Lecture 30: Abnormal Psychology: Depression and Suicide

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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

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- 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

	Females	Males	
14 or less	135	88	223
15 or more	**31 (19%)**	**10 (10%)**	**41 (17%)**
TOTAL	166	98	264

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1)	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
2)	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and that things can't improve.
3)	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4)	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.

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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 Seratonin.
    - Left frontal lobes less active.
  - **Psychoanalytic**:
    - Unconscious anger turned inward. Loss which produces anger that is turned inward.

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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?
  - **1. 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 nomals mistakenly believe that they have control.
  - Depressed people are "SADDER but WISER".

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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

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- **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.

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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.

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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)
7. Risk of suicide decreases after an improved mood
   - Suicide are more common after there is some recovery
8. 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?

- Be direct. Talk openly and matter-of-factly about suicide.
- Be willing to listen and accept the feelings.
- 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.
- Become available. Show interest and support.
- Don't dare him or her to do it.
- Don't act shocked. This will put distance between you.
- Don't be sworn to secrecy. Seek support.
- Offer hope that other options are available but do not offer glib reassurance.
- Take action. Remove means, such as guns or stockpiled pills.
- 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 cycles 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.