Theory & Treatment

Psychoanalysis
- Caused by fixation in the oral stage
- Treatment focuses on decreasing dependency on others
- Through childhood loss, the adult internalizes the loss and then identifies with that person.
- Because we harbor many feelings and anger toward that person, the mourner then becomes the object for his/her own hate and anger.
- This internalized anger towards the lost one continues to be directed inwardly increasing self blame, self abuse, and depression
- There is little support for this theory

Cognitive Theory
- An individual thinking is biased towards negative interpretations.
- The individual develops negative schemas or perceptual sets

\[
\text{Negative Triad} \\
\text{(pessimistic view of the self, world, & future)} \\
\downarrow \uparrow \\
\text{Negative schema or beliefs are triggered by} \\
\text{Negative life events} \\
\downarrow \downarrow \\
\text{Cognitive Biases} \\
\text{(arbitrary reference} \\
\text{selective abstraction} \\
\text{over-generalization} \\
\text{magnifying & minimizing)}
\]

Learned Helplessness/Hopelessness
- An individuals passivity and sense of being unable to act and to control his/her own life is acquired through unpleasant experiences and trauma and that the individual tried unsuccessfully to control, bring on a sense of helplessness and depression
- Little Support

Interpersonal Theory
- Depressed individuals tend to have sparse social networks and to regard themselves as providing little support which reduces the individuals ability to handle negative life events and makes them more vulnerable to depression

Existential Theory
- Victor Frankl developed Logotherapy (meaning therapy) in which the individual and therapist try to restore meaning in the individuals life

Behavior Theory
- The individual experiences a severe drop in reinforcers or increase in punishments
Psychological Theories of Manic Depression are similar. The depression component may be related to the same factors while the mania component may be seen as a defense against a debilitating psychological state.

**Biological Theory**
- Both unipolar and bipolar disorder appear to be genetically determined to some extent.
- Prime neurotransmitters (NT) are norepinephrine (NE) and serotonin (S).
- Tricyclic antidepressants (Tofranil/imipramine)
  - Have 3 fused carbon rings and prevent the reuptake of NE and S in the presynaptic neuron by increasing the concentrations in the synapse and facilitating the next transmission.
- MAO inhibitors (Parnate/tranylcypromine)
  - Keep the enzyme monoamine oxidase from deactivating the NT thus increasing the concentrations of S and NE in the synapse.
- SSRI's (Prozac/flouxetine)
  - More selective and block the reuptake channels.

How do we check?
- Urine levels of NE decrease in depression and increase in mania.
- Levels of the metabolite MHPG (3-methoxy-4-hydroxyphenyl glycol) are decreased in depression and increased in mania.
- The S metabolite 5-HIAA (5-hydroxyindole acetic acid) decreases in depression.
- Ingesting L-tryptophan which in the precursor of S decreases depression.
- Drugs that deplete tryptophan in those individuals with a family history of depression have more depressed mood.
- NOTE: MAO-I's and tricyclics increase levels of NE and S only to return to pre-treatment levels within a few days!
- There is a 2 to 4 week lag time before any behavior effects.

Post-synaptic effects may be critical in that drug treatment may change the sensitivity of the post synaptic receptors.

Even bipolar disorder theory of NE is confusing.
- Lithium carbonate is used to treat both the mania and the depressive symptoms suggesting it may only be one system working!
- Lithium may work by the regulation of G-proteins (guanine nucleotide-binding proteins) in the post synaptic membrane (G-protein increases in mania and decreases in depression).

The neuroendocrine system – Hypothalamic-pituitary-adrenal axis is over active in depression.
- vegetative symptoms
- cortisol increases in depression
- cortisol increases the size of the adrenal glands
- hippocampal damage in depression
- DST (dexamethasone suppression test)
- Diseases of the thyroid may be related to bipolar disorder and involve the hypothalamic-pituitary-adrenal axis.
<table>
<thead>
<tr>
<th>Category</th>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tricyclic antidepressants</td>
<td>Imipramine</td>
<td>Tofranil</td>
<td>Heart attack, stroke, hypotension, blurred vision, anxiety, tiredness, dry mouth, constipation, gastric disorders, erectile failure, weight gain</td>
</tr>
<tr>
<td></td>
<td>Amitriptyline</td>
<td>Elavil</td>
<td></td>
</tr>
<tr>
<td>MAO inhibitors</td>
<td>Tranylcypromine</td>
<td>Parnate</td>
<td>Possibly fatal hypertension, dry mouth, dizziness, nausea, headaches</td>
</tr>
<tr>
<td>Selective serotonin reuptake inhibitors</td>
<td>Fluoxetine</td>
<td>Prozac</td>
<td>Nervousness, fatigue, gastrointestinal complaints, dizziness, headaches, insomnia</td>
</tr>
<tr>
<td>Lithium</td>
<td>Lithium</td>
<td>Lithium</td>
<td>Tremors, gastric distress, lack of coordination, dizziness, cardiac arrhythmia, blurred vision, fatigue, death</td>
</tr>
</tbody>
</table>
Criteria for Major Depressive Episode

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

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

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

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

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

(4) Insomnia or hypersomnia nearly every day.

