CHAPTER OUTLINE

TYPES OF MOOD DISORDERS 248–259
Major Depressive Disorder
Dysthymic Disorder
Bipolar Disorder
Cyclothymic Disorder

CAUSAL FACTORS IN DEPRESSIVE DISORDERS 259–269
Stress and Depression
Psychodynamic Theories
Humanistic Theories

Learning Theories
Cognitive Theories
Learned Helplessness (Attributional) Theory
Biological Factors

CAUSAL FACTORS IN BIPOLAR DISORDERS 269–270

TREATMENT OF MOOD DISORDERS 270–278
Treating Depression
Biological Approaches

Treating Bipolar Disorder

SUICIDE 278–285
Who Commits Suicide?
Why Do People Commit Suicide?
Theoretical Perspectives on Suicide
Predicting Suicide

SUMMING UP 285–286
William Styron (1925–2006), the celebrated author of *The Confessions of Nat Turner* and *Sophie’s Choice*, suffered at age 60 from depression that was so severe that he planned to commit suicide. In a 1990 memoir he speaks about this personal darkness and about reclaiming his commitment to life.

**Darkness Visible**

I watched myself in mingled terror and fascination as I began to make the necessary preparation: going to see my lawyer in the nearby town—there rewriting my will—and spending part of a couple of afternoons in a muddled attempt to bestow upon posterity a letter of farewell. It turned out that putting together a suicide note, which I felt obsessed with a necessity to compose, was the most difficult task of writing that I had ever tackled. . . .

But even a few words came to seem to me too longwinded, and I tore up all my efforts, resolving to go out in silence. Late one bitterly cold night, when I knew that I could not possibly get myself through the following day, I sat in the living room of the house bundled up against the chill; something had happened to the furnace. My wife had gone to bed, and I had forced myself to watch the tape of a movie in which a young actress, who had been in a play of mine, was cast in a small part. At one point in the film, which was set in late-nineteenth-century Boston, the characters moved down the hallway of a music conservatory, beyond the walls of which, from unseen musicians, came a contralto voice, a sudden soaring passage from the Brahms *Alto Rhapsody*.

This sound, which like all music—indeed, like all pleasure—I had been numbly unresponsive to for months, pierced my heart like a dagger, and in a flood of swift recollection I thought of all the joys the house had known: the children who had rushed through its rooms, the festivals, the love and work, the honestly earned slumber, the voices and the nimble commotion, the perennial tribe of cats and dogs and birds. . . . All this I realized was more than I could ever abandon, even as what I had set out so deliberately to do was more than I could inflict on those memories, and upon those, so close to me, with whom the memories were bound. And just as powerfully I realized I could not commit this desecration on myself. I drew upon some last gleam of sanity to perceive the terrifying dimensions of the mortal predicament I had fallen into. I woke up my wife and soon telephone calls were made. The next day I was admitted to the hospital.

—From *Darkness Visible* by William Styron

**A distinguished author stands at the precipice of taking his own life. The depression that enshrouded him and that nearly cost him his life—this darkness visible—is an unwelcome companion for millions of people. Depression is a disturbance of mood that casts a long, deep shadow over many facets of life.**

Moods are feeling states that color our psychological lives. Most of experience changes in mood. We feel elated when we have earned high grades, a promotion, or the affections of Ms. or Mr. Right. We feel down or depressed when we are rejected by a date, flunk a test, or suffer financial reverses. It is normal and appropriate to be happy about uplifting events. It is just as normal, just as appropriate, to feel depressed by dismal events. It might very well be abnormal if we did not feel down or depressed in the face of tragic or deeply disappointing events or circumstances. But people with mood disorders experience disturbances in mood that are unusually severe or prolonged and impair their ability to function in meeting their normal responsibilities. Some people become severely depressed even when things appear to be going well or when they encounter mildly upsetting events that others take in stride. Still others experience extreme mood swings. They ride an emotional roller coaster with dizzying

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**TRUTH or FICTION**

- **T** F** Feeling sad or depressed is abnormal. (p. 249)**
- **T** F** The economic toll of depression is about half that of heart disease or diabetes. (p. 251)**
- **T** F** Most people who experience a major depressive episode never have another one. (p. 252)**
- **T** F** Men are about twice as likely as women to develop major depression. (p. 252)**
- **T** F** The bleak light of winter casts some people into a diagnosable state of depression. (p. 253)**
- **T** F** The ancient Greeks and Romans used a chemical to curb turbulent mood swings that is still used today. (p. 276)**
- **T** F** Placing a powerful electromagnet on the scalp can help relieve depression. (p. 278)**
- **T** F** People who threaten suicide are basically attention seekers. (p. 282)**

**mood disorders** Psychological disorders characterized by disturbances of mood.
heights and abysmal depths when the world around them remains largely on an even keel. Let us begin our study of these types of emotional problems by examining the different types of mood disorders.

TYPES OF MOOD DISORDERS

This chapter explores major forms of mood disorder: depressive disorders and bipolar disorders (mood swing disorders). We will see that there are two major types of depressive disorders that vary in severity: major depressive disorder, the more severe type, and dysthymic disorder (also called dysthymia), the milder type. Similarly, bipolar or mood swing disorders vary in terms of severity—the more severe disorder is called bipolar disorder, whereas the milder disorder is termed cyclothymic disorder (also called cyclothymia). Note that depressive disorders are also called unipolar disorders, because the mood disturbance is in only one emotional direction or pole: down. By contrast, mood swing disorders are labeled bipolar disorders because they involve states of both depression and elation, which often appear in an alternating pattern. Table 8.1 provides an overview of these disorders. A convenient way of conceptualizing differences in mood states corresponding to these disorders is shown in the form of a mood thermometer in Figure 8.1.

Many of us, probably most of us, have periods of sadness from time to time. We may feel down in the dumps, cry, lose interest in things, find it hard to concentrate, expect the worst to happen, or even consider suicide. For most of us, mood changes pass

William Styron. The celebrated author William Styron suffered from severe depression—a “darkness visible” that led him to the precipice of suicide.

### Table 8.1 Overview of Mood Disorders

<table>
<thead>
<tr>
<th>TYPE OF DISORDER</th>
<th>Lifetime Prevalence (approx.)</th>
<th>Primary Features or Symptoms</th>
<th>Related Features</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depressive Disorders</strong></td>
<td></td>
<td></td>
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<tr>
<td>Major depression</td>
<td>12% in men; 21% in women; 16.5% overall</td>
<td>Episodes of severe depression characterized by downcast mood, feelings of hopelessness and worthlessness, changes in sleep patterns or appetite, loss of motivation, loss of pleasure in pleasant activities</td>
<td>Following a depressive episode, the person may return to his or her usual state of functioning, but recurrences are common. Seasonal affective disorder (SAD) is a type of major depression.</td>
</tr>
<tr>
<td>Dysthymic disorder</td>
<td>4.3%</td>
<td>A chronic pattern of mild depression</td>
<td>Person feels “down in the dumps” most of the time, but is not as severely depressed as in major depression.</td>
</tr>
<tr>
<td><strong>Bipolar Disorders</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>0.4% to 1.6% (4 to 16 people in 1,000) for bipolar I disorder; 0.5% for bipolar disorder II</td>
<td>Periods of shifting moods between mania and depression, perhaps with intervening periods of normal mood; two general subtypes are bipolar I disorder (history of manic episode and possible major depressive episode) and bipolar II disorder (major depressive episode and hypomanic episode)</td>
<td>Manic episodes are characterized by pressured speech, flight of ideas, poor judgment, high levels of restlessness and excitability, and inflated mood and sense of self.</td>
</tr>
<tr>
<td>Cyclothymic disorder</td>
<td>0.4% to 1% (4 to 10 people in 1,000)</td>
<td>Mood swings that are milder in severity than those in bipolar disorder</td>
<td>Cyclothymia usually begins in late adolescence or early adulthood and tends to persist for years.</td>
</tr>
</tbody>
</table>

Severe mania
Hypomania (mild to moderate mania)
Normal/balanced mood
Mild to moderate depression
Severe depression

Mood states can be conceptualized as varying along a spectrum or continuum. One end represents severe depression and the other end severe mania, which is a cardinal feature of bipolar disorder. Mild or moderate depression is often called “the blues” but is classified as “dysthymia” when it becomes chronic. In the middle of the spectrum is normal or balanced mood. Mild or moderate mania is called hypomania, which characterizes cyclothymic disorder.


Feeling sad or depressed is abnormal. ✓ FALSE. Feeling depressed is not abnormal in the context of depressing events or circumstances.

Major Depressive Disorder
The diagnosis of major depressive disorder (also called major depression) is based on the occurrence of one or more major depressive episodes in the absence of a history of mania or hypomania. In a major depressive episode, the person experiences either a depressed mood (feeling sad, hopeless, or “down in the dumps”) or loss of interest or pleasure in all or virtually all activities for a period of at least 2 weeks (APA, 2000). Table 8.2 lists some of the common features of depression. The diagnostic criteria for a major depressive episode are listed in Table 8.3.

Common Features of Depression

| Changes in Emotional States | • Changes in mood (persistent periods of feeling down, depressed, sad, or blue)  
                             | • Evidence of tearfulness or crying  
                             | • Increased irritability, jumpiness, or loss of temper |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| Changes in Motivation      | • Feeling unmotivated, or having difficulty getting going in the morning or even getting out of bed  
                             | • Reduced level of social participation or interest in social activities  
                             | • Loss of enjoyment or interest in pleasurable activities  
                             | • Reduced interest in sex  
                             | • Failure to respond to praise or rewards |
| Changes in Functioning and Motor Behavior | • Moving about or talking more slowly than usual  
                                           | • Changes in sleep habits (sleeping too much or too little, awakening earlier than usual and having trouble getting back to sleep in early morning hours—so-called early morning awakening)  
                                           | • Changes in appetite (eating too much or too little)  
                                           | • Changes in weight (gaining or losing weight)  
                                           | • Functioning less effectively at work or school; failing to meet responsibilities and neglecting one’s physical appearance |
| Cognitive Changes          | • Difficulty concentrating or thinking clearly  
                             | • Thinking negatively about oneself and one’s future  
                             | • Feeling guilty or remorseful about past misdeeds  
                             | • Lack of self-esteem or feelings of inadequacy  
                             | • Thinking of death or suicide |

major depressive disorder A severe mood disorder characterized by major depressive episodes.

mania A state of unusual elation, energy, and activity.

hypomania A relatively mild state of mania.
Table 8.3: Diagnostic Features of a Major Depressive Episode

A major depressive episode is denoted by the occurrence of five or more of the following features or symptoms during a 2-week period, which represents a change from previous functioning. At least one of the features must involve either (1) depressed mood, or (2) loss of interest or pleasure in activities. Moreover, the symptoms must cause either clinically significant levels of distress or impairment in at least one important area of functioning, such as social or occupational functioning, and must not be due directly to the use of drugs or medications, to a medical condition, or be accounted for by another psychological disorder.* Further, the episode must not represent a normal grief reaction to the death of a loved one—that is, bereavement.

1. Depressed mood during most of the day, nearly every day. Can be irritable mood in children or adolescents.
2. Greatly reduced sense of pleasure or interest in all or almost all activities, nearly every day for most of the day.
3. A significant loss or gain of weight (more than 5% of body weight in a month) without any attempt to diet, or an increase or decrease in appetite.
4. Daily (or nearly daily) insomnia or hypersomnia (oversleeping).
5. Excessive agitation or slowing down of movement responses nearly every day.
6. Feelings of fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or misplaced or excessive or inappropriate guilt nearly every day.
8. Reduced ability to concentrate or think clearly or make decisions nearly every day.
9. Recurrent thoughts of death or suicide without a specific plan, or occurrence of a suicidal attempt or specific plan for committing suicide.

*The DSM includes separate diagnostic categories for mood disorders due to medical conditions or use of substances such as drugs of abuse.

Source: Adapted from the DSM-IV-TR (APA, 2000).

Major depression is not simply a state of sadness or “the blues.” People with major depressive disorder (MDD) may have poor appetite, lose or gain substantial amounts of weight, have trouble sleeping or sleep too much, and become physically agitated or—at the other extreme—show a marked slowing down in their motor activity. Here, a woman recounts how depression—the “Beast” as she calls it—affects every fiber of her being.

“The Beast Is Back”

My body aches intermittently, in waves, as if I had malaria. I eat with no appetite, simply because the taste of food is one of my dwindling number of pleasures. I am tired, so tired. Last night I lay like a pile of old clothes, and when David came to bed I did not stir. Sex is a foreign notion. At work today I am forgetful; I have trouble forming sentences, I lose track of them halfway through, and my words keep getting tangled. I look at my list of things to do today, and keep on looking at it; nothing seems to be happening. Things are sad to me. This morning I thought of the woman who used to live in my old house, who told me she went to Sears to buy fake lace curtains. It seemed a forlorn act—having to save your pennies, not being able to afford genuine lace. (Why? A voice in my head asks. The curtains she bought looked perfectly nice.) I feel as if my brain were a lump of protoplasm with tiny circuits embedded in it, and some of the wires keep shorting out. There are tiny little electrical fires up there, leaving crispy sections of neurons smoking and ruined. . . .

I don’t even know when this current siege began—a week ago? A month ago? The onset is so gradual, and these things are hard to tell. All I know is, the Beast is back.

It is called depression, and my experiences with it have shaped my life—altered my personality, affected my most intimate relationships, changed the course of my career—in ways I will probably never be fully aware of.

—From Thompson, 1995
Major depression impairs people’s ability to meet the ordinary responsibility of everyday life. People with major depression may lose interest in most of their usual activities and pursuits, have difficulty concentrating and making decisions, have pressing thoughts of death, and attempt suicide. They even show impaired driving skills in driving simulation tests (Bulmash et al., 2006).

Many people don’t seem to understand that people who are clinically depressed can’t simply “shake it off” or “snap out of it.” Many people still view depression as a sign of weakness, not a diagnosable disorder. Even many people with major depression believe they can handle the problem themselves. These attitudes may explain why, despite the availability of safe and effective treatments, only about half of people with diagnosable major depression in a recent nationwide survey received any treatment during the preceding year, and fewer than one-third of these received treatment from a mental health specialist (Kessler et al., 2003). All told, only about one in five people with major depressive disorder in the nationwide survey received adequate treatment. One factor explaining the lack of adequate care is that many depressed patients seek help from their family physicians, who often fail to treat depression aggressively (Duenweld, 2003; Simon et al., 2004).

Major depressive disorder or MDD is the most common type of diagnosable mood disorder. According to a recent nationally representative survey, lifetime prevalence for major depression is about 12% for men, 21% for women, and 16.5% overall (Conway et al., 2006) (see Figure 8.2). About 7% of U.S. adults suffer from the disorder in any given year (Kessler et al., 2003). An estimated 120 million people worldwide suffer from depression (E. Olson, 2001).

The economic costs of depression are staggering, amounting to an estimated $44 billion annually in the United States in lost productive time (Stewart et al., 2003). The average worker with major depression loses 27.2 workdays to the disorder per year—for bipolar disorder, 65.5 days are lost (Kessler et al., 2006). The economic toll of depression is as great if not greater than the costs of major medical illnesses, such as heart disease and diabetes (Druss, Rosenheck, & Sledge, 2000; Stewart et al., 2003). On the other hand, effective treatment for depression leads not only to psychological improvement but also to more stable employment and increased income, as people return to a more productive level of functioning (Wells et al., 2000).

Major depression, particularly in more severe episodes, may be accompanied by psychotic features, such as delusions that one’s body is rotting from illness. People with severe depression may also experience hallucinations, such as “hearing” voices condemning them for perceived misdeeds.

The following case illustrates the range of features connected with major depressive disorder.

**TRUTH or FICTION**

The economic toll of depression is about half that of heart disease or diabetes.

