Chapter 6
Mood Disorders (and Suicide)

Rick Grieve, Ph.D.
Psy 440: Abnormal Psychology
Western Kentucky University

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- https://www.youtube.com/watch?v=SicnnTI9IW4
- https://www.youtube.com/watch?v=MVmfiOdkwO0

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Mood Disorders - Overview

- Characterized by gross deviations in mood
  - Mood – enduring states of feeling; pervasive quality of an individual's experience
- Depression and mania, either singly or together, contribute
- Mood disturbances are severe or prolonged and impair ability to function

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DSM-5 Depressive Disorders

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

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DSM-5 Bipolar Disorders

- Bipolar I disorder
- Bipolar II disorder
- Cyclothymic disorder

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DSM-5 Criteria: Major Depressive Episode (1 of 2)

Features of a major depressive episode include the following, occurring most of the day nearly every day for at least 2 weeks:

- Five of the following:
  - Depressed mood (may be irritable mood in children or adolescents)
  - Markedly diminished interest or pleasure in most daily activities
  - Significant weight loss when not dieting, weight gain, or significant decrease or increase in appetite
  - Insomnia or hypersomnia
  - Noticeable psychomotor agitation or retardation

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DSM-5 Criteria: Major Depressive Episode (2 of 2)

- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Diminished ability to think, concentrate, or make decisions
- Recurrent thoughts of death, suicide ideation, or a suicide attempt

- Clinically significant distress or impairment
- Symptoms are not due to the effects of a substance (e.g., drug abuse) or a general medical condition (e.g., hypothyroidism)

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DSM-5 Disorder: Manic Episode (1 of 2)

Features of a manic episode include the following:

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting at least 1 week
- Significant degree of at least three of the following: inflated self-esteem, decreased need for sleep, excessive talkativeness, racing thoughts, distractibility, increase in goal-directed activity or psychomotor agitation, excessive involvement in high-risk behaviors
- Mood disturbance is severe enough to cause impairment in normal functioning or requires hospitalization, or there are psychotic features

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DSM-5 Disorder: Manic Episode (2 of 2)

- Symptoms are not caused by the direct physiological effects of a substance or a general medical condition

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Types of Mood Episodes, Part 1

- Major depressive episode
  - Extremely depressed mood and/or loss of pleasure (anhedonia)
    - Lasts most of the day, nearly every day for at least 2 weeks
  - At least four additional physical or cognitive symptoms:
    - E.g., indecisiveness, feelings of worthlessness, fatigue, appetite change, restlessness or feeling slowed down, sleep disturbance

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Types of Mood Episodes, Part 2

- Manic episode
  - Elevated, expansive mood for at least 1 week
  - Inflated self-esteem, decreased need for sleep, excessive talkativeness, flight of ideas or sense that thoughts are racing, easy distractibility, increase in goal-directed activity or psychomotor agitation, excessive involvement in pleasurable but risky behaviors
  - Impairment in normal functioning

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Types of Mood Episodes, Part 3

- Hypomanic episode
  - Shorter, less severe version of manic episodes
  - Last at least 4 days
  - Have fewer and milder symptoms
  - Associated with less impairment than a manic episode (e.g., less risky behavior)
  - May not be problematic in and of itself, but usually occurs in the context of a more problematic mood disorder

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Types of Mood Episodes, Part 4

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

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Major Depressive Disorder: An Overview

- Clinical features
  - One or more major depressive episodes separated by periods of remission
  - Single episode—highly unusual
  - Recurrent episodes—more common
- From grief to depression
  - Previously could not be diagnosed during periods of mourning
  - Now recognized that major depression may occur as part of the grieving process

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Persistent Depressive Disorder: An Overview, Part 1

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

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Persistent Depressive Disorder: An Overview, Part 2

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

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DSM-5 Criteria: Premenstrual Dysphoric Disorder, Part 1

Features of premenstrual dysphoric disorder include the following:

- In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to improve within a few days after the onset of menses, and become minimal or absent in the week post menses
- One (or more) of the following symptoms must be present:
  - marked affective lability (e.g., mood swings)
  - marked irritability or anger
  - marked depressed mood
  - marked anxiety and tension

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DSM-5 Criteria: Premenstrual Dysphoric Disorder, Part 2

- One (or more) of the following symptoms must additionally be present, to reach a total of five symptoms when combined with symptoms above:
  - Decreased interest in usual activities
  - Difficulty in concentration
  - Lethargy, fatigability, lack of energy
  - Marked change in appetite, overeating, or specific food cravings;
  - Hypersomnia or insomnia
  - A sense of being overwhelmed or out of control
  - Physical symptoms such as breast tenderness or weight gain

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DSM-5 Criteria: Premenstrual Dysphoric Disorder, Part 3

- Clinically significant distress or interference with work, school, usual social activities, or relationships
- Symptoms are not attributable to the effects of a substance (e.g., drug abuse) or another medical condition

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DSM-5 Criteria: Premenstrual Dysphoric Disorder, Part 4

- Controversial diagnosis
  - Advantage: Legitimizes the difficulties some women face when symptoms are very severe
  - Disadvantage: Pathologizes an experience many consider to be normal

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DSM-5 Criteria Summary: Disruptive Mood Dysregulation Disorder (1 of 2)

Features of disruptive mood dysregulation disorder include the following:

- Severe temper outbursts occurring three or more times per week for at least 1 year, manifested verbally and/or behaviorally that are out of proportion in intensity or duration to the situation and are inconsistent with developmental level
- The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, is observable by others in at least two of three settings (i.e., at home, at school, with peers), and is severe in at least one of these settings

