2-9 Pattern

Scale 2 (Dep)

Elevations of this magnitude for this Scale taking this group's data into Consideration, indicate these clinical features could be present in this person's behavior and history:

> They are worried, pre-occupied with their personal affairs and carry the burden of a private sadness. Sadness is intermingled in most of their activities. They experience the new, unique, and unexpected as barriers they must expend inordinate amounts of energy to overcome. They are sad and unhappy most of the time. They look at the future through wistful eyes, and out of their reach. They are easily discouraged and quickly put off from initiating important plans and activities. 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. They are severely depressed, tired, and indifferent to everyday human contacts. Mental retardation and lethargy interfere with everyday activities. Case review may indicate their need for medication referral.

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.

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. Sleep abnormalities occur in ninety percent of persons hospitalized from treatment of major depressions (APA 2000).

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

People treated in outpatient settings have a 40 to 60 percent chance of experiencing sleep disturbances. Sleep abnormalities persist after recovery from a depressive episode (Thase 1999).

Thase, M. E., (1999) Mood disorders: Neurobiology. In H. I. Kaplan and B.J. Sadock (Eds.), Comprehensive textbook of psychiatry (7th ed., pp. 1318-1327), Vol. I. Philadelphia: Lippincott, Williams & Wilkins.

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. Postpartum depression occurs in 10 percent of mothers. The rates for reported depression in pre-adolescents is 18 percent (Dubovsky and Buzan 1999).

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.

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 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
	Hyperparathyroidism
	Hypothyroidism
	Menses-related Depression
	Postpartum Depression

Metabolic/Nutritional	Foliate 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
	Neoplasm's
	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.

Prescription medications associated with Mood Disorders:

Systems	Medication/Substance
Neurologic/Psychiatric	Amantadine
	Anticholinesterase
	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	Aspariginase Azothioprine Bleomycine Hexamethylamine Vincristine Vinblastine
Cardiovascular	Clonidine Digitalis Guanethidine Methyldopa Propranolol Resperine
Gastrointestinal	Cimetidine Ranitidine
Mixed	Alcohol Anxiolitics 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.

Research studies. Franklin et al., (2002) using Taxometric analyses tested directly whether the MMPI-2 depression scales could differentiate 2000 psychiatric patients with depressive symptoms from patients with other disorders. Taxometric analyses did not find a MMPI-2 Depression scale cut point that categorizes patients with depressive symptoms form other patients. The findings support the assumption that there is an underlying dimensionality of depression.

Franklin, C. L., Strong, D. R., & Greene, R. L., (2002) A Taxometric analysis of the MMPI-2 Depression Scales. Journal of Personality Assessment, August 79(1), 110-121.

Rohling et al., (2002) examined the effect of depression on neurocognitive performance with patients who passed symptom validity testing. No differences occurred on objective cognitive and psychomotor measures with groups sorted based on their self-reported depression. These data suggest that depression have no impact on objective neurocognitive functioning.

Rohling, M. L., Green, Paul, Allen, L. M. III, & Iverson, G. L., (2002) Depressive Symptoms and neurocognitive test scores with patients passing symptom validity tests. Archives of Clinical Neuropsychology. 17(3), 205-222.

Scale 2 (Dep)

Scale 2 (Dep) measures the presence of clinical depression (Dahlstrom et al. 1972). The MMPI has 60 items. The MMPI-2 has 57 items. Thirty-seven of these items are scored in the false direction, 20 in the true direction. A false response set will elevate Scale 2 (Dep), along with Scale 1 (Hs) and Scale 3 (Hy). Item overlap is: L (2), F (2), K (8), 1 (10), 3 (13), 4 (7), 5 (2), 6 (2), 7 (13), 8 (10), 9 (5), Sie (8).

Dahlstrom, W. G., Welsh, G. S., & Dahlstrom, L. E., (1972) An MMPI hand-Book: Vol. 1. Clinical Interpretation. (Rev. ed.). Minneapolis: University of Minnesota Press.

Hunsley et al., (1988) provided meta-analytic derived test-retest data for retest intervals of 1 day to 2 years. An average interval consistency of 0.87 was reported for 74 Scale 2 (Dep) studies. Butcher et al. (1989) reported Scale 2 (Dep) test-retest correlations in the 0.79 ranges for the MMPI-2.

Hunsley, J., Hanson, R. K., & Parker, C. H. K. (1988) A summary of the reliability and stability of MMPI Scales. Journal of Clinical Psychology. 44, 44-46.

