

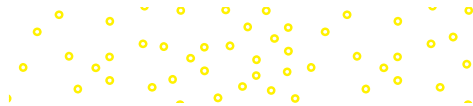
ABNORMAL PSYCHOLOGY

Clinical Perspectives on Psychological Disorders
NINTH EDITION

SUSAN KRAUSS WHITBOURNE

University of Massachusetts Boston

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ABNORMAL PSYCHOLOGY: CLINICAL PERSPECTIVES ON PSYCHOLOGICAL DISORDERS,
NINTH EDITION

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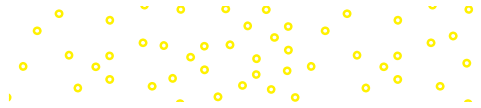
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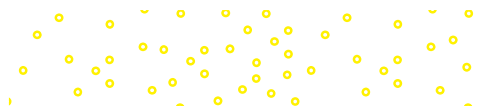
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*To my wonderful, and growing, family: Richard,
Stacey, Jenny, Taylor, Erik, Teddy, and Scarlett*



ABOUT THE AUTHOR



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Susan Krauss Whitbourne is professor emerita of Psychological and Brain Sciences at the University of Massachusetts Amherst, and adjunct professor of Gerontology at University of Massachusetts Boston. She has taught large undergraduate classes in addition to teaching and supervising doctoral students in developmental and clinical psychology. Her clinical experience has covered both inpatient and outpatient settings. Professor Whitbourne is a Fellow of the American Psychological Association.

Professor Whitbourne received her PhD from Columbia University and has a Diplomate in Geropsychology from the American Board of Professional Psychology. She taught at the State University of New York at Geneseo and the University of Rochester prior to moving to the University of Massachusetts Amherst, where she received the university's Distinguished Teaching Award, the Outstanding Advising Award, and the College of Arts and Sciences Outstanding Teacher Award. In 2001, she received the Psi Chi Eastern Region Faculty Advisor Award, and in 2002, the Florence Denmark Psi Chi National Advisor Award. In 2003, she received both the APA Division 20 and Gerontological Society of America Mentoring Awards. In 2018, she was recognized as a Psi Chi Distinguished Member.

As the departmental honors coordinator from 1990–2010, Professor Whitbourne was also the Psi Chi faculty advisor from 1990 through 2017, and the director of the Office of National Scholarship Advisement in the Commonwealth Honors College from 1999 through 2017. The author of 18 books and over 170 journal articles and book chapters, Professor Whitbourne is regarded as an expert on personality development in middle and late life. She is immediate past president of the Eastern Psychological Association and past chair of the Behavioral and Social Sciences Section of the Gerontological Society of America and was a member of the APA Board of Educational Affairs. She serves as APA Council Representative to Division 20 (Adult Development and Aging), having also served as Division 20 president. She is a fellow of APA's Divisions 20, 1 (General Psychology), 2 (Teaching of Psychology), 9 (Society for the Psychological Study of Social Issues), 12 (Clinical Psychology), and 35 (Society for the Psychology of Women). In 2018, Professor Whitbourne was nominated for president-elect of APA. She is also a member of the Board of Directors of the Massachusetts Psychological Association, where she also chairs the Nominations and Governance Committee.

Professor Whitbourne served as an item writer for the Educational Testing Service, was a member of APA's High School Curriculum National Standards Advisory Panel, wrote the APA High School Curriculum Guidelines for Life-Span Developmental Psychology, and serves as an item writer for the Examination for Professional Practice of Psychology. Her 2010 book, *The Search for Fulfillment*, was nominated for an APA William James Award. In 2011, she was recognized with a Presidential Citation from APA. In addition to her academic writing, she writes a highly popular blog on *Psychology Today* entitled "Fulfillment at Any Age" and has appeared on numerous media outlets, including *NBC Dateline* and *Today Show*, *AM Canada*, and CNN.

ABOUT THE CONTRIBUTOR

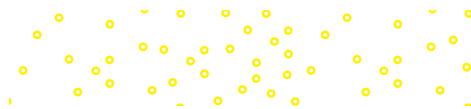
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Courtesy of Jennifer O'Brien



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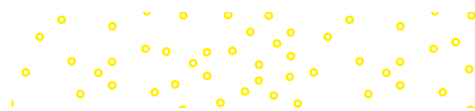
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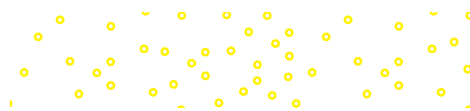
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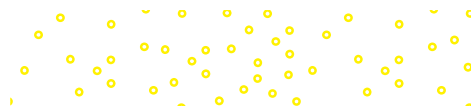
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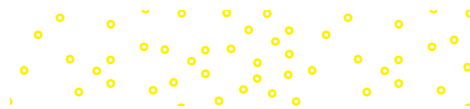
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PREFACE

With its case-based approach, *Abnormal Psychology: Clinical Perspectives on Psychological Disorders* helps students understand the human side of psychological disorders. The Ninth Edition ties concepts together with an integrated, personalized learning program, providing students the insight they need to study smarter and improve performance.

A Personalized Experience that Leads to Improved Learning and Results

How many students think they know everything about abnormal psychology but struggle on the first exam? Students study more effectively with Connect and SmartBook.

- SmartBook helps students study more efficiently by highlighting what to focus on in the chapter, asking review questions, and directing them to resources until they understand.
- Connect's assignments help students contextualize what they've learned through application, so they can better understand the material and think critically.
- SmartBook creates a personalized study path customized to individual student needs.
- Connect reports deliver information regarding performance, study behavior, and effort so instructors can quickly identify students who are having issues or focus on material that the class hasn't mastered.

New to this edition, SmartBook is now optimized for mobile and tablet and is accessible for students with disabilities. Content-wise, it has been enhanced with improved learning objectives that are measurable and observable to improve student outcomes. SmartBook personalizes learning to individual student needs, continually adapting to pinpoint knowledge gaps and focus learning on topics that need the most attention. Study time is more productive and, as a result, students are better prepared for class and coursework. For instructors, SmartBook tracks student progress and provides insights that can help guide teaching strategies.



SMARTBOOK®

Experience the Power of Data

Abnormal Psychology: Clinical Perspectives on Psychological Disorders harnesses the power of data to improve the instructor and student experiences.