**FALSE.** Actually, the economic burden to the nation of depression is estimated to be as great if not greater than that for heart disease or diabetes.
Most people who experience a major depressive episode never have another one. ❌

Most people who experience a major depressive episode have recurrences.

**DEPRESSION:**

**The Case of Helen**

“I had electroshock treatments every other day for two weeks.”

**TRUTH OR FICTION**

Men are about twice as likely as women to develop major depression.

✓ FALSE. Actually, women are nearly twice as likely as men to develop major depression.

**Slowly Killing Herself: A Case of Major Depressive Disorder**

A 38-year-old female clerical worker has suffered from recurrent bouts of depression since she was about 13 years of age. Most recently, she has been troubled by crying spells at work, sometimes occurring so suddenly she wouldn’t have enough time to run to the ladies room to hide her tears from others. She has difficulty concentrating at work and feels a lack of enjoyment from work she used to enjoy. She harbors severe pessimistic and angry feelings, which have been more severe lately because she has been putting on weight and has been neglectful in taking care of her diabetes. She feels guilty that she may be slowly killing herself by not taking better care of her health. She sometimes feels that she deserves to be dead. She has been bothered by excessive sleepiness for the past year and a half, and her driving license has been suspended due to an incident the previous month in which she fell asleep while driving, causing her car to hit a telephone pole. She wakes up most days feeling groggy and just “out of it,” and remains sleepy throughout the day. She has never had a steady boyfriend, and lives quietly at home with her mother, with no close friends outside of her family. During the interview, she cried frequently and answered questions in a low monotone, staring downward continuously.

—Adapted from Spitzer et al., 1989, pp. 59–62

Major depressive episodes may resolve in a matter of months or last for a year or more (APA, 2000; USDHHS, 1999a). Some people experience a single episode with a full return to previous levels of functioning. However, the great majority of people with major depression eventually have repeated occurrences (Kanai et al., 2003; Kennedy et al., 2003). Over the course of a lifetime, the average person with major depression can expect to have four episodes (Judd, 1997). Relapses tend to be more frequent in people who continue to have some leftover depressive symptoms following a first depressive episode (Judd, Paulus et al., 2000). Given a pattern of repeated occurrences and long-lasting symptoms, many professionals view major depression as a chronic disorder. However, the longer the period of recovery from major depression, the lower the risk of eventual relapse (Solomon et al., 2000).

**Risk Factors in Major Depression**

Factors that place people at increased risk of developing major depression include age (initial onset is most common among young adults); socioeconomic status (people lower down the socioeconomic ladder are at greater risk than those who are better off); and marital status (people who are separated or divorced have higher rates than married or never-married people).

Women are nearly twice as likely as men to be diagnosed with major depressive disorder (major depression) (Hasin et al., 2005). The difference in relative risk between males and females begins in early adolescence and persists through at least the mid-50s (Barefoot et al., 2001; Kessler et al., 1993). Noting the existence of a gender gap in the diagnosis of depression is one thing; explaining it is quite another (see Controversies in Abnormal Psychology).

**Seasonal Affective Disorder**

Are you glum on gloomy days? Is your temper short during the brief days of winter? Are you dismal during the long, dark winter nights and sunny when spring and summer return?

Many people report that their moods do vary with the weather. For some people, the changing of the seasons from summer into fall and winter leads to a type of major depression called seasonal affective (mood) disorder (SAD). SAD is not a diagnostic category in its own right in the DSM-IV but is a specifier or subcategory of a mood disorder involving major depression. For example, major depressive disorder that occurs seasonally would be diagnosed as major depressive disorder with seasonal pattern. Although the causes of SAD remain unknown, one possibility is that seasonal changes in light may alter the body’s underlying biological rhythms that regulate such processes as body temperature and sleep–wake cycles (Lewy et al., 2006). Another possibility is that some parts of the central nervous system may have deficiencies in transmission of
Evidence shows that women are about twice as likely as men to suffer from clinical depression (NIMH, 2000). The gender gap is found in many other countries, including Canada, Brazil, Germany, and Japan (Gilbert, 2004). Professionals continue to debate the issue. Might the gender gap be a function of biological differences between men and women? Some professionals argue that biological factors, such as hormonal fluctuations, may contribute to depression in women (Cyranowski et al., 2000).

Might the gender difference be explained, at least in part, by a reporting bias that leads men to underreport depression? In our culture, men are expected to be tough and resilient. Consequently, they are less likely to report depression or seek treatment for it. Even physicians are not immune from these social expectations. As one male physician put it, “I’m the John Wayne generation... I thought depression was a weakness—there was something disgraceful about it. A real man would just get over it” (cited in Wartik, 2000). The stigma associated with depression shows signs of lessening, but not disappearing. Although depression was long viewed by men as a sign of personal weakness, more men are coming forward to get help. The male ego has been battered by assaults from corporate downsizing and growing financial insecurity.

An expert panel convened by the American Psychological Association (APA) debated the question of gender differences in depression and concluded that they are largely the result of the greater amount of stress that women encounter in contemporary life (Magrath et al., 1990). The panel recognized that women are more likely than men to encounter such stressful life factors as physical and sexual abuse, poverty, single parenthood, and sexism.

More recently, psychologist Janet Nolen-Hoeksema proposed that differences in coping styles may also underlie women’s greater proneness toward depression. Regardless of whether the factors that precipitate depression are biological, psychological, or social, one’s coping responses may either exacerbate or reduce the severity and duration of depressive episodes. Nolen-Hoeksema and her colleagues (1991; Nolen-Hoeksema, Morrow, & Fredrickson, 1993) proposed that women are more likely to amplify depression by sitting at home when they are depressed and ruminating about their feelings or trying to understand the reasons they feel the way they do, whereas men are more likely to distract themselves by doing something they enjoy, such as going to a favorite hangout to get their mind off their feelings. On the other hand, men often turn to alcohol as a form of self-medication, which can lead to another set of psychological and social problems (Nolen-Hoeksema et al., 1993). We shouldn’t think that rumination is limited to women, however (Treynor, Gonzalez, & Nolen-Hoeksema, 2003). Evidence shows that both men and women who ruminate more following the loss of loved ones or when feeling down or sad are more likely to become depressed and to suffer longer and more severe depression than those who ruminate less (Just & Alloy, 1997; Nolen-Hoeksema, 2000).

More research is needed to fully understand the gender gap in depression. Hopefully, research into factors such as hormonal influences, stress burdens, and ruminative styles will lead to the development of more specifically targeted interventions for treating depression in women. Likewise, by understanding men’s culturally instilled resistance to reporting depression, we can help destigmatize the disorder so that men suffering from depression will seek help rather than suffer in silence (Cochran & Rabinowitz, 2003).

Critical Thinking

• How might a theorist in the biopsychosocial tradition account for gender differences in depression?
• Give an example of how more knowledge about the causes of gender differences in depression can lead to improved treatment approaches.

The bleak light of winter casts some people into a diagnosable state of depression.

TRUE. The changing of the seasons does lead to a major depressive disorder in some people.
Postpartum depression is a form of major depression in which the onset of the depressive episode begins within 4 weeks after childbirth (APA, 2000). A major review article of studies on postpartum depression reported that 7.1% of women experienced an episode of major depression during the first 3 months postpartum (Gavin et al., 2005).

Postpartum depression typically is less severe than other forms of major depression and lifts relatively sooner than most (Whiffen & Gotlib, 1993). Yet some suicides are linked to postpartum depression. Factors associated with a heightened risk of PPD include stress, single or first-time motherhood, financial problems, a troubled marriage, social isolation, lack of support from partners and family members, a history of depression, or having an unwanted, sick, or temperamentally difficult infant (Forman et al., 2000; Ritter et al., 2000; Swendsen & Mazure, 2000). Having PPD also increases the risk that the woman will suffer future depressive episodes. Fortunately, there are effective treatments available, including different forms of psychotherapy and antidepressant drugs (e.g., Cooper et al., 2003; Murray et al., 2003; Stuart et al., 2003). Much less common than PPD are psychotic reactions following childbirth involving a loss of contact with reality. These reactions, labeled post-partum psychosis, usually involve manic episodes of bipolar disorder rather than schizophrenia or another form of psychotic disorder (Blackmore et al., 2006; Stotland, 2006).

Postpartum depression is not limited to our culture. A study in an urban area in Portugal reported a similar prevalence rate (13%) (Augusto et al., 1996). Researchers have found high rates of PPD among South African women (Cooper et al., 1999) and Chinese women from Hong Kong (D. T. S. Lee et al., 2001). In the South African sample, a lack of psychological and financial support from the baby’s father was associated with an increased risk of the disorder in this sample, mirroring findings with U.S. samples.

dysthymic disorder A mild but chronic type of depressive disorder.

Dysthymic Disorder

Major depressive disorder is severe and marked by a relatively abrupt change from one's preexisting state. A milder form of depression seems to follow a chronic course of development that often begins in childhood or adolescence (Klein, Keller et al., 2000; Klein, Schwartz et al., 2000). Earlier diagnostic formulations of this type of chronic sadness were labeled “depressive neurosis” or “depressive personality.” It was so labeled in an effort to account for several features traditionally identified with neurosis, such as early childhood origins, a chronic course, and generally mild levels of severity. The DSM classifies this form of depression dysthymic disorder, or dysthymia, which derives from Greek roots dys-, meaning “bad” or “hard” and thymos, meaning “spirit.”

Persons with dysthymic disorder do feel “bad spirited” or “down in the dumps” most of the time, but they are not so severely depressed as those with major depressive disorder. Whereas major depressive disorder tends to be severe and time limited, dysthymic disorder is relatively mild and nagging, typically lasting for years (Klein, Schwartz et al., 2000). Feelings of depression and social difficulties continue even after the person makes an apparent recovery (USDHHS, 1999a). The risk of relapse is quite high (Keller et al., 2000), as is the risk of major depressive disorder: 90% of people with dysthymia eventually develop major depression (Friedman, 2002).

Dysthymia affects about 4% of the general population at some point in their lifetimes (APA, 2000; Conway et al., 2006). Like major depressive disorder, dysthymic disorder is more common in women than men (see Figure 8.3).

In dysthymic disorder, complaints of depression may become such a fixture of people’s lives that they seem to be intertwined with the personality structure.

Long therapy. Exposure to bright artificial light for a few hours a day during the fall and winter months can often bring relief from seasonal affective disorder.
Women and depression.

Women are more likely to suffer from major depression than men. A panel convened by the American Psychological Association attributed the higher rates of depression among women to factors such as unhappy marriages, physical and sexual abuse, impoverishment, single parenthood, sexism, hormonal changes, childbirth, and excessive caregiving burdens. APA panel member Bonnie Strickland expressed surprise that even more women were not clinically depressed, because they are treated as second-class citizens.

Some people are affected by both dysthymic disorder and major depression at the same time. The term **double depression** applies to those who have a major depressive episode superimposed on a longer-standing dysthymic disorder. People suffering from double depression generally have more severe depressive episodes than do people with major depression alone (Klein, Schwartz et al., 2000).

We have noted that major depressive disorder and dysthymic disorder are depressive disorders in the sense that the disturbance of mood is only in one direction—down. Yet people with mood disorders may have fluctuations in mood in both directions that exceed the usual ups and downs of everyday life. These types of disorders are called bipolar disorders. Here we focus on the major types of mood-swing disorders: (1) bipolar disorder and (2) cyclothymic disorder.
Chapter 8

Bipolar Disorder

Kay Redfield Jamison, a psychologist and leading authority on the treatment of bipolar disorder, herself suffers from the disorder. Within 3 months of beginning her first professional appointment as an assistant professor in the Department of Psychiatry at UCLA, she became, in her own words, “ravingly psychotic.” Jamison has suffered from bipolar disorder since her teens but wasn’t diagnosed until she was 28 (Ballie, 2002).

An Unquiet Mind

In her 1995 memoir, An Unquiet Mind, Jamison described her early and milder episodes of mania as “absolutely intoxicating states that gave rise to great personal pleasure, an incomparable flow of thoughts, and a ceaseless energy that allowed the translation of new ideas into papers and projects” (p. 5). “But then . . . as night inevitably goes after the day, my mood would crash, and my mind again would grind to a halt. I lost all interest in my schoolwork, friends, reading, wandering, or daydreaming. I had no idea of what was happening to me, and I would wake up in the morning with a profound sense of dread that I was going to have to somehow make it through another entire day. I would sit for hour after hour in the undergraduate library, unable to muster up enough energy to go to class. I would stare out the window, stare at my books, rearrange them, shuffle them around, leave them unopened, and think about dropping out of college. . . . I understood very little of what was going on, and I felt as though only dying would release me from the overwhelming sense of inadequacy and blackness that surrounded me.

—From Jamison, 1995

People with bipolar disorder ride an emotional roller coaster, swinging from the heights of elation to the depths of depression without external cause. The first episode may be either manic or depressive. Manic episodes, typically lasting from a few weeks to several months, are generally shorter in duration and end more abruptly than major depressive episodes. Some people with recurring bipolar disorder attempt suicide “on the way down” from the manic phase (Baldessarini & Tondo, 2003). They report that they would do nearly anything to escape the depths of depression they know lie ahead.

The DSM distinguishes between two general types of bipolar disorder, bipolar I disorder and bipolar II disorder. The distinction can be confusing, so let us try to clarify. The distinction is made on the basis of whether the person has suffered a full-blown manic episode. For bipolar I disorder to be diagnosed, the person must have experienced at least one full manic episode at some point in life. For bipolar II disorder to be diagnosed, the person must have experienced one or more major depressive episodes and at least one hypomanic episode (a mild form of mania). But unlike bipolar I disorder, the person has never had a full-blown manic episode.

The question that remains to be determined is whether bipolar I and bipolar II disorders are actually two qualitatively different disorders or simply different points along a continuum of severity of bipolar disorder. We may very well see a clarification of the distinction between these two forms of bipolar disorder when the next edition of the DSM, the DSM-V is published.

Bipolar disorder is relatively uncommon, with reported lifetime prevalence rates of about 0.4% to 1.6% for bipolar I disorder and about 0.5% for bipolar II disorder (APA, 2000; Kupfer, 2005b; USDHHS, 1999a). Bipolar disorder typically develops around age 20 in both men and women and becomes a chronic, recurring condition requiring long-term treatment (Frank & Kupfer, 2003; Tohen, Zarate et al., 2003).
Unlike major depression, rates of bipolar I disorder appear about equal in men and women. In men, however, the onset of bipolar I disorder typically begins with a manic episode, whereas with women, it usually begins with a major depressive episode. The underlying reason for this gender difference remains unknown. Bipolar II disorder appears to be more common in women (APA, 2000).

In some cases, a pattern of “rapid cycling” occurs in which the individual experiences two or more full cycles of mania and depression within a year without any intervening normal periods. Rapid cycling is relatively uncommon, but occurs more often among women than men (Schneck et al., 2004). It is usually limited to a year or less, but is associated with a more severe form of the disorder and more serious suicide attempts (Coryell et al., 2003; Schneck et al., 2004).

Many observers have noted connections between mood disorders, especially bipolar disorder, and creativity (e.g., McDermott, 2001; Nettle, 2001). Many distinguished writers, artists, and composers seemed to have suffered from major depression or bipolar disorder. The list of luminaries who suffered from mood disorders stretches from artists Michelangelo and Vincent van Gogh, to composers William Schumann and Peter Tchaikovsky, to novelists Virginia Woolf and Ernest Hemingway, and to poets Alfred Lord Tennyson, Emily Dickinson, Walt Whitman, and Sylvia Plath. Perhaps some creative people are able to channel the seemingly boundless energy and rapid stream of thoughts associated with manic periods to enhance their productivity and ability to express themselves in novel ways. However, the great majority of writers and artists do not suffer from mood disorders, nor does creativity typically spring from psychological disturbance. Moreover, not all studies find links between psychological disorders and creativity, so it’s best to reserve judgment on the nature of the relationship (Bailey, 2003).

