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Chapter

Chapter 7

Mood Disorders and Suicide

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Outline

- Understanding and Defining Mood Disorders
  - Depressive Disorders
  - Bipolar Disorders
- Prevalence of Mood Disorders
- Causes of Mood Disorders
- Treatment of Mood Disorders
- Suicide

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Focus Questions

- *What are the clinical features of mood disorders?*
- *How does the prevalence of mood disorders change across the lifespan?*
- *What factors contribute to the development of mood disorders?*
- *What treatments exist for mood disorders?*
- *What is the prevalence of suicide, and what are the risk factors for suicide?*

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An Overview of Depression and Mania

- Mood disorders = gross deviations in mood
- Composed of different types of mood “episodes”
  - Periods of depressed or elevated mood lasting days or weeks, including:
    - Major depressive episodes
    - Manic episodes
    - Hypomanic episodes

Major Depressive Episode

- Extremely depressed mood and/or loss of pleasure (anhedonia)
  - Lasts most of the day, nearly every day, for at least two weeks
- At least four additional physical or cognitive symptoms:
  - E.g., indecisiveness, feelings of worthlessness, fatigue, appetite change, restlessness or feeling slowed down, sleep disturbance

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DSM-5 Criteria: Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition or mood-incongruent delusions or hallucinations.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). *Note:* in children and adolescents can be irritable mood.

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. *Note:* in children, consider failure to make expected weight gains

DSM-5 Criteria: Major Depressive Episode, continued

4. Insomnia or hypersomnia nearly every day

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

6. Fatigue or loss of energy nearly every day

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC

Manic Episode

- Elevated, expansive mood for at least one week
- Examples of symptoms:
  - Inflated self-esteem, decreased need for sleep, excessive talkativeness, flight of ideas or sense that thoughts are racing, easy distractibility, increase in goal-directed activity or psychomotor agitation, excessive involvement in pleasurable but risky behaviors
- Impairment in normal functioning

DSM-5 Criteria: Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1. Inflated self-esteem or grandiosity

2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

3. More talkative than usual or pressure to keep talking

4. Flight of ideas or subjective experience that thoughts are racing

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (e.g., purposeless non-goal-directed activity).

DSM-5 Criteria: Manic Episode, continued

7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another general medical condition.

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence of a manic episode and, therefore, a bipolar I diagnosis.

From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

Types of Mood Episodes

- Hypomanic episode
  - Shorter, less severe version of manic episodes
  - Last at least four days
  - Have fewer and milder symptoms
  - Associated with less impairment than a manic episode (e.g., less risky behavior)
  - May not be problematic in and of itself, but usually occurs in the context of a more problematic mood disorder

Types of Mood Episodes, continued

- "Mixed features" = term for a mood episode with some elements reflecting the opposite valence of mood
  - Example: Depressive episode with some manic features
  - Example: Manic episode with some depressed/ anxious features

The Structure of Mood Disorders

- *Unipolar mood disorder*: Only one extreme of mood is experienced
  - E.g., only depression or only mania
  - Depression alone is much more common than mania alone

- *Bipolar mood disorder:* Both depressed and elevated moods are experienced
  - E.g., some depressive episodes and some manic or hypomanic episodes

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DSM-5 (Unipolar) Depressive Disorders

- Major depressive disorder
- Persistent depressive disorder
- New to DSM-5:
  - Premenstrual dysphoric disorder
  - Disruptive mood dysregulation disorder

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Major Depressive Disorder: An Overview

- Clinical features
  - One or more major depressive episodes separated by periods of remission
  - Single episode – highly unusual
  - Recurrent episodes – more common

DSM-5 Criteria: Major Depressive Disorder

A. At least one major depressive episode (DSM-5 Table 7.1 Criteria A–C).

B. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

C. There has never been a manic episode or hypomanic episode. *Note:* This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance induced or are attributable to the direct physiological effects of another medical condition.

Specify the clinical status and/or features of the current or most recent major depressive episode:

Single episode or recurrent episode; Mild, moderate, severe; With anxious distress; With mixed features; With melancholic features; With atypical features; With mood-congruent psychotic features; With mood-incongruent psychotic features; With catatonia; With peripartum onset; With seasonal pattern (recurrent episode only); In partial remission, in full remission

From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

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Persistent Depressive Disorder: An Overview

- At least two years of depressive symptoms
  - Depressed mood most of the day on more than 50% of days
  - No more than 2 months symptom free
  - Symptoms can persist unchanged over long periods (≥ 20 years)
  - May include periods of more severe major depressive symptoms
    - Major depressive symptoms may be intermittent or last for the majority or entirety of the time period

Persistent Depressive Disorder: An Overview, continued

- Types of PDD
  - Mild depressive symptoms without any major depressive episodes (“with pure dysthymic syndrome”)
  - Mild depressive symptoms with additional major depressive episodes occurring intermittently (previously called “double depression”)
  - Major depressive episode lasting 2+ years (“with persistent major depressive episode”

DSM-5 Criteria: Major Depressive Disorder (Dysthymia)

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years. *Note:* In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating

2. Insomnia or hypersomnia

3. Low energy or fatigue

4. Low self-esteem

5. Poor concentration or difficulty making decisions

6. Feelings of hopelessness

DSM-5 Criteria: Major Depressive Disorder (Dysthymia), continued

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in criteria A and B for more than 2 months at a time.

