7-9 Pattern

Clinical Scale Elevations

Scale(s) 7 (Pt)

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 have a low threshold for anxiety. They are methodical, punctual, and organized. They are productive, hard working persons. They are sensitive to the moods and feelings of others. They do not wish to give offense. They follow the rules. They drive at or very near the speed limit. They may not be particularly original in their approach to problems, but once they have mastered a task, they perform it without errors or complaints. They prefer routine, changeless futures, and the predictable. They have a high tolerance for boredom.

Scale(s) 7 (Pt)

T-score 70-84

They are dissatisfied with their social relationships.They are not confident about what to expect from others much less themselves. They are rigid, habit bound, and self-critical. They cannot stop themselves from thinking unpleasant and frightening thoughts. They sweat the small things. They often overlook the most important parts of the “Big Picture.” They often overlook salient features of a problem or social situation. They can feel “dumb” when they realize what they had missed or left out. They are meticulous about their work and person. They drive themselves hard to reach personally import goals. They are unusually persistent. Their rigid approach to life may intensify should they become ill, suffer accidents or injuries.

Scale(s) 7 (Pt)

T-score ≥ 85

They ruminate about their problems. They go over and over their problems, but rarely find satisfactory solutions for them. They feel miserable most of the time. They suffer from chronic tension. They sometimes find themselves so tied up in their own thoughts that they cannot make decision or attend adequately to everyday duties. They bear a heavy sense of responsibility, which is not called for by the objective facts of the situations in which they find themselves. They get little to no joy or satisfaction out of life. They are long suffering, as are their partners. They are not considered ”The Life of the Party.” They find it hard to laugh. Life is too serious for them to bear the thought of

anything racy, erotic, or improper. They are good, if not, inspiring neighbors. They are dependable. Their sense of morality demands exceptionally high standards, for both themselves and others. They are straight laced. Most people would probably not want to go to lunch with them, unless job or social demands required it. They freeze when suddenly confronted with off colored jokes. They panic when faced with an insensitive "move" is placed upon them.

Psychasthenia

Pierre Janet (1903) defined psychasthenia as "…the lack of psychological strength associated with a narrowing of consciousness. (Ellenberger 1970) p. 375.

Ellenberger, H. F., (1970). The Discovery of the Unconscious: the history and evolution of dynamic psychiatry. New York: Basic Books, Inc., Publishers.

Janet distinguishes "…two types of psychasthenia crises, fits of anxiety, and all kinds of conspicuous manifestations related to fixed ideas". "…Those fixed ideas were conscious in the form of obsessions and phobias". (Ellenberger, 1970 p. 376).

Janet (1930) wrote, "In my description of the symptoms of the psychasthenic neurosis (Janet, 1903), I stressed particularly the pathological feelings (*sentiments pathologiques*), which I designated at the time as feelings of inadequacy (*sentiments d'incomplétude*) and which have become in my last book a part of the feelings of emptiness (*sentiments du vide*)". Janet includes the symptom of "…the maladies of doubt".

Janet, P., (1903). *Les obsessions et la psychasthenia*, 2 volumes(Paris: Alcan. Vol. I by Pierre Janet, Vol. II by F. Raymond, and P. Janet.

Neurotic disorders were the preferred designation of all anxiety related mental disorders prior to the development of the Diagnostic and Statistical Manuals classifications, which now lists them as anxiety disorders. The DSM-IV-TR, (2000) classifies anxiety disorders into nine categories.

Panic Disorder is the recurrent episodes of panic attacks. At least one month (or more) has followed one of the attacks of the following: Persistent concern about having additional attacks. Worry about the consequences of an attack, i.e., "I'm going crazy", having a heart attack, and loosing self-control. Significant changes in behavior are feared. Panic disorder with and without agoraphobia and additional diagnoses with panic disorder is also a possible diagnosis.

Phobic Disorder is an irrational fear of an object or situation that persists although the person recognizes the fear is irrational. These specific phobias are **Agoraphobia**, the fear of being alone in an open or public area where escape might be difficult. The person is often terrified of leaving their home or residence; **Social Phobia**, the fear of situations where one might be seen and embarrassed or criticized. Speaking to person in authority, speaking in public or performing before an audience are avoided; **Specific Phobia**, a fear of a specific object, activity, or situation, i.e., fear of flying (Jong's Syndrome), snakes, mice, and closed places, amongst others.