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(s) 9 (Ma)

T-score 60-69

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

They are excitable, high-energy people. They enter social situations with ease. They do not need sleep as much 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 not 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, 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 (pp. 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 minds fill 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 tight hemisphere loci, which are 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 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 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 valid 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 Wed, 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 own 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 Sunk, 7 Sept 2003. Re: MMPI-2/Rorschach follow-up. Rorschach@MAELSTROM.ST.JOHNS.EDU.

Scale 9 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. Northwestern University. Chicago, IL.

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 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 engaging in indiscriminant sex acts with strangers from a private metropolitan swinging club with the MMPI. 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. They had the necessary funds to pay for their memberships.

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 2-9 Pattern on the MMPI-A are 0.00 percent and on the MMPI 0.20 percent. Base rates for adolescent females with the 2-9 Pattern are 0.00 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.

The 2-9 adolescent Pattern is rarely encountered. No descriptors are listed.

The adult 2-9 Pattern reflects both depressive and manic features. Greene (1997) says, "These clients are narcissistically absorbed in their ruminations".

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

Instability of mood is characteristic of the adult 2-9 Pattern. Rapid changes from happiness to angry outbursts surprise people. It is difficult to be around 2-9 Pattern individuals because they turn on others so quickly. One never knows what to expect from them moment to moment. Histories of serious depressions are often in their

charts. The 2-9 Pattern adult is often self-centered to the point of feeling entitled to special treatment. They are demanding. The force with which they confront others is disconcerting. They often get what they want from people when this force is applied. The person is caught off balance. They are left without alternative means of defending themselves. Alcohol and drug addiction is part of the chronic self-medication pattern encountered with the 2-9 adult Pattern. Suicide attempts are frequent (Craig and Olson, 1990).

Craig, R. J., & Olson, R. E., (1990). MMPI characteristics of drug abusers with and without histories of suicide attempts. Journal of Personality Assessment, 55, 717-728

Older persons who have a 2-9 Pattern may have brain lesions or deterioration (Lachar 1974).

Lachar, D., (1974). The MMPI: Clinical assessment and automated interpretation. Los Angeles: Western Psychological Services.

Aggression and confrontational behavior is encountered with the 2-9 Pattern. Excuses and justifications are used to counter complaints of inappropriate conduct (Drake and Oetting (1959).

Drake, L. E., & Oetting, E. R., (1959). An MMPI codebook for counselors. Minneapolis: University of Minnesota Press.

Marks writes patients with this profile often are tense, jumpy, moody, and irritable. Their optimism and expansiveness are frequently suppressed by the depression. The effect is abrupt changes in mood from being happy, good natured, optimistic and joking one moment to feeling angry, sullen, negativistic and explosive the next.

The central issue is generally their moodiness and irritability. Frequently these patients were raised in families where they were constantly urged to achieve, but no matter what they accomplished they were seldom rewarded or rewarded consistently. As adults, they typically are quite achievement/failure oriented so that small blocks to their goals, some self-imposed, can easily precipitate bursts of explosive irritability. This type of clinical picture is sometimes associated with a psychotic disorder, which may be paranoid or manic- depressive. A precipitating factor of referral that is often the blocking of some kind of goal directed activity.

This profile is also associated with a high frequency of addictive behavior, which often reflects the reliance on drugs to control their moods with self-medication.

Marks writes that 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." They are blocked in the "despair" phase of the mourning process and 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 these patients about their health and focus them on their psychological problems only increases their fear that they will be overwhelmed by pain with 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.

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 raised them, which the child was given only partial or periodic rewards. 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.

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.

Therapy should concentrate on helping them distinguish between their own goals and desires and the goals that they have internalized of parents or others. Behavioral management of their mood swings can be useful. Gestalt techniques are usually effective in "forcing" them to express their feelings now, rather than trying to deal with events of the past or anticipated events in the future (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	0.89
White Adult Males	0.95
White Adolescent Males	0.15

White Adult Females	0.99
White Adolescent Females	0.46
African American Males	1.13
African American Adolescent Males	5.79
African American Adult Females	0.40

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

40. Bipolar I Disorder, Most Recent Episode Hypomanic
13. Cyclothymic Disorder
83. Mood Disorder Due To (existing medical condition)
80. Cognitive Disorder NOS

Axis II

301.83 Borderline Personality Disorder