**Manic Episode**

Manic episodes, or periods of mania, typically begin abruptly, gathering force within days. During a manic episode, the person experiences a sudden elevation or expansion of mood and feels unusually cheerful, euphoric, or optimistic. The person seems to have boundless energy and is extremely sociable, although perhaps to the point of becoming overly demanding and overbearing toward others. Other people recognize the sudden shift in mood to be excessive in the light of the person’s circumstances. It is one thing to feel elated if one has just won the state lottery. It is another to feel euphoric because it’s Wednesday. Here, a young man with bipolar disorder describes what a manic episode is like for him (Behrman, 2002).

**Electroboy**

Manic depression is about buying a dozen bottles of Heinz ketchup and all eight bottles of Windex in stock at the Food Emporium on Broadway at 4 A.M., flying from Zurich to the Bahamas and back to Zurich in three days to balance the hot and cold weather (my “sweet and sour” theory of bipolar disorder), carrying $20,000 in $100 bills in your shoes into the country on your way back to Tokyo, and picking out the person sitting six seats away at the bar to have sex with only because he or she happens to be sitting there. It’s about blips and burps of madness, moments of absolute delusion, bliss, and irrational and dangerous choices made in order to heighten pleasure and excitement and to ensure a sense of control. The symptoms of manic depression come in different strengths and sizes. Most days I need to be as manic as possible to come as close as I can to destruction, to get a real good high—a $25,000 shopping spree, a four-day drug binge, or a trip around the world. Other days a simple high from a shoplifting excursion at Duane Reade for a toothbrush or a bottle of Tylenol is enough. I’ll admit it: There’s a great deal of pleasure to mental illness, especially to the mania associated with manic depression. It’s an emotional state similar to Oz, full of excitement, color, noise, and speed—an overload of sensory stimulation—whereas the same state of Kansas is plain and simple, black and white, boring and flat. Mania has such a dreamlike quality that often I confuse my manic episodes with dreams I’ve had. . . .

Mania is about desperately seeking to live life at a more passionate level, taking second and sometimes third helpings on food, alcohol, drugs, sex, and money, trying to live a whole life in one day. Pure mania is as close to death as I think I have ever come. The euphoria is both
pleasurable and frightening. My manic mind teems with rapidly changing ideas and needs; my head is cluttered with vibrant colors, bizarre thoughts, sharp details, secret codes, symbols, and foreign languages. I want to devour everything—parties, people, magazines, books, music, art, movies, and television.

—From Electroboy by Andy Behrman

People in a manic episode tend to show poor judgment and to become argumentative, sometimes going so far as destroying property. Roommates may find them abrasive and avoid them. They may become extremely generous and make large charitable contributions they can ill afford or give away costly possessions.

People in a manic episode tend to speak very rapidly (with pressured speech). Their thoughts and speech may jump from topic to topic in a rapid flight of ideas. Others find it difficult to get a word in edgewise. They typically experience an inflated sense of self-esteem that may range from extreme self-confidence to wholesale delusions of grandeur (Schulze et al., 2005). They may feel capable of solving the world’s problems or of composing symphonies, despite a lack of any special knowledge or talent. They may spout off about matters on which they know little, such as how to eliminate world hunger or create a new world order. It soon becomes clear that they are disorganized and incapable of completing their projects. They also become highly distractible. Their attention is easily diverted by irrelevant stimuli like the sounds of a ticking clock or people talking in the next room. They tend to take on multiple tasks, more than they can handle. They may suddenly quit their jobs to enroll in law school, wait tables at night, organize charity drives on weekends, and work on the great American novel in their “spare time.” They may not be able to sit still or sleep restfully. They almost always show decreased need for sleep. They tend to awaken early yet feel well rested and full of energy. They sometimes go for days without sleep and without feeling tired. Although they may have abundant stores of energy, they seem unable to organize their efforts constructively. Their elation impairs their ability to work and to maintain normal relationships.

People in manic episodes tend to exercise poor judgment and fail to weigh the consequences of their actions. They may get into trouble as a result of lavish spending, reckless driving, or sexual escapades. In severe cases, they may experience hallucinations or become grossly delusional, believing, for example, that they have a special relationship with God.

Cyclothymic Disorder

Cyclothymia is derived from the Greek kyklos, which means “circle,” and thymos, meaning “spirit.” The notion of a circular-moving spirit is an apt description, because this disorder represents a chronic cyclical pattern of mood disturbance characterized by mild mood swings lasting at least 2 years (1 year for children and adolescents). Cyclothymic disorder usually begins in late adolescence or early adulthood and persists for years. Few, if any, periods of normal mood last for more than a month or two. However, neither the periods of elevated or depressed mood are severe enough to warrant a diagnosis of bipolar disorder. Estimates from community studies indicate lifetime prevalence rates for cyclothymic disorder of between 0.4% to 1% (4 to 10 people in 1,000), with men and women about equally likely to be affected (APA, 2000).

The periods of elevated mood are called hypomanic episodes (from the Greek prefix hypo-, meaning “under” or “less than”). They are less severe than manic episodes and are not accompanied by the severe social or occupational problems associated with full-blown manic episodes. During hypomanic episodes, people may have an inflated sense of self-esteem, may feel unusually charged with energy, and may be more alert, restless, and irritable than usual. They may be able to work long hours with little fatigue or need for sleep. Their projects may be left unfinished when their moods reverse, however. Then they enter a mildly depressed mood state and feel lethargic and depressed, but not to the extent typical of a major depressive episode. Social relationships
may become strained by shifting moods, and work may suffer. Sexual interest waxes and wanes with the person’s moods.

The boundaries between bipolar disorder and cyclothyemic disorder are not yet clearly established. Some forms of cyclothyemic disorder may represent a mild, early type of bipolar disorder. Approximately 33% of people with cyclothyemic disorder eventually develop bipolar disorder, a figure that is about 33 times higher than the general population (USDHHS, 1999a). We presently lack the ability to distinguish persons with cyclothymia who are likely to develop bipolar disorder. The following case presents an example of the mild mood swings that typify cyclothyemic disorder.

### “Good Times and Bad Times”: A Case of Cyclothyemic Disorder

The man, a 29-year-old car salesman, reports that since the age of 14 he has experienced alternating periods of “good times and bad times.” During his “bad” periods, which generally last between 4 and 7 days, he sleeps excessively and feels a lack of confidence, energy, and motivation, as if he were “just vegetating.” Then his moods abruptly shift for a period of three or four days, usually upon awakening in the morning, and he feels aflush with confidence and sharpened mental abilify. During these “good periods” he engages in promiscuous sex and uses alcohol, in part to enhance his good feelings and in part to help him sleep at night. The good periods may last upwards of 7 to 10 days at times, before shifting back into the “bad” periods, generally following a hostile or irritable outburst.

—Adapted from Spitzer et al., 1994, pp. 155–157

### CAUSAL FACTORS IN DEPRESSIVE DISORDERS

Mood disorders are best understood in terms of complex interactions of biological and psychosocial influences (Kendler, Gardner, & Prescott, 2002; NIMH, 2003). Although a full understanding of the causes of mood disorders presently lies beyond our grasp, we have begun to identify many of the important contributors to mood disorders, especially depression. In the next sections, we examine contemporary understandings of the causal factors in both depressive disorders and bipolar disorders. Many factors are implicated in the development of these disorders, including stressful life events as well as psychological and biological factors.

#### Stress and Depression

Stress plays an important role in determining vulnerability in bipolar disorder and even more strongly in major depression. Sources of stress may include the loss of a loved one, the breakup of a romantic relationship, prolonged unemployment, physical illness, marital or relationship problems,economic hardship, pressure at work, exposure to racism and discrimination, or living in an unsafe, distressed neighborhood (Cutrona, Wallace, & Wesner, 2006; Drieling, Calker, & Hecht, 2006; Kendler et al., 2004). For reasons that remain to be studied further, major stressful events in life are more strongly connected to the initial onset of major depression than to subsequent episodes (Monroe et al., 2007). People are also more likely to become depressed when they experience humiliating events involving key life roles (as parents, for example) and when they hold themselves responsible for undesirable events, such as school problems, financial difficulties, unwanted pregnancy, interpersonal problems, and legal problems (e.g., Kendler, Hettema et al., 2003).

Yet the relationship between stress and depression may cut both ways: Stressful life events may contribute to depression, and depressive symptoms in themselves may be stressful or lead to additional sources of stress, such as divorce or loss of employment.
“Gotta have friends.” Social support from friends and family members appears to buffer the effects of stress and may reduce the risk of depression. People who lack important relationships and who rarely join in social activities are more likely to suffer from depression.

When you’re depressed, for example, you may find it more difficult to keep up with work, which can lead to more stress as your work backs up. The stress of unemployment and financial hardship may lead to depression, but depression may also lead to unemployment and lower income (Whooley et al., 2002). Stressful events, especially severe negative events, may also trigger depressive episodes in bipolar patients (Johnson, 2005). However, many depressive episodes in bipolar patients appear unrelated to negative life events.

Although stress is often implicated in depression, not everyone who encounters stress becomes depressed. Factors such as coping skills, genetic endowment, and availability of social support may all contribute to the likelihood of depression in the face of stressful events (USDHHS, 1999a). Increased vulnerability to depression is associated with adverse experiences in early life, including parental divorce and physical abuse (Wainwright & Surtees, 2002). Consistent with the diathesis-stress model (see Chapter 2), researchers find that young women are more likely to develop depression in the face of stressful life events if they possessed a diathesis in the form of exposure to childhood adversities such as family violence or having parents with a psychological disorder or alcoholism (Hammen, Henry, & Daley, 2000). Moreover, physical or sexual abuse in childhood can disrupt the development of early attachment bonds to parents, setting the stage for later relationship problems and emotional disorders involving depression and anxiety (USDHHS, 1999a).

A strong marital relationship may provide a source of support during times of stress. Not surprisingly, people who are divorced or separated have higher rates of depression and suicide attempts than those who are married (Weissman et al., 1991). People with major depression often lack skills needed to solve interpersonal problems they have with friends, coworkers, or supervisors (Marx, Williams, & Claridge, 1992). But those who take an active approach to solving their interpersonal problems tend to have better clinical outcomes than depressed people who assume a passive style of coping (Sherbourne, Hays, & Wells, 1995).

Psychodynamic Theories

The classic psychodynamic theory of depression of Freud (1917/1957) and his followers (e.g., Abraham, 1916/1948) holds that depression represents anger directed inward rather than against significant others. Anger may become directed against the self following either the actual or threatened loss of these important others.

Freud believed that mourning, or normal bereavement, is a healthy process by which one eventually comes to separate oneself psychologically from a person who is lost through death, separation, divorce, or other reason. Pathological mourning, however, does not promote healthy separation. Rather, it fosters lingering depression. Pathological mourning is likely to occur in people who hold powerful ambivalent feelings—a combination of positive (love) and negative (anger, hostility) feelings—toward the person who has departed or whose departure is feared. Freud theorized that when people lose, or even fear losing, an important figure about whom they feel ambivalent, their feelings of anger turn to rage. Yet rage triggers guilt, which in turn prevents the person from venting anger directly at the lost person (called an “object”).

To preserve a psychological connection to the lost object, people introject, or bring inward, a mental representation of the object. They thus incorporate the other person into the self. Now anger is turned inward, against the part of the self that represents the inward representation of the lost person. This produces self-hatred, which in turn leads to depression.

From the psychodynamic viewpoint, bipolar disorder represents shifting dominance of the individual’s personality between the ego and superego. In the depressive phase, the superego is dominant, producing exaggerated notions of wrongdoing and flooding the individual with feelings of guilt and worthlessness. After a time, the ego rebounds and asserts supremacy, producing feelings of elation and self-confidence that characterize the manic phase. The excessive display of ego eventually triggers a return of guilt, once again plunging the individual into depression.
While also emphasizing the importance of loss, more recent psychodynamic models shift the focus toward the individual’s sense of self-worth or self-esteem. One model, called the self-focusing model, considers how people allocate their attentional processes after a loss, such as the death of a loved one or a personal failure or significant disappointment (Pyszczynski & Greenberg, 1987). In this view, depressed people have difficulty thinking about anything other than themselves and the loss they experienced.

Consider a person who must cope with the termination of a failed romantic relationship. The depression-prone individual gets wrapped up in thinking about the relationship and hopes of restoring it, rather than recognizing the futility of the effort and getting on with life. Moreover, the lost partner was a source of emotional support on whom the depression-prone individual had relied to maintain self-esteem. Following the loss, the depression-prone individual feels stripped of hope and optimism because these positive feelings had depended on the lost object. The loss of self-esteem and of feelings of security, not of the relationship per se, precipitates depression. Similarly, loss of a specific occupational goal may trigger self-focusing and consequent depression. Only by surrendering the object or lost goal and fostering alternate sources of identity and self-worth can the cycle be broken.

**Research Evidence** Psychodynamic theorists focus on the role of loss in depression. Research does show that loss of significant others (through death or divorce, for example) is often associated with the development of depression (Kendler et al., 2002; Kendler, Hettema et al., 2003). Such a loss may also lead to other psychological disorders, however. There is yet a lack of research to support Freud’s view that repressed anger toward the departed loved one is turned inward in depression.

Evidence supports the view that a self-focusing style—an inward or self-absorbed focus of attention—is associated with depression, especially in women (Mor & Winquist, 2002; Muraven, 2005). Yet self-focused attention is not limited to depression; it is also linked to other disorders, including anxiety disorders, alcoholism, mania, and schizophrenia (Ingram, 1991). Thus, the general linkage between self-focused attention and psychopathology may limit the model’s value as an explanation of depression.

**Humanistic Theories**

From the humanistic framework, people become depressed when they cannot imbue their existence with meaning and make authentic choices that lead to self-fulfillment. The world is then a drab place. People’s search for meaning gives color and substance to their lives. Guilt may arise when people believe they have not lived up to their potential. Humanistic psychologists challenge us to take a long hard look at our lives. Are they worthwhile and enriching? Or are they drab and routine? If the latter, perhaps we have frustrated our needs for self-actualization. We may be settling, coasting through life. Settling can give rise to a sense of dreariness that becomes expressed in depressive behavior—lathargy, sullen mood, and withdrawal.

Like psychodynamic theorists, humanistic theorists focus on the loss of self-esteem that can arise when people lose friends or family members or suffer occupational setbacks. We tend to connect our personal identity and sense of self-worth with our social roles as parents, spouses, students, or workers. When these role identities are lost, through the death of a spouse, the departure of children to college, or loss of a job, our sense of purpose and self-worth can be shattered. Depression is a frequent consequence of such losses. It is especially likely when we base our self-esteem on our occupational role or success. The loss of a job, a demotion, or a failure to achieve a promotion are common precipitants of depression, especially for individuals who value themselves on the basis of occupational success.

**Learning Theories**

Whereas the psychodynamic perspectives focus on inner, often unconscious, causes, learning theorists emphasize situational factors, such as the loss of positive reinforcement. We perform best when levels of reinforcement are commensurate with our efforts.
Recent evidence suggests that regular physical activity or exercise may be helpful in combating depression, especially in people facing significant life stressors.

The Role of Reinforcement Learning theorist Peter Lewinsohn (1974) proposed that depression results from an imbalance between behavior and reinforcement. A lack of reinforcement for one's efforts can sap motivation and induce feelings of depression. Inactivity and social withdrawal reduce opportunities for reinforcement; lack of reinforcement exacerbates withdrawal.

The low rate of activity typical of depressed individuals may also be a source of secondary reinforcement. Family members and other people may rally around people suffering from depression and release them from their responsibilities. Sympathy may thus become a source of reinforcement that helps maintain depressed behavior.

