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A Comparative Clinical Investigation of the "How" and "Charlie" MMPI Subtypes

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We studied the thought and affective disturbance of Megargee and Bohn's (1979) most psychopathological Minnesota Multiphasic Personality Inventory (MMPI) subtypes, the "How" and "Charlie" profiles. 75 subjects, consisting of three groups of How and Charlie subtypes in inpatient and outpatient forensic settings and two control groups, are tested using the Whitaker Index of Schizophrenic Thinking (WIST) and Profile of Mood States (POMS). Results indicate both How and Charlie subtypes have mild formal thought disorder, with the former showing greater variance of thought disorder. Charlie subtypes, however, are more angry, less depressed, more vigorous, and more constricted and defensive than the How subtypes. We conclude that the How subtype needs further actuarial refinement to be diagnostically useful.

Historical attempts to classify criminal offenders have resulted in a proliferation of typologies based on constitutional, physiological, criminal, social, cultural, psychiatric, developmental, and psychoanalytic data (Megargee & Bohn, 1979). None of these approaches have resulted in a reliable, valid, and efficient method of classifying criminal offenders.

Megargee and Bohn (1979) published a typology based on the actuarial use of the MMPI following research in the Federal Correctional Institute at Tallahassee, FL. Using a sample of 1,214 inmates, 96% of their MMPI profiles could be assigned to 1 of their 10 MMPI subtypes. Further research has both validated (Booth & Howell, 1983; Megargee & Bohn, 1979) their hypotheses that significant between group differences exist on certain behavioral measures and questioned the system's predictive validity (Hanson, Moss, Hosford, & Johnson, 1983; Louscher, Hosford, & Moss, 1983). Another study has questioned the

typology's applicability to non-White populations (Carey, Garske, & Ginsberg, 1986).

The purpose of our study was to further investigate their two most psychopathological subtypes, the "How" and "Charlie" profiles. These subtypes, according to the Goldberg Index (Goldberg, 1965), both fall within the psychotic range. They represented 13% (How) and 9% (Charlie) of the Megargee–Bohn original sample (Megargee & Bohn, 1979) and are described as having extreme mental health needs.

We chose these two subtypes because they are the most likely to come to the attention of mental health treatment staff in forensic settings. And with growing interest in the identification and treatment of the mentally disordered offender (Halleck, 1986; Monahan & Steadman, 1983), it is timely to empirically and psychometrically refine the assessment of the severely mentally disordered individual in the criminal justice system (Meloy, 1986).

The Charlie profile describes an individual who is estranged from his family, has low achievement motivation, and very poor interpersonal relationships. He behaves antagonistically, and is aggressive, hostile, and paranoid. He usually has an extensive prior criminal record and a polydrug abuse history. He is asocial and emotionally constricted, and will adapt poorly to a custody environment. Charlie exhibits high state and trait anxiety and can be very violent. He is unempathic and views others as threats. His thinking is rigid, dogmatic, and constricted. Charlie is perceived by others as having a "don't tread on me" attitude (Megargee & Bohn, 1979).

The How profile describes an individual who is also low in achievement motivation, withdrawn, and introverted. He has a polydrug abuse history. He evidences high state and trait anxiety and is preoccupied with personal problems. How has little ego strength to cope with life stressors and will show the most pervasive pattern of poor adjustment to custody. He will complain of sleeplessness and "nervousness" and is very likely to be exploited and abused by other inmates. He is likely to manifest a thought disorder (Megargee & Bohn, 1979).

The Charlie profile is characterized by marked elevations on MMPI Scales 4, 6, and 8. The highest scale is equal to or greater than 80T and less than 110T; Scale 8 is equal to or greater than 80T, with Scale 6 equal to or greater than 65T and Scales 4 or 6 greater than 70T. The How profile is also characterized by an elevated, but less jagged, profile. Scale 8 is generally the high point and must be equal to or greater than Scale 9. The top scale is equal to or greater than 80T. Scale 2 is equal to or greater than 70T, and at least three scales must be equal to or greater than 70T. Oftentimes five scales exceed 70T.

Despite the severity of symptoms and the degree of psychological disturbance within these two groups, the research of Megargee and Bohn (1979) and our clinical observation suggested that not all How and Charlie subtypes were thought disordered or deserved a psychotic diagnosis. We hypothesized that

between these groups there would be significant differences at the .05 level in both thought and affective disturbance. We also hypothesized that the degree of psychopathological disturbance among groups would be significantly different if sampled from an inpatient or an outpatient forensic setting.

To investigate these questions, we decided to study How and Charlie subtypes within both forensic inpatient and outpatient settings and compare them to forensic inpatient and outpatient control groups.