Common Phobias

Feared Object Or Situation	Clinical Name
Animal	Zoophobia
Being Alone	Monophobia
Blood	Hematophobia
Closed Places	Claustrophobia
Darkness	Nyctophobia
Electrical Storms	Astrophobia
Fire	Pyrophobia
Germs/Dirt	Mysophobia
Heights	Acrophobia
Open Spaces	Agoraphobia
Strangers	Xenophobia
Talking	Glossophobia
Water	Hydrophobia

Obsessive-Compulsive Disorder (OCD) defines a preoccupation with persistent intrusive thoughts, impulses, or images. **Compulsions** are repetitive behaviors or mental acts that the person feels driven to perform in order to reduce distress or prevent a dreaded event or situation.

The person knows the obsessions/compulsions are excessive and unreasonable. The obsession/compulsion is time consuming and can cause distress.

Generalizes Anxiety Disorder (GAD) is defined as excessive worry and anxiety more days than not over a period of the preceding six months. The person cannot control their worrying. The anxiety and worry is associated with three or more of these six symptoms: Restlessness, feeling keyed-up, easy fatigue ability, difficulty concentrating, irritability, muscular tension, and sleep disturbances. The anxiety and worry as well as physical symptoms, which follow on the anxiety and worry cause significant impairment in other areas of important functioning.

Clinical Presentation of Anxiety Disorders

Panic Disorder: A panic attack is the sudden appearance of intense fear or dread, which may announce impending doom. Terror paralyzes its victim. Terror shakes the individual's hold on the elements of reality. They can neither see nor think clearly. They may think they are losing their minds. Physical sensations including palpitations, chest pain, suffocation, nausea, chills and hot flashes erupt unexpectedly. The abrupt onset of these attacks last a number of minutes and then subsides.

Panic Disorder and Agoraphobia characterizes recurring panic attacks, which combine with agoraphobia.

Phobias are persistent, irrational fears of specific objects or situations, which an individual avoids. High levels of anxiety and distress arise from contact with objects or situations, which most people find innocuous, i.e., the sight of blood, looking down from heights, thunder and lightning, viewing open expanses over water, enclosed spaces, among many others.

Social Phobias involve fear and anxiety arising from engagement in social situations or situations in which a performance is expected of the person. Afflicted persons fear they will say something foolish, which would expose them to ridicule or shame; not being able to answer a simple question, which would reveal they are stupid; forgetting their lines or saying them wrong in a play would expose them as inept are examples of social phobias. Fear of speaking in public is a common social fear. The life of persons living with social phobias becomes more and more constricted as they avoid more and more objects and situations which cause them to be paralyzed with fear. Alcohol and drugs reduce the distress they experience.

Obsessive-Compulsive Disorder: Obsessions are experienced as thoughts or images that keep recurring without let-up. They are meaningless in and of themselves. They occur within a matrix of persistent intense anxiety.

Compulsions are procedures adopted and followed rigorously, to control the experience of anxiety and reduce the intensity of the anxiety. These procedures lead to temporary relief. A tune repeated repeatedly is one's head is such an example. Repeated questioning such as, "Did I turn off the stove" "Did I turn off

the lights”,” Did I lock the door?” drive the person to check their activities many times over and often lead to self-dissatisfaction. Crippling doubts centering on violence, illness or death, contamination, and sexuality cause the individual to feel humiliated, shamed, and disgusted with him or herself. The demand-performances, procedures, and rituals involved in compulsions interfere with accomplishing necessary everyday activities and the fulfillment of obligations to other people.

Generalized Anxiety Disorder is overweening worry and anxiety, which has persisted over the foregoing six months and is present along with sleeplessness, tension, irritability, poor concentration, tiredness, and fidgeting. The person worries about letting people down, not being able to earn enough money, illness with family members, doing poorly at work with a fear of being fired, and feeling they are not up to the task of effective living. They spend their nights going over the day’s failures, seeking means to make things come out right and solving problems in their heads. They continuously review past mistakes, problems and fret over future developments. They fear making mistakes of even the simplest sorts. They view their own decisions as inadequate and problematical.