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

(6) Fatigue or loss of energy nearly every day.

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

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

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

B. The symptoms do not meet criteria for a Mixed Episode (see p. 335).

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

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

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

1. inflated self-esteem or grandiosity
2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. more talkative than usual or pressure to keep talking
4. flight of ideas or subjective experience that thoughts are racing
5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
6. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode (see p. 335).

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

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

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.
Criteria for Hypomanic Episode

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
   (1) inflated self-esteem or grandiosity
   (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
   (3) more talkative than usual or pressure to keep talking
   (4) flight of ideas or subjective experience that thoughts are racing
   (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
   (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
   (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

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

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.
Between 10 and 12 per 100,000 occur in the United States. It is among the top 5 causes of death for men 10 to 55 in the U.S. and is the second leading cause of death for white males 15 to 19. Men commit suicide 3:1 when compared to women but more women actually attempt, 3:1 when compared to men.

**Signs**

1. **Perturbation** – Subjective distress (disturbed or agitated)

2. **Lethality** – Probability of individual committing suicide

3. **Inimicality** – General lifestyle. How much is the person his or her own worst enemy? - These include self-defeating behaviors such as alcohol, drugs, maiming or self-abuse, neglecting one’s medical needs, and unstable relations.

4. **Emotionality** – Level of hostility, despair, shame, guilt, dependency, hopelessness, and sadness. Are the feelings overwhelming, arming, or mobilizing?

5. **Suicidal Events have three features**, they are:
   a. Brief
   b. Ambivalent
   c. Dyadic

6. **Intentionality** – Intentional, sub-intentional, unintentional?

7. **Sudden lifestyle changes – Relief**
### Table 10.3: Comparison of Suicide Attempters and Completers

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Attempters</th>
<th>Completers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Majority female</td>
<td>Majority male</td>
</tr>
<tr>
<td>Age</td>
<td>Predominantly young</td>
<td>Risk increases with age</td>
</tr>
<tr>
<td>Method</td>
<td>Low lethality (pills, cutting)</td>
<td>More violent (gun, jumping)</td>
</tr>
<tr>
<td>Common diagnoses</td>
<td>Dysthymic disorder</td>
<td>Major mood disorder</td>
</tr>
<tr>
<td></td>
<td>Borderline personality disorder</td>
<td>Alcoholism</td>
</tr>
<tr>
<td></td>
<td>Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Dominant emotion</td>
<td>Depression with anger</td>
<td>Depression with hopelessness</td>
</tr>
<tr>
<td>Motivation</td>
<td>Change in situation</td>
<td>Death</td>
</tr>
<tr>
<td></td>
<td>Cry for help</td>
<td></td>
</tr>
<tr>
<td>Hospital course</td>
<td>Quick recovery from dysphoria</td>
<td></td>
</tr>
<tr>
<td>Attitude toward attempt</td>
<td>Relief to have survived</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promises not to repeat</td>
<td></td>
</tr>
</tbody>
</table>

The Ten Commonalities of Suicide

I. The common purpose of suicide is to seek a solution.

II. The common goal of suicide is the cessation of consciousness.

III. The common stimulus in suicide is intolerable psychological pain.

IV. The common stressor in suicide is frustrated psychological needs.

V. The common emotion in suicide is hopelessness-helplessness.

VI. The common cognitive state in suicide is ambivalence.

VII. The common perceptual state in suicide is constriction.

VIII. The common action in suicide is egression.

IX. The common interpersonal act in suicide is communication of intention.

X. The common consistency in suicide is with lifelong coping patterns.

Fiction

1. People who talk about suicide don’t kill themselves.

2. Suicide happens without warning.

3. People who really want to commit suicide are confident in their decision.

4. Once someone is suicidal they always are suicidal.

5. Improvement in the suicide risk signals that the crisis is over.

6. Suicide happens to those better off when compared to those worse off.

7. Suicidal behavior is inherited.

8. Suicidal persons are mentally ill and the act is that of someone that is psychotic.
What to do!

1. Assess the situation.

2. Get help if necessary.

3. Remain calm and take control of the situation.

4. Try to mobilize family and/or community resources, even during the crisis.

5. Consult with peers regarding situation. This will allow you to obtain some objectivity.

6. Call the police if necessary to prevent the person from harming himself or herself and use the hospital as preventative intervention.

7. Monitor the individual for changes in depression, behavior, attitude, and provide support. When talking to the individual try to listen closely and provide support not advice.

8. Always take suicidal verbalizations and behaviors seriously. You may not be able to get a second chance.