D. Criteria for major depressive disorder may be continuously present for 2 years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

DSM-5 Criteria: Major Depressive Disorder (Dysthymia), part 3

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Current severity: Mild, moderate, severe; With anxious distress; With mixed features; With melancholic features; With atypical features; With mood-congruent psychotic features; With mood-incongruent psychotic features; With peripartum onset; Early onset: If onset is before age 21 years;

DSM-5 Criteria: Major Depressive Disorder (Dysthymia), part 4

Late onset: if onset is at age 21 years or older; specify (for most recent 2 years of dysthymic disorder):

With pure dysthymic syndrome: if full criteria for a major depressive episode have not been met in at least the preceding 2 years.

With persistent major depressive episode: if full criteria for a major depressive episode have been met throughout the preceding 2-year period.

With intermittent major depressive episodes, with current episode: if full criteria for a major depressive episode are currently met, but there have been periods of at least 8 weeks in at least the preceding 2 years with symptoms below the threshold for a full major depressive episode.

With intermittent major depressive episodes, without current episode: if full criteria for a major depressive episode are not currently met, but there has been one or more major depressive episodes in at least the preceding 2 years.

In full remission, in partial remission

From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

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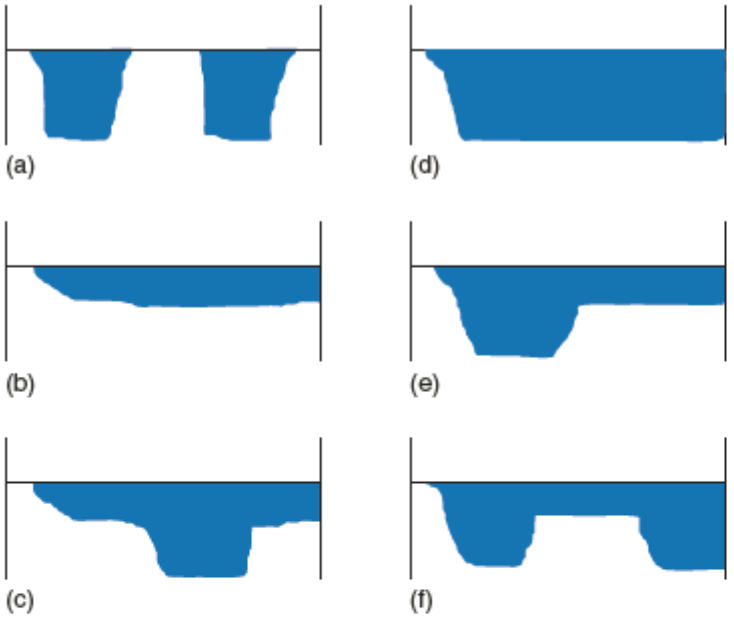
Possible Course of Depressive Disorders



● FIGURE 7.1 Pictorial representation of various course configurations of non-bipolar depression. The horizontal axis represents time and the vertical axis represents mood, with the horizontal black line representing euthymic, or normal, mood, and the magnitude of downward deflection (the blue area) reflecting severity of depressive symptoms. Panel (a) is nonchronic major depressive disorder (in this case, recurrent, as two depressive episodes are depicted). Panel (b) is persistent depressive disorder with pure dysthymic syndrome. Panel (c) is double depression (major depressive episode occurring within the course of dysthymia). Panel (d) is chronic major depressive episode. Panel (e) is major depressive episode in partial remission. Panel (f) is recurrent major depression without full interepisode recovery. (Based on Klein, D. N. (2010). Chronic depression: Diagnosis and classification. *Current Directions in Psychological Science, 19*(2), 96–100.)

Diagnostic Specifiers for Depressive Disorders

- *Specifier*: Additional diagnostic label used by clinicians to convey extra information about symptoms
- Specifiers are not mandatory; only assigned if appropriate

Diagnostic Specifiers for Depressive Disorders, continued

- Psychotic features specifier
  - Major depressive episodes which also include some psychotic features
    - Hallucinations: Sensory experience in the absence of sensory input
    - Delusions: Strongly held inaccurate beliefs
- Anxious distress specifier
  - Depression is accompanied by several significant symptoms of anxiety
  - Predicts poorer outcome

Diagnostic Specifiers for Depressive Disorders, part 3

- Mixed features specifier
  - Depressive episodes which also include several manic symptoms
- Melancholic features specifier
  - Major depressive episode accompanied by additional severe symptoms such as early morning awakenings, lack of reactivity to positive stimuli

Diagnostic Specifiers for Depressive Disorders, part 4

- Catatonic features specifier:
  - Extremely rare muscular symptoms such as remaining in a still stupor, “waxy” limbs that remain in place when manipulated, repetitive or purposeless movement
- Atypical features specifier:
  - Presence of several symptoms less common in depression, including oversleeping and overeating

Diagnostic Specifiers for Depressive Disorders, part 5

- Peripartum onset specifier:
  - Depression occurring around the time of giving birth
- Seasonal pattern specifier: Depression occurring primarily in certain seasons (usually winter)
  - Sometimes called *seasonal affective disorder*.
  - Result of phase-delayed circadian misalignment, meaning that the patient's circadian rhythm is misaligned with the environmental day-night cycle
  - May be treated effectively with light therapy

Onset and Duration of Depressive Disorders

- Rare in childhood
- Risk increases in adolescence and young adulthood, decreases in middle adulthood, increases again in old age (U-shaped pattern)
- Depressive episodes are variable in length
  - Usually last several months untreated, but may last several years