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Better Data, Smarter Revision, Improved Results

For this new edition, data were analyzed to identify the concepts students found to be the most difficult, allowing for expansion upon the discussion, practice, and assessment of challenging topics. The revision process for a new edition used to begin with gathering information from instructors about what they would change and what they would keep. Experts in the field were asked to provide comments that pointed out new material to add and dated material to review. Using all these reviews, authors would revise the material. But now, a new tool has revolutionized that model.

McGraw-Hill Education authors now have access to student performance data to analyze and to inform their revisions. These data are anonymously collected from the many students who use SmartBook, the adaptive learning system that provides students with individualized assessment of their own progress. Because virtually every text paragraph is tied to several questions that students answer while using SmartBook, the specific concepts with which students are having the most difficulty are easily pinpointed through empirical data in the form of a “heat map” report.

Powerful Reporting

Whether a class is face-to-face, hybrid, or entirely online, McGraw-Hill Connect provides the tools needed to reduce the amount of time and energy instructors spend administering their courses. Easy-to-use course management tools allow instructors to spend less time administering and more time teaching, while reports allow students to monitor their progress and optimize their study time.

- The **At-Risk Student Report** provides instructors with one-click access to a dashboard that identifies students who are at risk of dropping out of the course due to low engagement levels.
- The **Category Analysis Report** details student performance relative to specific learning objectives and goals, including APA learning goals and outcomes and levels of Bloom's taxonomy.
- **Connect Insight** is a one-of-a-kind visual analytics dashboard—now available for both instructors and students—that provides at-a-glance information regarding student performance.
- The **SmartBook Reports** allow instructors and students to easily monitor progress and pinpoint areas of weakness, giving each student a personalized study plan to achieve success.

Informing and Engaging

McGraw-Hill Connect offers several ways to actively engage students. McGraw-Hill Education Connect is a digital assignment and assessment platform that strengthens the link between faculty, students, and course work. Connect for Abnormal Psychology includes assignable and assessable videos, quizzes, exercises, and Interactivities, all associated with learning objectives for *Abnormal Psychology: Clinical Perspectives on Psychological Disorders*, Ninth Edition.

New to the Ninth Edition, **Power of Process** guides students through the process of critical reading and analysis. Faculty can select or upload content, such as journal articles, and assign guiding questions to move students toward higher-level thinking and analysis.

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PowerPoint Presentations The PowerPoint presentations, available in both dynamic, lecture-ready and accessible, WCAG-compliant versions, highlight the key points of the chapter and include supporting visuals. All of the slides can be modified to meet individual needs.

Image Gallery The Image Gallery features the complete set of downloadable figures and tables from the text. These can be easily embedded by instructors into their own PowerPoint slides.

Clinical Perspectives on Psychological Disorders

The subtitle, *Clinical Perspectives on Psychological Disorders*, reflects the emphasis on the experience of clients and clinicians in their efforts to facilitate each individual's maximum functioning. Each chapter begins with an actual case study that typifies the disorders in that chapter, then returns to the case study at the end with the outcome of a prescribed treatment on the basis of the best available evidence. Throughout the chapter, the author translates the symptoms of each disorder into terms that capture the core essence of the disorder. The philosophy is that students should be able to appreciate the fundamental nature of each disorder without necessarily having to memorize all of its diagnostic criteria. In that way, students can gain a basic understanding that will serve them well regardless of their ultimate professional goals.

In this Ninth Edition, the author refreshes many of the cases to reflect stronger ethnic, international, gender, sexual orientation, and age diversity. In particular, the mini cases in each chapter are based on cases intended to reflect the importance of cultural variations that psychologists see in their private offices, clinics, hospitals, and counseling centers.

Above all, the study of abnormal psychology is the study of profoundly human experiences. To this end, the author has developed a biographical feature entitled "Real Stories." You will read narratives from the actual experiences of celebrities, sports figures, politicians, authors, musicians, and artists ranging from Ludwig van Beethoven to Herschel Walker. Each story is written to provide insight into the particular disorder covered within the chapter. By reading these fascinating biographical pieces, you will come away with a more in-depth personal perspective to use in understanding the nature of the disorder.

The author has developed this text using a scientist-practitioner framework. In other words, you will read about research informed by clinical practice. The author presents research on theories and treatments for each of the disorders based on the principles of evidence-based practice. This means that the approaches are tested through extensive research informed by clinical practice. Many researchers in the field of abnormal psychology also treat clients in their own private offices, hospitals, or group practices. As a result, they approach their work in the lab with the knowledge that their findings can ultimately provide real help to real people.

CHAPTER-BY-CHAPTER CHANGES

This edition reflects the most recent revision to the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association in 2013 and known as *DSM-5*. The *DSM-5* was written following a lengthy process of revising the previous edition, the *DSM-IV-TR*, involving hundreds of researchers contributing to task forces intended to investigate each of the major categories of disorders.

Though replaced, the *DSM-IV-TR* still remains relevant, if only as a contrast to the *DSM-5*. Each chapter has a section entitled “What’s in the *DSM-5*” that highlights the critical changes introduced in 2013 and shows why they matter. Because so much of our current understanding of research on psychological disorders used earlier editions of the *DSM* for diagnostic purposes, students will still encounter findings based on its diagnostic system. It generally takes several years for research to catch up with new diagnostic terminology, both because of the amount of time required for articles to reach publication stage, and also because of the dearth of available research instruments based on the new diagnostic criteria. From the student’s point of view, the conceptual frameworks that inform the way we think about psychological disorders are most important.

Adding to this complexity is the fact that an entirely different classification system, the *International Classification of Diseases (ICD)*, is used by countries outside the United States and Canada, as well as by governmental insurance agencies in the United States. We will discuss the *ICD* when relevant, particularly as it relates to international comparisons.

The heat-map-directed revisions in this new edition are reflected primarily in Chapters 3, 5, 14, and 15. Other content changes include the following:

CHAPTER 1

- Reorganized presentation of themes throughout history to distinguish how each theme evolved over time.
- Added section on open-access journals and associated difficulties in relying on sources that did not receive extensive peer review.
- Updated examples of research designs and approaches in abnormal psychology.

CHAPTER 2

- Added further discussion on “client” vs. “patient” terminology.

- Expanded section on “Cultural Concepts of Distress” and updated the accompanying Table 3.
- Added new research on evidence-based practice in psychology.

CHAPTER 3

- Updated information on the SCID for *DSM-5*.
- Provided updated descriptions of personality assessment methods.
- Added section on Cultural Formulation Interview.
- Revised and updated section on neuropsychological assessment.