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DSM-5 Criteria Summary: Disruptive Mood Dysregulation Disorder (2 of 2)

- The diagnosis should not be made for the first time before age 6 years or after age 18 years
- There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met
- The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition
- Designed in part to combat overdiagnosis of bipolar disorder in youth

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Bipolar I Disorder: An Overview

- Overview and defining features
  - Alternations between full manic episodes and major depressive episodes
- Facts and statistics
  - Average age of onset is 15 to 18 years
  - Can begin in childhood
  - Tends to be chronic
  - Suicide is a common consequence

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Bipolar II Disorder: An Overview

- Overview and defining features
  - Alternations between major depressive and hypomanic episodes
- Facts and statistics
  - Average age of onset is 19 to 22 years
  - Can begin in childhood
  - 10% to 25% of cases progress to full bipolar I disorder
  - Tends to be chronic

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DSM-5 Criteria: Bipolar II Disorder

Features of bipolar II disorder include the following:

- Presence (or history) of one or more major depressive episodes
- Presence (or history) of at least one hypomanic episode
- No history of a full manic episode
- Mood symptoms are not better accounted for by another mental disorder
- Clinically significant distress or impairment of functioning

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DSM-5 Criteria: Cyclothymic Disorder (1 of 2)

Features of cyclothymic disorder include the following:

- For at least 2 years, numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet the criteria for a major depressive episode
- Since onset, the person has not been without the symptoms for more than 2 months at a time
- No major depressive episode, manic episode, or hypomanic episode has been present during the first 2 years of the disturbance

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DSM-5 Criteria: Cyclothymic Disorder (2 of 2)

- Mood symptoms are not better accounted for by another mental disorder, the physiological effects of a substance, or a general medical condition
- Clinically significant distress or impairment of functioning

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

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Cyclothymic Disorder: An Overview, Part 1

- Overview and defining features
  - Chronic version of bipolar disorder
  - Hypomanic or depressive mood states may persist for long periods
  - Must last for at least 2 years (1 year for children and adolescents)

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Cyclothymic Disorder: An Overview, Part 2

- Facts and statistics
  - Average age of onset is 12 to 14 years
  - More common among females
  - Cyclothymia tends to be chronic and lifelong
  - One third to one half develop full-blown bipolar

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Prevalence of Mood Disorders, Part 1

- Worldwide lifetime prevalence
  - 16% for major depression
    - 6% have experienced major depression in last year
  - Children
  - Adolescents

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Prevalence of Mood Disorders, Part 2

- Sex differences
  - Females are twice as likely to have major depression
  - Bipolar disorders approximately equally affect males and females
  - Women more likely to experience rapid cycling
  - Women more likely to be in depressive period

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Prevalence of Mood Disorders, Part 3

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

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Bipolar Disorder

- Prevalence rates

Country	Age	Dx	Lifetime	12-month
China	18-70	Bipolar I/II	0.1	
Germany	18-65	Any Bipolar	1.0	0.8
	14-24	Bipolar I	1.4	1.3
	14-24	Bipolar II	0.4	0.4
Japan	>19	Bipolar I/II		0.1
Lebanon	>17	Bipolar	2.4	
Mexico	18-65	Bipolar I/II	1.9	
New Zealand	16-64	Bipolar		1.8
Nigeria	>17	Bipolar I/II	0.0	0.0
Switzerland		Bipolar I/II	1.7	
United States	>11	Bipolar I	3.3	2.0
	>54	Bipolar I/II	0.8	0.4
	>17	Bipolar I	1.0	0.6
	>17	Bipolar II	1.1	0.8
	>17	Subthreshold	2.4	

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Life Span Developmental Influences on Mood Disorders, Part 1

- Three-month-olds can show depressive symptoms
- Young children typically don't show classic mania or bipolar symptoms
- Mood disorder may be misdiagnosed as ADHD
- Children are being diagnosed with bipolar at increasingly high rates

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Life Span Developmental Influences on Mood Disorders, Part 2

- Depression in elderly between 14% and 42%
  - Co-occurence with anxiety disorders
  - Less gender imbalance after 65 years of age

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Life Span Developmental Influences on Mood Disorders, Part 3

- Cultural differences exist
  - Hopi say they are "heartbroken"
  - Native American population have four times the rate of depressive disorders as the general population

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Mood Disorders: Familial and Genetic Influences, Part 1

- Family studies
  - Rate is high in relatives of probands
  - Relatives of bipolar probands are more likely to have unipolar depression

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Mood Disorders: Familial and Genetic Influences, Part 2

- Twin studies
  - Concordance rates are high in identical twins
    - Two to three times more likely to present with mood disorders than a fraternal twin of a depressed cotwin
  - Severe mood disorders have a strong genetic contribution
  - Heritability rates are higher for females compared to males

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Mood Disorders: Familial and Genetic Influences, Part 3

- Twin studies
  - Vulnerability for unipolar or bipolar disorder
    - Appears to be inherited separately
  - Some genetic factors are common for mood and anxiety disorders

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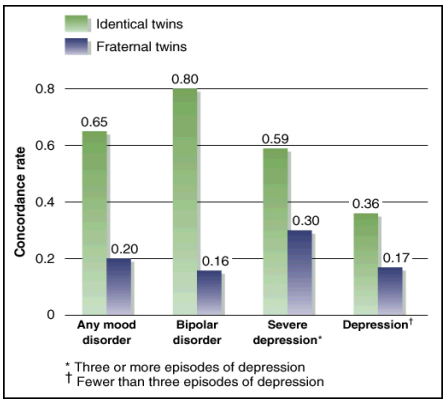

