PERSONALITY AND MANIC STATES:
A STATUS DYNAMIC FORMULATION OF BIPOLAR DISORDER

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ABSTRACT

A psychological formulation of manic-depressive disorder is presented which complements the biological theories; biological theories alone cannot account for either the variability of the manic cycles or the specific nature of the manic's behaviors. Manics are proposed to have a self-concept which makes a loss of status unthinkable in certain domains of their lives. When such a loss occurs, the manic episode is a manifestation of the interaction between psychologically-determined efforts to recoup that status, through an escalating cycle of attempts at self-affirmation, and biologically-determined acceleration of thought and behavior. The personality characteristics of manics are directly related to the onset, course, symptomatology, and psychotherapy of the disorder.

The notion of a "mental disorder" immediately becomes problematic when distinctions between "brain" and "mind" are introduced. Descrip-

Advances in Descriptive Psychology, Volume 6, pages 203-233.
Editors: Mary Kathleen Roberts and Raymond M. Bergner.

ISBN: 0-9625661-1-X.

tion on a biological level is put in opposition to description on a psychological level. Historically, one description has been given precedence, with accompanying denigration of the other. Bipolar disorder is one mental disorder where this state of affairs is particularly evident. It is labeled a "biochemical illness" and studied solely from the biological perspective; only passing acknowledgment is given to psychological factors. More adequate conceptualization at the psychological level of description is needed, conceptualization which at the same time overtly acknowledges the complementary biological level.

What follows attempts to do just that—develop a conceptualization that is consistent with the facts about people and their behavior that are observed for mania; the facts are both psychological and biological. I will be presenting a psychological formulation of mania and manic states that economically explains those facts. The formulation is offered as more useful than existing accounts in relating the disordered behaviors of people in manic states to their personality characteristics. I am proposing that manics have a particular kind of self-concept which leaves them vulnerable to losses of *status*. A person's self-concept operates as a summary formulation of his or her status (i.e., the person's "place" in his or her world). When such a loss of status occurs, the manic episode is a manifestation of the interaction between psychologically-determined efforts to recoup that status and physiologically-determined acceleration of thought and behavior.

The formulation builds from earlier work on manic states by Schwartz (1976) and is based upon *status dynamics*. The status dynamic approach is a way of describing why and what people do, via a systematic understanding of the logical relationships between the concepts of person, behavior, and reality (Ossorio, 1982).

PERSONALITY AND AFFECTIVE DISORDER

The causal relationship between personality and affective disorders is both controversial and complex (Akiskal, Hirschfeld, & Yerevanian, 1983; Widiger, 1989). The key issue is the hypothesized causal direction of the influence: Do personality characteristics predispose a person towards disturbances in mood or are the personality characteristics a consequence of the mood disturbance? Assuming they are not co-determined by some other factor(s), at least three general perspectives on the relationship between personality and affective disorders are possible.

The first perspective is the psychological, which includes both the psychoanalytic and the cognitive-behavioral accounts. The psychoanalytic account (Aleksandrowicz, 1980) hypothesizes that certain personality traits (e.g., narcissism) leave people vulnerable to affective episodes.

These traits are a consequence of developmental deficits or fixations. The cognitive-behavioral account hypothesizes that affective disorders result from particular learned maladaptive patterns of self-appraisal (Beck, 1976).

Second, an intermediate position remains noncommittal as to the direction of causal influence. This position maintains that personality, while not necessarily causally related to the affective disorder, nonetheless significantly influences the symptomatology or outcome. For example, the patient may have a concurrent personality disorder (e.g., borderline personality disorder), which significantly affects treatment compliance (Jamison, Gerner, & Goodwin, 1979).

The third perspective, the biological, considers personality to be either: (a) a prodromal form of the illness (i.e., a subthreshold expression of the genetic make-up), or, (b) a secondary consequence of the recurrent affective instability in the person's psychosocial development (Milden, 1984). The manic episodes themselves are construed as a consequence of an endogenous elevation in mood, which usually occurs spontaneously and often in conjunction with episodic depression in mood. The actual manic behaviors exhibited are considered epiphenomenal; they are only an expression of the changed mood, rather than having any significance in their own right.

Critical Examination of the Biological Perspective

Support for the biological perspective comes from several sources. First, the lack of effectiveness of psychotherapy and the relative effectiveness of medication have been cited as evidence for mania as merely a "physical" disorder. For example, Fieve (1975) states: "Mania and mental depression *must* [italics added] be due to biochemical causes handed down through the genes, since they are corrected so rapidly by chemical rather than by talking therapy" (p. 13). Second, genetic studies (Nurnberger & Gershon, 1984) also strongly support the role of heritable factors in the illness, perhaps more so than with any other major mental illness. For example, manics are significantly more likely to have relatives with manic-depressive illness than with other forms of depression (e.g., unipolar depression) or schizophrenia. Concordance rates in twin studies are also a source of supporting evidence. These rates simply express the correlation between the twin pairs for the presence or absence of the condition. For identical twins reared apart, the concordance rates range from approximately 0.6 to 0.8. Third, the reported "normality" of manic-depressives during the symptom free or "euthymic" period has been cited as support for the biological perspective (MacVane, Lange, Brown, & Zayat, 1978).

The exclusively biological approach to manic states can be criticized on a number of grounds, however. Two key issues are the variability of the manic cycles and the specificity of the manic symptoms. The frequency of episodes and the timing of onset within individuals cannot be accounted for by biological functioning alone (O'Connell, 1986). The nervous system's functioning is simply too regular to exhibit that much variability in episode sequencing. At the same time, the nervous system does not function at a sufficient level of detail to account for the highly specific things that people do in a manic state. If an endogenous euphoria makes a manic feel so good that he wants to sing, why not join the local barbershop quartet? Instead, the manic presents himself as a great operatic star as he bellows in the local supermarket. Furthermore, the nervous system has no synapses which decree the "denial" which is so prevalent in a manic state. No synapses exist which make the manic buy a Mercedes when he can only realistically afford to buy a Chevrolet.

When the apparent ineffectiveness of psychotherapy in treating manic states and the relative effectiveness of medications are considered more closely, three issues emerge. First, the variety of treatment outcomes possible, even when differing diagnostic criteria and treatment methods are controlled for in the studies, is not consistent with an exclusively biological view (O'Connell, 1986); other factors are clearly at work. Second, a variety of medications (e.g., lithium carbonate, carbamazepine, valproic acid, and clonazepam) all appear to be effective in treatment of manic states. Some of these medications have quite differing courses of action, suggesting that mania is not merely the product of a single biochemical process. Third, the apparent ineffectiveness of psychotherapy may be partially due to a poor understanding of mania (and therefore a failure to address the cogent psychological issues), rather than the failure of psychotherapy *per se* as an effective form of treatment.

When the findings from the genetic studies are examined more closely, the relationship between environmental and hereditary influences varies widely, depending upon the concordance rate used. By squaring the concordance rate, one can obtain a figure that expresses the percent of variance accounted for by the relationship. The figures range from 36% to 64% of the variance attributable to causes other than genetic. If a conservative concordance rate of 0.7 is selected, even this accounts for only 49% of the variance. Thus, we can conclude that, at best, genetic factors are only half the story. Any adequate formulation of mania must deal with environmental and psychological influences as well as hereditary (Reiss, Plomin, & Heatherington, 1991).