METHOD

The instruments used were the MMPI (Hathaway & McKinley, 1940), the WIST (Leslie, Landmark, & Whitaker, 1984; Whitaker, 1980), and the POMS (McNair, Lorr, & Droppleman, 1981).

This study was designed to detect a moderate (Cohen, 1977, p. 284) effect size of $f = .20$ in an analysis of variance (ANOVA), with alpha = .05 and power = .80. Because no previous studies have reported data for How and Charlie profiles on the variables measured here, the effect size is based on our judgment of what would constitute a clinically significant outcome. The sample size of 75 supplied more than enough power for this purpose.

The 75 subjects consisted of five roups: 15 adult male offenders incarcerated in the San Diego County Jail and admitted to the Psychiatric Security Unit, a maximum security inpatient psychiatric treatment program, who met the criteria for How on the MMPI; 15 adult male offenders in the Psychiatric Security Unit who met the criteria for Charlie on the MMPI; 15 adult male offenders who met the criteria for How but were not in custody; 15 adult male offenders admitted to the Psychiatric Security Unit who did not meet the criteria for either How or Charlie subtypes; and 15 adult male offenders not in custody who also did not meet the How or Charlie subtype criteria.

All individuals admitted to the Psychiatric Security Unit and all individuals being evaluated by DiFrancesca (the first author) in the forensic outpatient setting who consented to participate in this study were sequentially administered the MMPI, WIST, and POMS until all five groups were filled: Charlie Inpatient (ChI), How Inpatient (HI), How Outpatient (HO), Control Inpatient (CI), and Control Outpatient (CO). We were never able to fill a Charlie Outpatient group. Subjects whose MMPI *F* Scale exceeded a raw score of 24 ($T > 100$) were excluded. The groups were compared using a one-way ANOVA for each of the dependent variables; *t* tests were used to locate significance (McNemar, 1962).

RESULTS

The mean age of the subjects was 30.34 ($SD = 10.65$). There were no significant between group age differences.

Whitaker Index of Schizophrenic Thinking

There were no significant differences between ChI and HI, HI and HO, ChI and HO, and CI and CO. There were significant differences, $p < .05$, between HI and CI, and between HO and CO. The HI subjects were the most thought disordered group. The HO subjects showed the most variance in formal thought disorder (see Table 1).

POMS

There were significant differences within each of the six variables (see Table 2). All raw scores, however, were subclinical ($T < 70$) when compared to college student norms (McNair et al., 1981). We performed twenty-one t tests to locate the most likely significant differences. It was found that:

1. Tension – When grouped together, ChI, HI, and HO were more tense than CI and CO, $p = .0000$.
2. Depression – HI and HO were both more depressed than ChI, $p = .018$ and .046, respectively. When grouped together, ChI, HI, and HO were significantly more depressed than CI and CO, $p = .0000$.
3. Anger – When grouped together, ChI, HI, and HO were more angry than CI and CO, $p = .0000$.
4. Vigor – HI was less vigorous than ChI, $p = .023$, the latter group less vigorous than CI, $p = .002$. HO was less vigorous than CI, $p = .0005$.
5. Fatigue – HI was more fatigued than CI, $p = .003$.
6. Confusion – There were significant differences between groups, with HI and HO being the most confused, followed by ChI, CO, and then, surprisingly, CI being the least confused.

Additional Variables

Because anger is such an important clinical variable in any criminal population, we decided to look at the MMPI Manifest Hostility scale (Wiggins, Goldberg, &

TABLE 1
Mean Thought Disorder Index as Measured by the WIST Across Five Groups

	ChI	*HI*	*CI*	*HO*	*CO*
M	18.60	21.93	13.47	18.13	10.07
SD	11.48	14.33	6.64	16.67	5.84

Note. ChI vs. HI n.s. HI vs. HO n.s. ChI vs. HO n.s. HI vs. CI $p = .024$. ChI vs. CI n.s. HO vs. CO $p = .044$. CI vs. CO n.s.

TABLE 2
One-Way ANOVA of POMS Raw Scores Across Three Experimental (ChI, HI, HO) and Two Control (CI, CO) Groups

		ChI	*HI*	*CI*	*HO*	*CO*	*F*	*P*
Tension	*M*	17.73	20.67	11.53	21.93	12.33	5.43	.0007
	SD	8.19	7.95	8.88	7.99	6.11		
Depression	*M*	23.80	34.07	17.40	33.00	15.87	5.34	.0008
	SD	12.19	13.50	16.76	16.33	11.60		
Anger	*M*	16.33	22.00	7.93	17.67	6.93	6.48	.0002
	SD	7.77	11.59	9.18	11.68	8.63		
Vigor	*M*	16.27	11.27	19.37	10.20	14.13	4.99	.0013
	SD	6.19	6.85	7.43	5.58	5.97		
Fatigue	*M*	10.27	14.33	7.07	14.93	7.07	4.82	.0017
	SD	6.97	7.32	6.15	7.69	5.05		
Confusion	*M*	11.87	15.47	7.27	15.87	9.07	6.16	.0003
	SD	6.05	6.31	5.81	7.18	3.83		

Note. n = 15 for each group.