Figure 7.3
Mood disorders among twins

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Mood Disorders: Neurobiological Influences, Part 1

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

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Mood Disorders: Neurobiological Influences, Part 2

- The endocrine system
  - Elevated cortisol
  - Stress hormones decrease neurogenesis in the hippocampus > less able to make new neurons

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Mood Disorders: Neurobiological Influences, Part 3

- Sleep disturbance
  - Hallmark of most mood disorders
  - Depressed patients have quicker and more intense REM sleep
  - Sleep deprivation may temporarily *improve* depressive symptoms in bipolar patients

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Mood Disorders: Psychological Dimensions (Stress)

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

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Mood Disorders: Psychological Dimensions (Learned Helplessness)

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

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Mood Disorders: Depressive Attributional Style

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

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TYPES OF ATTRIBUTIONS

	INTERNAL	EXTERNAL
Stable Global	I am so incompetent that I will never get hired.	The job interview is such an unfair way to assess the competence of prospective employees.
Stable Specific	I never interview well when I do not have enough time to prepare.	That interviewer likes to ask impossible questions so that she can reject candidates.
Unstable Global	I never do well at interviews.	They probably rejected me because they had another candidate in mind all along.
Unstable Specific	I was caught off guard by the focus of this interview and therefore made a bad impression.	I think the interviewer woke up on the wrong side of the bed today, because he was simply nasty in the interview.

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Mood Disorders: Psychological Dimensions (Cognitive Theory), Part 1

- Negative coping styles
  - Depressed persons engage in cognitive errors
  - Tendency to interpret life events negatively

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Mood Disorders: Psychological Dimensions (Cognitive Theory), Part 2

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

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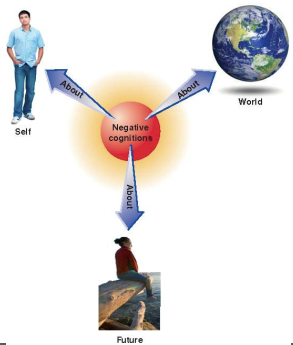
The Depressive Cognitive Triad



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Mood Disorders: Psychological Dimensions (Cognitive Theory), Part 3

- Rumination
- **Cognitive Errors/Distortions**
  - **All or Nothing Thinking, Overgeneralization, Mental Filter, Disqualifying the Positive, Jumping to Conclusions, Magnification & Minimization, Emotional Reasoning, Should Statements, Labeling & Mislabeling, Personalization**

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Mood Disorders: Social and Cultural Dimensions, Part 1

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

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Mood Disorders: Social and Cultural Dimensions, Part 2

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

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Gender Differences in Mood Disorders, Part 1

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

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Gender Differences in Mood Disorders, Part 2

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

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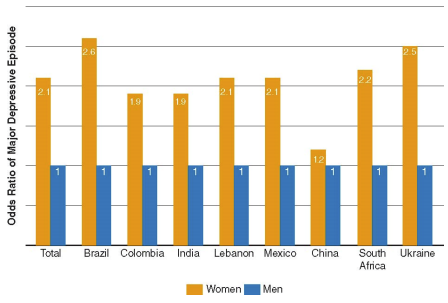
Odds Ratio of Major Depressive Episode per Country



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An Integrative Theory

- Shared biological vulnerability
  - Overactive neurobiological response to stress
- Inadequate coping and depressive cognitive style
  - Diathesis-stress model
- Biological, psychological, and social factors all influence the development of mood disorders
- Exposure to stress

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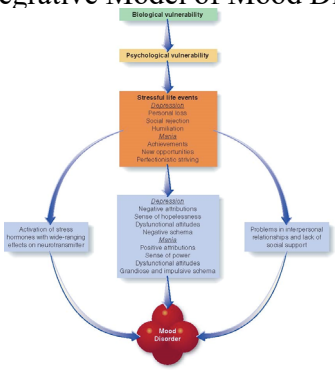
An Integrative Model of Mood Disorders



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Treatment

- The number of people being treated for depression is on the rise
- Now for the bad news…

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Treatment Guidelines

- For initial treatment for adults, the gold standard is either psychotherapy or second-generation antidepressant medication
  - For older adults (age 60 or older), initial treatment is either group life review treatment or group Cognitive Behavioral Therapy
    - Maybe not meds

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Treatment of Mood Disorders: Medication

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

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Selective Serotonin Reuptake Inhibitors

- Called SSRIs
- Specifically block reuptake of serotonin so more serotonin is available in the brain
  - Fluoxetine (Prozac) is the most popular SSRI
- SSRIs pose some risk of suicide particularly in teenagers
- Negative side effects are common

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Tricyclic Antidepressants

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

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Mixed Reuptake Inhibitors

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

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Monoamine Oxidase (MAO) Inhibitors

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

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Table 7.7 Efficacy of Various Antidepressant Drugs for Major Depressive Disorder

	Drug Efficacy		Drug-Placebo	
Drug	Inpatient	Outpatient	Inpatient	Outpatient
Tricyclics	50.0%	51.5%	25.1%	21.3%
SD	(6.5)	(5.2)	(11.5)	(3.9)
N	[33]	[102]	[8]	[46]
Monoamine oxidase inhibitors (MAOIs)	52.7%	57.4%	18.4%	30.9%
SD	(9.7)	(5.5)	(22.6)	(17.1)
N	[14]	[21]	[9]	[13]
Selective serotonin reuptake inhibitors (SSRIs)	54.0%	47.4%	25.5%	20.1%
SD	(10.1)	(12.5)	(21.7)	(7.8)
N	[8]	[39]	[2]	[23]

Note: The percentage shown in the *Drug Efficacy* column is the anticipated percentage of patients provided the treatment shown who will respond. The *Drug-Placebo* column shows the expected percentage difference in patients given a drug versus a placebo based on direct drug-placebo comparisons in trials that included at least these two cells. The numbers in parentheses are the standard deviations of the estimated percentage of responders. The bracketed numbers give the number of sudies for which these estimates are calculated.