The last contention is that manic depressives are "normal" between their episodes. A careful review of the existing literature on this topic,

however, clearly leaves this conclusion open to question (Ludolph, Milden, & Lerner, 1988). The evidence suggests that a variety of abnormalities are present in the personalities of manic-depressives during periods of normal mood. In fact, manics' apparent inclination to affirm their normality and to deny their problems may be what gives the appearance of normal psychological functioning. For example, Donnelly, Murphy, and Goodwin (1976) compared Minnesota Multiphasic Personality Inventory profiles upon admission and after recovery (*M* interval = 5.8 months) for 17 unipolar and 17 bipolar depressives. They found evidence of a peculiar test response bias in the self-reports of the bipolars and concluded:

> Because bipolar groups characteristically give less manifest evidence of psychopathology on psychological assessment, it has been inferred that this group resembles normals more than the unipolar group. However, it is suggested that attenuation of psychopathology may represent successful denial of conflicts by activity or by other-directed behaviors often attributed to manic-depressives. (p. 236)

In a more recent study comparing management of self-esteem in remitted manics with unipolar depressives and normals, Winter and Neal (1985) found: "Bipolar patients have negative feelings of self which are not revealed in usual self-report inventories" (p. 282).

Thus, the jury is still out on the exact nature of the disorder and the personalities of those afflicted. Further prospective studies of high risk individuals (Beardslee, Bemporad, Keller, & Klerman, 1983) will ultimately be necessary to sort out this question. Premature closure only means that our clinical work with this population will be handicapped by the narrowness of our perspective. The relevant questions will not be asked and the existing theoretical explanations will become increasingly cumbersome as they attempt to account for the clinical phenomena. The formulation which follows seeks to broaden our field of vision, rather than narrow it.

A FORMULATION OF MANIC STATES

A Thought Experiment

Manic states exemplify more general notions about psychological states (Shideler, 1988) and, as such, cannot be understood simply from observing manic behaviors alone. The problems with trying to understand manic states solely from behavioral observation will become readily apparent in the following thought experiment. Imagine observing

ten people in the same room who are all in a manic state. Assume for a moment that questions of misdiagnosis do not arise.

First, you would observe that people in a manic state all do different things, that is, exhibit different "manic" behaviors. Scanning the room, you might perhaps observe one person talking on the phone and attempting to buy a helicopter; another loudly talking nonstop about whatever comes to mind (compact disks, Donald Duck, rutabagas, etc.); a third claiming to be Napoleon and reading travel brochures on Corsica; and so forth. Little commonality, if any, is apparent in what they literally do. This observation poses a problem, as we have agreed that each is indubitably in a manic state, and yet all are behaving differently.

If we attempt to understand the psychology of manic states by observation of manic behaviors alone, few regularities are readily apparent. What they have in common is not observable as a behavior; rather it is an achievement deficit. In other words, *what manics cannot do (by virtue of being in a manic state) is what they all have in common, rather than what they can do or actually do.* The implications of this deficit model (Ossorio, 1983/1985) will be explored shortly.

Second, you would also recognize, as you scanned the room of people in a manic state, that a person need not be in a manic state to engage in the same actions. For example, an actor in a theater may also claim to be Napoleon, as might someone at a Halloween party. The person attempting to buy a helicopter on the telephone might not be considered manic if he or she were a millionaire and actually had the financial resources to do just that. In other words, *a person does not have to be in a pathological state per se to engage in "manic" behavior.*

Third, people in other pathological states besides mania can engage in seemingly identical behaviors. For example, a person in a manic state may claim to be Napoleon, but so may a paranoid schizophrenic, a person with an acute toxic psychosis, or a person with central nervous system syphilis (Hoffman, 1982). Thus, *even if the behaviors appear alike with reference to their overt performance, they are dissimilar in being expressions of differing deficits and having different significance.*

The actual behavior of a person in a manic state depends on his or her personal characteristics, and will reflect certain limitations imposed by the manic state. Mania, as a type of pathological state, results in a systematic difference in the manic's *dispositions* and/or *powers*, that is, what he is inclined to do and/or is able to do. The net result is a significant restriction in the manic's behavior potential—literally the amount and kinds of behavior that can be engaged in.

Description of the Condition

If the behaviors *per se* do not provide an adequate account of manic states, then an alternative can be formulated which does. Because the manic state produces an indirect deficit (it alters how people do things, not what they do), the approach to understanding manic states is to go beyond the literal behaviors themselves to their meaning or their *significance* (Ossorio, 1969/1981). The question of significance asks: "What is the person doing by engaging in behavior X"? The person may be doing Y by doing X, such as quenching thirst by drinking water. Y is the significance of X, while X is the way that Y is done. In the case of manic behaviors, the same question of their significance can be asked.

Take, for example, a manic's behavior of driving his car at 90 miles per hour in a 55 mile per hour zone. You can ask: "What is he doing by doing that (i.e., by driving so fast)"? A series of answers are possible, starting perhaps with: "He's getting from one place to another more rapidly", and going to: "He's breaking the law." You can still ask: "What is he doing by breaking the law"? The end of the series comes when you reach the following description: "He's enacting a status that is above the law—he is acting as if the rules of the road do not apply to him." In effect, he is claiming a particular status and behaving in accordance with that status. For example, if he sees himself as "James Bond", he is simply doing those things that James Bond would do. The speed limit is not applicable to "Agent 007". The primary problem is that he is claiming a status that, in reality, he does not have.

Description of the person's behavior from the standpoint of the observer is of a different order. While the manic directs his behavior under the description of "Doing what I, James Bond, can do", the observer's description is of the manic's achievement. The *achievement description* (Ossorio, 1969/1981) of the behavior, in this case, "driving too fast", is that it is a *self-affirmation*, or the result of acting upon a particular self-affirmation. A self-affirmation is a form of *self-presentation* (Ossorio, 1976) and is a status claim made by a person about himself and maintained. This claim to have a certain status corresponds to having certain behavior potential, which the person attempts to actualize. Thus, *one aspect of what constitutes the condition of mania from the observer's perspective is that manic behaviors are self-affirmations.*

The second aspect comprising the observer's appraisal of the condition of mania is that the person's self-affirmations are unrealistic. This distortion of reality is what differentiates ordinary self-affirmation

from a manic's. The self-affirmation of the millionaire who attempts to buy a helicopter differs from that of the manic patient who attempts to do so. The millionaire can successfully claim to be a person who can afford to buy helicopters. The manic patient does not have the resources and, in effect, is insisting that he has the status he purports to have. Therefore, *the significance of manic behaviors is that they are self-affirmations; what makes them indicative of a pathological state is they are unrealistic and entail a distortion of reality.*

Explanation of the Condition

If the condition of mania is formulated as unrealistic self-affirmation, an explanation of the condition is required. In other words, the question then arises: What sort of circumstances would call for self-affirmation, or alternatively, motivate someone to enact a greater status? The answer is that a threatened degradation calls for self-affirmation. A degradation formally represents a reduction in status with a corresponding loss of behavior potential (Bergner, 1987; Garfinkel, 1957; Ossorio, 1971/1978; Schwartz, 1979). For example, in the military, to be reduced in rank from a sergeant to a private represents lower pay, exclusion from the noncommissioned officer's club, and an ineligibility to give orders.