CHAPTER 4

- Updated and expanded treatment of genetic theories.
- Expanded the theoretical background and case regarding Core Conflictual Relationship Theme.
- Revised definitions of positive and negative reinforcement with new examples.
- Updated description of cognitive perspective.
- Added section on acceptance-based perspective.

CHAPTER 5

- Revised and updated section on intellectual disability.
- Updated section on treatment of autism spectrum disorder.
- Provided updated information and research on learning and communication disorders.
- Condensed information in Table 2.
- Added section on “Project Search.”
- Updated information on ADHD, including ADHD in adults.
- Added new research on motor disorders.

CHAPTER 6

- Provided updated statistics on schizophrenia, including health care costs.
- Updated section on the course of schizophrenia.
- Reorganized biological perspectives section and updated research evidence in support of genetic contributions.

- Updated information about CBT for treatment of psychotic disorders.

CHAPTER 7

- Provided extensive updates of prevalence statistics.
- Expanded section on health problems for individuals with bipolar disorder.
- Added new information about biological contributors to mood disorders.
- Updated research on psychotherapy vs. medication effectiveness.
- Provided updates from recent data on suicide rates in the United States.

CHAPTER 8

- Updated prevalence statistics.
- Added new information about virtual reality exposure therapy.
- Provided new information about the role of personality traits in agoraphobia and panic disorder.
- Added new information comparing younger and older adults in generalized anxiety disorder.
- Included ACT treatment for anxiety disorders.
- Added new evidence in favor of CBT for obsessive compulsive disorder.
- Added research on PTSD in female combat veterans.
- Included new treatment guidelines published by APA for treatment of PTSD.
- Added new studies on couples therapy and post-traumatic growth in PTSD.

CHAPTER 9

- Added new section on treatment of dissociative identity disorder.
- Incorporated new research on brain imaging studies for individuals with motor conversion disorder.
- Updated research on malingering along with information on structured malingering assessment.
- Added new studies on ACT as treatment for illness anxiety disorder.
- Expanded treatment of workplace stress and health.

- Included new research on psychoeducation in behavioral medicine.

CHAPTER 10

- Provided new research on the relationship between altered brain activity and eating disorders.
- Added information about ACT as treatment for eating disorders.
- Summarized new research on treatment of childhood elimination disorders.
- Added information about the role of wearable technology in treatment of sleep disorders.
- Included new information about social competence therapy in treatment of oppositional defiant disorder.
- Updated treatment of intermittent explosive disorder with CBT.
- Added new longitudinal research on conduct disorder.
- Updated section on treatment of kleptomania with CBT.

CHAPTER 11

- Clarified terminology in section on definitions of paraphilic disorders.
- Added new perspectives on fetishistic disorder based on updated studies.
- Updated information about frotteuristic disorder.
- Provided new survey data on sexual sadism and sexual masochism disorders.
- Added new information about treatment of paraphilic disorders based on biological approaches.
- Incorporated new studies on the use of sexual diaries in treatment of women with sexual dysfunctions.
- Summarized research on body image and sexual dysfunction in women.
- Added section on CBT in treating couples with sexual dysfunctions.
- Clarified terms and theories in gender dysphoria.
- Summarized new APA Guidelines for Transgender and Gender Nonconforming People.

CHAPTER 12

- Updated statistics on use of alcohol and illicit substances based on new SAMHSA data.
- Clarified relationship between socialization and alcohol use disorders.
- Included updated discussion of marijuana based on changes in federal and state legislation on legality.
- Added new studies on prevalence of caffeine-related conditions.
- Updated information about e-cigarettes.
- Evaluated new research on biological treatments for substance-related disorders.
- Added new research on gambling disorder in older adult women.
- Provided new evidence on the pathways model of gambling disorder and related treatment.

CHAPTER 13

- Provided streamlined definitions of neurocognitive disorders and their symptoms.
- Expanded discussion of delirium and revised Table 2 to provide more accessible information.
- Updated prevalence statistics on Alzheimer's disease and clarified distinction between "dementia" and neurocognitive disorder."
- Evaluated new treatments for Alzheimer's disease.

- Revised section on neurocognitive disorder with Lewy bodies.
- Updated statistics on traumatic brain injury.
- Added new information about chronic traumatic encephalography (CTE).

CHAPTER 14

- Revised and simplified presentation of alternative personality disorder diagnostic system in *DSM-5*.
- Developed more concise approach to theories and treatments of antisocial personality disorder, along with updated research.
- Provided new information about treatment of antisocial personality disorder.
- Added information about attachment style in dependent personality disorder.

CHAPTER 15

- Ensured that all guidelines are compliant with APA updates and revisions.
- Added information about "duty to warn or otherwise protect."
- Added new section on ruling by Massachusetts Supreme Judicial Court based on MIT lawsuit regarding suicide prevention in college students.
- Updated information based on landmark forensic cases and the current status of the offenders.

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It has been particularly satisfying to work on this edition with my daughter, Jennifer L. O'Brien, PhD, who served as

my research assistant and author of all the Case Reports and Real Stories in the text. A psychologist at the Massachusetts Institute of Technology (MIT) Medical Mental Health and Counseling Services, Jenny received her PhD in 2015 from American University and completed a predoctoral internship at the Durham V.A. Hospital and a postdoctoral internship at the Boston V.A. Hospital. Her wide range of experiences with both veterans and university students from all over the world gives her a unique perspective and set of insights that inform the entire book.

Finally, a great book can't come together without a great publishing team. I'd like to thank the editorial team, all of whom worked with me through various stages of the publishing process. Ryan Treat was terrific in getting the revision off the ground, and I appreciate his enthusiasm and support. Dawn Groundwater has also been wonderful, and her long-term commitment to the book means a great deal to me. I would also like to thank my Content Project Manager Ryan Warczynski, whose patience and diligence helped ensure my vision was carried out effectively. I also wish to thank Sandy Wille, who has been wonderful in serving as Production Project Manager throughout previous editions and who is now back on the team. Kelly Heinrichs, the Program Manager, has ensured that all of the aspects of this revision have gone smoothly. Kristine Janssens, who helped me select photos for this revision, has shown terrific resourcefulness in dealing with the many issues involved in providing excellent photos to illustrate key points. Traci Vaske, Content Licensing Specialist, has been invaluable in assisting me in the complex process of acquiring permissions. Finally, I wish to give heartfelt thanks to Elisa Adams, Product Developer, not only for her vigilance in making sure that this revision reads as well as it can, but also for her friendly encouragement throughout the entire process. In this Ninth Edition, I feel very grateful to be part of the McGraw-Hill family, whose commitment to student success is truly remarkable.