Source Adapted from Depression Guideline Panel, 1993, April

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Treatment of Mood Disorders: Lithium

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

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Other Medications for Mood Disorders

- Depakote
- Lamictal
- Combination of antidepressant and antipsychotic
  - e.g., Prozac and Risperadone

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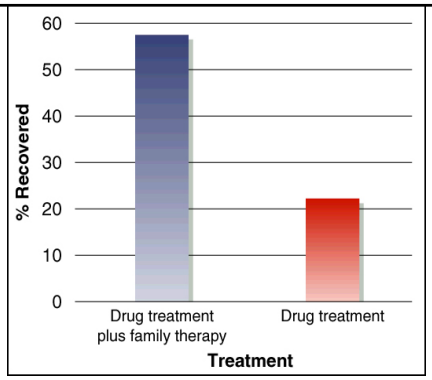

Figure 7.10
Percentage of patients with bipolar disorder recovered after standard drug treatment or drug treatment plus family therapy

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Treatment of Mood Disorders: Electroconvulsive Therapy (ECT)

- Effective for medication-resistant depression
  - Most viable option
- Used in about 5% of hospital presentations
  - Underutilized?
  - People older than 65, women, and severe depression = receive ECT
- The nature of ECT
  - Brief electrical current applied to the brain
  - Results in temporary seizures
  - Usually 6 to 10 outpatient treatments are required

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Treatment of Mood Disorders: Electroconvulsive Therapy (ECT), Part 2

- Side effects:
  - Short-term memory loss, which is usually restored
  - Some patients suffer long-term memory loss
- Adverse Effects
- Mechanism is unclear

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Treatment of Mood Disorders: Transcranial Magnetic Stimulation

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

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Treatment of Bipolar Disorders: Other Treatments

- **Maintaining practical lifestyle habits**
  - **New research**
    - **Sleep**
    - **Maintain routine**
    - **Omega 3**

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Psychosocial Treatments for Depression

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

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Psychosocial Treatments for Bipolar Disorders

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

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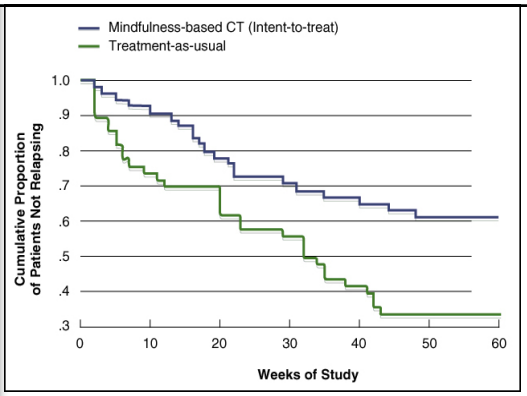

Figure 7.9
Data from Teasdale 2000 study on patients treated with severe depression

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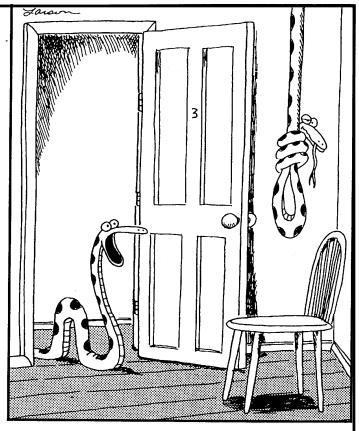
Suicide



"Oh no, Elliott! Why? … Why? …"

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- "Suicide is man's way of telling God, You can't fire me, I quit."
- Bill Maher

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Suicide Assessment

- Personal Reactions to Suicide
  - As we discuss suicide and suicide assessment, be sure to monitor your own personal reactions and take time to talk with someone you trust if this topic raises strong emotions in you

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Statistics, Part 1

- 12th leading cause of death in the United States
  - Underreported; actual rate may be 2x to 3x higher
- Particularly prevalent in young adults
  - Second or third leading cause of death among teenagers
  - Second or third leading cause of death in college students
  - 12% of college students consider suicide in a given year
  - Second leading cause of death in those 10-34; fourth leading cause of death in those 35-54

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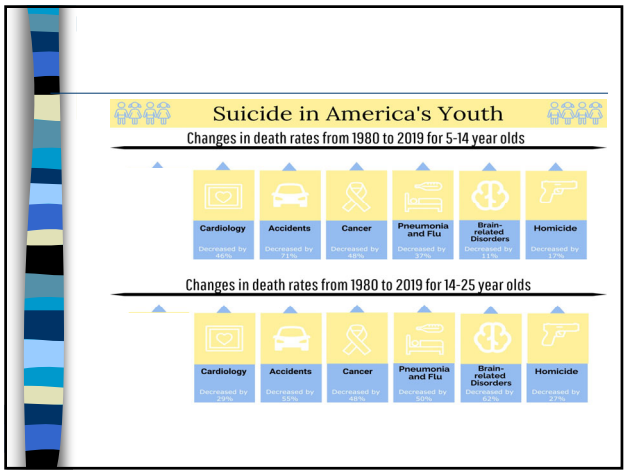
Ten Leading Causes of Death