Self-affirmation, in and of itself, does not lead to the development of a manic state. What is required are particular personal characteristics: (a) a self-concept such that a loss of status is so unacceptable as to be literally *unthinkable* (Ossorio, 1976) and (b) a physiology susceptible to activation. When a state of affairs is unthinkable for a person, he or she cannot experience that occurrence in the first person (i.e., as actually occurring). If the manic's self-concept makes a loss of status unthinkable, then the manic will distort reality to keep from seeing that such a loss has taken place; otherwise an impossible world (i.e., a world that does not have a place for the person) would be created. In other words, *if the condition of mania is construed as unrealistic self-affirmation, then the explanation of the condition is that the person's self-concept precludes a loss of status.*

A person is normally able to accept degradations. As a result of doing so, he or she will experience regret, sadness, or depression (the emotions which accompany perceiving oneself as having a lower status and a correspondingly reduced behavior potential). In the case of the manic, however, the course of events at this point is very different.

Should the person's self-concept preclude a loss of status, (i.e., it is unthinkable), only one outcome is possible. To self-affirm successfully in the face of a threatened degradation (i.e., to claim a status and be able to enact it successfully) presents no challenge to the person's

self-concept; how he or she conceives of himself or herself is maintained. Should the self-affirmation be unsuccessful, however, then that person is faced with an impossible situation. Since the individual cannot accept the status loss implicit in an actual degradation (i.e., it is unthinkable), the world will be seen some other way—a way such that the status loss seems nonexistent. An observer will consider this new way of seeing the world a distortion of reality, however.

THE LOGIC OF THE MANIC STATE

Once the logic of the manic state is grasped, it becomes a powerful heuristic for explaining a variety of clinical phenomena. In particular, the formulation elucidates: (a) why people get manic when they do, (b) why the clinical course goes the way it does, and (c) why the clinical symptoms take the form that they do. What follows will elaborate these issues.

Precipitants for Manic States

The frequent failure to observe precipitants for manic states has led researchers and clinicians alike to hypothesize an immutable biological process as their cause. Ambelas (1979) notes this phenomenon when he writes: "The deeply rooted ideas as to the genetic and biochemical aetiology of mania militate against doctors asking the relevant questions" (p. 19). In addition, much of the research which has been conducted examining life events and the course of bipolar disorder has been marked by "pervasive methodological flaws and theoretical limitations" (Ellicott, Hammen, Gitlin, Brown, and Jamison, 1990, p. 1194). The primary flaw has been the use of retrospective designs to identify life stresses and assess their impact on the course of bipolar disorder. Retrospective designs ask subjects to recall their life experiences and are subject to the vagaries of memory (including state dependent recall), whereas prospective designs study subjects over time as they are actually living through life events.

The evidence seems to be, nonetheless, that an identifiable stress has preceded most manic episodes, particularly when the better designed studies are examined. For example, Ellicott et al. (1990) prospectively studied 61 carefully diagnosed bipolar patients in an outpatient clinic over a two-year period. They found: "a significant association between life events and relapse or recurrence of the disorder. These effects could not be explained by differences in levels of medication or compliance" (p. 1194).

Life Stresses as Precipitants

The notion of "life stresses" is necessary but not sufficient in understanding precipitants for manic states. Merely identifying life stresses does not conceptually link these particular stresses to the disorder (either from the psychological or the biological perspectives). As Ambelas (1979) writes: "In virtually all of the cases reported, the stressful life event is one of a loss or a threat, but it is not easy to explain why such stresses should operate as precipitants for mania" (p. 20). Researchers have only now begun to examine more closely the meaning of the stressful life events to the individual (Hammen, Ellicott, Gitlin, & Jamison, 1989).

The work of Glassner, Haldipur, and Dessauersmith (1979) comes closest to the status dynamic account in grasping the significance of the life stresses precipitating mania. In their study, they classified life events occurring prior to the onset of manic episodes in their population according to whether they entailed "role loss". They write:

> A role loss . . . consists of removal from the primary social position(s) and concomitant activities that one uses to organize one's place in the world. Thus an exit or loss will not constitute a role loss for a person who: a) is able to maintain the role status despite the exit (e.g., when a widow finds a new partner or when a child leaves home but other children remain); b) replaces that role (e.g., when a widow joins her child's home); or c) considers the role unimportant or devalued prior to the loss. (p. 533)

Thus, the notion of "role loss" is conceptually quite similar to the notion of "status loss" which has been presented; each entails a substantial revision of the organizing dimensions of the person's world.

Status Losses as Precipitants

The key to understanding what precipitates manic states lies within the notion of threatened degradation in the present formulation. The logic of the manic state is insistence that such a status loss has not taken place. In trying to understand what constitutes the threatened degradation which is unthinkable for manics, several difficulties arise. One difficulty is that loss of status seems to be unthinkable in only certain *domains* or subsets of a person's total status (e.g., occupational functioning, fatherhood, or sexual attractiveness). A second difficulty is that degradations are often highly person-specific. A third difficulty is that what counts as a threatened degradation (an unthinkable state of affairs) for a person may be related to seemingly minor events in the

person's life. Mester (1986), in describing his psychotherapy of a manic patient, reports:

> At this stage of the therapeutic exploration Ron brought up his memories of the initiation of the manic reaction. According to his reconstruction, the sequence of events was as follows: one day during rifle-shooting exercises his sergeant severely criticized him for his poor performance; Ron reacted by feeling all of a sudden ablaze with enthusiasm and boundless energy, convinced at the time that he was the great diver he had always wanted to be. (p. 17)

In addition, manic episodes can arise from quite diverse sources. For example, mania has been associated with various drugs, infections, neoplasms, epilepsy, and metabolic disturbances (Krauthammer & Klerman, 1978; Stasiek & Zetlin, 1985). The euphoria observed may often be created by actual brain-based changes secondary to the physical disease process or the medications used to treat the illness. One could also conceive of cases where the mania is reactive to a status loss created by the medical condition itself. For example, the hard driving businessman who suffers a heart attack might be unable to face the sense of vulnerability or anticipated limitations in his new status as cardiac patient. Overall, the literature reports mania to be associated with a wide variety of circumstances, ranging from funerals (Rickarby, 1977) to weaning (Joyce, Rogers, & Anderson, 1981).

Clearly in a number of cases of mania, no precipitating event can be reported. The failure to elicit description of precipitants by self-report has been used to confirm the exclusively biological view of the disorder. Other ways of understanding this phenomenon are possible, however. One is that the self-report might simply overlook precipitating stresses or not recognize them as such. In fact, if a loss of status (in the relevant domains) is *unthinkable*, manics will not see a status loss as such until it is thinkable. Therefore, attempts to ascertain precipitants in an admitting interview or from a retrospective account during an euthymic period may be fruitless, even when the interviewer has the concept of status loss in mind.