Changes in life circumstances may also alter the balance of effort and reinforcement. A prolonged layoff may reduce financial reinforcement, which may in turn force painful cutbacks in lifestyle. A disability or an extended illness may also impair one's ability to ensure a steady flow of reinforcements. Lewinsohn's model is supported by research findings that connect depression to a low level of positive reinforcement, and importantly, to evidence that encouraging depressed patients to participate in rewarding activities and goal-oriented behaviors can help alleviate depression (Otto, 2006).

Encouraging depressed patients to engage in regular physical activity or regular exercise may also have direct benefits in combating depression, especially in the face of major life stressors (Harris, Cronkite, & Moos, 2006).

Interactional Theory Difficulties in social interactions may help explain the lack of positive reinforcement. Interactional theory, developed by psychologist James Coyne (1976), proposes that the adjustment to living with a depressed person can become so stressful that the partner or family member becomes progressively less reinforcing.

Interactional theory is based on the concept of reciprocal interaction. People's behavior influences and, in turn, is influenced by the behavior of others. The theory holds that depression-prone people react to stress by demanding greater reassurance and social support from significant others. At first people who become depressed may succeed in garnering support. Over time, however, their demands and behavior begin to elicit anger or annoyance. Although loved ones may keep their negative feelings to themselves, these feelings may surface in subtle ways that spell rejection. Depressed people may react to rejection with deeper depression and greater demands, triggering a vicious cycle of further rejection and more profound depression. They may also feel guilty about distressing their family members, which can exacerbate their negative feelings about themselves.

Family members may find it stressful to adjust to the depressed person's behavior, especially withdrawal, lethargy, despair, and constant requests for reassurance. People whose spouses are being treated for depression tend to report higher-than-average levels of emotional distress (Benazon, 2000). Research evidence generally supports Coyne's belief that people who suffer from depression elicit rejection from others. But investigators suspect that a lack of social skills may best explain this rejection (Segrin & Abramson, 1994). Depressed people tend to be unresponsive, uninvolved, and even impolite when they interact with others. For example, they tend to gaze very little at the other person, to take an excessive amount of time to respond, to show very little approval or validation of the other person, and to dwell on their problems and negative feelings. They even dwell on negative feelings when interacting with strangers. In effect, they turn other people off, setting the stage for rejection.
Cognitive Theories

Cognitive theorists relate the origin and maintenance of depression to the ways in which people see themselves and the world around them. One of the most influential cognitive theorists, psychiatrist Aaron Beck (Beck, 1976; Beck et al., 1979), relates the development of depression to the adoption early in life of a negatively biased or distorted way of thinking—the **cognitive triad of depression** (see Table 8.4). The cognitive triad includes negative beliefs about oneself (“I’m no good”), the environment or the world at large (“This school is awful”), and the future (“Nothing will ever turn out right for me”). Cognitive theory holds that people who adopt this negative way of thinking are at greater risk of becoming depressed in the face of stressful or disappointing life experiences, such as getting a poor grade or losing a job.

Beck views these negative concepts of the self and the world as mental templates that are adopted in childhood on the basis of early learning experiences. Children may find that nothing they do is good enough to please their parents or teachers. As a result, they come to regard themselves as basically incompetent and to perceive their future prospects as dim. These beliefs may sensitize them later in life to interpret any failure or disappointment as a reflection of something basically wrong or inadequate about themselves. Even a minor disappointment becomes a crushing blow or a total defeat that can quickly lead to states of depression.

The tendency to magnify the importance of minor failures is an example of an error in thinking that Beck labels a **cognitive distortion**. He believes cognitive distortions set the stage for depression in the face of personal losses or negative life events. Psychiatrist David Burns (1980) enumerated a number of the cognitive distortions associated with depression:

1. **All-or-nothing thinking.** Seeing events as either all good or all bad, or as either black or white with no shades of gray. For example, one may perceive a relationship that ended in disappointment as a totally negative experience, despite any positive feelings or experiences that may have occurred along the way. Perfectionism is an example of all-or-nothing thinking. Perfectionists judge any outcome other than perfect success to be complete failure. They may consider a grade of B or even A- to be tantamount to an F. Perfectionism is connected with an increased vulnerability to depression as well as to poor treatment outcomes (Blatt et al., 1998; Minarik & Ahrens, 1996).

2. **Overgeneralization.** Believing that if a negative event occurs, it is likely to occur again in similar situations in the future. One may interpret a single negative event as foreshadowing an endless series of negative events. For example, receiving a letter of rejection from a potential employer leads one to assume that all other job applications will be similarly rejected.

### TABLE 8.4

<table>
<thead>
<tr>
<th>Negative View of Oneself</th>
<th>Perceiving oneself as worthless, deficient, inadequate, unlovable, and as lacking the skills necessary to achieve happiness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative View of the Environment</td>
<td>Perceiving the environment as imposing excessive demands and/or presenting obstacles that are impossible to overcome, leading continually to failure and loss.</td>
</tr>
<tr>
<td>Negative View of the Future</td>
<td>Perceiving the future as hopeless and believing that one is powerless to change things for the better. One expects of the future only continuing failure and unrelenting misery and hardship.</td>
</tr>
</tbody>
</table>

*Note: According to Aaron Beck, depression-prone people adopt a habitual style of negative thinking—the so-called cognitive triad of depression.*

*Source: Adapted from Beck & Young, 1985; Beck et al., 1979.*
3. **Mental filter.** Focusing only on negative details of events, thereby rejecting the positive features of one’s experiences. Like a droplet of ink that spreads to discolor an entire beaker of water, focusing only on a single negative detail can darken one’s vision of reality. Beck called this cognitive distortion *selective abstraction*, meaning the individual selectively abstracts the negative details from events and ignores the events’ positive features. One thus bases one’s self-esteem on perceived weaknesses and failures, rather than on positive features or on a balance of accomplishments and shortcomings. For example, a person receives a job evaluation that contains both positive and negative comments but focuses only on the negative ones.

4. **Disqualifying the positive.** This refers to the tendency to snatch defeat from the jaws of victory by neutralizing or denying one’s accomplishments. An example is dismissal of congratulations for a job well done by thinking and saying, “Oh, it’s no big deal. Anyone could have done it.” By contrast, taking credit where credit is due may help people overcome depression by increasing their belief that they can make changes that will lead to a positive future (Needles & Abramson, 1990).

5. **Jumping to conclusions.** Forming a negative interpretation of events, despite a lack of evidence. Two examples of this style of thinking are “mind reading” and “the fortune teller error.” In *mind reading*, a person arbitrarily jumps to the conclusion that others don’t like or respect him or her, as in interpreting a friend’s not calling for a while as a rejection. The *fortune teller error* is the prediction that something bad is always about to happen. The person believes the prediction of calamity is factually based, even though there is no evidence to support it. For example, the person concludes that a passing tightness in the chest *must* be a sign of heart disease, discounting the possibility of more benign causes.

6. **Magnification and minimization.** Magnification, or *catastrophizing*, refers to the tendency to make mountains out of molehills—to exaggerate the importance of negative events, personal flaws, fears, or mistakes. Minimization is the mirror image, a type of cognitive distortion in which one minimizes or underestimates one’s good points.

7. **Emotional reasoning.** Basing reasoning on emotions—for example, thinking, “If I feel guilty, it must be because I’ve done something really wrong.” One interprets feelings and events based on emotions rather than on fair consideration of evidence.

8. **“Should” statements.** Creating personal imperatives or self-commandments—“shoulds” or “musts.” For example, “I should always get my first serve in!” or “I must make Chris like me!” By creating unrealistic expectations, *musterbation*—the label given this form of thinking by Albert Ellis—can lead one to become depressed when one falls short.

9. **Labeling and mislabeling.** Explaining behavior by attaching negative labels to oneself and others. You may explain a poor grade on a test by thinking you were “lazy” or “stupid” rather than simply unprepared for the specific exam or, perhaps, ill. Labeling other people as “stupid” or “insensitive” can engender hostility toward them. Mislabeling involves the use of labels that are emotionally charged and inaccurate, such as calling yourself a “pig” because of a minor deviation from your usual diet.

10. **Personalization.** Assuming that one is responsible for other people’s problems and behavior. For example, an individual may feel blame if his or her partner or spouse is crying, rather than recognizing that other causes may be involved.

Consider the errors in thinking illustrated in the following case example.

Distorted thinking tends to be experienced as automatic, as if the thoughts had just popped into one’s head. Automatic
Christie’s Errors in Thinking

Christie was a 33-year-old real estate sales agent who suffered from frequent episodes of depression. Whenever a deal fell through, she would blame herself: “If only I had worked harder . . . negotiated better . . . talked more persuasively . . . the deal would have been done.” After several successive disappointments, each one followed by self-recriminations, she felt like quitting altogether. Her thinking became increasingly dominated by negative thoughts, which further depressed her mood and lowered her self-esteem: “I’m a loser. . . . I’ll never succeed. . . . It’s all my fault. . . . I’m no good and I’m never going to succeed at anything.”

Christie’s thinking included cognitive errors such as the following: (1) personalization (believing herself to be the sole cause of negative events); (2) labeling and mislabeling (labeling herself to be a loser); (3) overgeneralization (predicting a dismal future on the basis of a present disappointment); and (4) mental filter (judging her personality entirely on the basis of her disappointments). In therapy, Christie learned to think more realistically about events and not to jump to conclusions that she was automatically at fault whenever a deal fell through, or to judge her whole personality on the basis of disappointments or perceived flaws in herself. In place of this self-defeating style of thinking, she began to think more realistically when disappointments occurred, like telling herself, “Okay, I’m disappointed. I’m frustrated. I feel lousy. So what? It doesn’t mean I’ll never succeed. Let me discover what went wrong and try to correct it the next time. I have to look ahead, not dwell on disappointments in the past.”

—From the Author’s Files

thoughts are likely to be accepted as statements of fact rather than as opinions or habitual ways of interpreting events.

Beck and his colleagues formulated a cognitive-specificity hypothesis, which proposes that different disorders are characterized by different types of automatic thoughts. Beck and his colleagues showed some interesting differences in the types of automatic thoughts people with depressive and anxiety disorders reported (Beck et al., 1987) (see Table 8.5).

cognitive-specificity hypothesis
The belief that different emotional disorders are linked to particular kinds of automatic thoughts.

### Table 8.5

<table>
<thead>
<tr>
<th>Common Automatic Thoughts Associated with Depression</th>
<th>Common Automatic Thoughts Associated with Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I’m worthless.</td>
<td>1. What if I get sick and become an invalid?</td>
</tr>
<tr>
<td>2. I’m not worthy of other people’s attention or affection.</td>
<td>2. I am going to be injured.</td>
</tr>
<tr>
<td>3. I’ll never be as good as other people are.</td>
<td>3. What if no one reaches me in time to help?</td>
</tr>
<tr>
<td>4. I’m a social failure.</td>
<td>4. I might be trapped.</td>
</tr>
<tr>
<td>5. I don’t deserve to be loved.</td>
<td>5. I am not a healthy person.</td>
</tr>
<tr>
<td>6. People don’t respect me anymore.</td>
<td>6. I’m going to have an accident.</td>
</tr>
<tr>
<td>7. I will never overcome my problems.</td>
<td>7. Something will happen that will ruin my appearance.</td>
</tr>
<tr>
<td>8. I’ve lost the only friends I’ve had.</td>
<td>8. I am going to have a heart attack.</td>
</tr>
<tr>
<td>9. Life isn’t worth living.</td>
<td>9. Something awful is going to happen.</td>
</tr>
<tr>
<td>10. I’m worse off than they are.</td>
<td>10. Something will happen to someone I care about.</td>
</tr>
<tr>
<td>11. There’s no one left to help me.</td>
<td>11. I’m losing my mind.</td>
</tr>
<tr>
<td>12. No one cares whether I live or die.</td>
<td></td>
</tr>
<tr>
<td>13. Nothing ever works out for me anymore.</td>
<td></td>
</tr>
<tr>
<td>14. I have become physically unattractive.</td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Beck et al., 1987.
People with diagnosable depression more often reported automatic thoughts concerning themes of loss, self-deprecation, and pessimism. People with anxiety disorders more often reported automatic thoughts concerning physical danger and other threats.

**Research Evidence on Cognitions and Depression** Evidence that depressed people show higher levels of distorted or dysfunctional thinking than nondepressed controls supports Beck’s model (e.g., Clark, Cook, & Snow, 1998; Riso et al., 2003). Yet more recent evidence links cognitive errors and depression among African American, Caucasian, and Hispanic adolescents (Kennard et al., 2006). We also find that dysfunctional attitudes (above a certain threshold) increase vulnerability to depression in the face of negative life events (Lewinsohn, Joiner, & Rohde, 2001). Lending support to the cognitive-specificity hypothesis, investigators also find that thoughts relating to loss or personal failure were strongest predictors of depressive symptoms among a sample of children and adolescents, whereas thoughts relating to social threat were strongest predictors of anxiety symptoms (Schniering & Rapee, 2004).

Although dysfunctional cognitions (negative, distorted, or pessimistic thoughts) are more common among people who are depressed, the causal pathways remain unclear. We can’t yet say whether dysfunctional or negative thinking causes depression or is merely a feature of depression. Thus the central theme of cognitive theory, that negative, distorted thoughts are causally related to depression, is yet to be confirmed (e.g., Oei, Bulbeck, & Campbell, 2006).

The causal linkages may work both ways. In other words, thoughts may affect moods, and moods may affect thoughts. For example, depressed mood may induce negative, distorted thinking. The more negative and distorted depressed individuals’ thinking becomes, the more depressed they may feel, and the more depressed they feel, the more dysfunctional their thinking becomes. However, it is equally possible that dysfunctional thinking comes first in the cycle, perhaps in response to a disappointing life experience, which then leads to a downcast mood. This in turn may accentuate negative thinking, and so on. We are still faced with the old “chicken or the egg” dilemma of determining which comes first in the causal sequence, distorted thinking or depressed mood. Future research may help tease out these causal pathways. Even if it becomes clear that distorted cognitions play no direct role in causing depression, the mutual interaction between thoughts and moods may contribute to the maintenance of depressive episodes and increase the likelihood of their recurrence (Kwon & Oei, 1994). We know, for example, that people who recover from depression but continue to hold distorted cognitions tend to be at greater risk of relapse (Rush & Weissenburger, 1994). Fortunately, evidence shows that dysfunctional attitudes tend to decrease with effective treatment for depression (Fava et al., 1994).

**Learned Helplessness (Attributional) Theory**

The learned helplessness model proposes that people may become depressed because they learn to view themselves as helpless to change their lives for the better. The originator of the learned helplessness concept, Martin Seligman (1973, 1975), suggests that people learn to perceive themselves as helpless because of their experiences. The learned helplessness model therefore straddles the behavioral and the cognitive: Situational factors foster attitudes that lead to depression.

Seligman and his colleagues based the learned helplessness model on early laboratory studies of animals. In these studies, dogs exposed to an inescapable electric shock showed the “learned helplessness effect” by failing to learn to escape when escape became possible (Overmier & Seligman, 1967; Seligman & Maier, 1967). Exposure to uncontrollable forces apparently taught the animals they were helpless to change their situation. Animals who developed learned helplessness showed behaviors that were similar to those of people with depression, including lethargy, lack of motivation, and difficulty acquiring new skills (Maier & Seligman, 1976).
Seligman (1975, 1991) proposed that some forms of depression in humans might result from exposure to apparently uncontrollable situations. Such experiences can instill the expectation that future reinforcements will also be beyond the individual’s control. A cruel vicious cycle may come into play in many cases of depression. A few failures may produce feelings of helplessness and expectations of further failure. Perhaps you know people who have failed certain subjects, such as mathematics. They may come to believe themselves incapable of succeeding in math. They may thus decide that studying for the quantitative section of the Graduate Record Exam is a waste of time. They then perform poorly, completing the self-fulfilling prophecy, which further intensifies feelings of helplessness, leading to lowered expectations, and so on, in a vicious cycle.