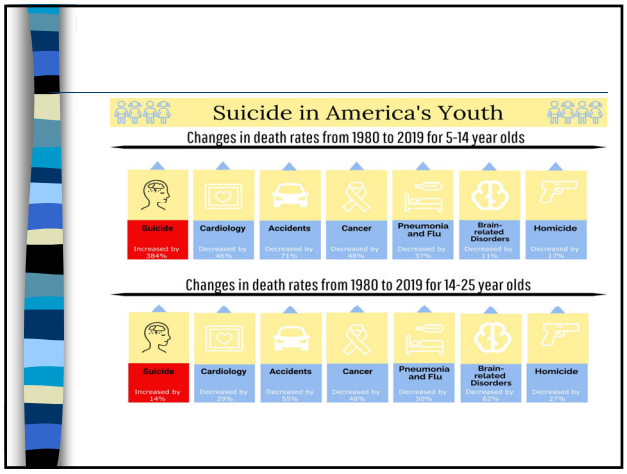
Rank	Age Groups										
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 4,043	Unintentional Injury 1,153	Unintentional Injury 689	Unintentional Injury 891	Unintentional Injury 15,117	Unintentional Injury 31,315	Unintentional Injury 31,097	Malignant Neoplasms 34,589	Malignant Neoplasms 110,243	Heart Disease 556,985	Heart Disease 696,962
2	Short Gestation 3,141	Congenital Anomalies 382	Malignant Neoplasms 382	Suicide 581	Homicide 6,466	Suicide 8,454	Heart Disease 12,177	Heart Disease 34,169	Heart Disease 88,551	Malignant Neoplasms 440,753	Malignant Neoplasms 602,350
3	SIDS 1,389	Homicide 311	Congenital Anomalies 171	Malignant Neoplasms 410	Suicide 6,052	Homicide 7,125	Malignant Neoplasms 10,730	Unintentional Injury 27,819	COVID-19 42,090	COVID-19 282,836	COVID-19 350,831
4	Unintentional Injury 1,194	Malignant Neoplasms 307	Homicide 169	Homicide 285	Malignant Neoplasms 1,306	Heart Disease 3,984	Suicide 7,314	COVID-19 16,964	Unintentional Injury 29,815	Cerebro-vascular 137,392	Unintentional Injury 200,955
5	Maternal Pregnancy Comp. 1,116	Heart Disease 112	Heart Disease 56	Congenital Anomalies 150	Heart Disease 870	Malignant Neoplasms 3,573	COVID-19 6,079	Liver Disease 9,503	Chronic Low Respiratory Disease 18,816	Alzheimer's Disease 132,741	Cerebro-vascular 160,264
6	Placenta Cord Membranes 700	Influenza & Pneumonia 84	Influenza & Pneumonia 55	Heart Disease 111	COVID-19 501	COVID-19 2,254	Liver Disease 4,938	Diabetes Mellitus 7,546	Diabetes Mellitus 18,002	Chronic Low Respiratory Disease 128,712	Chronic Low Respiratory Disease 152,657
7	Bacterial Sepsis 542	Cerebro-vascular 55	Chronic Low Respiratory Disease 54	Chronic Low Respiratory Disease 93	Congenital Anomalies 384	Liver Disease 1,631	Homicide 4,482	Suicide 7,249	Liver Disease 16,151	Diabetes Mellitus 72,194	Alzheimer's Disease 134,242
8	Respiratory Distress 388	Perinatal Period 54	Cerebro-vascular 32	Diabetes Mellitus 50	Diabetes Mellitus 312	Diabetes Mellitus 1,168	Diabetes Mellitus 2,904	Cerebro-vascular 5,686	Cerebro-vascular 14,153	Unintentional Injury 52,796	Diabetes Mellitus 102,188
9	Circulatory System Disease 386	Septicemia 43	Benign Neoplasms 28	Influenza & Pneumonia 50	Chronic Low Respiratory Disease 220	Cerebro-vascular 600	Cerebro-vascular 2,008	Chronic Low Respiratory Disease 3,538	Suicide 7,160	Nephritis 42,675	Influenza & Pneumonia 53,544
10	Neonatal Hemorrhage 317	Benign Neoplasms 35	Suicide 20	Cerebro-vascular 44	Complicated Pregnancy 191	Complicated Pregnancy 594	Influenza & Pneumonia 1,148	Homicide 2,842	Influenza & Pneumonia 6,295	Influenza & Pneumonia 42,511	Nephritis 52,547

CDC, 2022 (2020 data)

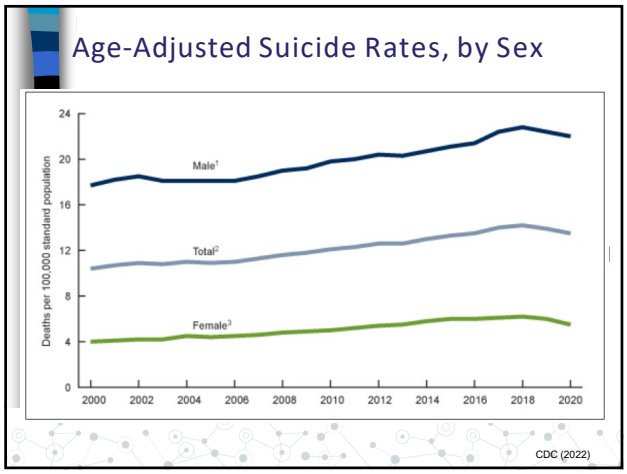
81


Suicide in America's Youth
Changes in death rates from 1980 to 2019 for 5-14 year olds
Cardiology
Decreased by 46%
Accidents
Decreased by 71%
Cancer
Decreased by 48%
Pneumonia and Flu
Decreased by 37%
Brain-related Disorders
Decreased by 11%
Homicide
Decreased by 17%
Changes in death rates from 1980 to 2019 for 14-25 year olds
Cardiology
Decreased by 29%
Accidents
Decreased by 55%
Cancer
Decreased by 48%
Pneumonia and Flu
Decreased by 50%
Brain-related Disorders
Decreased by 62%
Homicide
Decreased by 27%

