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, 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". (Eds.) Garattini, S. & Sigg, E.B. 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 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 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 (Ma) 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 (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 (Ma) 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) and 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 (Ma) 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 with the MMPI from a private metropolitan swinging club, 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.