Although it stimulated much interest, Seligman’s model failed to account for the low self-esteem typical of people who are depressed. Nor did it explain why depression persists in some people but not in others. Seligman and his colleagues (Abramson, Seligman, & Teasdale, 1978) offered a reformulation of the theory to meet such shortcomings. The revised theory held that perception of lack of control over reinforcement alone did not explain the persistence and severity of depression. It was also necessary to consider cognitive factors, especially the ways in which people explain their failures and disappointments to themselves.

Seligman and his colleagues recast helplessness theory in terms of the social psychology concept of attributional style. An attributional style is a personal style of explanation. When disappointments or failures occur, we may explain them in various characteristic ways. We may blame ourselves (an internal attribution), or we may blame the circumstances we face (an external attribution). We may see bad experiences as typical events (a stable attribution) or as isolated events (an unstable attribution). We may see them as evidence of broader problems (a global attribution) or as evidence of precise and limited shortcomings (a specific attribution). The reformulated helplessness theory holds that people who explain the causes of negative events (such as failure in work, school, or romantic relationships) according to the following three types of attributions are most vulnerable to depression:

1. Internal factors, or beliefs that failures reflect their personal inadequacies, rather than external factors, or beliefs that failures are caused by environmental factors
2. Global factors, or beliefs that failures reflect sweeping flaws in personality rather than specific factors, or beliefs that failures reflect limited areas of functioning
3. Stable factors, or beliefs that failures reflect fixed personality factors rather than unstable factors, or beliefs that the factors leading to failures are changeable

Let us illustrate these attributional styles with the example of a college student who goes on a disastrous date. Afterward he shakes his head in wonder and tries to make sense of his experience. An internal attribution for the calamity is characterized by self-blame, as in “I really messed it up.” An external attribution would place the blame elsewhere, as in “Some couples just don’t hit it off,” or “She must have been in a bad mood.” A stable attribution would suggest a problem that cannot be changed, as in “It’s my personality.” An unstable attribution, on the other hand, would suggest a transient condition, as in “It was probably the head cold.” A global attribution for failure magnifies the extent of the problem, as in “I really have no idea what I’m doing when I’m with people.” A specific attribution, in contrast, chops the problem down to size, as in “My problem is how to make small talk to get a relationship going.”

The revised theory holds that each attributional dimension makes a specific contribution to feelings of helplessness. Internal attributions for negative events are linked to lower self-esteem. Stable attributions help explain the persistence—or, in medical terms, the chronicity—of helplessness cognitions. Global attributions are associated with the generality or pervasiveness of feelings of helplessness following negative events. Attributional style should be distinguished from negative thinking (Gotlib et al., 1993). Whether you think negatively (pessimistically) or positively (optimistically), you may still hold yourself to blame for your perceived failures.
Depressed people are more likely than nondepressed people to have a negative attributional style (attributing negative life events to internal, stable, and global factors) (Riso et al., 2003; Seligman et al., 1988). Further support for the model comes from findings that negative attributional styles and dysfunctional attitudes predict higher lifetime rates of major depression (Alloy et al., 2000). However, attributional style may have a stronger relationship to depression in people who tend to think more about the causes of events (Haaga, 1995).

**Biological Factors**

Biological factors, especially genetics and neurotransmitter functioning, play important roles in depressive disorders.

**Genetic Factors** Genetic factors play a significant role in determining proneness to mood disorders, including major depression and bipolar disorder (Holmans et al., 2007; Levinson et al., 2007; McGuffin et al., 2003). Let us look more closely at the evidence for genetic factors in major depression. Not only does major depression tend to run in families, but the closer the genetic relationship people share, the more likely they are to share a depressive disorder (e.g., Klein et al., 2001). Yet families share environmental as well as genetic similarities. To better tease out the effects of genetic factors, investigators have turned to studies of twins. They examine the relative percentages of cases in which MZ or identical twins share a common trait or disorder, as compared to DZ or fraternal twins. The percentage of cases in which the twin of a person who is identified as having a given trait or disorder also has the trait or disorder is called the concordance (agreement) rate. Because MZ twins have 100% of these in common, as compared to 50% among DZ twins, evidence of a higher concordance rate among MZ twins provides strong support for a genetic contribution. Evidence shows more than double the concordance rate for major depression among MZ twins than DZ twins (Kendler et al., 1992b, 1993). This provides strong support for a genetic component, but is short of the 100% concordance we would expect if genetics were solely responsible for these disorders. Although heredity appears to play an important role in major depression, it isn’t the only determinant, nor is it necessarily the most important one. Environmental factors, such as exposure to stressful life events, appear to play at least as great a role—if not a greater role—than genetics (Kendler & Prescott, 1999).

An emerging model in the field focuses on interactions of genetic and environmental factors in the development of major depression and other mood disorders (Jokela et al., 2007). For example, investigators recently discovered that people who inherit a variation of a particular gene stand more than double the chance of developing major depression following stressful life events than those who have another version of the gene (Caspi et al., 2003; NIMH, 2003). The gene regulates production of a protein that plays a key role in transmission of serotonin, the neurotransmitter targeted by antidepressants such as Prozac and Zoloft. More work examining the relationship between genetics and depression is needed.

**Biochemical Factors and Brain Abnormalities** Research on the biological underpinnings of mood disorders has largely focused on abnormalities in neurotransmitter activity in the brain. Early research more than 50 years ago showed that drugs we now call antidepressants, which increase levels in the brain of the neurotransmitters norepinephrine and serotonin, often helped relieve depression (Berton & Nestler, 2006; Mann, 2005). Might depression be caused simply by a lack of key neurotransmitters in the brain? Investigators discount this view, in part because antidepressants boost levels of neurotransmitters in the brain within a few days or even hours of use, but it usually takes a week or more before a therapeutic benefit is achieved (Jacobs, 2004; Taylor et al., 2006). Therefore, it is unlikely that these drugs work by simply boosting levels of neurotransmitters in the brain.

We are still learning more about how antidepressants work. More complex views of the role of neurotransmitters are evolving (Andreasen, 2003). Several intriguing possibilities drawing attention among scientists involve irregularities in the numbers of...
receptors on receiving neurons where neurotransmitters dock (having either too many or too few), abnormalities in the sensitivity of receptors to particular neurotransmitters, or irregularities in the process by which these chemicals bind to receptors (Oquendo et al., 2007; Sharp, 2006). Perhaps, then, antidepressants work by altering the number of these receptors or their sensitivity to these chemical messengers, a process that takes time to occur. Complicating matters further, we need to recognize that several different types of receptors exist for each neurotransmitter along with different subtypes for each type. The actions of particular antidepressants may be specific to certain types or subtypes of receptors. Antidepressants possibly also perform therapeutic actions on more than one neurotransmitter system (USDHHS, 1999a). Complicated indeed.

Another avenue of research into the biological underpinnings of mood disorders focuses on abnormalities in certain areas of the brain. Brain-imaging studies show lower metabolic activity in the prefrontal cortex of clinically depressed people as compared to healthy controls (Davidson et al., 2002; Schatzberg, 2002). The prefrontal cortex lies in the frontal lobes of the cerebral cortex and is the area of the brain responsible for higher mental functions, such as thinking, problem solving and decision making, and organizing thoughts and behaviors. The neurotransmitters serotonin and norepinephrine play important roles in regulating nerve impulses in the prefrontal cortex, so it is not surprising that evidence points to irregularities in this region of the brain. Other research reveals brain abnormalities in people with mood disorders (major depression and bipolar disorder) in parts of the brain involved in governing emotions (Parsey et al., 2006; Raeburn, 2005; Society for Neuroscience, 2005; Steele et al., 2007).

As research using brain-imaging techniques continues, we will likely develop a clearer picture of how the brains of people with mood disorders differ from those of healthy individuals and perhaps even ways of better diagnosing these disorders and treating them. Other systems in the body, such as the endocrine system, may also play a role in the development of mood disorders in ways that future research may help clarify.

CAUSAL FACTORS IN BIPOLAR DISORDERS

Most investigators suspect that multiple causes acting together contribute to the development of bipolar disorder. Genetic factors play a major role. In a large population-based study in Finland, investigators found the concordance rate to be seven times greater among MZ twins than DZ twins (43% versus 6%, respectively) (Kieseppä et al., 2004). Genetics appears to play an even stronger role in bipolar disorder that it does in major depressive disorder (McGuffin et al., 2003). Scientists are actively involved in tracking down specific genes implicated in bipolar disorder (Baum et al., 2007; Schulze et al., 2005). However, genes don’t tell the whole story. If bipolar disorder were caused entirely by heredity, then an identical twin of someone having the disorder would
always develop the disorder, but this isn’t the case (NIMH, 2001). Consistent with the diathesis–stress model, stressful life factors and other biological influences may interact with a genetic predisposition to increase vulnerability to the disorder. Moreover, we have learned that stressful life events can trigger mood episodes in people with bipolar disorder (Alloy et al., 2005).

We continue to learn more about the role of psychosocial factors in bipolar disorders. For example, recent evidence suggests that the social support from family members and friends can enhance functioning of bipolar patients by providing a buffer against the negative effects of stress (Alloy et al., 2005). Moreover, the availability of social support appears to play a role in helping speed recoveries from mood episodes and reducing the likelihood of recurrent episodes (Alloy et al., 2005; Johnson, Winett et al., 1999).

**TREATMENT OF MOOD DISORDERS**

Just as different theoretical perspectives point to many factors that may be involved in the development of mood disorders, these models have spawned different approaches to treatment. Here we focus on the leading contemporary approaches.

**Treating Depression**

Depressive disorders are typically treated with psychotherapy, such as in the form of psychodynamic therapy, behavior therapy, or cognitive therapy, or with biomedical approaches, such as antidepressant medication or electroconvulsive therapy (ECT). Sometimes a combination of treatment approaches is used.

**Psychodynamic Approaches**

Traditional psychoanalysis aims to help people who become depressed understand their ambivalent feelings toward important people (objects) in their lives they have lost or whose loss was threatened. By working through feelings of anger toward these lost objects, people can turn anger outward—through verbal expression of feelings, for example—rather than leave it to fester and turn inward.

Traditional psychoanalysis can take years to uncover and deal with unconscious conflicts. Modern psychoanalytic approaches also focus on unconscious conflicts, but they are more direct, relatively brief, and focus on present as well as past conflicted relationships. Some psychodynamic therapists also use behavioral methods to help clients acquire the social skills needed to develop a broader social network.

A newer psychodynamic model, called *interpersonal psychotherapy* (IPT), is a relatively brief form of therapy (usually no more than 9 to 12 months) that focuses on the client’s current interpersonal relationships (Klerman et al., 1984). The developers of IPT believe that depression occurs within an interpersonal context and that relationship issues should be emphasized in treatment. IPT has been shown to be an effective treatment for major depression and shows promise in treating other psychological disorders, including dysthymic disorder, bulimia, and posttraumatic stress disorder (PTSD) (Bleiberg & Markowitz, 2005; Frank et al., 2007; Weissman, 2007). Investigators find IPT effective in treating depressed patients from other parts of the world, including sub-Saharan Africa (Bolton et al., 2003).

Although IPT shares some features with traditional psychodynamic approaches (principally the belief that early life experiences and rigid personality features affect psychological adjustment), it differs from traditional psychodynamic therapy by focusing on clients’ current relationships rather than on unconscious internal conflicts of childhood origins.
Interpersonal Psychotherapy in a Case of Depression

Sal began to explore his marital problems in the fifth therapy session, becoming tearful as he recounted his difficulty expressing his feelings to his wife because of feelings of being “numb.” He felt that he had been “holding on” to his feelings, which was causing him to become estranged from his wife. The next session zeroed in on the similarities between himself and his father, in particular how he was distancing himself from his wife in a similar way to how his father had kept a distance from him. By session 7, a turning point had been reached. Sal expressed how he and his wife had become “emotional” and closer to one another during the previous week and how he was able to talk more openly about his feelings, and how he and his wife had been able to make a joint decision concerning a financial matter that had been worrying them for some time. When later he was laid off from his job, he sought his wife’s opinion, rather than picking a fight with her as a way of thrusting his job problems on her. To his surprise he found that his wife responded positively—not “violently,” as he had expected—to times when he expressed his feelings. In his last therapy session (session 12), Sal expressed how therapy had led to a “reawakening” within himself with respect to the feelings he had been keeping to himself—an openness that he hoped to create in his relationship with his wife.

—Adapted from Klerman et al., 1984, pp. 111–113

Behavioral Approaches

Behavior therapists generally focus on helping depressed patients develop more effective social or interpersonal skills and increasing their participation in pleasurable or rewarding activities. Evidence shows that behavioral techniques can produce substantial benefits in treating depression in both adults and adolescents (Cuijpers, van Straten, & Warmen, 2007). In fact, this model of therapy, generally called behavioral activation, produced higher rates of remission in treating severely depressed patients in one recent study than did alternative forms of treatment (Dimidjian et al., 2006). Let’s now turn to cognitive therapy, which is perhaps the most widely used form of psychological treatment for depression.

Cognitive Therapy

Cognitive therapists believe that distorted thinking (cognitive distortions) play a key role in the development of depression. Depressed people typically focus on how they are feeling rather than on the thoughts that may underlie their feeling states. That is, they usually pay more attention to how bad they feel than to the thoughts that may trigger or maintain their depressed moods. Aaron Beck and his colleagues have developed a multicomponent treatment approach, called cognitive therapy, that focuses on helping people with depression learn to recognize and correct their dysfunctional thinking patterns. Table 8.6 shows some common examples of distorted, automatic thoughts, the types of cognitive distortions they represent, and rational alternative responses that can be used to replace these distorted thoughts.

Cognitive therapy, like behavior therapy, is relatively brief, lasting perhaps 14 to 16 weekly sessions. Therapists use a combination of behavioral and cognitive techniques to help clients identify and change dysfunctional thoughts and develop more adaptive behaviors. For example, they help clients connect thought patterns to negative moods by having them monitor the automatic negative thoughts they experience throughout
the day using a thought diary or daily record. They note when and where negative thoughts occur and how they feel at the time. Then the therapist helps the client challenge the negative thoughts and replace them with more adaptive thoughts. The following case example shows how a cognitive therapist works with a client to challenge the validity of thoughts that reflect the cognitive distortion called selective abstraction (the tendency to judge oneself entirely on the basis of specific weaknesses or flaws in character). The client judged herself to be totally lacking in self-control because she ate a single piece of candy while she was on a diet.