Additional Examples: Courses of Depression

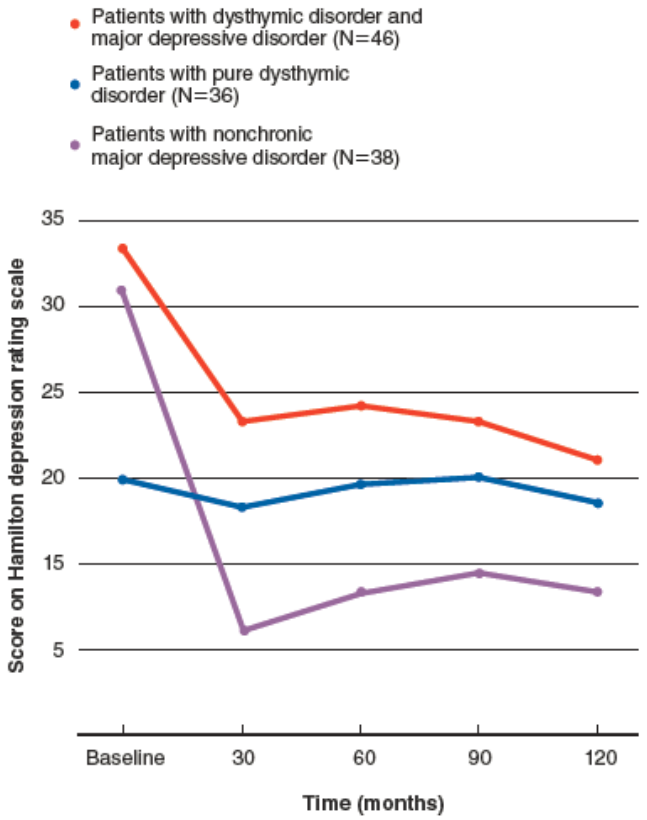


FIGURE 7.2 Hamilton Depression Rating Scale scores of dysthymic disorder patients with and without concurrent major depressive disorder episode and patients with nonchronic major depressive disorder over a 10-year follow-up period. (Based on Klein, D., Shankman, S., & Rose, S. [2006]. Ten-year prospective follow-up study of the naturalistic course of dysthymic disorder and double depression. *American Journal of Psychiatry, 163*, 872–880. © American Psychiatric Association.)

From Grief to Depression

- In previous editions of the *DSM*, depression could not be diagnosed during periods of mourning
- Now recognized that major depression may occur as part of the grieving process

- Acute grief: Occurs immediately after loss
- Integrated grief: Eventual coming to terms with meaning of the loss
- Complicated grief: Persistent acute grief and inability to come to terms with loss

Other Depressive Disorders

- Premenstrual Dysphoric Disorder
  - Significant depressive symptoms occurring prior to menses during the majority of cycles, leading to distress or impairment
  - Controversial diagnosis
    - Advantage: Legitimizes the difficulties some women face when symptoms are very severe
    - Disadvantage: Pathologizes an experience many consider to be normal

DSM-5 Criteria: Premenstrual Dysphoric Disorder

- At least five symptoms must be present final week before the onset of menses, improve days after onset, and minimal/absent in week post menses
- Mood swings, sensitivity, etc
- Irritability or anger
- Depressed mood
- Anxiety and tension
- Decreased interests in usual activities
- Difficulty concentrating’
- Lethargy
- Change in appetite
- Problems sleeping
- Feeling out of control
- Physical symptoms

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Disruptive Mood Dysregulation Disorder

- Disruptive Mood Dysregulation Disorder
  - Severe temper outbursts occurring frequently, against a backdrop of angry or irritable mood
  - Diagnosed only in children 6 to 18
  - Criteria for manic/hypomanic episode are not met
  - Designed in part to combat overdiagnosis of bipolar disorder in youth

DSM-5 Criteria: Disruptive Mood Dysregulation Disorder

- Recurring temper outbursts
- Outbursts inconsistent with development
- 3 or more times a week
- Persistent irritability
- Between 6 to 18 years old
- Onset 10 years old

DSM-5 Bipolar Disorders

- Bipolar I disorder
  - Alternations between major depressive episodes and manic episodes
- Bipolar II disorder
  - Alternations between major depressive episodes and hypomanic episodes
- Cyclothymic disorder
  - Alternations between less severe depressive and hypomanic periods

DSM-5 Criteria: Bipolar II Disorder

A. Criteria have been met for at least one hypomanic episode *and* at least one major depressive episode.

Criteria for a hypomanic episode are identical to those for a manic episode (see DSM-5 Table 7.2), with the following distinctions: 1) Minimum duration is 4 days; 2) Although the episode represents a definite change in functioning, it is not severe enough to cause marked social or occupational impairment or hospitalization; 3) There are no psychotic features.