A Letter from the Author

I am very glad that you are choosing to read my textbook. The topic of abnormal psychology has never been more fascinating or relevant. We constantly hear media reports of celebrities having meltdowns for which they receive quickie diagnoses that may or may not be accurate. Given all this misinformation in the mind of the public, I feel that it's important for you to be educated in the science and practice of abnormal psychology. At the same time, psychological science grabs almost as many headlines in all forms of news media. It seems that everyone is eager to learn about the latest findings, ranging from the neuroscience of behavior to the effectiveness of the newest treatment methods. Advances in brain-scanning methods and studies of psychotherapy effectiveness are greatly increasing our understanding of how to help treat and prevent psychological disorders.

Particularly fascinating to me was covering the changes made in the *DSM-5*. Each revision of the *DSM* brings with it controversies and challenges, and the *DSM-5* was no exception. Despite challenges in the new ways that the *DSM-5* defines and categorizes psychological disorders, it is perhaps more than any earlier edition based on strong research. Scientists and practitioners will continue to debate the best ways to interpret this research. We all will benefit from these dialogues.

The profession of clinical psychology is also undergoing rapid changes. With changes in health care policy, it is very likely that more professionals, from psychologists to mental health counselors, will be employed in providing behavioral interventions. By taking this first step toward your education now, you will be preparing yourself for a career that is increasingly being recognized as vital to helping individuals of all ages and all walks of life to achieve their greatest fulfillment.

I hope you find this text as engaging to read as I found it to write. Please feel free to e-mail me at swhitbo@psych.umass.edu with your questions and reactions to the material. As a long-time user of McGraw-Hill's Connect in my own abnormal psychology class, I can also vouch for its effectiveness in helping you achieve mastery of the content of abnormal psychology. I am also available to answer any questions you have, from an instructor's point of view, about how best to incorporate this book's digital media into your own teaching.

Thank you again for choosing to read this book!

Best,
Susan

Depressive and Bipolar Disorders

OUTLINE

Case Report: Janice Butterfield
Depressive Disorders
 Major Depressive Disorder
 Persistent Depressive Disorder (Dysthymia)
 Disruptive Mood Dysregulation Disorder
 Premenstrual Dysphoric Disorder
Disorders Involving Alterations in Mood
 Bipolar Disorder
Real Stories: Carrie Fisher: Bipolar Disorder
 Cyclothymic Disorder
Theories and Treatment of Depressive and Bipolar Disorders
 Biological Perspectives
 Biological Theories
 Antidepressant Medications
What's in the *DSM-5*: Depressive and Bipolar Disorders
 Bipolar Medications
 Alternative Biologically Based Treatments
 Psychological Perspectives
 Psychodynamic Approaches
 Behavioral and Cognitive-Behavioral Approaches
 Interpersonal Approaches
 Sociocultural Perspectives
Suicide
You Be the Judge: Do-Not-Resuscitate Orders for Suicidal Patients
Depressive and Bipolar Disorders: The Biopsychosocial Perspective
Return to the Case: Janice Butterfield
Summary
Key Terms

Learning Objectives

- 7.1 Explain the key features of major depressive disorder and persistent depressive disorder, including prevalence.
- 7.2 Compare and contrast bipolar I, bipolar II, and cyclothymic disorder.
- 7.3 Understand theories and treatments of depressive and bipolar disorders.
- 7.4 Discuss the relationships among age, gender, and suicide.
- 7.5 Analyze the biopsychosocial model of depressive and bipolar disorders.



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Case Report: Janice Butterfield

Demographic information: 47-year-old married heterosexual African American female

Presenting problem: Janice was referred for psychotherapy after a recent hospitalization following a suicide attempt. Janice reported that the precipitant to her suicide attempt was the loss of her job in a real estate company, where she had worked for 25 years. Although she realized her company had downsized due to the economy, she found herself feeling profoundly guilty for the negative impact her unemployment would have on her family. Janice reported she has been married for 27 years and has three daughters, one of whom lives at home. Another is in college, and her youngest will be attending college at the start of the next school year. Janice reported she had become increasingly overwhelmed by stress about her financial situation, because her family mainly relied on her income.

Along with feelings of guilt, Janice reported she had felt so depressed and down that she had spent many days in the past 2 weeks in bed and often found herself thinking of ending her life. She stopped taking the pain pills prescribed for her chronic backaches, “to save up if I needed them later.” One evening when her husband was out, she attempted suicide by taking all her saved-up medications at once. Janice’s husband returned to find her unresponsive and rushed her to the hospital just in time to save her life. She was hospitalized in an inpatient psychiatric unit and given medication until her suicidal thoughts and severe depression decreased enough so that the doctors deemed her no longer a threat to herself. She followed the referral given to her by the psychiatrists on the inpatient unit to attend weekly psychotherapy for follow-up. She had never been in therapy before.

During her first therapy session, Janice reported that she had thought about going to therapy many times before. She explained that her depressive episodes

usually lasted about 1 month, but sometimes as long as 3 months. During these episodes, she missed a few days of work but would manage to go about her normal routine, although with much difficulty. She described how, while she was at work, she would go out to her car to cry because it was too painful to be around others. “I just didn’t want anything to do with life at those points,” she recalled. Her depression would eventually improve on its own, and she would lose interest in getting treatment as a result. She reported that she had occasionally thought about suicide in the past when feeling depressed, but she had never before made and carried out a plan as she had during the most recent episode. Janice cited her family as her main reason for never taking her thoughts about suicide more seriously.

Janice went on to explain how these depressed moods always caught her off guard, because they would occur directly after long periods when she felt happy and energetic. She stated these moods usually started after she had made a large real estate sale and felt “invincible” afterwards. During these times, she described how she often needed very little sleep due to the seemingly endless amounts of energy she possessed, and she would begin to take on many new projects and clients at work—much more than would be expected of her. She also splurged on lavish clothing or jewelry, and during her last energetic period she had purchased new cars for herself and her husband. These expenditures were uncharacteristic for Janice; she described herself as usually being quite frugal.