<table>
<thead>
<tr>
<th>Automatic Thought</th>
<th>Kind of Cognitive Distortion</th>
<th>Rational Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m all alone in the world.</td>
<td>All-or-nothing thinking</td>
<td>It may feel like I’m all alone, but there are some people who care about me.</td>
</tr>
<tr>
<td>Nothing will ever work out for me.</td>
<td>Overgeneralization</td>
<td>No one can look into the future. Concentrate on the present.</td>
</tr>
<tr>
<td>My looks are hopeless.</td>
<td>Magnification</td>
<td>I may not be perfect looking, but I’m far from hopeless.</td>
</tr>
<tr>
<td>I’m falling apart. I can’t handle this.</td>
<td>Magnification</td>
<td>Sometimes I just feel overwhelmed. But I’ve handled things like this before. I’ll just take it a step at a time and I’ll be okay.</td>
</tr>
<tr>
<td>I guess I’m just a born loser.</td>
<td>Labeling and mislabeling</td>
<td>Nobody is destined to be a loser. Stop talking yourself down.</td>
</tr>
<tr>
<td>I’ve only lost 8 pounds on this diet. I should just forget it. I can’t succeed.</td>
<td>Negative focusing/Minimization/ Disqualifying the positive/Jumping to conclusions/All-or-nothing thinking</td>
<td>Eight pounds is a good start. I didn’t gain all this weight overnight, and I have to expect that it will take time to lose it.</td>
</tr>
<tr>
<td>I know things must really be bad for me to feel this awful.</td>
<td>Emotional reasoning</td>
<td>Feeling something doesn’t make it so. If I’m not seeing things clearly, my emotions will be distorted too.</td>
</tr>
<tr>
<td>I know I’m going to flunk this course.</td>
<td>Fortune teller error</td>
<td>Give me a break! Just focus on getting through this course, not on jumping to negative conclusions.</td>
</tr>
<tr>
<td>I know John’s problems are really my fault.</td>
<td>Personalization</td>
<td>Stop blaming yourself for everyone else’s problems. There are many reasons why John’s problems have nothing to do with me.</td>
</tr>
<tr>
<td>Someone my age should be doing better than I am.</td>
<td>Should statements</td>
<td>Stop comparing yourself to others. All anyone can be expected to do is their best. What good does it do to compare myself to others? It only leads me to get down on myself rather than get motivated.</td>
</tr>
<tr>
<td>I just don’t have the brains for college.</td>
<td>Labeling and mislabeling</td>
<td>Stop calling yourself names like “stupid.” I can accomplish a lot more than I give myself credit for.</td>
</tr>
<tr>
<td>Everything is my fault.</td>
<td>Personalization</td>
<td>There you go again. Stop playing this game of pointing blame at yourself. There’s enough blame to go around. Better yet, forget placing blame and try to think through how to solve this problem.</td>
</tr>
<tr>
<td>It would be awful if Sue turns me down.</td>
<td>Magnification</td>
<td>It might be upsetting, but it needn’t be awful unless I make it so.</td>
</tr>
<tr>
<td>If people really knew me, they would hate me.</td>
<td>Mind reader</td>
<td>What evidence is there for that? More people who get to know me like me than don’t like me.</td>
</tr>
<tr>
<td>If something doesn’t get better soon, I’ll go crazy.</td>
<td>Jumping to conclusions/Magnification</td>
<td>I’ve dealt with these problems this long without falling apart. I just have to hang in there. Things are not as bad as they seem.</td>
</tr>
<tr>
<td>I can’t believe I have another pimple on my face. This is going to ruin my whole weekend.</td>
<td>Mental filter</td>
<td>Take it easy. A pimple is not the end of the world. It doesn’t have to spoil my whole weekend. Other people get pimples and seem to have a good time.</td>
</tr>
</tbody>
</table>
Cognitive Therapy for Depression

CLIENT: I don’t have any self-control at all.

THERAPIST: On what basis do you say that?

C: Somebody offered me candy and I couldn’t refuse it.

T: Were you eating candy every day?

C: No, I just ate it this once.

T: Did you do anything constructive during the past week to adhere to your diet?

C: Well, I didn’t give in to the temptation to buy candy every time I saw it at the store. . . . Also, I did not eat any candy except that one time when it was offered to me and I felt I couldn’t refuse it.

T: If you counted up the number of times you controlled yourself versus the number of times you gave in, what ratio would you get?

C: About 100 to 1.

T: So if you controlled yourself 100 times and did not control yourself just once, would that be a sign that you are weak through and through?

C: I guess not—not through and through (smiles).

—Adapted from Beck et al., 1979, p. 68

Cognitive therapy and other forms of cognitive-behavioral therapy have produced impressive results in treating major depression and reducing the risks of recurrent episodes (e.g., DeRubeis et al., 2005; Hamilton & Dobson, 2002; Hollon, Stewart, & Strunk, 2006; Merrill, Tolbert, & Wade, 2003; Miranda et al., 2006). The benefits of cognitive therapy appear to be at least equal to those of antidepressant medication in treating depression, even moderate to severe depression, at least when practiced by experienced cognitive therapists (DeRubeis et al., 1999, 2005).

Might the combination of drugs and therapy be more effective still? A recent review of scientific evidence showed that the combination of antidepressant medication and psychotherapy produced slightly better outcomes as compared to either psychotherapy or medication alone (Friedman et al., 2004). Combined treatment might be especially beneficial in cases of more severe, recurrent depression (Mann, 2005).

Biological Approaches

The most common biological approaches to treating mood disorders are the use of antidepressant drugs and electroconvulsive therapy for depression and lithium carbonate for bipolar disorder.

Antidepressant Drugs Today, we have three major classes of antidepressants that increase the availability of key neurotransmitters in the brain: (1) tricyclic antidepressants (TCAs), monoamine oxidase (MAO) inhibitors, and selective serotonin-reuptake inhibitors (SSRIs) (Berton & Nestler, 2006; Mann, 2005). All antidepressants increase availability of neurotransmitters, but they do so in different ways (see Figure 8.4).

The tricyclics, which include imipramine (trade name Tofranil), amitriptyline (Elavil), desipramine (Norpramin), and doxepin (Sinequan), are so named because of their three-ring molecular structure. They increase brain levels of the neurotransmitters norepinephrine and serotonin by interfering with the reuptake (reabsorption by the transmitting cell) of these chemical messengers. The SSRIs, such as fluoxetine (trade name Prozac) and sertraline (trade name Zoloft), work in a similar fashion but have more specific effects on raising the levels of serotonin in the brain. The MAO inhibitors, such as phenelzine (trade name Nardil), increase the availability of neurotransmitters by inhibiting the action of monoamine oxidase, an enzyme that normally breaks down or degrades neurotransmitters in the synapse. MAO inhibitors are used less widely than other antidepressants because of potentially serious interactions with certain foods and alcoholic beverages.

We understand how antidepressants affect neurotransmitter levels, but as noted earlier, we don’t clearly understand the underlying mechanisms explaining how they work to
relieve depression. The potential side effects of tricyclics and MAO inhibitors include dry mouth, a slowing down of motor responses, constipation, blurred vision, sexual dysfunction, and less frequently, urinary retention, paralytic ileus (a paralysis of the intestines, which impairs the passage of intestinal contents), confusion, delirium, and cardiovascular complications, such as reduced blood pressure. Tricyclics are also highly toxic, which raises the prospect of suicidal overdoses if the drugs are used without close supervision.

Antidepressants help relieve symptoms of depression and help prevent recurrent episodes when patients continue taking them (Lépine et al., 2004; Reynolds et al., 2006). However, clinical trials typically show that only 30% or less of patients treated with antidepressants achieve complete symptom relief or remission (Menza, 2006; Trivedi et al., 2006). Moreover, despite dramatic responses to antidepressants shown in drug company commercials, antidepressants produce only modestly stronger effects overall than placebo (inert) drugs (Boyles, 2002; Kirsch et al., 2002). However, among patients who fail to respond to one antidepressant, about one in four experience complete symptom relief when switched to another one (Rush et al., 2006).

There is little difference in levels of effectiveness among the different SSRIs or between SSRIs and the older generation of tricyclic antidepressants (Mann, 2005; Serrano-Blanco et al., 2006). Yet because they hold two major advantages, the SSRIs have largely replaced the earlier drugs. The first advantage is that they are less toxic and so are less dangerous in overdose. Secondly, they have fewer cardiovascular effects and other common side effects (such as dry mouth, constipation, and weight gain) associated with the tricyclics and MAO inhibitors. Still, Prozac and other SSRIs may produce side effects such as upset stomach, headaches, agitation, insomnia, lack of sexual drive, and delayed orgasm (Michelson et al., 2000). Another significant concern is that use of antidepressants appears to be connected with increased suicidal thinking in some children, and adolescents, and young adults—an important issue discussed further in Chapter 14.

Another concern with psychiatric drugs is the high rate of relapse in patients who are withdrawn from active medication and even in those who continue to take antidepressant medication (Kellner et al., 2006; McGrath et al., 2006; Yager, 2006). Cognitive-behavioral therapies provide greater protection against relapse than antidepressant
medication, perhaps because patients learn skills in therapy they can then use to handle life stressors and disappointments that patients receiving only medication do not (Bockting et al., 2005; Hollon, Stewart, & Strunk, 2006; Tang et al., 2007). Adding cognitive-behavioral therapy to pharmacological treatment may also help reduce the risk of relapse after psychiatric drugs are withdrawn (Friedman et al., 2004).

Overall, about 50% to 70% of depressed patients treated on an outpatient basis respond favorably to either psychotherapy or antidepressant medication (USDHHS, 1999a). Some people who fail to respond to psychotherapy respond to antidepressants. The opposite is also true: Some people who fail to respond to drug therapy respond to psychotherapy.

**St. John’s Wort—A Natural “Prozac”?** Might a humble herb be a remedy for depression? The herb, called St. John’s wort, or *Hypericum perforatum*, has been used for centuries to help heal wounds. Now, people are using it to relieve depression. The herb appears to increase levels of serotonin in the brain by interfering with reabsorption of the neurotransmitter, as does Prozac. Although people seeking help for depression may be attracted to the idea of using a natural product such as St. John’s wort, the results of outcome studies are mixed (Kalb, 2002). Hopes were lowered by the results of a study showing that St. John’s wort worked no better than a placebo in treating major depression (Shelton et al., 2001). However, other evidence suggests that the herb may have therapeutic benefits in treating milder forms of depression (Lecrubier et al., 2002).

**Electroconvulsive Therapy** *Electroconvulsive therapy* (ECT), more commonly called shock therapy, continues to evoke controversy. The idea of passing an electric current through someone’s brain may seem barbaric. Yet ECT is a generally safe and effective treatment for severe depression, and it can help relieve major depression in many cases in which alternative treatments have failed (UK ECT Review Group, 2003).

In ECT, an electrical current of between 70 and 130 volts is applied to the head to induce a convulsion that is similar to a grand mal epileptic seizure. ECT is usually administered in a series of 6 to 12 treatments, given three times per week over several weeks (USDHHS, 1999a). The patient is put to sleep with a brief-acting general anesthetic and given a muscle relaxant to avoid wild convulsions that might result in injury. As a result, spasms may be barely perceptible to onlookers. The patient awakens soon after the procedure and generally remembers nothing. Although ECT had earlier been used in the treatment of a wide variety of psychological disorders, including schizophrenia and bipolar disorder, the American Psychiatric Association recommends that ECT only be used to treat major depressive disorder in people who do not respond to antidepressant medication.

ECT leads to significant improvement in a majority of people with major depression who have failed to respond to antidepressant medication (Ebmeier, Donaghey, & Steele, 2006; Prudic et al., 2004; Reifler, 2006). It can also have dramatic effects on relieving suicidal thinking (Kellner et al., 2005). Although no one knows exactly how ECT works, one possibility is that ECT normalizes neurotransmitter activity in the brain.

Although ECT can be an effective short-term treatment of severe depression, it too is no panacea. There is an understandable concern among patients, relatives, and professionals themselves about possible risks, especially memory loss for events occurring around the time of treatment (Glass, 2001). As noted in Chapter 4, another nagging problem with ECT is a high rate of relapse following treatment (Sackeim et al., 2001). In one recent study, about two-thirds of patients whose depression had remitted following ECT experienced a relapse within 6 months (Prudic et al., 2004). Depression often returns even among patients who continue to be treated with antidepressant medication (Sackeim et al., 1994). All in all, many professionals view ECT as a treatment of last resort, to be considered only after other treatment approaches have been tried and failed.
Clinical Practice Guidelines for Depression  A government-sponsored expert panel set up to develop guidelines for treating depression found the following treatments to be effective (Depression Guideline Panel, 1993b):

- Antidepressant medication (tricyclics or selective serotonin-reuptake inhibitors)
- Three specific forms of psychotherapy: cognitive therapy, behavioral therapy, and interpersonal psychotherapy
- A combination of one of the recommended forms of psychotherapy and antidepressant medication
- Other specified forms of treatment, including ECT and phototherapy for seasonal depression

Treating Bipolar Disorder

Bipolar disorder is most commonly treated with drugs that aim to stabilize mood swings. Lithium and Other Mood Stabilizers  It could be said that the ancient Greeks and Romans were among the first to use lithium as a form of chemotherapy. They prescribed mineral water that contained lithium for people with turbulent mood swings. Today, the drug lithium carbonate, a powdered form of the metallic element lithium, is widely used in treating bipolar disorder.

Lithium, the most widely used and widely studied drug for bipolar disorder, is effective in stabilizing moods in bipolar patients and reducing the risk of recurrent manic episodes as well as suicides (Bowden et al., 2003; Cipriani et al., 2005; López-Muñoz et al., 2006). However, we don’t yet know whether lithium reduces the risk of recurrent depressive episodes (Geddes et al., 2004).

People with bipolar disorder may need to use lithium indefinitely to control their mood swings, just as diabetics use insulin continuously to control their illness. Despite more than 40 years of use as a therapeutic drug, we still can’t say how lithium works. Despite its benefits, lithium is no panacea. At least 30% to 40% of patients with mania either fail to respond to the drug or cannot tolerate it (Dubovsky, 2000). Lithium treatment must be closely monitored because of potential toxic effects and other side effects. Lithium can also lead to mild memory problems, which may lead people to stop taking it. The drug can lead to weight gain, lethargy, and grogginess, and to a general slowing down of motor functioning. It can also produce gastrointestinal distress and lead to liver problems over the long term.

Although lithium is still widely used, the drug’s limitations have prompted efforts to find alternative treatments. Investigators find that anticonvulsant drugs used in the treatment of epilepsy, including carbamazepine (brand name Tegretol), divalproex (brand name Depakote), and lamotrigine (brand name Lamictal), can reduce manic symptoms and may help stabilize moods in people with bipolar disorder (Nasrallah, Ketter, & Kalali, 2006; “New Studies,” 2006; Nierenberg et al., 2006). Anticonvulsant drugs may benefit people with bipolar disorder who either do not respond to lithium or cannot tolerate the drug because of side effects. Anticonvulsant drugs usually cause fewer or less severe side effects than lithium. However, some patients have only a partial response to lithium or anticonvulsant drugs, and some fail to respond at all. Recent evidence points to therapeutic benefits of combining mood stabilizers with a class of antipsychotic drugs, called atypical antipsychotics, which are generally used to treat schizophrenia (see Chapter 12) (Scherk, Pajonk, & Leucht, 2007).

For Kay Jamison, managing manic depression involved both medication (lithium) and psychotherapy.

“Leading a Normal Life”

At this point in my existence, I cannot imagine leading a normal life without both taking lithium and having had the benefits of psychotherapy. Lithium prevents my seductive but disastrous high, diminishes my depressions, clears out the wool and webbing from my disordered thinking,
Mood disorders involve the interplay of multiple factors (see the accompanying Concept Map for Abnormal Psychology). Consistent with the diathesis–stress model, depression may reflect an interaction of biological factors (such as genetic factors, neurotransmitter irregularities, or brain abnormalities), psychological factors (such as cognitive distortions or learned helplessness), and social and environmental stressors (such as divorce or loss of a job). The concept map illustrates a possible causal pathway based on the diathesis–stress model. Stressful life events, such as prolonged unemployment or a divorce, may have a depressing effect by reducing neurotransmitter activity in the brain. These biochemical effects may be more likely to occur or be more pronounced in people with a genetic predisposition, or diathesis, for depression. However, a depressive disorder may not develop, or may develop in a milder form, in people with more effective coping resources for handling stressful situations. For example, people who receive emotional support from others may be better able to withstand the effects of stress than those who have to go it alone. So, too, for people who make active coping efforts to meet the challenges they face in life.

Sociocultural factors can be sources of stress that influence the development or recurrence of mood disorders (Ostler et al., 2001). These factors include poverty; overcrowding; exposure to racism, sexism, and prejudice; violence in the home or community; unequal stressful burdens placed on women; and family disintegration. Other sources of stress that can contribute to mood disorders include negative life events such as the loss of a job, the development of a serious illness, the breakup of a romantic relationship, and the loss of a loved one.