B. There has never been a manic episode.

C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

DSM-5 Criteria: Bipolar II Disorder, continued

D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify current or most recent episode:

Hypomanic: If currently (or most recently) in a hypomanic episode

Depressed: If currently (or most recently) in a major depressive episode

Specify if: With anxious distress; With mixed features; With rapid cycling; With mood-congruent psychotic features; With mood-incongruent psychotic features; With catatonia; With peripartum onset; With seasonal pattern

Specify course if full criteria for a mood episode are not currently met:

In full remission, in partial remission

Specify severity if full criteria for a mood episode are currently met: Mild, moderate, severe

From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

Cyclothymic Disorder: An Overview

- Chronic version of bipolar disorder
- Alternating between periods of mild depressive symptoms and mild hypomanic symptoms
  - Episodes do *not* meet criteria for full major depressive episode, full hypomanic episode, or full manic episode
- Hypomanic or depressive mood states may persist for long periods
- Must last for at least two years (one year for children and adolescents)

DSM-5 Criteria: Cyclothymic Disorder

A. For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.

B. During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.

C. Criteria for a major depressive, manic, or hypomanic episode have never been met.

DSM-5 Criteria: Cyclothymic Disorder, continued

D. The symptoms in criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With anxious distress

From American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

Diagnostic Specifiers for Bipolar Disorders

- All of the specifiers for depressive disorders may also apply to bipolar disorders
- Additional specifer unique to bipolar disorders: Rapid cycling specifier
  - Moving quickly in and out of mania and depression
  - Individual experiences at least four manic or depressive episodes within a year
  - Occurs in between 20 to 50% of cases
  - Associated with greater severity

Prevalence of Mood Disorders

- Worldwide lifetime prevalence of MDD: 16%
  - 6% have experienced major depression in last year
- Sex differences
  - Females are twice as likely to have major depression
  - Bipolar disorders approximately equally affect males and females
  - Women more likely to experience rapid cycling
  - Women more likely to be in depressive period

Prevalence of Mood Disorders, continued

- Occurs less often in prepubertal children
- Rapid rise in adolescents
- Adults over 65 have about 50% less prevalence than general population
- Bipolar same in childhood, adolescence, and adults
- Prevalence of depression seems to be similar across subcultures

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Life Span Developmental Influences on Mood Disorders

- 3-month-olds can show depressive symptoms
- Young children typically don't show classic mania or bipolar symptoms
- Mood disorder may be misdiagnosed as ADHD
- Children are being diagnosed with bipolar disorders at increasingly high rates
- Depression in elderly between 14% and 42%
  - Co-occurrence with anxiety disorders
  - Less gender imbalance after 65 years of age

Prevalence of Mood Disorders

- Across Cultures
  - Similar prevalence among U.S. subcultures, but experience of symptoms may vary
    - E.g., some cultures more likely to express depression as somatic concern
  - Higher prevalence among Native Americans: Four times the rate of the general population

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Causes of Mood Disorders: Familial and Genetic Influences

- Family studies
  - Risk is higher if relative has a mood disorder
  - Relatives of bipolar probands are more likely to have unipolar depression

Causes of Mood Disorders: Familial and Genetic Influences, continued

- Twin studies
  - Concordance rates are high in identical twins
    - Two to three times more likely to present with mood disorders than a fraternal twin of a depressed co-twin
  - Severe mood disorders have a strong genetic contribution
  - Heritability rates are higher for females compared to males
  - Some genetic factors confer risk for both anxiety and depression

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Causes of Mood Disorders: Neurobiological Influences

- Neurotransmitter systems
  - Serotonin and its relation to other neurotransmitters
    - Serotonin regulates norepinephrine and dopamine
  - Mood disorders are related to low levels of serotonin
  - Permissive hypothesis: Low serotonin “permits” other neurotransmitters to vary more widely, increasing vulnerability to depression

Causes of Mood Disorders: Neurobiological Influences, continued

- The endocrine system
  - Elevated cortisol
  - Stress hormones decrease neurogenesis in the hippocampus > less able to make new neurons
- Sleep disturbance
  - Hallmark of most mood disorders
  - Depressed patients have quicker and more intense REM sleep
  - Sleep deprivation may temporarily *improve* depressive symptoms in bipolar patients

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Mood Disorders: Psychological Dimensions (Stress)

- Stressful life events
  - Stress is strongly related to mood disorders
    - Poorer response to treatment
    - Longer time before remission
  - Context of life events matters
  - Gene-environment correlation: People who are vulnerable to depression might be more likely to enter situations that will lead to stress
  - The relationship between stress and bipolar is also strong

Diagram of Context and Meaning in Life Stress Situations

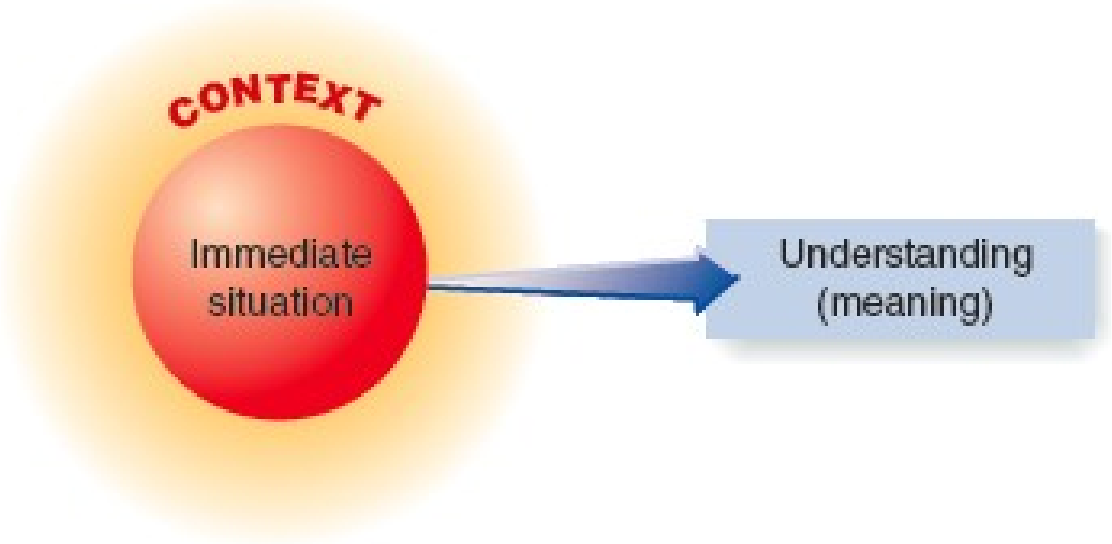

FIGURE 7.4 Context and meaning in life stress situations. (Reprinted, with permission, from Brown, G. W. [1989b]. Life events and measurement. In G. W. Brown & T. O. Harris, Eds., *Life events and illness*. New York, NY: Guilford Press, © 1989 New York, NY: Guilford Press.)