Due to her constantly moving thoughts, Janice found it difficult to concentrate and was so distracted she was rarely able to finish anything she began to take on at work. She would feel disappointed that she had to give up some of her projects, and her joyful feelings would turn to irritability and anger. She reported that her

Case Report *continued*

husband usually experienced the brunt of her irritable mood, and this caused major problems in their marriage. Janice further reported that she felt like she ignored her family altogether due to her work habits when she was feeling particularly energetic. She remarked, “When I’m feeling that good, I can only think about myself and what feels good to me. I stop being a mother and a wife.” Her extreme spending periods eroded her family’s savings, which was especially a concern now that she had lost her job. She also felt incredibly guilty for not being able to pay for her daughters’ college tuition. Janice had never talked directly with her husband or her children about her vast mood shifts. She worried that if she told her family about her personal difficulties, they would “see me as a weakling, instead of the head of the household.”

Relevant history: Janice had never received psychiatric treatment or therapy in the past, though she reported she had experienced mood swings since she was 19. She estimated that she had severe mood episodes (either manic or depressive) about three to four times per year. When reflecting on the severity of her mood episodes, she stated that she felt her behaviors had been more “extreme” in more recent years than when she was younger. Janice reported that she noticed the patterns in her mood swings always began with an energetic period, directly followed by a depressive episode, and then a period of several months of stability. More recently, though, she noted that the periods of stability had only

been lasting 1 or 2 months, and her mood episodes had been lasting longer.

Case formulation: Janice’s initial diagnosis from the psychiatric unit was major depressive episode, and her current presentation also met this criteria. However, in the initial therapy session she reported also having a history of manic episodes that were followed by periods of depression, which she had not mentioned while she had been hospitalized. The symptoms of the manic episode she described caused significant financial problems for Janice, due to her excessive spending sprees. In combination with losing her job, these financial problems caused significant stress and may have contributed to the severity of her most recent depressive episode, which eventually led to a suicide attempt. Therefore, her diagnosis is bipolar I disorder, most recent episode depressed.

Treatment plan: It is recommended that Janice continue to attend weekly psychotherapy. In therapy, it will be necessary to make a suicide safety plan, given her history of suicidal ideation and recent suicide attempt. Therapy should initially focus on psychoeducation, symptom management, and mood monitoring. She will also be referred to an outpatient psychiatrist for medication reconciliation, given that psychotherapeutic medication is clinically recommended in the treatment of bipolar disorder.

Sarah Tobin, PhD

depressive disorder

A disorder characterized by periods in which, among other symptoms, an individual experiences an unusually intense sad mood.

dysphoria

An unusually elevated sad mood.

major depressive disorder

A disorder in which the individual experiences acute but time-limited episodes of depressive symptoms.

major depressive episode

A period in which the individual experiences intense psychological and physical symptoms accompanying feelings of overwhelming sadness (dysphoria).

People can experience day-to-day highs and lows, but when their disturbances of mood reach a point of clinical significance, they may be considered to have a depressive or bipolar disorder. In *DSM-5*, these two disorders (sometimes referred to as mood disorders) carry a set of criteria that allow clinicians to establish whether their clients show alterations in mood that significantly deviate from the individual’s baseline or ordinary emotional state.

7.1 Depressive Disorders

A **depressive disorder** is characterized by periods in which, among other symptoms, an individual experiences an unusually intense sad mood. The disorder’s essential element—this sad mood—is known as **dysphoria**.

Major Depressive Disorder

Major depressive disorder consists of acute but time-limited periods of depressive symptoms that are called **major depressive episodes** (see Table 1).

Major depressive disorder can be diagnosed with a range of other disorders including, for example, personality disorders, substance use disorders, and anxiety disorders. A number of

TABLE 1 Criteria for a Major Depressive Episode

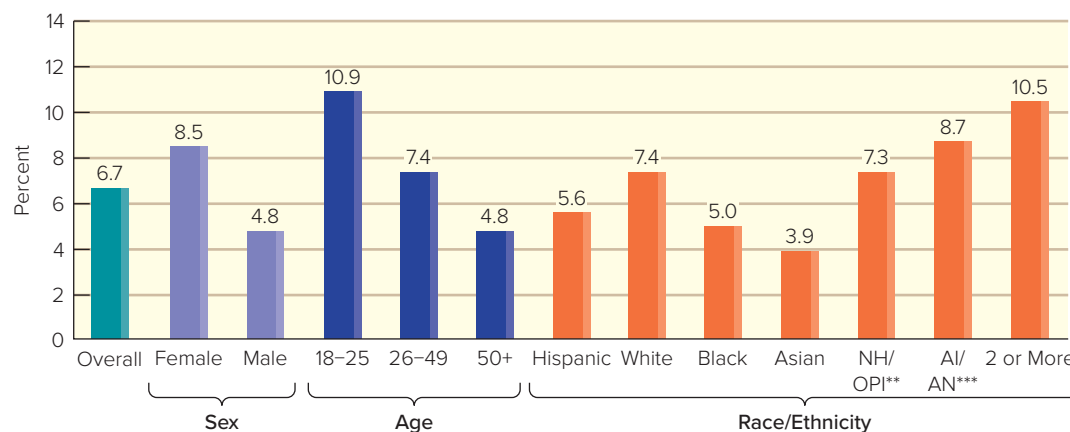
For most of the time during a 2-week period, a person experiences at least five or more of the first nine symptoms in addition to the last two. He or she must experience a change from previous functioning, and at least one of the first two symptoms must be present. During this 2-week period, most of these symptoms must be present nearly every day.

- Depressed mood most of the day
- Markedly diminished interest or pleasure in all or most daily activities
- Significant unintended weight loss or unusual increase or decrease in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation observable by others
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Difficulty maintaining concentration or making decisions
- Recurrent thoughts of death or having suicidal thoughts, plans, or attempts
- The symptoms are not attributable to a medical condition or use of a substance
- The symptoms cause significant distress or impairment

conditions can mimic major depressive disorder, including those associated with disorders that we discussed in the chapter “Schizophrenia Spectrum and Other Psychotic Disorders,” which include or are related to schizophrenia. These include schizophrenia, schizoaffective disorder, schizophreniform disorder, and delusional disorder. The clinician must rule out these specific disorders before assigning the diagnosis of major depressive disorder to the client.

Second only to lower back pain as a cause of years lived with disability around the world, major depressive disorder is also the 19th most common global disease (Vos et al., 2012). In the United States, the lifetime prevalence of major depressive disorder is 16.6 percent of the adult population (Kessler et al., 2012). The 1-year prevalence of a major depressive episode is estimated to be 6.7 percent of all adults in the United States, or 16.2 million individuals (National Institute of Mental Health, 2018). Figure 1 summarizes the 1-year prevalence of major depressive episodes along with variations by sex, age, and race/ethnicity.