The diathesis for depression may take the form of a psychological vulnerability involving a depressive thinking style, one characterized by tendencies to exaggerate the consequences of negative events, to heap blame on oneself, and to perceive oneself as helpless to effect positive change. This cognitive diathesis may increase the risk of depression in the face of negative life events. These cognitive influences may also interact with a genetically based diathesis to further increase the risk of depression following stressful life events. Then, too, the availability of social support from others may help bolster a person’s resistance to stress during difficult times. People with more effective social skills may be better able to garner and maintain social reinforcement from others and thus be better able to resist depression than people lacking social skills. But biochemical changes in the brain might make it more difficult for the person to cope effectively and bounce back from stressful life events. Lingerling biochemical changes and feelings of depression may exacerbate feelings of helplessness, compounding the effects of the initial stressor.

Gender-related differences in coping styles may also come into play. According to Nolen-Hoeksema, women are more likely to ruminate when facing emotional problems, and men are more likely to abuse alcohol. These or other differences in coping styles may propel women into longer and more severe bouts of depression while setting the stage for the development of drinking problems in men. As you can see, a complex web of contributing factors is likely involved in the development of mood disorders.

Psychological Approaches Large-scale investigations of the effects of psychological treatments for bipolar disorder are underway. Early studies suggest that psychosocial treatments, such as cognitive-behavioral therapy, interpersonal therapy, and family therapy, may be helpful adjunctive therapies when used along with drug therapy in the treatment of bipolar disorder (Alloy et al., 2005; Frank et al., 2005; Miklowitz et al., 2007). We also have evidence that psychological treatment can improve the level of functioning and adherence to a medication regimen in bipolar patients (Johnson & Leahy, 2003; Miklowitz et al., 2003; Rougeta & Aubry, 2007). Moreover, a recent randomized controlled study showed that cognitive therapy reduced the rate of relapse in bipolar patients (Lam et al., 2003).
Chapter 8

SUICIDE

Suicidal thoughts are common enough. At times of great stress, many, if not most, people have considered suicide. A nationally representative survey found that 13% of U.S. adults reported having experienced suicidal thoughts, and 4.6% reported making a suicide attempt (Kessler, Borges, & Walters, 1999). It is fortunate that most people who have suicidal thoughts do not act on them. Still, each year in the United States some 500,000 people are treated in hospital emergency rooms for attempted suicide, and more than 30,000 “succeed” in taking their lives (Lemonick, 2003a; Mokdad et al., 2004; National Strategy for Suicide Prevention, 2001). There are twice as many deaths from suicide as from HIV/AIDS (NIMH, 2003). Suicide exacts a heavy toll on the nation, as you can see in statistics reported by the U.S. Surgeon General (see Table 8.7).

Suicidal behavior is not a psychological disorder in itself. But it is often a feature or symptom of an underlying psychological disorder, usually a mood disorder (Bernal et al., 2007), which is the reason we discuss it in this chapter. The federal government estimates that about 60% of people who commit suicide suffer from a mood disorder (National Strategy for Suicide Prevention, 2001).

A CLOSER LOOK

Magnetic Stimulation Therapy for Depression

Mesmer would be proud. Franz Friedrich Mesmer (1734–1815) was the 18th-century Austrian physician from whose name the term mesmerism is derived (we still sometimes speak of people being “mesmerized” by things). He believed that hysteria was caused by an underlying imbalance in the distribution of a magnetic fluid in the body—a problem he believed he could correct by prodding the body with metal rods. A scientific commission of the time debunked Mesmer’s claims and attributed any cures he obtained to the effects of natural recovery or self-delusion (what we might today call the power of suggestion). The chairperson of the commission was none other than our own Benjamin Franklin, who served at the time as ambassador to France from the newly independent United States. Although Mesmer’s theories and practices were discredited, recent evidence into the therapeutic use of magnetism suggests that he might have been on to something.

Fast forward 200 years. Australian doctors identified 60 patients with major depression who had failed to respond to different types of antidepressants (Fitzgerald et al., 2003). In a double-blind controlled design, they treated these patients with either strong magnetic stimulation to the head (called transcranial magnetic stimulation, or TMS) or a fake treatment that had all the trappings of the active treatment except that the magnet was angled away to prevent magnetic stimulation of the brain. With TMS, a powerful electromagnet placed on the scalp generates a strong magnetic field that passes through the skull and affects the electrical activity of the brain.

After 2 weeks of treatment, patients receiving TMS showed clinical improvement in depression as opposed to the minimal change found in the sham group. Improvement was modest and did not occur in all patients. The investigators believe that longer treatment (at least 4 weeks) may be necessary to produce more meaningful therapeutic benefits. This study adds to a growing body of evidence supporting the antidepressant effects of TMS (e.g., Avery et al., 2006; Herwig et al., 2003; Mantovani et al., 2007). The specific form and intensity of TMS needed to produce therapeutic effects remains under study. We should also note that TMS carries some potential risks, such as the possibility of seizures. However, the risk of seizures may be reduced by using low-frequency stimulation.

In sum, TMS shows promise as a new form of treatment for moderate depression (Gershon, Dannon, & Grunhaus, 2003). Although it has been approved for medical use in Canada, it is still experimental in the United States (Dubovsky, 2006). It also appears promising as an alternative to ECT in cases of major depression that fail to respond to pharmacological treatment. TMS may be particularly helpful in treating depression because the prefrontal cortex in the left cerebral hemisphere becomes less active in depressed patients, and this part of the brain can be directly affected by TMS (Henry, Pascual-Leone, & Cole, 2003). Yet investigators caution that more evidence is needed to support its efficacy and safety before it can be recommended for general use in treating depression (Aarre et al., 2003; Martin et al., 2003). TMS may also have therapeutic benefits in treating other disorders, such as posttraumatic stress disorder (Cohen et al., 2004).

TRANSCRANIAL MAGNETIC STIMULATION

In a number of research studies magnetic stimulation of the head has been shown to have antidepressant effects.

TRUE.

Placing a powerful electromagnet on the scalp can help relieve depression.
TABLE 8.7
U.S. Surgeon General’s Report on Suicide: Cost to the Nation

- Every 17 minutes another life is lost to suicide. Every day, 86 Americans take their own lives and over 1,500 attempt suicide.
- Suicide is now the eighth leading cause of death in Americans.
- For every two victims of homicide in the United States, there are three deaths from suicide.
- There are now twice as many deaths due to suicide than due to HIV/AIDS.
- Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled.
- In the month prior to their suicide, 75% of elderly persons had visited a physician.
- Over half of all suicides occur in adult men, ages 25 to 65.
- Many who make suicide attempts never seek professional care immediately after the attempt.
- Males are four times more likely to commit suicide than are females.
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease, combined.
- Suicide takes the lives of more than 30,000 Americans every year.

Source: Center for Mental Health Services, 2001.

Who Commits Suicide?

What do you think is the second leading cause of death among college students, after motor vehicle accidents? Drugs? Homicide? The answer is suicide, with an estimated 1,000 suicides and 24,000 suicide attempts annually among the nation’s college students age 18 to 24 (Lamberg, 2006; Rawe & Kingsbury, 2006). Although attention is focused on the tragedy of youthful suicide, as well it should be, suicide rates are actually highest among adults age 65 and older, especially older White males (Bruce et al., 2004; Joe et al., 2006; see Figure 8.5). (We discuss youth suicide further in Chapter 14.)

FIGURE 8.5 Suicide rates according to age.
Although adolescent suicides may be more highly publicized, adults, especially older adults, have higher suicide rates.

Suicide in Older Adults  Despite life-extending advances in medical care, some older adults find the quality of their lives less than satisfactory. Older people are more susceptible to diseases such as cancer and Alzheimer’s, which can leave them with feelings of helplessness and hopelessness that, in turn, can give rise to depression and suicidal thinking (Starkstein et al., 2005).

Many older adults also suffer a mounting accumulation of losses of friends and loved ones, leading to social isolation (Stroebe, Stroebe, & Abakoumkin, 2005). These losses, as well as the loss of good health and of a responsible role in the community, may wear down the will to live. Not surprisingly, the highest suicide rates in older men are among those who are widowed or socially isolated. Society’s increased acceptance of suicide in older people may also play a part. Whatever the causes, suicide has become an increased risk for elderly people. Perhaps society should focus its attention on the quality of life that is afforded our elderly, in addition to providing them the medical care that helps make longer life possible.

Gender and Ethnic/Racial Differences  More women attempt suicide, but more men “succeed” (Houry, 2004; Miller et al., 2004). For every female suicide, there are four male suicides. More males “succeed” in large part because they tend to choose quicker-acting and more lethal means, such as handguns.

Suicides are more common among (non-Hispanic) White Americans and Native Americans than African Americans, Asian Americans, or Hispanic Americans (Garlow, Purselle, & Heninger, 2005; Gone, 2004; see Figure 8.6). White Americans are more than twice as likely to take their own lives as African Americans (Joe et al., 2006). Yet the highest suicide rates in the nation are found among Native American adolescent and young adult males (Meyers, 2007).

Hopelessness and exposure to others who have attempted or committed suicide may contribute to the increased risk of suicide among Native American youth. Native American youth at greatest risk tend to be reared in communities that are largely isolated from U.S. society at large. They perceive themselves as having relatively few opportunities to gain the skills necessary to join the workforce in the larger society and are also relatively more prone to substance abuse, including alcohol abuse. Knowledge that peers have attempted or completed suicide renders suicide a highly visible escape from psychological pain.

![FIGURE 8.6 Ethnicity and suicide rates.](image)

Suicide rates are higher among males than females, and higher among White (European) Americans and Native Americans than other ethnicities.

Why Do People Commit Suicide?

To many lay observers, suicide seems so extreme an act that they believe only “insane” people (meaning people who are out of touch with reality) would commit suicide. However, suicidal thinking does not necessarily imply loss of touch with reality, deep-seated unconscious conflict, or a personality disorder. Having thoughts about suicide generally reflects a narrowing of the range of options people think are available to them to deal with their problems. That is, they are discouraged by their problems and see no other way out.

The risk of suicide is much higher among people with severe mood disorders, such as major depression and bipolar disorder (Bruce et al., 2004). As many as one in five people with bipolar disorder eventually commit suicide (Cowan & Kandel, 2001). Attempted or completed suicide is also linked to many other psychological disorders, including alcoholism and drug dependence, anorexia, schizophrenia, panic disorder, personality disorders, posttraumatic stress disorder, and borderline personality disorder (e.g., Franko & Keel, 2006; McGirra et al., 2006; Moran et al., 2003; Walker et al., 2004).

Past suicidal behavior plays an important role in later suicidal behavior (Joiner et al., 2005). Sadly, people who fail on a first attempt often complete suicide on a subsequent attempt. Those who survive an attempt but express to others that they wished they had died are more likely to go on to eventually complete suicide than are those who expressed ambivalence about the attempt (Henriques et al., 2005). Adolescents who have a history of attempted suicide stand a risk of a later completed suicide that is 14 times higher in females and 22 times higher in males as compared to the general adolescent population (Olfson et al., 2005).

Not all suicides are connected with psychological disorders. Some people suffering from painful and hopeless physical illness seek to escape further suffering by taking their own lives. These suicides are sometimes labeled “rational suicides” in the belief that they are based on a rational decision that life is no longer worth living in the light of continual suffering. However, in perhaps many of these cases the person’s judgment and reasoning ability may be colored by an underlying and potentially treatable psychological disorder, such as depression. Other suicides are motivated by deep-seated religious or political convictions, such as in the case of people who sacrifice themselves in acts of protest against their governments or who kill themselves and others in suicide bombings in the belief that their acts will be rewarded in an afterlife.

Suicide attempts often occur in response to highly stressful life events, especially “exit events,” such as the death of a spouse, close friend, or relative; divorce or separation; a family member’s leaving home; or the loss of a close friend. People who consider suicide in times of stress may lack problem-solving skills and be unable to find alternative ways of coping with stressors. Underscoring the psychological impact of severe stress, researchers find suicides to be more common among survivors of natural disasters, especially severe floods (Krug et al., 1998).

Theoretical Perspectives on Suicide

The classic psychodynamic model views depression as the turning inward of anger against the internal representation of a lost love object. Suicide then represents inward-directed anger that turns murderous. Suicidal people, then, do not seek to destroy themselves. Instead, they seek to vent their rage against the internalized representation of the love object. In so doing, they destroy themselves as well, of course. In his later writings, Freud speculated that suicide may be motivated by the “death instinct,” a tendency to return to the tension-free state that preceded birth. Existential and humanistic theorists relate suicide to the perception that life is meaningless and hopeless. Suicidal people report they find life duller, emptier, and more boring than nonsuicidal people (Mehrabian & Weinstein, 1985).
In the 19th century, social thinker Emile Durkheim (1897/1958) noted that people who experienced anomie—who feel lost, without identity, rootless—are more likely to commit suicide. Sociocultural theorists likewise believe that alienation may play a role in suicide. In our modern, mobile society, people frequently move hundreds or thousands of miles to schools and jobs. Executives and their families may be relocated every 2 years or so. Military personnel and their families may be shifted about yet more rapidly. Many people are thereby socially isolated or cut off from their support groups. Moreover, city dwellers tend to limit or discourage informal social contacts because of crowding, overstimulation, and fear of crime. It is thus understandable that many people find few sources of support in times of crisis. In some cases, the family support is available but not helpful. Family members may be perceived as part of the problem, not part of the solution.

Learning theorists focus largely on the lack of problem-solving skills for handling significant life stress. According to Shneidman (1985), those who attempt suicide wish to escape unbearable psychological pain and may perceive no other way out. People who threaten or attempt suicide may also receive sympathy and support from loved ones and others, perhaps making future—and more lethal—attempts more likely. This is not to suggest that suicide attempts or gestures should be ignored. People who threaten suicide are not merely seeking attention. Although those who threaten suicide may not carry out the act, they should be taken seriously. People who commit suicide often tell others of their intentions or provide clues. Moreover, many people make aborted suicide attempts before they go on to make actual suicide attempts.

Social-cognitive theorists suggest that suicide may be motivated by personal expectancies, such as beliefs that one will be missed by others or that survivors will feel guilty for having mistreated the person, or that suicide will solve one’s own problems or even other people’s problems (e.g., “He won’t have to worry about me any longer”) in one fell swoop.

Social-cognitive theorists also focus on the potential modeling effects of observing suicidal behavior in others, especially among teenagers who feel overwhelmed by academic and social stressors. A social contagion, or spreading of suicide in a community, may occur in the wake of suicides that receive widespread publicity. Teenagers, who seem to be especially vulnerable to these modeling effects, may even romanticize the suicidal act as one of heroic courage. The incidence of suicide among teenagers sometimes rises markedly in the period following news reports about suicide. Copycat suicides may be more likely to occur when reports of suicides are sensationalized, so that other teenagers expect their deaths to have a meaningful impact on their communities (Kessler et al., 1990).

Biological factors are also implicated in suicide, including reduced utilization or availability of the mood-regulating chemical serotonin (Joiner, Brown, & Wingate, 2005; Malone et al., 2003). Because serotonin is linked to depression, the relationship with suicide is not surprising. Yet serotonin also acts to curb or inhibit nervous system activity, so perhaps lowered serotonin activity leads to disinhibition, or release, of impulsive behavior that takes the form of a suicidal act in vulnerable individuals. Suicide also tends to run in families, which hints at genetic factors. Genes may influence susceptibility to suicide by affecting the regulation of serotonin in the brain (Lemonde et al., 2003; Zhou et al., 2005).