82


Suicide in America's Youth
Changes in death rates from 1980 to 2019 for 5-14 year olds
Suicide
Increased by 184%
Cardiology
Decreased by 46%
Accidents
Decreased by 71%
Cancer
Decreased by 48%
Pneumonia and Flu
Decreased by 37%
Brain-related Disorders
Decreased by 11%
Homicide
Decreased by 17%
Changes in death rates from 1980 to 2019 for 14-25 year olds
Suicide
Increased by 14%
Cardiology
Decreased by 29%
Accidents
Decreased by 55%
Cancer
Decreased by 48%
Pneumonia and Flu
Decreased by 50%
Brain-related Disorders
Decreased by 62%
Homicide
Decreased by 27%

83


Age-Adjusted Suicide Rates, by Sex
Deaths per 100,000 standard population
24
20
16
12
8
4
0
Male1
Total2
Female3
2000
2002
2004
2006
2008
2010
2012
2014
2016
2018
2020
CDC (2022)

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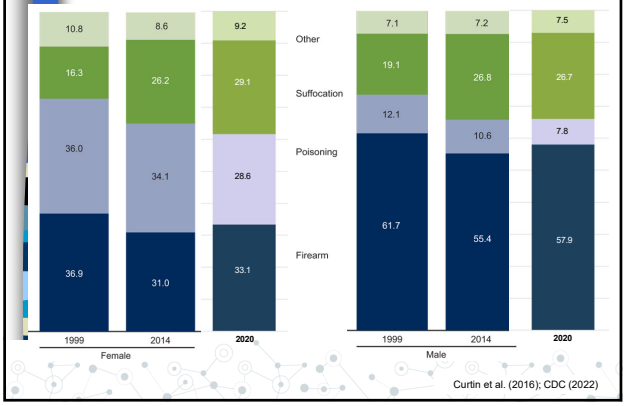
Suicide Deaths, by Method and Sex



Curtin et al. (2016); CDC (2022)

85

Statistics, Part 2

- Suicide Statistics
  - In 1991, the average suicide rate was 12.2 deaths per 100,000 people
  - It was under 10.0 deaths per 100,000 people in 1999
  - In 2004, it was 11.0 deaths per 100,000 people
  - In 2014, it was 13.0 deaths per 100,000 people
  - In 2019 (the most recent data), it was 13.93 deaths per 100,000 people (the most since 1986)

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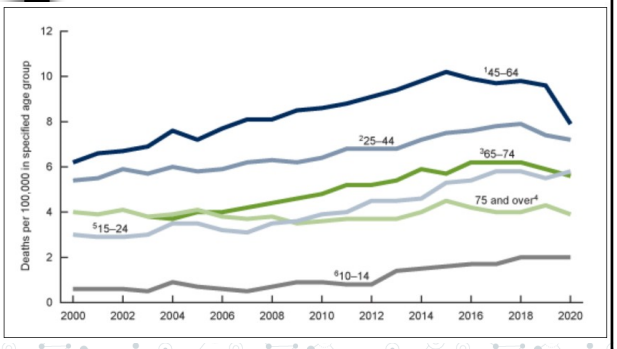
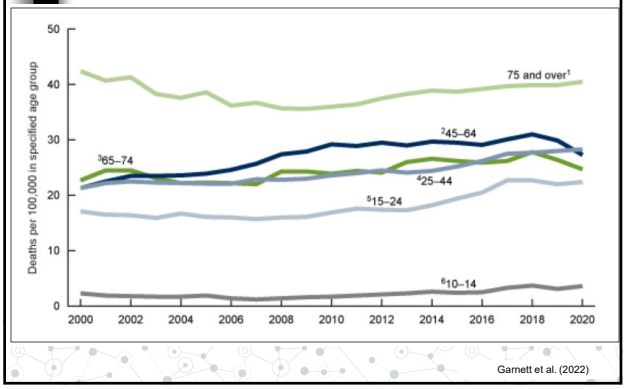
Suicide Rates for Females, by age



Garnett et al. (2022)

87

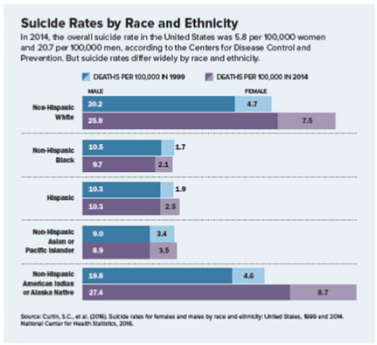
Suicide Rates for Males, by age



Garnett et al. (2022)

88

Statistics, Part 3



89

Statistics, Part 4

- Suicide Statistics
  - Worse in military veterans
    - 22-23 per day
  - The suicide rate for American men is about four times higher than for American women
    - Women are more likely to attempt suicide, but men are more likely to succeed
      - Lethality of methods
  - Prevalent in sexual minorities
    - 20.1% of sexual minority teens attempted in 2017
  - Suicide is very difficult to predict

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Statistics, Part 5

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

91

Suicide in Kentucky

- A total of 800 people committed suicide in 2020
- 11th leading cause of death overall
- 2nd leading cause of death for ages 10-34
- State has a suicide rate of 17.42 per 100,000 which is higher than the national average