As you can see from this figure, the highest 1-year prevalence of major depressive episode is found among individuals 18–25 years of age, and the numbers decrease after that to 4.8 percent at ages 50 and older. These generational differences may reflect a number of



*All other groups are non-Hispanic or Latino; **NH/OPI = Native Hawaiian/Other Pacific Islander; ***AI/AN = American Indian/Alaskan Native

FIGURE 1 One-Year Prevalence of Major Depressive Episodes in the United States, 2016

SOURCE: <https://www.nimh.nih.gov/health/statistics/major-depression.shtml>

MINI CASE

Major Depressive Disorder, Recurrent Episode

Daryll is a 37-year-old married heterosexual African American male. His wife recently took him to a psychiatric facility for evaluation. Although Daryll has been functioning normally for the past several years, he suddenly became severely disturbed and depressed. At the time of admission, Daryll was agitated, dysphoric, and suicidal, even going as far as to purchase a gun to kill himself. He

had lost his appetite and had developed insomnia during the preceding 3 weeks. As each day went by, he found himself feeling more and more exhausted, less able to think clearly or to concentrate, and uninterested in anyone or anything. He had become hypersensitive in his dealings with neighbors, co-workers, and family, insisting that others were being too critical of him. This was the second such episode in Daryll's history, the first having occurred 5 years earlier, following the loss of his job due to a massive layoff.

factors, including a tendency for younger adults to be more open about reporting their symptoms, and the lower survival rates into the later decades of people with major depressive disorder. Age differences in the nature of reported symptoms may also influence prevalence statistics, in that depressive symptoms may be reported as physical rather than psychological concerns in older adults (Schaakxs et al., 2017).

Persistent Depressive Disorder (Dysthymia)

The mood disturbance occurring with major depressive disorder may take a chronic, enduring form. People with **persistent depressive disorder (dysthymia)** have, for at least 2 years (1 year for children and adolescents), a more limited set of the symptoms that occur with major depressive disorder, including sleep and appetite disturbances, low energy or fatigue, low self-esteem, difficulty with concentration and decision making, and feelings of hopelessness. However, people with persistent depressive disorder currently do not meet the criteria for a major depressive episode, which requires that the client meet five of the criteria in Table 1.

Despite the fact that people with persistent depressive disorder do not experience all the symptoms of a major depressive episode, they are never free of their symptoms for longer than 2 months. Moreover, they are likely to have other serious psychological disorders, including a heightened risk for developing major depressive disorder, personality disorder, and substance use disorder.

Approximately 2.5 percent of the adult population will develop dysthymic disorder in the course of their lives, with a peak (as of the early 2000s) in the 45- to 59-year-old age group (Kessler, Berglund, et al., 2005). The 12-month prevalence for dysthymic disorder is 1.5 percent of the U.S. population, with almost half these cases (0.8 percent of the adult population) classified as severe (Kessler, Chiu, et al., 2005). As is true for major depressive disorder, dysthymic disorder symptoms take on a different form in older adults, who are more likely to report disturbances in physical than in psychological functioning (Oxman, Barrett, Sengupta, & Williams, 2000).

Disruptive Mood Dysregulation Disorder

The diagnosis of **disruptive mood dysregulation disorder** is used for children who exhibit chronic and severe irritability and have frequent temper outbursts that occur, on average, three or more times per week over at least 1 year and in at least two settings. These outbursts must be developmentally inappropriate, meaning that, for example, in an older child or young teen they take the form of the behavior of a much younger child.

Between outbursts, children with this disorder remain angry or at least extremely irritable. The criteria specify that the diagnosis should not be made for the first time for children whose first episode occurs when they are younger than 6 or older than 18. However, either by directly observing the child or from the child's history, the clinician must determine that

persistent depressive disorder (dysthymia)

Chronic but less severe mood disturbance in which the individual does not experience a major depressive episode.

disruptive mood dysregulation disorder

A depressive disorder in children who exhibit chronic and severe irritability and have frequent temper outbursts.

MINI CASE

Persistent Depressive Disorder (Dysthymia)

Kimiko is a single 34-year-old heterosexual Japanese American female. She currently works as a community college instructor, and for the past 3 years has had persistent feelings of depressed mood, inferiority, and pessimism. She realizes that, since her graduation from college, she has never felt really happy and that, in recent years, she has struggled with thoughts of

worthlessness and sad mood. Her appetite is low, and she struggles with insomnia. During waking hours, she lacks energy and finds it difficult to do her work. She often finds herself staring out the window of her office, consumed by thoughts of how inadequate she is. She fails to fulfill many of her responsibilities and has received consistently poor teacher evaluations for the past 3 years. Getting along with her colleagues has become increasingly difficult. Consequently, she spends most of her free time alone in her office.

the disorder had its onset before the age of 10. In other words, a teen of 13 must be reported by parents or teachers, for example, to have been subject to angry episodes prior to turning 10 years old.

The authors of *DSM-5* recognized a potential criticism of this disorder that might be characterized as pathologizing a child's "temper tantrums," but they believed it was important to have a disorder earmarked for children and teens who in the past would have been diagnosed with bipolar disorder. Follow-up data of children who show this pattern of extreme irritability and angry outbursts suggest that, rather than developing bipolar disorder, they are at risk of developing depressive and/or anxiety disorders when they reach adulthood.

Premenstrual Dysphoric Disorder

Women who experience depressed mood or changes in mood, irritability, dysphoria, and anxiety during the premenstrual phase that subside after the menstrual period begins for most of the cycles of the preceding year may be diagnosed with **premenstrual dysphoric disorder (PMDD)**. This disorder was in the Appendix (it was not a diagnosable condition) in *DSM-IV-TR*. By making this disorder part of the standard psychiatric nomenclature, the *DSM-5* authors believed that better diagnosis and treatment could result for women who experience its symptoms.

Critics argue that the PMDD diagnosis pathologizes the normal variations in mood that can occur over the course of a woman's monthly menstrual cycle. However, the counterargument is that the majority of women do not experience monthly mood alterations so severe that they would show such extreme symptoms. Including PMDD as a diagnosis allows those with these severe episodes of depression to receive treatment that might not otherwise be available to them.

premenstrual dysphoric disorder (PMDD)

Changes in mood, irritability, dysphoria, and anxiety that occur during the premenstrual phase of the monthly menstrual cycle and subside after the menstrual period begins for most of the cycles of the preceding year.