TABLE 3
One-Way ANOVA of MMPI Manifest Hostility Scale Across Five Groups

	ChI	*HI*	*CI*	*HO*	*CO*	*F*	*P*
M	14.73	12.07	9.07	9.67	6.53	5.32	.0008
SD	6.08	4.59	6.18	4.75	4.24		

Applebaum, 1971) for all groups. There were significant between group differences (see Table 3). It appears that ChI was the most manifestly angry group.

Because alcohol and drug abuse are ubiquitous in criminal populations, we also looked at the MacAndrew Alcoholism Scale (MacAndrew, 1965). There were no significant between group differences. All groups, however, fell within the mild-to-moderate addiction proneness range. When the inpatients and outpatients were grouped and compared, the inpatients (M = 28.55) had a significantly higher addiction proneness, p = .02, than the outpatients (M = 26.07).

DISCUSSION

Thought Disorder

Although the data did not support significant differences between all groups, and specifically found no significant difference among the Charlie and How groups, all experimental groups scored within or near the mild range of thought disorder. In Whitaker's (1980) normative sample, a cutoff index of 20 correctly

identified 89 of 111 subjects as schizophrenic. He characterized "mild thinking impairment" as indicated by an index of 20–29 on the WIST. Note a great amount of variance in thought disorder among the HI and HO, particularly the latter group (see Table 1).

Affective Disorder

The settings (inpatient + custody vs. outpatient + noncustody) did not appear to play a significant role in the subjects' perceived affective disturbance.

ChIs perceive themselves as just as tense as How subjects, but less depressed. They perceive themselves as more vigorous and less confused, but just as angry, as both HI and HOs. The MMPI Manifest Hostility scale, however, suggests that Charlie is more angry than How.

How patients see themselves as very tense, but much more depressed than Charlie. HIs also see themselves as having little vigor and a great amount of fatigue. They acknowledge greater confusion and anger, more so than Charlie. It may be that How patients are more willing to admit their emotional states. This is supported by the observation that their self-rated anger on the POMS is higher than Charlie, whereas Charlie scored higher on the Manifest Hostility scale of the MMPI.

CONCLUSION

ChIs appear to have an absent-to-mild thinking impairment. They are affectively disturbed, but unlike the How groups who describe themselves in the extreme on every dimension, there is a more distinctive pattern to their affective disorder. Their depression and confusion are more moderate, and they are quite vigorous. In keeping with the Megargee and Bohn (1979) description of Charlie subjects as misanthropes, both the POMS Anger scale and the MMPI Manifest Hostility scale suggest that anger is a serious clinical concern when treating and managing the Charlie subtype. Their defensiveness in perceiving their own anger and sense of vigor suggests a higher probability of actual violence in the Charlie subtype when compared to How. We have found that Charlie is most likely to be diagnosed as either paranoid schizophrenic with probable antisocial personality characteristics or a paranoid and antisocial personality disorder (American Psychiatric Association, 1980).

On the basis of our observations and Megargee and Bohn's (1979) research, How subjects appear to be quite variable in the area of thinking impairment, ranging from no formal thought disorder to severe thought disorder. There is less variability in their affective disorder. They are disturbed and readily admit to feeling badly. They appear to have very limited adaptive or defensive coping abilities. The genesis of their affective symptoms and cognitive impairments,

however, is likely to vary. One still needs to rule out an affective disorder or organic impairment before a schizophrenic diagnosis can be made. Many How subjects probably also fit the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (*DSM-III*; American Psychiatric Association, 1980) classification of borderline personality disorder. Yet, even within the borderline diagnosis itself there appear to be distinct groups. Andrulonis, Glueck, Stroebel, and Vogel (1982) found three different borderline subcategories: a nonorganic group; a group with history of trauma, encephalitis, or epilepsy; and a group with a history of attention deficit disorder or learning disabilities. These authors suggested different treatment approaches for the three subcategories. We recommend that the How subtype needs actuarial refinement and that when a forensic patient or inmate yields a How profile, he or she should be further evaluated so that a differential diagnosis can be made and the best treatment approach developed.

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