Chapter 8
Mood Disorders and Suicide

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Mood Disorders

- Mood disorders - Psychological disorders characterized by disturbances of mood.
- Major forms of mood disorder:
  - depressive disorders and
  - bipolar disorders (mood swing disorders).
- Two major types of depressive disorders that vary in severity:
  - major depressive disorder and
  - dysthymic disorder
- Similarly, bipolar or mood swing disorders vary in severity

Table 8.1 Overview of Mood Disorders

<table>
<thead>
<tr>
<th>Type of Disorder</th>
<th>Lifespan Prevalence</th>
<th>Major Depressive Disorder</th>
<th>Bipolar Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive Disorders</td>
<td>Life-long prevalence</td>
<td>Major depression</td>
<td>Bipolar disorder</td>
</tr>
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<td>Bipolar Disorders</td>
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<td>Bipolar disorder</td>
</tr>
</tbody>
</table>

Primary Features

- Major depressive disorder: Characterized by depressed mood, feelings of worthlessness, and loss of interest.
- Bipolar disorder: Characterized by episodes of mania and depression.

Related Features

- Major depressive disorder: Commonly associated with family history, genetic factors, and environmental stressors.
- Bipolar disorder: Associated with family history, genetic factors, and environmental stressors.

Note: This is a simplified overview and does not cover all aspects of mood disorders.
Mood states can be conceptualized as varying along a spectrum or continuum.

**Major Depressive Disorder**

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.

**Common Features of Depression**

<table>
<thead>
<tr>
<th>Category</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in Emotional States</td>
<td>Changes in usual (premorbid) periods of feeling down, depressed, sad, or blue</td>
</tr>
<tr>
<td>Changes in Motivation</td>
<td>Feeling uninterested, or having difficulty getting going in the morning or even getting out of bed</td>
</tr>
<tr>
<td>Changes in Food Intake and Eating Behavior</td>
<td>Changes to appetite (eating too much or too little) eating habits (eating too little or too much early morning, awakening)</td>
</tr>
<tr>
<td>Cognitive Changes</td>
<td>Difficulty concentrating or thinking clearly</td>
</tr>
</tbody>
</table>

![A Mood Thermometer](image)

FIGURE 8.1 A mood thermometer.
Major depressive episodes affect about twice as many women as men.
Major Depressive Disorder

**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).

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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)
- **Marital status** (people who are separated or divorced have higher rates than married or never-married people).

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Seasonal Affective Disorder

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.
Postpartum Depression
Postpartum derives from the Latin roots *post*, meaning “after,” and *papere*, meaning “to bring forth.”

**Postpartum depression (PPD)** - Persistent and severe mood changes that occur after childbirth.

PPD is often accompanied by disturbances in appetite and sleep, low self-esteem, and difficulties in maintaining concentration or attention.

Dysthymic Disorder
*Dysthymia* derives from Greek roots *dys-*, meaning “bad” or “hard” and *thymos*, meaning “spirit.”

**Dysthymic disorder** - A mild but chronic type of depressive disorder.

Dysthymia affects about 4% of the general population at some point in their lifetimes (APA, 2000; Conway et al., 2006).

*FIGURE 8.3 Lifetime prevalence rates for dysthymic disorder.*

Like major depression, dysthymic disorder occurs in about twice as many women as men.
**Double Depression**

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).

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**Bipolar Disorder**

*Bipolar disorder* - A psychological disorder characterized by mood swings between states of extreme elation and depression.

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.

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**The Case of Craig**

*Bipolar Disorder*
### Manic Episode

**Manic episode** - A period of unrealistically heightened euphoria, extreme restlessness, and excessive activity characterized by disorganized behavior and impaired judgment.

- 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.

### Cyclothymic Disorder

Cyclothymia is derived from the Greek *kyklos*, which means “circle,” and *thymos*, meaning “spirit.”

**Cyclothymic disorder** - A mood disorder characterized by a chronic pattern of less-severe mood swings than are found in bipolar disorder.

- 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.

### 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
- Living in an unsafe, distressed neighborhood
**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.

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.

From the psychodynamic viewpoint, bipolar disorder represents shifting dominance of the individual’s personality between the ego and superego.

**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.

Evidence supports the view that a self-focusing style—an inward or self-absorbed focus of attention—is associated with depression, especially in women.

**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.

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.
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.

Changes in the frequency or effectiveness of reinforcement can shift the balance so that life becomes unrewarding.

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.

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*. 
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.

**Cognitive triad of depression** - The view that depression derives from adopting negative views of oneself, the environment or world at large, and the future.