7.2 Disorders Involving Alterations in Mood

Two sets of disorders are characterized by alterations in mood that go beyond everyday variations in levels of sadness or happiness. These are bipolar disorder and cyclothymic disorder. **Bipolar disorder** includes an intense and disruptive experience of a **manic episode**. During a manic episode, the individual may experience unusually high levels of **euphoria**, which is the feeling state of an abnormally positive mood.

Bipolar Disorder

Clinicians diagnose people who have manic episodes with bipolar disorder, a term that has replaced "manic depression." An individual must experience a manic episode in order for a

bipolar disorder

A mood disorder involving manic episodes—intense and disruptive experiences of heightened mood, possibly alternating with major depressive episodes.

manic episode

Acute but time-limited period of intense and unusual elation.

euphoria

A feeling state that is more cheerful and elated than average, possibly even ecstatic.

REAL STORIES

Carrie Fisher: Bipolar Disorder

Carrie Fisher was a U.S. actress, screenwriter, novelist, and lecturer who appeared in over 40 films—most notably as Princess Leia Organa in the *Star Wars* trilogy. She wrote four novels, one of which, *Wishful Drinking*, was turned into a one-woman play performed in venues across the country. In the book, she chronicles her life—from her growing up in a Hollywood family, her rise to fame, and her struggles with drugs and alcohol to her battles with bipolar disorder. Fisher talks about her experiences with humor and honesty, revealing the reality of her mental illness.

Born in 1956 in Beverly Hills, California, Fisher was the daughter of actress Debbie Reynolds and singer Eddie Fisher. As the product of a Hollywood marriage, she seemed to have been destined to be a Hollywood star from the very beginning. When she was 2 years old, Fisher's father left her mother for Elizabeth Taylor, her mother's best friend. The media highly publicized this story, although in her book, Fisher states that she doesn't believe her childhood experiences had a major impact on any of the problems she encountered later in life.

Fisher first began acting at the age of 12, appearing in Las Vegas with her mother. She later dropped out of high school in order to perform with her mother on tour. In 1973, Fisher appeared with her mother in the Broadway musical *Irene*, and 2 years later, after attending drama school in London, she made her film debut in the 1975 film *Shampoo* with Warren Beatty. Two years after that, at 21, she instantly became an icon and an international celebrity for her role in the *Star Wars* trilogy. According to Fisher, it was at this point that she began to heavily abuse cocaine and alcohol, having already experimented with marijuana at the age of 13. Looking back on her drug abuse, Fisher recalls that she used drugs as a way to self-medicate her extreme mood episodes. She first received a diagnosis of manic depression (as it was called at the time) when she was 24 years old. Although she did not pursue any treatment at that point, she began to understand what was driving much of her heavy substance use. In the

book, she describes how she did not accept her diagnosis and even felt personally insulted by it. Rather than taking medication as recommended by her psychiatrist, she dropped out of treatment and impulsively moved from Los Angeles to New York, marrying singer Paul Simon shortly after.

Fisher and Simon were married from 1983 to 1984, though they dated on and off for a total of 12 years. In 1992, Fisher had a daughter, Billie, with her partner Bryan Lourd.

Despite her chronic battles with substance abuse and bipolar disorder, Fisher continued to appear in films and television shows throughout the 1980s. Her substance abuse led to a hospitalization in the mid-1980s, inspiring her first novel, *Postcards from the Edge*, a semi-autobiographical account of an actress suffering from substance abuse, published in 1987. The book became a successful movie for which she received critical acclaim.

Throughout the 1990s, Fisher continued to appear in films and became well known in Hollywood for her screenwriting talents. In 1997, she suffered a psychotic break after she sought medication to treat her chronic depression. She describes that experience in *Wishful Drinking*: "Now, anyone who has stayed awake for six days knows that there's every chance that they'll wind up psychotic. Anyway, I did, and part of how that manifested was that I thought everything on television was about me . . . I watched CNN, and at the time Versace had just been killed by that man Cunanin, and the police were frantically scouring the

Eastern seaboard for him. So, I was Cunanin, Versace, and the police. Now this is exhausting programming." She was hospitalized for 6 days and then spent 6 months receiving outpatient treatment.

After having accepted her diagnosis of bipolar disorder and finally come to terms with her need for treatment, Fisher set out to educate the public about the stigmatization of mental illness. In the years leading up to her death, she was an active voice in speaking out about the need for government funding for mental health treatment and for greater public acceptance of mental illness.

In *Wishful Drinking*, Fisher describes her experiences switching between mania and depression. "I have two moods. . . . One is Roy, rollicking Roy, the wild ride of a mood. And Pam, sediment Pam, who stands on the shore and sobs . . . sometimes the tide is in, sometimes it's out." Fisher also writes of some of the various



After struggling for many years with substance abuse and bipolar disorder, Carrie Fisher became an activist for the destigmatization of mental illness.

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treatments for her illness that she has received, including electroconvulsive therapy (ECT).

She recalls her mix of emotions and reactions to receiving ECT, including fear, humiliation, and concern about dangerous side effects, particularly given the way the treatment had been portrayed in popular culture. However, she eventually decided that her symptoms were becoming far too severe and needed more intensive treatment.

“I’d been feeling overwhelmed and pretty defeated. I didn’t necessarily feel like *dying*—but I’d been feeling a lot like not

being alive. The second reason I decided to get ECT is that I was depressed. Profoundly depressed. Part of this could be attributed to my mood disorder, which was, no doubt, probably the source of the emotional intensity. That’s what can take simple sadness and turn it into sadness squared.” Fortunately for Fisher, ECT proved to be an effective treatment for combating her intense depressive episodes.

“At times,” she writes at the end of *Wishful Drinking*, “being bipolar can be an all-consuming challenge, requiring a lot of stamina and even more courage, so if

you’re living with this illness and functioning at all, it’s something to be proud of, not ashamed of.”

Fisher passed away on December 27, 2016, at the age of 60. The cause of her death was confirmed to be cardiac arrest, though there were also traces of several drugs in her system. In *Wishful Drinking*, she writes what she hoped to be in her obituary one day: “I want it reported that I drowned in moonlight, strangled by my own bra.”

SOURCE: *Wishful Drinking* by Carrie Fisher. Deliquescence Inc.

clinician to diagnose bipolar disorder, as Table 2 shows. The diagnosis does not require that the individual has ever experienced a major depressive episode.