07 Chapter

Psychological Dimensions: Learned Helplessness

- The learned helplessness theory of depression
  - Lack of perceived control over life events leads to decreased attempts to improve own situation
  - First demonstrated in research by Martin Seligman
  - Negative cognitive styles are a risk factor for depression

Psychological Factors: Depressive Attributional Style

- Internal attributions
  - Negative outcomes are one's own fault
- Stable attributions
  - Believing future negative outcomes will be one's fault
- Global attribution
  - Believing negative events will disrupt many life activities
- All three domains contribute to a sense of hopelessness

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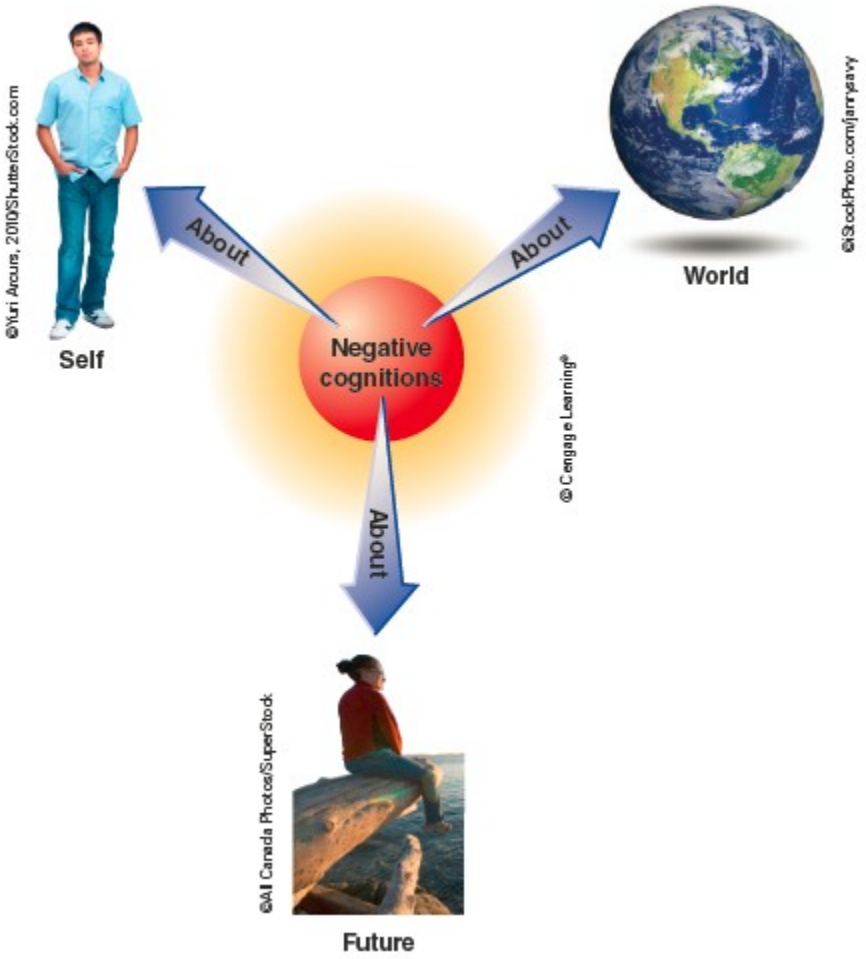
Psychological Dimensions: Cognitive Theory

- Negative coping styles
  - Depressed persons engage in cognitive errors
  - Tendency to interpret life events negatively
- Types of cognitive errors
  - Arbitrary inference – overemphasize the negative aspects of a mixed situation
  - Overgeneralization – negatives apply to all situations

Psychological Dimensions: Cognitive Theory, continued

- Cognitive errors and the depressive cognitive triad
  - Think negatively about oneself
  - Think negatively about the world
  - Think negatively about the future

The Depressive Cognitive Triad



Social and Cultural Dimensions

- Marital relations
  - Marital dissatisfaction is strongly related to depression
  - This relation is particularly strong in males

Social and Cultural Dimensions, continued

- Social support
  - Extent of social support is related to depression
  - Lack of social support predicts late onset depression
  - Substantial social support predicts recovery from depression

Gender Differences in Mood Disorders

- Women account for 7 out of 10 cases of major depressive disorder
- Recall that women also have higher rates of anxiety disorders