Further complicating the identification of precipitants is the situation where certain states of the person's world as a whole can constitute unthinkable degradations. In those cases where circumstance itself constitutes the degradation, the person frequently has great difficulty accounting for the way he or she feels. The manic episode seems to occur out of nowhere and may reinforce the person's own belief that he is a helpless pawn of biochemistry alone. The whole episode is experienced as completely alien, since the person lacks the relevant concepts to discriminate the precipitants.

How "circumstances" create a degradation can be understood as follows. This situation can occasionally be discerned in late onset mania, where the person is suddenly (or gradually) confronted by his or her own mortality and the impossibility of reaching many of the most desired life goals. The crisis may come as the person begins to sense limitations. As long as these limitations can be explained away, the person's status is preserved intact; when they no longer can be explained away, life circumstances pose a "threatened degradation".

The person for whom this particular loss of status is not unthinkable might simply undergo a period of grieving or even a period of depression, as he or she begins to accept the limitations of being "middle-aged" (and to explore and appreciate the benefits). In the case of the person for whom such a loss is unthinkable, a manic state might result as the person attempts to self-affirm and thereby reject the degrading life circumstances that alter his place in the world. The person might, for example, frantically try to adopt the lifestyle of someone twenty years his junior, obtain a divorce, buy a sports car, join the health spa, and so on.

In identifying precipitants of manic states, clinicians need to listen to their patients' life stories with an open mind. Surprisingly subtle or seemingly minor events can constitute the threatened degradation. In other instances, the degradation is much more straightforward: the break-up of a relationship, a failure in life, or an intolerable frustration. Sex differences also seem to be present in determining arenas where a loss of status is unthinkable (Wechsler, 1983), with men apparently more sensitive to losses of status in occupational and heterosexual roles, and women more sensitive to losses related to their roles as spouse and caretaker.

In some cases, a particular person in the manic's life can be consistently cast in the role of a denouncer and is regularly associated with the onset of episodes. In other words, the manic has a particular vulnerability to threatened degradations by that person. Recent research on the emotional quality of families of bipolar disorder patients has indicated that certain families typified by high levels of "expressed emotion" are predictive of relapse (Miklowitz, Goldstein, Nuechterlein, Snyder, & Mintz, 1988). High expressed emotion families have an apparent tendency to "express critical, hostile, or overinvolved attitudes" (Koenigsberg & Handley, 1986, p. 1362), attitudes which can be construed as degrading in nature.

Clinicians will also frequently explain the onset of a manic episode as caused by the patient's "stopping taking lithium". The research seems to suggest, however, that manics relapse even when compliant with their medication. For example, Lieberman and Strauss (1984) report:

> The three patients met *DSM-III* criteria for major affective disorder, manic type. All were maintained on apparently adequate doses of medication, with serum lithium levels in the high-therapeutic range. Yet all relapsed, seemingly with contributions from specific environmental stresses. These stresses seemed to share one major feature: They involved patients' failures and frustrations in achieving sought-after goals. In each instance, the patients seemed to relapse in situations where they felt trapped in an activity that they perceived as conflicting acutely with their own hopes, yet which they could neither avoid nor put behind them. (p. 77)

The discontinuation of medications can also be construed as an attempted self-affirmation in its own right; the manic seeks to affirm a non-disabled status (with often disastrous consequences).

To conclude this discussion of what precipitates manic states, an attempt will be made to tie the empirical data presented back to the conceptual formulation. Recall that status in the generic sense corresponds to all of a person's relationships considered simultaneously, and that domains were specifications of some portion of this totality. What this means is that loss of status in particular domains is unthinkable. The size of the domain within which status loss is unthinkable probably reflects how serious the condition is, since it is correlated with how frequently a loss of status is likely to be encountered.

The Course of Manic Episodes

Escalation

The manic state is marked by an escalating series of self-affirmations, resulting from the failure to reject the original degradation and the successive failure of each subsequent attempt to do so. The attempts to self-affirm will become more frequent and involve greater and greater distortions of reality. The logic of the manic state is analogous to the dubious business practice of "kiting" checks. In kiting, a person will draw money on one account to cover a second account or a third account, despite there being insufficient funds in the first account. The process is inherently time-limited because the checks eventually clear the banks and begin to bounce. Morris (1970) defines a "kite" as: "any negotiable paper representing a fictitious transaction, as a bad check, used temporarily to sustain credit or to raise money" (p. 723). This definition can be paraphrased to fit the manic's situation: to "sustain status" (after a loss, if a loss of status is unthinkable) or to "raise status" (if low status is unthinkable), the manic engages in a similar spiral in an effort to avoid the unthinkable, building distortion upon distortion. The situation cannot be maintained indefinitely, as is the case with kiting checks. The checks written come back to the bank they were drawn on and it is the same with the statuses the manic had been

claiming. The manic state is not timeless. The course of a manic state waxes and wanes with the manic's ability to insist upon the state of affairs he claims to be the case.

De-escalation

The average manic state, if untreated by medications, lasts about three months (Clayton, 1981). This eventual resolution may occur, in part, because a person's ability to explain away facts is not infinite (nor is the supply of neurotransmitters). At some point, the manic can no longer create further distortions. The person eventually encounters a critical juncture where to attempt further self-affirmation would create some other condition—also unthinkable. Once this point is reached, the escalation abates and a process of de-escalation begins. The distortions simply cannot be maintained.

The terminal state of a manic episode (i.e., whether it ends in a period of normal mood or in a depression) probably depends greatly on the actual status of the person's world when he or she returns to it. If the person lost a great deal of behavior potential during the manic episode, then he or she is more likely to become depressed (Bergner, 1988). For example, if in the course of the manic episode you lost your job and family fortune, alienated your friends and neighbors, and acquired a venereal disease and criminal charges, then a depression is understandable. Some people may end up depressed as a consequence of eventually accepting the original degradation that precipitated the manic episode. Still others may simply end up in a state of normal mood, apparently accepting themselves and their world. The exact likelihood of a depression as an outcome of a manic episode is, therefore, quite person-specific and situation-specific.

The person whose state of remission involves so-called narcissistic defenses may preclude a depression by maintaining (insisting upon) a sense of self-importance. In fact, the narcissistic personality could be construed as the enactment of a subclinical status claim, particularly given the narcissist's preoccupation with issues of status. Other manics in remission appear to revert to a more depressive and compulsive character, burdened by strong demands for self-perfection. Implicit in such patterns of self-criticism are various subtle forms of status claims (Driscoll, 1981). For example, to evaluate oneself using perfection as the criterion is, in effect, to act as if perfection were within one's grasp (if one only tried hard enough).

The consensus in the literature is that mania tends to be a recurrent disorder, despite prophylactic treatment with lithium, although there is great variability in outcomes. The status formulation would account for

this phenomenon as follows. Individual differences in outcomes are attributable to: (a) the size and number of domains that are unthinkable, (b) how susceptible the person's self-concept is to change, (c) whether the person's self-concept permits compliance with pharmacological treatment, (d) historical events in the person's life (i.e., what fortunes or misfortunes befell him or her), and (e) the person's physiological state.