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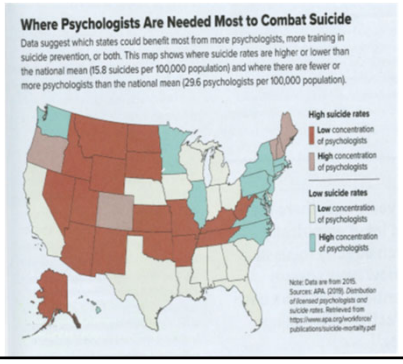
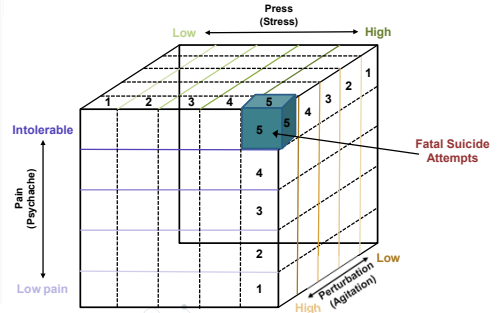
A Map to Consider



93

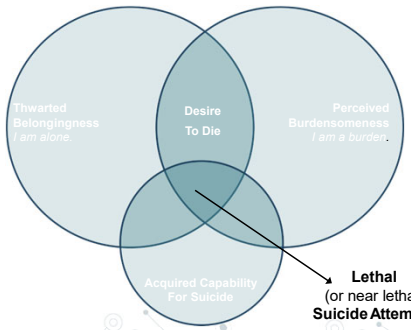
Shneidman's Cubic Model of Suicide



Shneidman (1987)

94

Interpersonal Theory of Suicide



Joiner (2005)

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Risk Factors

(increase likelihood of someone dying from suicide)

vs.

Warning Signs

(clues that someone could be currently at risk)

96

Risk Factors

(increase likelihood of someone dying from suicide)

	Examples
HEALTH	• Mental health conditions • Serious physical health conditions • Traumatic brain injury
ENVRIONMENTAL	• Access to lethal means • Prolonged stress • Stressful live events • Exposure to other's suicide
HISTORICAL	• Previous suicide attempts • Family history of suicide • Childhood abuse, neglect, trauma

American Foundation for Suicide Prevention (2019)

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Warning Signs

(clues that someone could be currently at risk)

	Examples
If a person talks about: **TALK**	• Having no reason to live • Being a burden • Feeling hopeless
BEHAVIOR	• Withdrawing from activities • Sleeping too much or too little • Giving way prized possessions • Aggression • Isolating from friends and family
MOOD	• Depression • Anxiety • Irritability • Humiliation/Shame • Relief/Sudden improvement

American Foundation for Suicide Prevention (2019)

98

Suicide Contagion

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

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Suicide Prevention, Part 1

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

100

Suicide Prevention, Part 2

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

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Safety Planning, Part 1

- Helps the client to understand what to do when they are experiencing suicidal ideation
- Steps to follow
  - Note warning signs
  - Internal strategies to use
  - People (who don't know what's happening) who can be distractions
  - People who can help—not a therapist
  - Professionals who can help
    - Therapist
    - Suicide crisis hotline
    - Hospital

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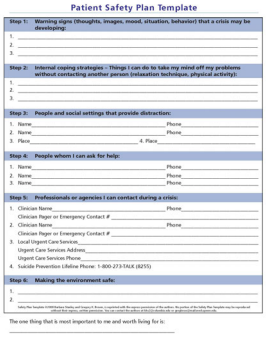
Safety Planning, Part 2



Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone:_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Template © 2008 Barbara Stanley, Ph.D. and Gregory K. Brown, Ph.D. This safety plan is the property of the authors. The contents of the Safety Plan Template may be reproduced without their express, written permission. You can contact the authors at bstanley@nki.rfmh.org or gregbrown@mail.med.upenn.edu.

The one thing that is most important to me and worth living for is:

_____

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How You Can Help

- Be Direct
- Be willing to listen
- Offer hope
- Don't dare the person to do it
- Take action
- Don't be sworn to secrecy
- Refer the person to a trained professional

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National Resources

- **National Suicide Prevention Lifeline** **988**
  Free and available 24 hours/day, 7 days/week
  Para Español oprima el 2
  For deaf and hard of hearing – TTY 1-800-799-4889 or chat at site below
  www.suicidepreventionlifeline.org
- **Crisis Text Line** Text LOU to 741-741 in the U.S.
- **Veterans Crisis Line** 1-800-273-TALK, Press 1
  Text 83-8255, or chat online at www.veteranscrisisline.net
- **IMAlive Chat** Online suicide crisis chat at www.imalive.org
- **The Trevor Project** 1-866-488-7386
  Hotline for LGBT Youth
  TrevorText – Available Fridays 4pm-8pm; Text TREVOR 1-202-304-1200
  TrevorChat – Available 7 days a week 3pm-9pm at the site below
  www.thetrevorproject.org
- **TransLifeline** 1-877-565-8860
  Peer hotline for transgender people experiencing a crisis