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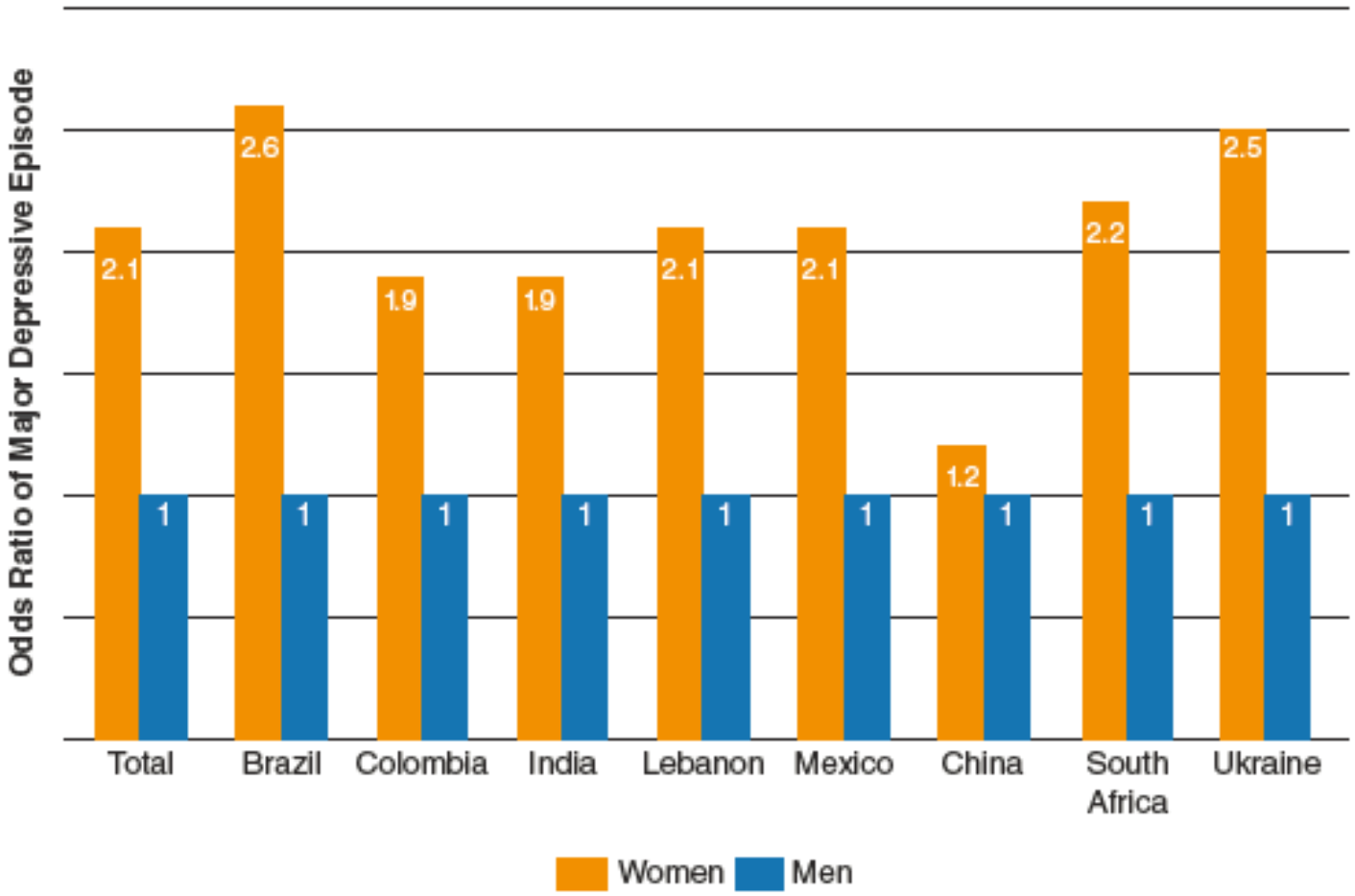
Gender Disparity in Depression Diagnosis Worldwide



Explanations for Gender Differences in Mood Disorders

- Possible explanations for gender disparity
  - Women socialized to have stronger perception of uncontrollability
  - Parenting style makes girls less independent
  - Women more sensitive to relationship disruptions (e.g., breakups, tension in friendships)
  - Women ruminate more than men

An Integrative Theory

- Biological and psychological vulnerabilities interact with stressful life events to cause depression
  - Biological vulnerability: e.g., overactive neurobiological response to stress
  - Psychological vulnterability: e.g., depressive cognitive style