Symptoms of Manic States

Clinical observers generally describe three stages of mania (hypomania, acute mania, and delirious mania) and emphasize a triad of symptoms (elation, flight of ideas, and increased psychomotor activity) as present in all three stages, but differing quantitatively in each stage. Paul Hoch, a keen observer of psychopathology, writes: "It is extremely important to realize that practically all of the symptomatology shown can be explained quite logically on the basis of the alteration of the basic mood of the patient" (Strahl & Lewis, 1972, p. 453). The logic of his and others' positions is that the mood of the patient is elevated and the symptoms follow from that basic mood elevation.

Mood as a Consequence of Cognitive Appraisal

In contrast, the present formulation gives precedence to a cognitive change over an affective one; the affective state results from the more primary changes in cognition (at least initially in the episode). These changes in cognition may occur in conjunction with intense physiological activation or arousal. The attendant mood elevation in a manic state has its origin in the manic's attempts to enact (i.e., to claim) greater and greater statuses—the self-affirmations. The mood elevation is produced by the enactment of a particular status that is greater, albeit unrealistic. The reverse is not usually the case; a mood elevation alone does not produce the enactment of a greater status. If the basic condition of mania was merely an elevated mood, recall that you are left trying to explain the specificity of what manics do in a manic state.

The basis of an emotional behavior is the appraisal of a particular relationship which some element or elements of the world bears to oneself, that by its very nature carries emotional significance and that one has learned to act on without deliberation. A key element in emotional behavior is the particular appraisal being made (Ossorio, 1986/1990). For example, in the emotional behavior of guilt, an act is appraised as one of wrong-doing. With that recognition comes a learned tendency to penance or restitution.

The manic is also making an appraisal of himself and his standing in the world. The manic's mood is cognitively initiated, arising from his perception of his greater status and his attempted realization or enactment of that status. The direction of the mood change can be understood better if one examines the definition of "elation": "an exalted feeling arising typically from a sense of triumph, power, or relief" (Morris, 1970, p. 419). With the manic's enactment of his grandiose statuses (e.g., the "prophet", the "wealthy entrepreneur", or the "Nobel prize laureate") comes a corresponding shift in mood. Feeling elated is to be expected if one is such an omnipotent and/or omnipresent and/or omniscient personage.

Several other factors need to be considered to understand the elation resulting from the enactment of a greater status. First is the rate of status change; an exaggerated effect is likely when the status change occurs all at once rather than gradually. A manic need only think it for a status change to be the case. Such a status change has a shock effect; it produces some degree of disorientation, which interferes with the person's ability to function effectively, at least for the time being. Second, because the manic often seeks to enact very greatly elevated statuses, the euphoria is intensified. For example, the manic may go from a mere mortal to someone with God-like abilities or insights.

The symptoms of mania are expressions of the condition of mania (i.e., unrealistic self-affirmation) and are harmonious with the status claimed, rather than the mood per se. To support this contention, the diagnostic criteria for mania in the *DSM-III-R* (American Psychiatric Association [APA], 1987) will be discussed in light of the status dynamic formulation. One of the major criticisms of the *DSM-III-R* is its failure to provide much conceptual coherence for the condition. This failure increases the likelihood that people will not appreciate the logic and the unity of the disorder and turn to an exclusively biological description.

Mood Symptoms

First, the *DSM-III-R* identifies: "a distinct period of abnormally and persistently elevated, expansive, or irritable mood" (APA, 1987, p. 217). The "elevated mood" has been discussed previously as the result of claiming a greater status to avoid a threatened degradation. The cognitive discrimination made of greater status is the basis of the mood, not vice versa. The mood is the feeling or experience of perceiving the greater status, not the status itself.

The "expansive" mood can be similarly understood. Morris (1970) defines expansiveness as: "disposed to be open and generous; outgoing" (p. 461). This symptom, too, can be considered a primary effect of the

status claim; the person experiences a world (and probably a brain) which lacks the normal inhibitions and limitations. Self-criticism is reduced and spontaneity increases (i.e., *actor* functioning). Thus, the manic is expansive as he or she relates to others unfettered by social convention (or reality). The mood state of expansiveness is found in the earlier or milder stages of mania, when the status enactment can be more successful (Carlson & Goodwin, 1973).

The other descriptor is "irritable" mood. The irritability frequently found in a manic state may be an expectable response to the many provocations the manic perceives (in addition to being a nonspecific sign of neurologic dysfunction). These provocations arise from the inevitable conflict between how the manic sees himself or herself eligible to be treated and how the rest of the world does. Put more simply, in the case of the manic (as it probably is for everyone), not to be treated as yourself is a provocation. No wonder the manic is irritable when others do not treat him in accordance with his status claim. The rage evolves from the overwhelming nature of the provocations the manic indignantly perceives. The greater the status claimed, the greater the degree of provocation the manic experiences when unable to assert successfully the status. Imagine the humiliation of being placed in seclusion and physical restraints, just at the time when you are seeing yourself as omnipotent, and/or omniscient, and/or omnipresent.

Behavioral Symptoms

The *DSM-III-R* then lists a number of more "behavioral" symptoms of mania: "During the period of mood disturbance, at least three of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree" (APA, 1987, p. 217). These criteria seem to emphasize that irritability is a somewhat milder symptom of mood disturbance and fail to appreciate the logic of the disorder. In other words, the significance of the provocation experienced by the manic corresponds to the degree of hostility expressed.

The first behavioral (as opposed to mood) symptom is: "inflated self-esteem or grandiosity" (APA, 1987, p. 217). This symptom identifies the central conceptual element in the status dynamic formulation of manic states. The distortion of reality implicit in this symptom relates to the *insistence* by the manic that the world is a certain way. To the observer, the manic is unrealistic in the status accredited to himself or herself.

The second behavioral symptom of mania is: "decreased need for sleep, e.g., feels rested after only three hours of sleep" (APA, 1987, p. 217). This symptom is a direct effect of being in a manic state, where

the person continues to have the reality basis for the emotiona behavior, the threatened degradation. The corresponding emotiona behavior, self-affirmation, has not been successfully enacted, however Thus, the person continues to attempt to self-affirm, with the motiva tion to do so becoming increasingly preemptive as the successiv attempts are unsuccessful and the degradations accumulate. In othe words, the person's motivation to self-affirm becomes so strong that hi or her motivation to do anything which is not self-affirming pales b comparison. In regard to this symptom in particular, a direct link to th biological processes which underlie this state of activation is probabl for the manic. The manic's state of activation is extreme, for the perso is dealing with a "life or death" situation—an unthinkable (i.e., a impossible) world. The accompanying physiological arousal in a mani episode likely contributes to the reduced need for sleep.