Mood disorders in family members and parental suicide are also connected with suicide risk (Brent et al., 2002). But what are the causal connections? Do people who attempt suicide inherit vulnerabilities to mood disorders that are connected with suicide? Does the family atmosphere promote feelings of hopelessness? Does the suicide of one family member give others the idea of doing the same thing? Does one suicide create the impression that other family members are destined to kill themselves? These are all questions researchers need to address.
Suicide is often motivated by the desire to escape from unbearable emotional pain. Here, the celebrated actress Patty Duke, who rose to acclaim in childhood by playing the role of Helen Keller in the movie *The Miracle Worker* and who battled bipolar disorder throughout much of her life, expresses how the desire to escape pain motivated many of the suicide attempts she had made in her life:

**Please Make This Stop**

I can’t even remember how many times I tried to kill myself. Not all of them got as far as actually taking the pills or digesting the pills. And it was almost always pills, although I did make a show sometimes of trying to use razors. But I always chickened out. A couple of times I tried to jump out of a moving car. But I didn’t seem willing to inflict physical pain on myself. Some of the attempts continued to be attention-getting devices. Others came out of so much pain. I just wanted it to stop. I wish I had a more colorful, more profound way to describe it, but the only thoughts that went through my head were “Please make this stop. Please make be brave enough to die so that this anguish will stop.”

*Source: Duke & Hochman, 1992*

Suicide is connected with a complex web of factors, and its prediction is not simple. Moreover, many myths about suicide abound (see Table 8.8). Yet it is clear that many suicides could be prevented if people with suicidal feelings received treatment for underlying disorders, including depression, bipolar disorder, schizophrenia, and alcohol and substance abuse. We also need strategies that emphasize the maintenance of hope during times of severe stress.

### Table 8.8

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who threaten suicide are only seeking attention.</td>
<td>Not so. Researchers report that most people who commit suicide gave prior indications of their intentions or consulted a health provider beforehand (Luoma, Martin, &amp; Pearson, 2002).</td>
</tr>
<tr>
<td>A person must be insane to attempt suicide.</td>
<td>Most people who attempt suicide may feel hopeless, but they are not insane (i.e., out of touch with reality).</td>
</tr>
<tr>
<td>Talking about suicide with a depressed person may prompt the person to attempt it.</td>
<td>An open discussion of suicide with a depressed person does not prompt the person to attempt it. In fact, extracting a promise that the person will not attempt suicide before calling or visiting a mental health worker may well prevent a suicide.</td>
</tr>
<tr>
<td>People who attempt suicide and fail aren’t serious about killing themselves.</td>
<td>Most people who commit suicide have made previous unsuccessful attempts.</td>
</tr>
<tr>
<td>If someone threatens suicide, it is best to ignore it so as not to encourage repeated threats.</td>
<td>Although some people do manipulate others by making idle threats, it is prudent to treat every suicidal threat as genuine and to take appropriate action.</td>
</tr>
</tbody>
</table>

Predicting Suicide

“I don’t believe it. I just saw him last week and he looked fine.”
“She sat here just the other day, laughing with the rest of us. How were we to know what was going on inside her?”
“I knew he was depressed, but I never thought he’d do something like this. I didn’t have a clue.”
“Why didn’t she just call me?”

Friends and family members often respond to news of a suicide with disbelief or guilt that they failed to pick up signs of the impending act. Yet even trained professionals find it difficult to predict who is likely to commit suicide.

Evidence points to the pivotal role of hopelessness about the future in predicting suicidal thinking and suicide attempts (Kaslow et al., 2002; Malone et al., 2000). But when does hopelessness lead to suicide?

People who commit suicide tend to signal their intentions, often quite explicitly, such as by telling others about their suicidal thoughts. In fact, most people who commit suicide make contact beforehand with a health-care provider (Luoma, Martin, & Pearson, 2002). Yet some cloak their intentions. However, behavioral clues may still reveal suicidal intent. Edwin Shneidman, a leading researcher on suicide, found that 90% of the people who committed suicide had left clear clues, such as disposing of their possessions (Gelman, 1994). People contemplating suicide may also suddenly try to sort out their affairs, as in drafting a will or buying a cemetery plot. They may purchase a gun despite lack of prior interest in firearms. When troubled people decide to commit suicide, they may seem to be suddenly at peace; they feel relieved because they no longer have to contend with life problems. This sudden calm may be misinterpreted as a sign of hope.

The prediction of suicide is not an exact science, even for experienced professionals. Many observable factors, such as hopelessness, do seem to be connected with suicide, but we cannot accurately predict when a hopeless person will attempt suicide, if at all.

Suicide hotlines. Telephone hotlines provide emergency assistance and referral services to people experiencing suicidal thoughts or impulses. If you know someone experiencing suicidal thoughts or threatening suicide, speak to a mental health professional or call a suicide hotline in your community for advice.
Mood Disorders and Suicide

A CLOSER LOOK

Suicide Prevention

Imagine yourself having an intimate conversation with a close campus friend, Chris. You know that things have not been good. Chris's grandfather died 6 weeks ago, and the two were very close. Chris's grades have been going downhill, and Chris's romantic relationship also seems to be coming apart at the seams. Still, you are unprepared when Chris says very deliberately, "I just can't take it anymore. Life is just too painful. I don't feel like I want to live anymore. I've decided that the only thing I can do is to kill myself."

When somebody discloses that he or she is contemplating suicide, you may feel bewildered and frightened, as if a great burden has been placed on your shoulders. It has. If someone confides suicidal thoughts to you, your goal should be to persuade him or her to see a professional, or to get the advice of a professional yourself as soon as you can. But if the suicidal person declines to talk to another person and you sense you can't break away for such a conference, here are some things you can do then and there:

1. **Draw the person out.** Shneidman advises framing questions such as "What's going on?" "Where do you hurt?" "What would you like to see happen?" (1985, p. 11). Such questions may prompt people to verbalize thwarted psychological needs and offer some relief. They also grant you the time to appraise the risk and contemplate your next move.

2. **Be sympathetic.** Show that you fathom how troubled the person is. Don't say something like, "You're just being silly. You don't really mean it."

3. **Suggest that means other than suicide can be discovered to work out the person's problems, even if they are not apparent at the time.** Shneidman (1985) notes that suicidal people can usually see only two solutions to their predicaments—suicide or some kind of magical resolution. Professionals try to broaden the available alternatives.

4. **Ask how the person expects to commit suicide.** People with explicit methods who also possess the means (for example, a gun or drugs) are at greatest risk. Ask if you may hold on to the gun, drugs, or whatever, for a while. Sometimes the person agrees.

5. **Propose that the person accompany you to consult a professional right away.** Many campuses, towns, and cities have hotlines that you or the suicidal individual can call anonymously. Other possibilities include the emergency room of a general hospital, a campus health center or counseling center, or the campus or local police. If you are unable to maintain contact with the suicidal person, get professional assistance as soon as you separate.

6. **Don't say something like “You're talking crazy.”** Such comments are degrading and injurious to the individual's self-esteem. Don't press the suicidal person to contact specific people, such as parents or a spouse. Conflict with these people may have given rise to the suicidal thoughts. Above all, keep in mind that your primary goal is to confer with a helping professional. Don't go it alone any longer than you have to.

SUMMING UP

Types of Mood Disorders

**What are mood disorders?** Mood disorders are disturbances in mood that are unusually prolonged or severe and serious enough to impair daily functioning.

**What are the major types of mood disorders?** There are various kinds of mood disorders, including depressive (unipolar) disorders, such as major depressive disorder and dysthmic disorder, and disorders involving mood swings, such as bipolar disorder and cyclothymic disorder.

**What is major depressive disorder?** In major depression, people experience a profound change in mood that impairs their ability to function. There are many associated features of major depressive disorder, including downcast mood; changes in appetite; difficulty sleeping; reduced sense of pleasure in formerly enjoyable activities; feelings of fatigue or loss of energy; sense of worthlessness; excessive or misplaced guilt; difficulties concentrating, thinking clearly, or making decisions; repeated thoughts of death or suicide; attempts at suicide; and even psychotic behaviors (hallucinations and delusions).

**What is dysthmic disorder?** Dysthmic disorder is a form of chronic depression that is milder than major depressive disorder but may nevertheless be associated with impaired functioning in social and occupational roles.

**What is bipolar disorder?** In bipolar disorder, people experience fluctuating mood states that interfere with the ability to function. Bipolar I disorder is identified by one or more manic episodes and typically, by alternating episodes of major depression. Bipolar II is characterized by the occurrence of at least one major depressive episode and one hypomanic episode, but without any full-blown manic episodes.

**What are the features of a manic episode?** Manic episodes are characterized by sudden elevation or expansion of mood and sense of self-importance, feelings of almost boundless energy, hyperactivity, and extreme sociability, which often takes a demanding and overbearing form. People in manic episodes tend to exhibit pressured or rapid speech, rapid “flight of ideas,” and decreased need for sleep.

**What is cyclothymic disorder?** Cyclothymic disorder is a type of bipolar disorder characterized by a chronic pattern of mild mood swings that sometimes progresses to bipolar disorder.

Causal Factors in Depressive Disorders

**How is stress related to mood disorders?** Exposure to life stress is associated with an increased risk of development and recurrence of mood disorders, especially major depression. Yet some people are more resilient in the face of stress, perhaps because of psychosocial factors such as social support.
How do psychodynamic theorists conceptualize mood disorders?

In classic psychodynamic theory, depression is viewed in terms of inward-directed anger. People who hold strongly ambivalent feelings toward people they have lost, or whose loss is threatened, may direct unresolved anger toward the inward representations of these people that they have incorporated or introjected within themselves, producing self-loathing and depression. Bipolar disorder is understood within psychodynamic theory in terms of the shifting balances between the ego and superego. More recent psychodynamic models, such as the self-focusing model, incorporate both psychodynamic and cognitive aspects in explaining depression in terms of self-absorption with the lost love object.

How do humanistic theorists view depression? Theorists working within the humanistic framework view depression as reflecting a lack of meaning and authenticity in a person's life.

How do learning theorists view depression? Learning perspectives explain depression by focusing on situational factors, such as changes in the level of reinforcement. When reinforcement is reduced, the person may feel unmotivated and depressed, which can occasion inactivity and further reduce opportunities for reinforcement. Coyne's interactional theory focuses on the negative family interactions that can lead the family members of people with depression to become less reinforcing toward them.

What are two major cognitive models of depression? Beck's cognitive model focuses on the role of negative or distorted thinking in depression. Depression-prone people hold negative beliefs toward themselves, the environment, and the future. This cognitive triad of depression leads to specific errors in thinking, or cognitive distortions, in response to negative events, which, in turn, lead to depression.

The learned helplessness model is based on the belief that people may become depressed when they come to view themselves as helpless to control the reinforcements in their environment or to change their lives for the better. A reformulated version of the theory held that the ways in which people explain events—their attributions—determine their proneness toward depression in the face of negative events. The combination of internal, global, and stable attributions for negative events renders one most vulnerable to depression.

What role do biological factors play in depression? Genetics appears to play a role in explaining major depressive disorder, as does imbalances in neurotransmitter activity in the brain. The diathesis-stress model is an explanatory framework that illustrates how biological or psychological diatheses may interact with stress in the development of mood disorders such as major depression.

Causal Factors in Bipolar Disorders

What causal factors are implicated in bipolar disorders? Genetics appears to play an important role, but stressful life experiences also contribute. Bipolar disorders are perhaps best explained in terms of multiple causes acting together within a diathesis–stress framework. Social support may be important in speeding recovery from mood episodes and reducing the risks of recurrences.

Treatment of Mood Disorders

What approaches to treatment are represented by each of the major theoretical perspectives? Psychodynamic treatment of depression has traditionally focused on helping the depressed person uncover and work through ambivalent feelings toward the lost object, thereby lessening the anger directed inward. Modern psychodynamic approaches tend to be more direct and briefer and focus more on developing adaptive means of achieving self-worth and resolving interpersonal conflicts. Learning theory approaches have focused on helping people with depression increase the frequency of reinforcement in their lives through such means as increasing the rates of pleasant activities in which they participate and assisting them in developing more effective social skills to increase their ability to obtain social reinforcements from others. Cognitive therapists focus on helping the person identify and correct distorted or dysfunctional thoughts and learn more adaptive behaviors. Biological approaches have focused on the use of antidepressant drugs and other biological treatments, such as electroconvulsive therapy (ECT). Antidepressant drugs may help normalize neurotransmitter functioning in the brain. Bipolar disorder is commonly treated with either lithium or anticonvulsant drugs.

Suicide

What factors are linked to suicide? Mood disorders are often linked to suicide. Although women are more likely to attempt suicide, more men actually succeed, probably because they select more lethal means. The elderly—not the young—are more likely to commit suicide. People who attempt suicide are often depressed, but they are generally in touch with reality. They may, however, lack effective problem-solving skills and see no other way of dealing with life stress than suicide. A sense of hopelessness also figures prominently in suicides.

What are the major theoretical approaches to understanding suicide? These draw on the classic psychodynamic model of anger turned inward; the role of social alienation; and learning, social-cognitive, and biologically based perspectives.

Why should you never ignore a person’s threat to commit suicide? Although certainly not all people who threaten suicide go on to commit the act, many do. People who commit suicide often signal their intentions, such as by telling others about their suicidal thoughts.
KEY TERMS

- mood disorders (p. 247)
- major depressive disorder (p. 249)
- mania (p. 249)
- hypomania (p. 249)
- postpartum depression (PPD) (p. 253)
- dysthymic disorder (p. 254)
- double depression (p. 255)
- bipolar disorder (p. 256)
- manic episode (p. 257)
- cyclothymic disorder (p. 258)
- cognitive triad of depression (p. 263)
- cognitive-specificity hypothesis (p. 265)
- learned helplessness (p. 266)

MEDIA TOOLS

A variety of digital and online learning tools are available to enrich your learning experience and help you succeed in the course. These resources include:

- **MyPsychLab**, an online learning system for your course in abnormal psychology that allows you to test your mastery of concepts in the book by using chapter-by-chapter diagnostic tests. Results from the diagnostic tests help you build a customized study plan. To access MyPsychLab, visit www.prenhall.com/mypsychlab and follow the instructions on the site.

- **“SPEAKING OUT” PATIENT INTERVIEWS**, a set of video case examples of actual patients you can access on the companion CD-ROM included with the text. Icons in the margins of the chapter highlight the video case examples included on the CD-ROM.

- **COMPANION WEB SITE**, an online study center that offers computer-scored quizzes you can use to test your knowledge, along with other study tools and links to related sites to enhance your learning of abnormal psychology. To access the companion web site, visit www.prenhall.com/nevid and use the various tabs and links on the site to access these learning resources.
Mood Disorders

Disturbances of mood states and related behaviors

- Biomedical therapies, such as antidepressant medication, mood stabilizers, phototherapy, and electroconvulsive therapy
- Cognitive-behavioral therapy to correct distorted thinking and increase opportunities for positive reinforcement
- Interpersonal psychotherapy to resolve interpersonal problems and lingering grief reactions

and may be treated by

- Biological factors, including genetic influences, neurotransmitter irregularities, and brain abnormalities
- Social-environmental factors, such as stressful life events or losses
- Cognitive factors, such as a biased or distorted way of thinking or a depressive attributional style
- Interaction of multiple factors, as represented in this diathesis-stress model of depression:

and include such types as

- Major Depressive Disorder
- Dysthymic Disorder
- Bipolar Disorder
- Cyclothymic Disorder
Diathesis–Stress Model of Depression

Potential Protective Factors
Factors reducing the likelihood of depression:
• Coping resources
• Social support

Potential Stress Factors
• Unemployment
• Death of loved one
• Divorce
• Sociocultural factors
• Loss of reinforcement
• Major life failure or disappointment

“I screwed up again. Nothing will ever work out for me.”

Diathesis
• Psychological Vulnerability (e.g., dysfunctional thinking patterns)
• Biological Vulnerability (e.g., genetic predisposition)