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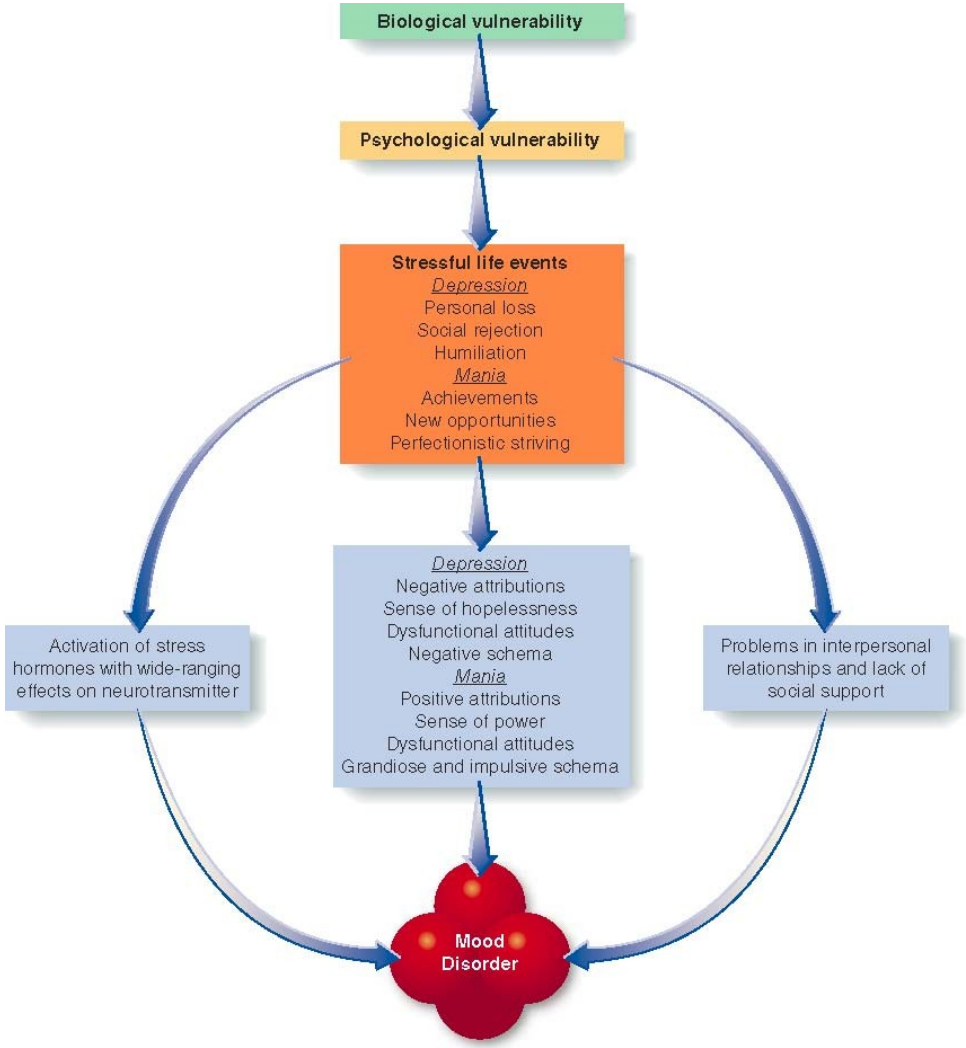
Integrative Model of Mood Disorders



Treatment of Mood Disorders: Medication

- Antidepressants
  - Selective serotonin reuptake inhibitors
  - Tricyclic antidepressants
  - Monoamine oxidase inhibitors
  - Mixed reuptake inhibitors (e.g., serotonin/norepinephrine reuptake inhibitors)
- Approximately equally effective
  - Only 50% of patients benefit
  - Only 25% achieve normal functioning

Selective Serotonin Reuptake Inhibitors

- Called SSRIs
- Specifically block reuptake of serotonin so more serotonin is available in the brain
  - Fluoxetine (Prozac) is the most popular SSRI
- SSRIs pose some risk of suicide particularly in teenagers
- Negative side effects are common
- Some evidence that SSRI use during pregnancy lowered risk for birth complications

Tricyclic Antidepressants

- Include Tofranil, Elavil
- Mechanisms not well understood
  - Block reuptake norepinephrine and other neurotransmitters
- Negative side effects are common (e.g., drowsiness, weight gain)
  - Discontinuation is common
- May be lethal in excessive doses

Mixed Reuptake Inhibitors

- Block reuptake of norepinephrine as well as serotonin
- Best known is venlafaxine (Effexor)
- Have fewer side effects than SSRIs

Monoamine Oxidase (MAO) Inhibitors

- Block monoamine oxidase
- This enzyme breaks down serotonin/norepinephrine
- As effective as tricyclics, with fewer side effects
- Dangerous in combination with certain foods
  - Beer, red wine, cheese cannot be consumed; patients dislike dietary restrictions
  - Also dangerous in combination with cold medicine

Treatment of Mood Disorders: Lithium

- Lithium carbonate = a common salt
- Treatment of choice for bipolar disorder
- Considered a mood stabilizer because it treats depressive *and* manic symptoms
- Toxic in large amounts
  - Dose must be carefully monitored
- Effective for 50% of patients
- Why lithium works is partially understood

Treatment of Mood Disorders: Electroconvulsive Therapy (ECT)

- Effective for medication-resistant depression
- The nature of ECT
  - Brief electrical current applied to the brain
  - Results in temporary seizures
  - Usually 6 to 10 outpatient treatments are required
- Side effects:
  - Short-term memory loss which is usually restored
  - Some patients suffer long-term memory loss
- Mechanism is unclear

Treatment of Mood Disorders: Transcranial Magnetic Stimulation

- Uses magnets to generate a precise localized electromagnetic pulse
- Few side effects; occasional headaches
- Less effective than ECT for medication-resistant depression
- May be combined with medication

07 Chapter

Psychosocial Treatments for Depression

- Cognitive-behavioral therapy
  - Addresses cognitive errors in thinking
  - Also includes behavioral components including behavioral activation (scheduling valued activities)
- Interpersonal psychotherapy
  - Focus: Improving problematic relationships
- Prevention
  - Preemptive psychosocial care for people at risk
- Has longer-lasting effectiveness than medication

Preventing Relapse

- Research on relapse prevention is relatively less common
- Psychosocial and pharmacological treatments are both used
- Psychosocial interventions generally more effective at preventing relapse

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Psychosocial Treatments for Bipolar Disorders

- Medication (usually Lithium) is still first line of defense
- Psychotherapy helpful in managing the problems (e.g., interpersonal, occupational) that accompany bipolar disorder
- Family therapy can be helpful

Suicide: Facts and Statistics

- Eleventh leading cause of death in USA
  - Underreported; actual rate may be 2 to 3 times higher
- Most common among white and native Americans
- Particularly prevalent in young adults
  - Third leading cause of death among teenagers
  - Second leading cause of death in college students
  - 12% of college students consider suicide in a given year

