selectively report" to stay out of trouble.

Constantly seeking the "adrenaline rush" of a new challenge, they have chaotic personal lives with a history of interpersonal conflicts. It is likely that the profile results from an interaction of inheritance and learning experiences. Frequently one parent who was authoritarian and unreasonable and one who was indulgent and weak raised these patients. Their early relationships with the authoritarian parent presumably led to a disrespect but fear of authority and a "numbing out" of their own vulnerable feelings in order to survive.

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 have a chronic pattern of protecting themselves against the frustration and unhappiness associated with failure. It is very likely that parents who had high expectations of success for which the child was given only partial or periodic rewards raised them. Thus, the parents were seen as constantly pushing the child to achieve while at the same time trying to control the resulting surges of energy and impulsivity. The child's needs for reward were then met by the parent's withholding of regular rewards, which increased the drive-state and, in effect, increased the manic tendencies.

They responded to being treated arbitrarily by "playing the game" of the person they saw as unreasonable while in a constant "battle" over any attempts to control them. Therapy should concentrate on helping them see how their constant rationalizing, lying, and manipulating leaves them feeling empty and alone. Their projection to the

therapist of their own mistrust and transgressions will require constant work on the transference relationship. They tend to see the world as a "dog-eat-dog" place, where only the "top-dog" will ultimately survive.

It is important to note that college educated individuals with this type of profile experience similar alienation and a tendency to guard against emotional closeness but often avoid difficulties with the law. They do however experience relationship turmoil.

The purpose of therapy should be to help the patient stop and enjoy the "here and now." These patients often are future oriented and fearful of the present where they would have to deal with the pain and disappointment of slowing down. They are afraid that if they stop driving themselves they might achieve less in the future. They will need help to distinguish between their own needs and what they want in order to please others.

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, PA. (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	3.05
White Adult Males	2.34
White Adolescent Males	1.33.
White Adult Females	2.64.
White Adolescent Females	5.48
African American Males	3.60
African American Adolescent Males	1.76
African American Adult Females	0.00

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

296.40	Bipolar I Disorder, Most Recent Episode Manic, Unspecified
309.3	Adjustment Disorder With Disturbance of Conduct
305.0	Alcohol Abuse
297.1	Delusional Disorder
304.90	Other (Or Unknown) Substance Abuse
312.30	Impulse Control Disorder NOS
304.4	Dysthymic Disorder

Axis II

301.81	Narcissistic Personality Disorder
301.0	Paranoid Personality Disorder
301.7	Antisocial Personality Disorder
301.5	Histrionic Personality Disorder