The third behavioral symptom in the *DSM-III-R* is being overl talkative: "more talkative than usual or pressure to keep talking" (APA 1987, p. 217). This symptom can be viewed in a number of ways and ca arise in a variety of clinical contexts (e.g., an amphetamine abuser). Th manic's over-talkativeness may represent a filibuster of sorts, a unwillingness to give anyone else a chance to break in and ruin thing (R. Bergner, personal communication, January, 1991). In addition, th act of speaking itself is a self-affirmation and the person may tal excessively because to do so reflects his or her lofty status. What th manic has to say is perceived as supremely important; granting th world audience to one's omniscience is part of the self-affirmation Thus, being overly talkative can be a secondary symptom resulting fron acting on the status claim.

The greater the status claimed, the greater the presumed eligibility t speak one's mind. For example, the person who claims the status o "Socrates" thus becomes an expert in all fields, and may proceed t expound on them. Keep in mind that the manic may not literall attempt an impersonation of Socrates himself; what he claims instea is that status in the world personified by someone like Socrates—a wis man whose abilities and insights threatened those around him. Th manic may then construe the lithium carbonate which is being foiste on him as the modern day equivalent of "hemlock".

The fourth behavioral symptom listed is: "flight of ideas or subjectiv experience that thoughts are racing" (APA, 1987, p. 217). The phrasin of this description raises an important issue about the confuse perspectives in the actual diagnostic criteria. The criteria include bot the actor's perspective ("subjective experience that thoughts are racing") and the observer-describer's perspective ("flight of ideas"). Th essential feature of the manic's thoughts are their rapidity. The rat

may increase to the point where the thinking may accurately be described as incoherent.

Flight of ideas corresponds closely to the increased motor activity observed in manic states. As a primary effect of the status claim, the person's preemptive motivation to self-affirm might lead to pressured thoughts about how to self-affirm. The symptom is probably intensified by the change in status and the corresponding increase in eligibility. The person becomes eligible to think about much more as his greater status in the world faces him with a greater variety of choices. What you have to think about is a part of your behavior potential. For a moment, imagine yourself winning the state lottery. You might also momentarily experience racing thoughts as you pondered the myriad options to spend your suddenly bestowed wealth (Porsches, the Riviera, the stock market, the Internal Revenue Service, etc.).

From the newly claimed status, the manic suddenly can think about a great deal he could not before; new realms are now open and available for consideration. For example, by claiming the status of "President", the manic now must be occupied with various plans for world peace, national security, economic policy, and so on. He begins to consider what one would consider if one actually occupied that role. The manic may even begin to act accordingly by, for example, sending off telegrams to the press to disseminate his policies.

The fifth symptom listed in the *DSM-III-R* is: "distractibility, i.e., attention too easily drawn to unimportant or irrelevant external stimuli" (APA, 1987, p. 217). The manic's monitoring functions have been somehow rendered ineffective, for he fails to discriminate effectively and appropriately among stimuli. This impairment may stem from several causes. First, the manic needs to function less in the role of critical observer of the world, to permit the basic distortions of reality which deny the status losses. To insist the losses have not occurred, the manic must observe and describe the world, but not evaluate the veracity of those descriptions. The manic's insistence on a certain version of the world results from this active process of actor functioning, as he or she turns away from certain facts. Second, avenues for self-affirmation and avoidance of the inevitable degradation are constantly sought, which may lead the manic to skip away from one thought that leads to degradation and towards another thought that leads to self-affirmation. Third, the distractibility likely also directly reflects the elevated levels of arousal and poor control over processing of information concomitant with the manic state.

The sixth symptom addresses the increased psychomotor activity that is characteristic of mania: "increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation"

(APA, 1987, p. 217). The psychomotor activity can be directed or undirected and either a primary or a secondary effect of the status claim. As a primary effect, the psychomotor agitation might arise directly from the escalating spiral of attempts at self-affirmation. The overactivity is produced by the preemptive motivation to self-affirm, the decreasing ability to do so realistically, and an increasing likelihood that each attempt at self-affirmation will be unsuccessful. As a secondary effect, the increase in activity results from acting on a particular status claim or the elevated status more generally.

The manic now becomes able to do a great deal that he or she might not have been able (i.e., eligible) to do previously. By adopting the status, the person becomes freed from any number of social constraints, self-doubts, and roles which had previous limited his activity. Instead, the manic simply begins acting with great passion on the status claimed at the moment.

The exact nature of the manic's involvement depends on what is important and available to him or her. The lowly clerk who becomes manic may claim the status of "corporate president" and frantically act accordingly, directing perceived subordinates, faxing memos, and ostentatiously parking in his boss's space. The manic episode in college may take the form of exaggerated scholarly endeavors: the thousand page treatise of gibberish turned in at the end of the semester, the harangue unleashed during the professor's lecture, or simply dropping out of school (for someone with such great powers has little to learn from others). The manic whose sexual activity increases may simply be acting on the perceived eligibilities of the status claimed. For example, the person whose manic episode was precipitated by a rejection by a girlfriend may attempt to enact the status of a "stud" and become highly sexually active on that basis; having sex is simply what studs do.

The seventh behavioral symptom in the *DSM-III-R* pertains to the poor judgment exhibited in a manic state. Manics are said to manifest: "excessive involvement in pleasurable activities which have a high potential for painful consequences, e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments" (APA, 1987, p. 217). This description of the manic's activities as "unrestrained", "indiscreet", or "foolish" is clearly from the observer's perspective in the role of the critic. As observers and clinicians, we generate similar descriptions of the manic's behaviors: grandiose, showing poor judgment, unrealistic, impulsive, short-sighted, et cetera. These terms are, in fact, our status assignments reflecting our appraisal that the behavior entails a distortion of reality. The manic, attempting to self affirm, insists upon a certain status and then treats the world accordingly. This "treating the world accordingly" is what we

as clinicians call "psychotic behavior" or behavior that entails a distortion of reality.

From the manic's perspective, such action is simply being oneself, and attempting to act in accordance with the status claimed. If you are a millionaire and price is no object, why not buy what you wish? If you are beautiful and desirable, why not achieve the conquests due you? If you are a shrewd and talented businessman, why not wheel and deal to secure your profits?

Other Diagnostic Criteria

The *DSM-III-R* also proceeds to distinguish the psychotic features which accompany the disorder as "mood-congruent" versus "mood-incongruent". The psychotic features in mania are most often mood-congruent: "Delusions or hallucinations whose content is entirely consistent with the typical manic themes of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person" (APA, 1987, p. 218).

The status dynamic formulation, however, would consider the psychotic features to be status-congruent primarily, and mood-congruent secondarily. Embedded in the delusions are the status claims, that is, the "inflated self-esteem or grandiosity". The status claim is called "delusional" by the observer-describer when it is clearly a distortion of reality, although this label depends somewhat on the sensitivities of the person making that judgment. For example, the manic who attempts to enact the status of "J.P. Getty" will more readily be labeled delusional than one who merely becomes the more general "wheeler-dealer". Delusions, by virtue of their greater distortion of reality, are found in the more extreme manic states. Less extreme distortions of reality are perhaps labeled as merely "unrealistic".

