Lecture 30:
Abnormal Psychology:
Depression and Suicide

III. PSYCHOPATHOLOGY
A. MOOD DISORDER

- Major Depression
  - Defined
    - A mood disorder involving disturbances in emotion (excessive sadness), behavior (loss of interest in one’s usual activities), cognition (thoughts of hopelessness), and body function (fatigue and loss of appetite).
  - DSM IV Criteria (5 of following in past 2 weeks)
    - Depressed mood; Reduced interest in almost all activities; Significant weight gain or loss, without dieting; Sleep disturbance (insomnia or too much sleep); Change in motor activity (too much or too little); Fatigue or loss of energy; Feelings of worthlessness or guilt; Reduced ability to think or concentrate. Recurrent thoughts of death

- Incidence:
  - 6 - 19 % of adult population
  - More common in women than men
    - Men: 8-12%
    - Women: 20-26%
  - Assessment of WSU Introductory Psychology students (1998) with the Beck Depression Inventory

<table>
<thead>
<tr>
<th>Females</th>
<th>Males</th>
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<td>14 or less</td>
<td>135</td>
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<tr>
<td>15 or more</td>
<td>31 (19%)</td>
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<tr>
<td>TOTAL</td>
<td>166</td>
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III. PSYCHOPATHOLOGY
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2. Explanations and Treatments
- Bio-Psycho-Social model of psychopathology.
  - Genetic Factors: Inherited.
    * Identical Twins: 67%
    * Fraternal: 16%
  - Biological:
    * Depressed patients have lower levels of Norepinephrine and/or Serotonin.
    * Left frontal lobes less active.
  - Psychoanalytic:
    * Unconscious anger turned inward. Loss which produces anger that is turned inward.

III. PSYCHOPATHOLOGY
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- Bio-Psycho-Social model of psychopathology
  - Behavioral:
    * Animal Models: Learned Helplessness
      * Shuttle box: Escape shock vs. No escape shock
      * Later show acceptance of shock
    * Learned Helplessness in Humans
      * Escape or no escape from punishment
      * Later performed more poorly on anagrams.
  - Cognitive:
    * Cognition causes mood not the other way around.
    * Where will these come from?
  - I. Explanatory Style
    * Internal Attributions: They are the cause
    * Stable Attributions: The problem is permanent
    * Uncontrollable: They have control

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2. Rumination: Brooding and replying things over and over.
3. Causality and blame-worthiness: Depressive people make causality and blameworthiness judgments differently than non-depressive people.
   - Depressives: Take more responsibility and accept blame more readily.
   - Non-depressives: “Healthy” people often judge themselves as having more control than what they in fact have.
   - Rigged experiment: Depressives correctly think that they have no control over their environment, but normals mistakenly believe that they have control.
   - Depressed people are “SADDER but WISER”.

III. PSYCHOPATHOLOGY
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- Vulnerability-Stress model
  - Interactions between biology, cognition, and mood
    * Brain Chemistry (Level of Serotonin)
    * Cognition (Depressive Explanatory Study)
    * Mood (sad)
  - Interaction models can be explained by 4-step cycle.
  - Certain people may have
    1. a setback or stressful experience (Poor exam showing)
    2. Interpreted with a negative explanatory (I am poor student) by someone predisposed to such explanations.
    3. Leading to a change in cognition and behavior (giving up studying for the next exam)
    4. Which leads to more stressful events
### III. PSYCHOPATHOLOGY
#### A. MOOD DISORDER

- **2. Suicide** is associated with depression
  - USA suicide rate (12.8/100,000) compared to Western European 20/100,000 and Austrian Aborigines: No Suicides

- **Adolescent Suicide**
  - Tripling of adolescent suicide rate from 1960-1980
  - According to the Surgeon General, a youth commits suicide every two hours in our country.
  - Suicide claims more adolescents than any disease or natural cause.
  - Striking increases in suicidal behaviors among African American males, Native American males and children under 14.

### III. PSYCHOPATHOLOGY
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- **Risk factors for suicide include:**
  1. Previous suicide attempts
  2. Close family member who has committed suicide.
  3. Past psychiatric hospitalization
  4. Recent losses: This may include the death of a relative, a family divorce, or a breakup with a girlfriend.
  5. Social isolation: The individual does not have social alternatives or skills to find alternatives to suicide
  6. Drug or alcohol abuse: Drugs decrease impulse control making impulsive suicide more likely. Additionally, some individuals try to self-medicate their depression with drugs or alcohol.
  7. Exposure to violence in the home or the social environment: The individual sees violent behavior as a viable solution to life problems.
  8. Handguns in the home, especially if loaded.

### III. PSYCHOPATHOLOGY
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- **MYTHS**
  1. Talking about suicide does not lead to suicide
     - 8/10 who commit leaving a warning
  2. All people commit suicide because they wanted to die
     - 10 Unsuccessful attempts for each completed.
  3. Only the Wealthy commit suicide
     - Suicide affects all SES level
  4. Depression causes suicide
     - Some show no signs of depression (terminal illness)
  5. To commit suicide to you got to be crazy;
     - Not out of touch with reality (maybe more in touch)
  6. Risk of suicide decreases after an improved mood
     - Suicide are more common after there is some recovery
  7. Suicide is influenced by phases of the moon etc.
    - No correlation

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- **What can you do for someone who is threatening suicide?**
  2. Be willing to listen and accept the feelings.
  3. Be non-judgmental. Don’t debate whether suicide is right or wrong, or feelings are good or bad. Don’t lecture on the value of life.
  4. Become available. Show interest and support.
  5. Don’t dare him or her to do it.
  6. Don’t act shocked. This will put distance between you.
  7. Don’t be sworn to secrecy. Seek support.
  8. Offer hope that other options are available but do not offer glib reassurance.
  9. Take action. Remove means, such as guns or stockpiled pills.
  10. Get help from persons or agencies specializing in crisis intervention and suicide prevention.
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   3. Bipolar (Manic Depressive Disorder):
      Extreme depression followed by extreme elation (mania)
      - Bipolar Disorders: Depression is sometime relieved by people going to the opposite extreme.
        - From being morose, unhappy and sad, bipolar sufferers become euphoric, hyperactive, widely optimistic.
        - This cycle reoccurs again over time.
      - Bipolar is this shifting between depression and mania.

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   More on Bipolar Disorder
   - It usually begins in late adolescence appearing as depression during teen years although it can start in early childhood or later in life
   - An equal number of men and women develop this illness
   - It is found among all ages, races, ethnic groups and social classes.
   - The illness tends to run in families and appears to have a genetic link.