Posttraumatic Stress Disorder is intense fear, helplessness, and terror associated with the repeatedly re-experiencing memories of traumatic events where threatened or actual injury or death has occurred. Intrusive recall of these events in flashbacks, dreams, or incidental everyday experiences bring the recollected trauma backs to life in full force. The person refrains from reawakening memories of the trauma.

Feelings of emptiness, the loss of the capacity to respond emotionally, being distant and unavailable to others, the incapacity to connect and a hopeless sense of detachment lead to the conviction life must be lived in a vacuous isolation. Exaggerated startle responses, an all-pervasive guardedness, heightened vigilance, and a sense of an irremediable loss and death of essential portions of their emotional lives form barriers to full and productive lives. Self-medication, chemical abuse, re-fighting the traumas in real time with real people, as well as physical abuse of family members, and brushes with the law complicate social, economic, and civic behaviors.

Acute Stress Disorder is the reaction to an immediate stressor, which abates when the issues involved in causing the stress cease.

The DSM-IV-TR (2000) lists a mixed anxiety-depressive disorder wherein a dysphoric mood has lasted for a least one month; the dysphoric mood is associated with four or more of the following symptoms The Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition-Test-Revised (2000).

Difficulty concentrating, the mind goes blank, difficulty falling asleep or staying asleep or unsatisfying sleep, fatigue and low energy, irritability, worry, easily

moved to tears, heightened vigilance, anticipating the worst, catastrophizing, hopelessness, all encompassing pessimism, a bleak out look on the future, low self-esteem and a sense of being worthless. Additional comorbid disorders include substance abuse, Somatization, and physical disorders.

Anxiety Disorder	Base Rate	Comorbid- Diagnoses
Generalized Anxiety Disorder	4-5	Agoraphobia Major Depression Panic Disorder Somatoform Disorder
Panic Disorder	1-3.5	Agoraphobia
30-40		Major Depression
Phobias Major Depression	21.3%	Agoraphobia
2.8-5.3%		Anxiety Disorder Alcohol and Substance Abuse
Social Phobia Alcohol and Substance	7.9-13	Abuse
Obsessive-Compulsive Disorder Major Depressions	2-2.5	Panic Disorder Phobias
Posttraumatic Stress Disorder General Population	1.0	
Panic Attacks	2.0	Substance Abuse

Depression
Somatization

(Welkowitz, et al. 2000, and Horworth and Weisman, 2000).

Welkowitz, L. A., Strvening, E. L., Pittman, J., Guardino, M., and Welkowoitz, J., (2000). “Obsessive-compulsive disorder and comorbid anxiety problems in a national anxiety-screening sample”. Journal of Anxiety Disorders 14(5): 471-482.

Horworth, E., and Weissman, N. M., (2000). “The epidemiology and cross-national presentation of obsessive-compulsive disorder”. Psychiatric Clinics of North America 23(3): 493-507.

Tellegen, et al., (2003) created the MMPI-2 Restructured Clinical (RC) Scales as a response to the need to clarify the saturation of the MMPI scales with a common, emotionally saturated factor, which can be broadly specified as generalized anxiety. This emotional factor colors all emotional life. The negative manifestations are termed Demoralization.

This Demoralization Scale is composed of only 24 items drawn from clinical Scale 2 (Depression) and Scale 7 (Psychasthenia). The Demoralization Scale reflects overall emotional discomfort, which combines feelings of demoralization, discouragement, insecurity, pessimism, and poor self-esteem. A sense of failure pervades a person’s evaluations of their life’s achievements. The individual feels helpless, overwhelmed, and unable to make things turn out satisfactorily.

The RC factor corresponds well with Janet’s descriptions of his patients who suffered from Psychasthenia. Statistical confirmation of a century old clinical phenomenon is a hopeful sign.

Tellegen, A., Ben-Porath, Y. S., McNulty, J. L., Arbisi, P. A., Graham, J. R., and Kaemmer, B., (2003). “The MMPI-2 Restructured Clinical Scales: Development, validation, and interpretation”. Minneapolis, MN: University of Minnesota Press.