Persecutory delusions, in particular, contain either a more direct status claim or are in response to an attempt to claim a particular status. Such delusions tend to be found in conjunction with the dysphoric mood occasionally found in manic states, or the irritability frequently found. An example of delusions resulting from a direct status claim was my patient who avoided the status loss threatened when his girl rejected him, by determining that the "C.I.A." had interfered with their "communication". The delusion contains an implicit self-affirmation, that is, the rejection was not an accurate reflection of his status. Not only was his status thereby preserved vis-a-vis his girl, but he also became the kind of special and important person that the C.I.A. would be interested in. (In fact, this particular patient even went to a local

bank and asked a bank teller if the $500,000 from the C.I.A. had been deposited in his account, as he had been led to "believe".)

Hallucinations, like delusions, are frequently a vehicle for enacting the status claim. For example, a manic may hear the voice of God addressing him, making him a rather remarkable person to have been singled out in this manner. Hallucinations are probably rarer than delusions for most manics, but can easily be postulated to occur in the rush of thoughts the manic is experiencing, concomitant with the decrease in critical reality testing required to maintain the state of insistence. The manic misperceives his or her own thoughts and experiences them as others' voices.

INTEGRATION OF BIOLOGICAL AND PSYCHOLOGICAL PERSPECTIVES

As psychological and social factors are increasingly given credence in mania (O'Connell & Mayo, 1988), researchers are seeking ways to integrate the various perspectives. Several models are currently proposed. All lack a clear specification of what precipitates manic episodes and the significance of the manic behaviors themselves.

The first model is Gardner's (1982), which looks at bipolar disorder from an evolutionary perspective. He notes that dominance hierarchies, a normal part of evolutionary development, may be retained in the human species in the form of fixed action patterns. Depressive and manic states are seen as epitomizing low and high status behaviors respectively which have been inappropriately activated due to instability in the person's neural organization. Gardner writes: "For mania, at least, psychotic consequences may stem from a positive-feedback cycle in the person imbued with an inappropriate [sense of social rank] who reacts with primitive defenses to feedback that is contrary to his 'sense of state' " (1982, p. 1439).

A second approach is a dysregulation model (Goplerud & Depue, 1985) which proposes that certain people have a hereditarily determined vulnerability to affective dyscontrol in the face of environmental stresses. The vulnerable person has "less adequate inhibitory regulation systems responsible for maintaining normal limits of variation of behavior and mood. Such a system appears to be more affected by the challenge imposed by stresses" (Goplerud & Depue, 1985, p. 138). In this model, what may be inherited is a temperament which reacts to life events with exaggerated activation (i.e., mania) or deactivation (i.e., depression). Again, the exact nature of the life stresses which would initiate dysregulation are not specified.

O'Connell (1986) proposes a multifactorial model and writes: "Manic-depressive disease requires a multidimensional, interactive, systems model to explain the observed data, although a quantitative understanding of the relative weights of various factors may be difficult at this time" (p. 153). In the model, he suggests a genetic predisposition, with an unknown biochemical mechanism, in some but not all cases. Negative early experiences (e.g., parent loss, child rearing practices) also play a role, making the person vulnerable both biologically and psychologically to the expression of the disorder in adult life. Stressors precipitate episodes when they exceed the individual's threshold for maintaining equilibrium. The stresses are potentially both biological and psychological events. In turn, the episodes themselves become stresses, further deregulating the system.

A fourth model for bipolar disorder attempts to deal more directly with the physiological events which interact with the effects of stress. In this model, a "kindling effect" is proposed (Post, Rubinow, & Ballenger, 1984), whereby the brain becomes sensitized on the basis of prior experience to repeated episodes of mania. The model draws heavily on notions of behavioral neuroplasticity, or how experience creates actual changes in the likelihood of certain pattern of neuronal firing (Gold, Goodwin, & Chrousos, 1988). Additional support for the kindling model comes from the observation that in late and early onset mania, precipitating stresses seem differentially relevant. Thus, in those individuals with early onset mania, the episodes themselves may become more autonomously induced over time as the brain becomes more conditioned.

The next model to be discussed is the one proposed by Wehr, Sack, and Rosenthal (1987). They hypothesize that sleep deprivation may be the mechanism through which diverse psychological and biological events produce manic states; the manic state in turn produces further sleep deprivation in a vicious circle. In their model, sleep deprivation results from environmentally occurring and psychologically significant stressors. These stressors produce unspecified changes in brain chemistry, in turn initiating or facilitating the manic episode.

Recent application of chaos theory (Gleick, 1987) to brain function are particularly relevant to manic states. This approach sees mania and depression as alterations of basic rhythms of biological functioning. Sabelli, Carlson-Sabelli, and Javaid (1990) propose a model which "postulates that bipolarity results from an enhancement of biological energy driving psychobiological processes away from equilibrium (point attractors), an amplification of cyclic fluctuations (periodic attractors), and an increase in the frequency and intensity of turbulent and chaotic processes (chaotic attractors)" (p. 348).

All of the models mentioned attempt to deal with the complex interaction of psychological and physiological events. The status dynamic formulation is not inconsistent with any of them and directly addresses the key interface between psychological and physiological events. The formulation clearly specifies how and why manic episodes are precipitated, while at the same time leaving open the question of the exact nature of the *embodiment* (Ossorio, 1980/1982) necessary for these states to occur. Some thoughts are possible on the embodiment question, however.

If one construes the primary biological vulnerability as that of arousal or activation rather than mood *per se*, then a somewhat different perspective can be taken. In fact, if one looks closely at someone in a manic state, the euphoria or mood elevation is often quite short-lived. What seems most evident is the general state of activation as well as the irritability which accompanies it. The biological vulnerability for the manic may be a frontal/striatal/reticular dysfunction, which sets in motion the over-activity in response to the psychologically meaningful stresses. Disinhibition occurs on both the psychological and biological levels, with the manic ultimately becoming liable to further episodes via the conditioning of certain neural networks and the establishment of certain procedural or habit memories (Grigsby, Schneiders, & Kaye, 1991).

Treatment Implications of the Status Formulation

Biological Treatment

Pharmacological intervention in mania is crucial, particularly given the proven efficacy of the various medications, prescribed both prophylactically and acutely. Furthermore, preventing further manic episodes is essential, since they can wreak havoc in all aspects of a manic's life and compound the difficulties to be faced. In addition, psychotherapeutic intervention is not possible when the patient is in a manic state. The person must be euthymic for a psychotherapist to make meaningful contact with the person. Nonetheless, not all patients respond to medications and even when the episodes are apparently controlled, the person retains the vulnerability to further episodes.

Making contact with a manic is not easy under the best of circumstances, since they are notoriously poor at introspection and highly invested in presenting a socially desirable front. Treaters may have intuitively sensed the profound self-esteem vulnerabilities in manic patients, when they developed modalities such as lithium clinics. Under the guise of obtaining "medical" treatment for their "biochemical imbalance", manics can make better use of the support and structure

such a setting offers. Their status is preserved by treating their "illness" as external to who they are as people.