Suicide: Facts and Statistics, continued

- Gender differences
  - Males complete more suicides than females
  - Females attempt suicide more often than males
  - Disparity is due to males using more lethal methods
  - Exception: Suicide more common among women in China
    - May reflect cultural acceptability; suicide is seen as an honorable solution to problems

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The Nature of Suicide: Risk Factors

- Risk factors
  - Suicide in the family
  - Low serotonin levels
  - Preexisting psychological disorder
  - Alcohol use and abuse
  - Stressful life event, especially humiliation
  - Past suicidal behavior
  - Plan and access to lethal methods

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Chapter

Vulnerability for Suicidal Behavior

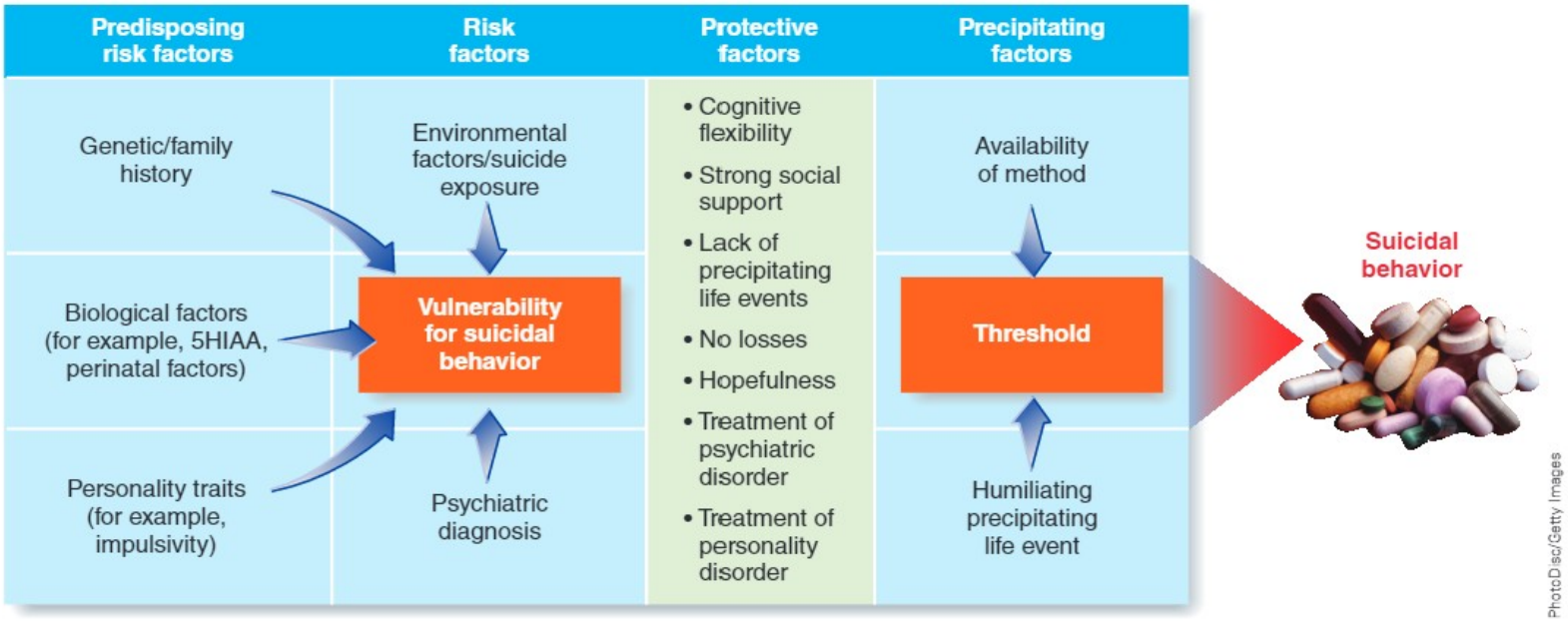

FIGURE 7.11

Threshold model for suicidal behavior. 5HIAA 5 5-hydroxyindoleacetic acid. (Based on Blumenthal, S. J., & Kupfer, D. J. (1988). Clinical assessment and treatment of youth suicide. *Journal of Youth and Adolescence, 17,* 1–24.)

Suicide Contagion

- Some research indicates that a person is more likely to commit suicide after hearing about someone else committing suicide
- Media accounts may worsen the problem by
  - Sensationalizing/romanticizing suicide
  - Describing lethal methods of committing suicide

Suicide Prevention

- In professional mental health
  - Clinician does risk assessment (ideation, plans, intent, means, etc.)
  - Clinician and patient develop safety plan (e.g., who to call, strategies for coping with suicidal thoughts)
  - In some cases, sign no-suicide contract
- Preventative programs for at-risk groups
  - CBT can reduce suicide risk
- Important: removing access to lethal methods

Suicide Prevention, continued

- If you think someone is at risk, talk to them and ensure they're getting needed support
  - Talking to someone about suicide is *not* likely to place them at greater risk or "plant the idea"
  - In contrast, the risk of *not* providing support to someone in need is huge

07 Chapter

Phone Numbers for Help

SUICIDE SUPPORT LINE:

1-800-273-TALK

(1-800-273-8255)

Summary of Mood Disorders

- All mood disorders share:
  - Gross deviations in mood
  - Common biological and psychological vulnerability
- Occur in children, adults, and the elderly
- Onset, maintenance, and treatment are affected by:
  - Stressful life events
  - Social support
  - Differential response to medication