Scale 7 (Pt) has 47 items in both the MMPI and MMPI-2. Thirty-nine items are scored in the true direction and nine are scored in the false direction. A K correction multiplier of 1.0 is added to the Scale 7 (Pt) raw score. Item overlap is: **L (0), F (1), K (2), 1 (2), 2 (13), 3 (7), 4 (6), 5 (1), 6 (4), 8 (17), 9 (3), Sie (9).** Scale 7 (Pt) and Scale 8 (Sc) have many items in common. Elevations on Scale 7 (Pt) will raise the score and Scale 8 (Sc). High scores may measure any of a variety of subjective difficulties ranging from concentration problems to frank psychoses (Comrey 1958). Test-retest correlations on Scale 7 (Pt) range from .83 to .86 in a 1 t 2 day interval for psychiatric patients and from to 0.49 to 0.58 for a one year interval, also for psychiatric patients (Dahlstrom et al. 1975). Butcher et al. (1989) reported similar results with the MMPI-2 with normals for intervals of 1 to 2 days.

Comrey, A. L., (1958). “A factor analysis of items on the MMPI Psychasthenia scale”. Educational and Psychological Measurement 18, 293-300.

Dahlstrom, W. G., Welsh, G. S., & Dahlstrom, L. E., (1975). “An MMPI Handbook: Vol. II. Research applications” (Rev. Ed.). Minneapolis: University of Minnesota Press.

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 the person is 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, 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”, (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 mind fills 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 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 et al., (1987).

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 than 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 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 (Ma) 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 (Ma). 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 (Ma) 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 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 (data) that we could derive from the patients seen over a 5-year period” (p. 57).

Individuals who are in the throes 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 (Ma) 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 (Ma) 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 MMI. 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 who engaged in high risk sexual behaviors 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.

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 an 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 7-9 Pattern on the MMPI-A are 1.70 percent and on the MMPI 1.50 percent. Base rates for adolescent females with the 7-9 Pattern are 1.70 percent and 1.40 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) says the adolescent 7-9 Pattern is a riddle. Few personological features are consistently associated with the 7-9 adolescent Pattern. Half of the 7-9 Pattern adolescents in the group studied were not placed in the age appropriate grade in school. Only two of the seventeen 7-9 Pattern adolescents in the group were described as elated; an observation which runs contrary to what would be expected from a Scale 9 (Ma) elevation where all or nearly all would be expected to show signs of elation. Therapists describe these adolescents as insecure and needy. The therapists also stated that they were “conventional”.

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) views the 7-9 Pattern adult as self-centered, inconsiderate, superficial, and immature. They are tense all the time, depressed, and ill at ease. They have an increased personal tempo. They talk rapidly and hard to follow in a conversation.

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

College students treated in a community mental health center had lost weight. They were tense and suspicious (Kelly and King, 1979).

Kelly, C. K., & King, G. D., (1979). “Behavioral correlates of infrequent two-point MMPI code types at a university mental health center”. Journal of Clinical Psychology 35, 576-585.

Marks has written that additional clinical characteristics of this profile include a profound fear of unpredictable frightening events. It is likely that this type of patients were at an early age teased and humiliated, or experienced some unpredictable and catastrophic event which led them to over-protect against unanticipated future events by thinking ahead and worrying.

Worrying is seen as trying to predict the future by thinking ahead of all possible eventualities.

These patients are amenable to almost any form of therapy. Implosion techniques in conjunction with insight therapy can be particularly useful as can desensitization to the originally unpredictable and frightening experiences.

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.

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.

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, P. A. (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	0.25
White Adult Males	0.29
White Adolescent Males	0.89
White Adult Females	0.18
White Adolescent Females	0.68
African American Males	0.33
African American Adolescent Males	0.50
African American Adult Females	0.12

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.	Schizophreniform Disorder
90.	Other (Or Unknown) Substance Abuse
1.	Delusional Disorder
300.	Obsessive-Compulsive Disorder
60.	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
4.	Dysthymic Disorder

2. Generalized Anxiety Disorder
90. Mood Disorder NOS

Axis II

20. Schizoid Personality Disorder
301. Paranoid Personality Disorder
301.82 Avoidant Personality Disorder