Psychological Treatment

The range of issues to be faced in the psychological treatment of manic patients is broad, since so many facets of their lives are affected by their condition. Their disorder faces them with grave interpersonal, social, economic, and existential consequences (Jamison & Goodwin, 1983; Walsh, 1989). The help offered will be much more effective if the condition is fully understood. What the present formulation offers is a means of achieving a broader understanding, which can lay the foundation for intervention. The interventions themselves can be framed within the techniques and strategies of a variety of theoretical perspectives. For example, the interventions made by Mester (1986) are from the perspective of "focal dynamic psychotherapy"; those of Jacobs (1982) are from the perspective of "cognitive therapy". The understanding the formulation provides is a conceptual one, rather than linked to a particular theory.

The in-principle solution for the manic's condition is to make the unthinkable thinkable, to paraphrase Freud's dictum about making the unconscious conscious. The overall goal is to alter the conditions of unthinkability, so that the person no longer finds certain states of affairs unthinkable. For example, the manic may come to recognize and accept the fact he is not the cleverest businessman in his profession but merely endowed with ordinary talents. The person's functioning in the role of critic establishes and perpetuates the conditions of unthinkability, thereby creating certain ways for the world to be or not to be—the givens and the options. If the person's functioning as a critic perpetuates the unthinkability, then the therapeutic task is to alter how the person evaluates himself or herself. Often a key initial treatment issue is simply fostering the patient's insight about having a mental disorder.

The work of Driscoll (1981) provides a systematic model for intervention with a variety of forms of self-criticism, some of which can lead to unthinkability. Depending on one's theoretical approach, other strategies are also possible. For example, from the psychodynamic perspective, one might address issues which emerge in the transference relationship pertaining to typical modes of self-evaluation. In a treatment using Gestalt techniques, role-playing the part of the self which criticizes as well as the part of the self which receives the criticism can serve to highlight critical standards.

The second primary treatment strategy is to increase the patient's status. The more realistic status the person has acquired, the less

vulnerable he or she will be to losses of status in any particular area. Thus, the person is better insulated from the expectable degradations that human society and the human condition offer. Bergner and Staggs (1987) talk about the therapeutic relationship itself as a means of accrediting the patient and thereby increasing the individual's status. An aspect of increasing the patient's status is to teach the person to be self-status-assigning. In this manner, patients will achieve some measure of control over who they are. Particularly relevant will be therapeutic efforts to consolidate a stable identity or sense of self.

The third strategy involves teaching the manic how to handle degradation when it inevitably comes. Coping with degradation is a part of life and manics are often deficient in their ability to reject degradation and to self-affirm in appropriate ways. When not manic, they are frequently more passive and limited in their means for genuinely autonomous self-expression. Manics frequently are impaired in their ability to self-affirm, and can be taught strategies like displacement, fantasy rehearsal, or eliciting the support of others. Bergner (1987) also describes a variety of therapeutic interventions designed to undo degradations. Techniques such as assertiveness training can be helpful as well in helping manics respond more appropriately.

In all of the approaches, the therapist needs to appeal to what matters to the patient. Manics live in a world of status concerns and respond well to overt labeling of them and even a delineation of the formulation; using the term "status" is a powerful label for the parameters of their worlds.

Beyond the difficulties inherent in psychotherapy with patients who are often reluctant to acknowledge even having psychological problems, an additional obstacle faces those who attempt to treat manics—the strong emotional reactions they can stir. Janowsky, Leff, and Epstein (1970) write: "Possibly, no other psychiatric syndrome is characterized by as many disquieting and irritating qualities as that of the manic phase of a manic-depressive psychosis" (p. 253). They noted five different types of activity found in acutely manic patients: "manipulation of the self-esteem of others . . . perceptiveness to vulnerability and conflict . . . projection of responsibility . . . progressive limit testing . . . alienating family members" (p. 253). While they attribute these characteristics to the manic's dependency issues, in fact, a more parsimonious explanation is possible. All of these issues pertain to the manic's extreme sensitivity to issues of status. Manics, being masters of accreditation and degradation themselves, are exquisitely attuned to the self-esteem vulnerabilities of others. Able to identify others' Achilles heel, they often exploit these vulnerabilities for their own purposes.

The status formulation offers several strategies for coping with the manic's challenges. First, by seeing more clearly what the manic's intentions are, a psychotherapist is better prepared to identify the status manipulations, rather than merely react to them. Second, greater empathy is possible with the self-esteem vulnerabilities in the manic, which underlie the manipulations. Third, one can achieve a sense of intellectual distance, admiring the manic's efforts to maintain his status.

CONCLUSIONS

One question which may be present in the reader's mind is that of etiology. While the proximate causes of manic states have been addressed, how people acquire such a self-concept in the first place has not been. This omission is a deliberate one, based on the notion that if two people have the same personal characteristic (i.e., a self-concept such that a loss of status is unthinkable), there is no logical reason for them to have acquired that characteristic in the same ways (Ossorio, 1982). One can only say, without longitudinal studies, that a developmental history is required which gives extreme priority to issues of status. For example, one manic patient I treated was the product of a "shotgun" marriage and an only child. It is probably no coincidence that the business stationery he produced in a manic state bore the heading: "Unique in All the World".

Another question can be raised about how the present formulation relates to other psychological theories of mania (e.g., the psychoanalytic account of narcissistic vulnerability). A brief answer is that narcissistic vulnerability, as explicated by writers such as Kohut (1971) or Kernberg (1975), must ultimately be described in status dynamic terms—those of unthinkability, critic functioning, and status. These theories do not make these particular conceptual distinctions explicitly and thus are limited in their ability to talk directly about such phenomena.

Much remains to be said about mania, from both the biological and the psychological perspectives. The answers lie not in the bifurcation of these two perspectives, but in their integration (Grigsby & Schneiders, 1991). The present formulation itself will ultimately require further empirical investigation, despite the difficulty operationalizing concepts such as "unthinkability" and "status". Further difficulty can be anticipated in teasing out the complex interplay between psychological and physiological states, both conceptually and empirically. Nonetheless, the status dynamic account of manic states, in its present form, offers clinicians a means of organizing and understanding the welter of clinical data their patients present to them. Furthermore, the formulation yields practical psychotherapeutic strategies amenable to a range of theoretical

perspectives. The formulation must be judged in this clinical arena, where it will be put to the most stringent of empirical tests.

ACKNOWLEDGMENTS

This paper was based on the author's doctoral dissertation, portions of which were presented at the sixth annual meeting of the Society for Descriptive Psychology in Boulder, Colorado in August of 1984. My deepest appreciation goes to Peter G. Ossorio, whose wisdom and patience guided this venture to completion. The thesis was only the culmination of a much broader learning experience under his tutelage. I am also grateful to the patients and staff of Boulder County Mental Health Center, who gave fully of their time and resources. Lastly, I am greatly appreciative of my friends and colleagues, including those at Menningers and Harding Hospital, whose enthusiasm, encouragement, and perseverance helped convince me I was eligible for the status of "author". Particular thanks goes to Jim Grigsby, Ph.D., for his careful reading of this paper from a neuropsychological perspective. This paper is dedicated to my late father, Irving R. Wechsler, who regrettably died shortly before its publication. He shared both his love and editorial genius in its creation. Author's address: Psychology Service (116B), Department of Veterans Affairs Medical Center, 1055 Clermont Street, Denver, CO 80220.

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