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References

- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (Fourth Ed.). Washington, D. C.: Author.
- Associated Press. (2002, September 16). State suicide rate higher than national average. *The Paducah Sun*, 5A.
- Baumeister, R. F. (1990). Suicide as escape from self. *Psychological Review, 97*, 90-113
- Bowen, L. (2011). Suicide risk is high among war veterans in college, study finds. *APA Monitor on Psychology, 42* (9), 13.
- Clay, R. A. (2005). On the practice horizon: Economic and demographic trends are among those changing the professional landscape. *APA Monitor on Psychology, 36* (2), 48-52.
- Cox, B. J., & Enns, M. W. (2003). Relative stability of dimensions of perfectionism in depression. *Canadian Journal of Behavioural Science, 35*, 124-132.
- DeAngelis, T. (2006). Promising new treatments for SAD: Light therapy improves symptoms in about half of seasonal affective disorder patients. Emerging research suggests that other modalities may help too. *APA Monitor on Psychology, 37* (2), 18-20.
- Fields, B. W., & Fristad, M. A. (2009). Assessment of childhood bipolar disorder. *Clinical Psychology: Science and Practice, 16, 166-181*.
- Finger, S., & Zaromb, F. (2006). Benjamin Franklin and shock-induced amnesia. *American Psychologist, 61*, 240-248.
- Forgend, M. J. C., Haigh, E. A. P., Beck, A. T., Davidson, F. J., Henn, F. A., Maier, S. F., Mayberg, H. S., & Seligman, M. E. P. (2011). Beyond depression: Toward a process-based approach to research, diagnosis, and treatment. *Clinical Psychology: Science and Practice, 18*, 275-299.

106

References

- Friedman, M. A., Detweiler-Bedell, J. B., Leventhal, H. E., Horne, R., Keitner, G. I., & Miller, I. W. (2004). Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clinical Psychology: Research and Practice, 11*, 47-68.
- Heisel, M. J., & Duberstein, P. R. (2005). Suicide prevention in older adults. *Clinical Psychology: Research and Practice, 12*, 242-259.
- Hewett, P. L., Flett, G. L., & Endler, N. S. (1995). Perfectionism, coping and depression symptomatology in a clinical sample. *Clinical Psychology and Psychotherapy, 2*, 47-58.
- Hewitt, P. L., Flett, G. L., Sherry, S. B., Habke, M., Parkin, M., Lam, R. W., McMurtry, B., Ediger, E., Fairlie, P., & Stein, M. B. (2003). The interpersonal expression of perfection: Perfectionistic self-presentation and psychological distress. *Journal of Personality and Social Psychology, 84*, 1303-1325.
- Jak, A. J., Shear, P. K., Rosenberg, H. L., DelBello, M. P., & Strakowski, S. M. (2002, August). *Intellectual functioning in children with bipolar disorder.* Poster presented at the annual convention of the American Psychological Association, Chicago, IL.
- Keenan-Miller, D., & Miklowitz, D. J. (2011). Interpersonal functioning in pediatric bipolar disorder. *Clinical Psychology: Research and Practice, 18*, 342-356.
- Kersting, K. (2003). Teen depression can affect adult happiness. *APA Monitor on Psychology, 34*(8), 11.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. R., Hughes, M., Eshleman, S., Wittchen, H. U., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 8-19.

107

References

- Koplewicz, H. S. (2002). More than moody: Recognizing and treating adolescent depression. *Brown University Child and Adolescent Behavior Letter, 18*(12), 6-7.
- Merikangas, K. R., & Pato, M. (2009). Recent developments in the epidemiology of bipolar disorder in adults and children: Magnitude, correlates, and future directions. *Clinical Psychology: Science and Practice, 16, 133.*
- Merrill, K. A., & Strauman, T. J. (2004). The role of personality in cognitive-behavioral therapies. *Behavior Therapist, 35*, 131-146.
- Nairne, J. S. (1999). *Psychology: The adaptive mind* (2nd Ed.). Albany, NY: Brooks/Cole Publishing Company.
- O'Connor, R. C., & O'Connor, D. B. (2003). Predicting hopelessness and psychological distress: The role of perfectionism and coping. *Journal of Counseling Psychology, 50*, 362-372.
- Oordt, M. S., Jobes, J. A., Rudd, M. D., Fonseca, V. P., Runyan, C. N., Stea, J. B., Campise, R. L., & Talcott, G. W. (2005). Development of a clinical guide to enhance care for suicidal patients. *Professional Psychology: Research and Practice, 36*, 208-218.
- Ougrin, D., Zundel, T., Kyriakopoulos, M., Banarsee, R., Stahl, D., & Taylor, E. (2012). Adolescents with suicidal and nonsuicidal self-harm: Clinical characteristics and response to therapeutic assessment. *Psychological Assessment, 24*, 11-20. doi: 10.1037/a0025043
- Price, M. (2010, October). Suicide among pre-adolescents: Parents and teachers ignore warning signs because they just don't think young children would attempt it. *APA Monitor on Psychology, 41 (9), 52-53.*
- Raulin, M. L. (2003). *Abnormal psychology.* Boston, MA: Allyn & Bacon.

108

References

- Seligman, M. E. P. (1990). *Learned optimism: How to change your mind and your life.* New York: Pocket Books.
- Sherry, S. B., Hewitt, P. L., Flett, G. L., & Harvey, M. (2003). Perfectionism dimensions, perfectionistic attitudes, dependent attitudes, and depression in psychiatric patients and university students. *Journal of Counseling Psychology, 50*, 373-386.
- Shiltz, T. (2004). Suicide prevention: Knowing what to do. *Rogers Memorial Hospital Update 2004*, 5.
- Waters, M. (1999). Men and women handle negative situations differently, study says. *APA Monitor, 30*(9), 8.
- Watkins, C. E. (2004). *Seasonal affective disorder: Winter depression.* Retrieved from the World Wide Web, October 12, 2006: http://www.ncpamd.com/seasonal.htm#What%20is%20SAD?
- Youngstrom, E. A. (2009). Definitional issues in bipolar disorder across the life cycle. *Clinical Psychology: Science and Practice, 16, 140-160.*