**Psychiatrist David Burns** (1980) enumerated a number of the cognitive distortions associated with depression:

1. All-or-nothing thinking.
2. Overgeneralization.
3. Mental filter.
4. Disqualifying the positive.
5. Jumping to conclusions.
7. Emotional reasoning.
8. “Should” statements.
9. Labeling and mislabeling.

**TABLE 8.4**

<table>
<thead>
<tr>
<th>Concept</th>
<th>Description</th>
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<tbody>
<tr>
<td>Negative View of Ourselves</td>
<td>Perceiving oneself as worthless, defective, inadequate, unlovable, and as lacking the skills necessary to achieve happiness.</td>
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<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 the future only continuing failure and evoking misery and helplessness.</td>
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</tbody>
</table>

After according to Aaron Beck, depressed people adopt a habitual style of negative thinking—the so-called cognitive triad of depression.

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.

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.

Learned Helplessness (Attributional) Theory

Learned helplessness - A behavior pattern characterized by passivity and perceptions of lack of control.

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.
Learned Helplessness (Attributional) Theory

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.

Genetic Factors

Genetic factors play a significant role in determining proneness to mood disorders, including major depression and bipolar disorder.

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.

An emerging model in the field focuses on interactions of genetic and environmental factors in the development of major depression and other mood disorders.

Biochemical Factors and Brain Abnormalities

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.

Brain-imaging studies show lower metabolic activity in the prefrontal cortex of clinically depressed people as compared to healthy controls.

Other research reveals brain abnormalities in people with mood disorders (major depression and bipolar disorder) in parts of the brain involved in governing emotions.
Causal Factors In Bipolar Disorders

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).

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.

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.

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

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.

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.

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.

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.

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.
Cognitive Therapy

Cognitive Therapy for Depression
CLIENT: I don't have any self-control at all.
THERAPIST: On what basis do you say that?
CLIENT: Somebody offered me candy and I couldn't refuse it.
THERAPIST: Were you eating candy every day?
CLIENT: No, I just ate it this once.
THERAPIST: Did you do anything constructive during the past week to adhere to your diet?
CLIENT: 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.
THERAPIST: If you counted up the number of times you controlled yourself versus the number of times you gave in, what ratio would you get?
CLIENT: About 100 to 1.
THERAPIST: 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?
CLIENT: I guess not—not through and through (smiles).

—Adapted from Beck et al., 1976, p. 36

Antidepressant Drugs

Today, we have three major classes of antidepressants that increase the availability of key neurotransmitters in the brain:

1. Tricyclic antidepressants (TCAs)
2. Monoamine oxidase (MAO) inhibitors
3. Selective serotonin-reuptake inhibitors (SSRIs)

The actions of various types of antidepressants at the synapse.
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.

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.

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.
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.

We also have evidence that psychological treatment can improve the level of functioning and adherence to a medication regimen in bipolar patients.

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.

Suicide

**TABLE 8.7**

<table>
<thead>
<tr>
<th>U.S. Surgeon General’s Report on Suicide: Cost to the Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Every 17 minutes another life is lost to suicide. Every day, 60 Americans take their own lives and over 1,500 attempt suicide.</td>
</tr>
<tr>
<td>• Suicide is now the eighth leading cause of death in Americans.</td>
</tr>
<tr>
<td>• For every two victims of homicide in the United States, there are three deaths from suicide.</td>
</tr>
<tr>
<td>• There are now twice as many deaths due to suicide than due to HIV/AIDS.</td>
</tr>
<tr>
<td>• Between 1992 and 2005, the incidence of suicide among adolescents and young adults nearly tripled.</td>
</tr>
<tr>
<td>• In the month prior to their suicide, 75% of elderly persons had visited a physician.</td>
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<tr>
<td>• Over half of all suicides occur in adult men, ages 25 to 64.</td>
</tr>
<tr>
<td>• Many who make suicide attempts never seek professional care immediately after the attempt.</td>
</tr>
<tr>
<td>• Males are four times more likely to commit suicide than are females.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• Suicide takes the lives of more than 30,000 Americans every year.</td>
</tr>
</tbody>
</table>

Source: Centers for Mental Health Services, 2001.
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.

Many older adults also suffer a mounting accumulation of losses of friends and loved ones, leading to social isolation.

Gender and Ethnic/Racial Differences

More women attempt suicide, but more men “succeed”.

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.
Ethnicity and suicide rates.

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

Predicting Suicide

Evidence points to the pivotal role of hopelessness about the future in predicting suicidal thinking and suicide attempts.

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.

QUESTIONS?