The two major categories of bipolar disorder are bipolar I and bipolar II. A diagnosis of bipolar I disorder describes a clinical course in which the individual experiences one or more manic episodes with the possibility, although not the necessity, of experiencing one or more major depressive episodes. In contrast, a diagnosis of bipolar II disorder means the individual has had one or more major depressive episodes and at least one **hypomanic episode**. The criteria for a hypomanic episode are similar to those for a manic episode but require a shorter duration (4 days instead of 1 week).

Individuals who are in a manic, hypomanic, or major depressive episode may show features of the opposite pole but not to an extreme enough degree to meet the relevant diagnostic criteria for bipolar disorder. For example, people in a manic episode may also report feeling sad or empty, fatigued, or suicidal. *DSM-5* uses a specifier of “mixed features” to apply to cases in which an individual experiences episodes of mania or hypomania when depressive features are present, and to episodes of depression in the context of major depressive disorder or bipolar disorder when features of mania/hypomania are present. The “mixed” category accounts for individuals with bipolar disorder who may show features of both depression and mania/hypomania, either simultaneously or nearly simultaneously.

hypomanic episode

A period of elated mood not as long as a manic episode.

TABLE 2 Criteria for a Manic Episode

A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy must last at least 1 week and the symptoms must be present most of the day, nearly every day (or for any duration if hospitalization is necessary).

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

- inflated self-esteem or grandiosity
- decreased need for sleep (the client feels rested after, say, only 3 hours of sleep)
- more talkative mood than usual or pressure to keep talking
- flight of ideas or subjective experience that thoughts are racing
- distractibility (attention is too easily drawn to unimportant or irrelevant external stimuli), as reported or observed
- increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
- excessive engagement in activities that have high potential for painful consequences (such as unrestrained buying sprees, sexual indiscretions, or foolish business investments)

This episode must represent a clearly observable change in functioning but not be severe enough to require hospitalization to prevent harm to self or others.

MINI CASE

Bipolar I Disorder, Current Episode Manic

Isabel is a single 38-year-old bisexual Hispanic American female. She works as a software engineer at a large tech company, where she has worked for about 10 years. For the past week, she has shown signs of uncharacteristically outlandish behavior, beginning with thoughts of quitting her job so that she could develop her own software company out of her apartment. Isabel went without sleep for 3 days, spending most of her time at her computer developing a business model for the company.

Within a few days, she took out nearly \$1 million in loans, although she had few resources to finance even one of them. She visited several banks and other investors, each time making a scene with anyone who expressed skepticism about her plan. While at a bank, she became so upset when she was denied a loan that she angrily pushed over the banker's desk, and screamed at the top of her lungs that the bank was keeping her from her multimillion-dollar profit. The police were called, and Isabel was brought to an emergency room, from which she was transferred for intensive evaluation and treatment at a nearby psychiatric hospital.

Bipolar disorder has a lifetime prevalence rate of 3.9 percent in the U.S. population (Kessler, Berglund, et al., 2005) and a 12-month prevalence of 2.6 percent (Kessler, Chiu, et al., 2005). Of those diagnosed with bipolar disorder in a given year, nearly 83 percent (2.2 percent of the adult population) have cases classified as severe. At least half of all cases begin before a person reaches the age of 25 (Kessler, Chiu, et al., 2005). Approximately 60 percent of all individuals with bipolar disorder can live symptom-free if they receive adequate treatment (Perlis et al., 2006). This means a large percentage continue to experience symptoms. According to one estimate, over the course of a 5-year period, people with bipolar disorder feel that their mood is normal only about half the time (Pallaskorpi et al., 2015).

Of all psychological disorders, bipolar disorder is the most likely to occur in people who also have problems with substance abuse. People with both bipolar and substance use disorders have earlier onset of bipolar disorder, more frequent episodes, and higher risk of developing anxiety- and stress-related disorders, aggressive behavior, problems with the law, and risk of suicide (Swann, 2010).

People with bipolar disorder are also at risk of more severe chronic health problems than others their own age. They have higher rates of heart disease and diabetes (Silarova et al., 2015) and higher levels of cholesterol (Kessing, Vradi, McIntyre, & Andersen, 2015). These may be the reasons that, according to a comprehensive population study conducted in Denmark, bipolar disorder is associated with lower life expectancy across a variety of causes (Kessing et al., 2015). In addition to higher mortality due to illness, people with bipolar disorder also have elevated rates of suicide and other forms of violent death (Hayes et al., 2015). Their risks are similar in magnitude to those found in people with schizophrenia; the gap between their mortality and that of the general population has also widened in the past decade (Hayes et al., 2017).

As you can see in Figure 2, bipolar disorder can cause people to experience a range of moods. You can also see that there is a range from depressed mood to severe mania, with some overlap occurring at the boundaries.

Clinicians diagnose people as having **bipolar disorder, rapid cycling** if they have had four or more episodes within the previous year that meet the criteria for manic,

bipolar disorder, rapid cycling

A form of bipolar disorder involving four or more episodes within the previous year that meet the criteria for manic, hypomanic, or major depressive disorder.

FIGURE 2 Range of Moods Present in People with Bipolar Disorder

SOURCE: <https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml>



MINI CASE

Cyclothymic Disorder

Larry is a divorced 60-year-old Caucasian heterosexual male who works as a bank cashier. For much of his adult life, co-workers, family, and friends have repeatedly told him he is very moody. He acknowledges that his mood never feels quite stable, although at times others tell him he seems more calm and pleasant than usual. Unfortunately, these intervals are quite brief, lasting for a few weeks and usually ending abruptly. Without warning, he may experience either a somewhat depressed mood or a period of elation.

During his depressive periods, Larry's confidence, energy, and motivation are very low. During his hypomanic periods, he willingly volunteers to extend his workday and to undertake unrealistic challenges at work. On weekends, he might decide to put in long shifts at a homeless shelter without getting any sleep. Larry disregards the urging of his family members to get professional help, insisting that it is his nature to be high-energy at times. He also states that he doesn't want some "shrink" to steal away the periods during which he feels on top of the world.

hypomanic, or major depressive disorder. In some individuals, the cycling may occur within 1 week or even 1 day. The factors that predict rapid cycling include earlier onset, higher depression scores, higher mania scores, and lower global assessment of functioning. A history of rapid cycling in the previous year and use of antidepressants also predict rapid cycling (Schneck et al., 2008). Medical conditions such as hypothyroidism, disturbances in sleep/wake cycles, and use of antidepressant medications can also contribute to the development of rapid cycling (Papadimitriou, Calabrese, Dikeos, & Christodoulou, 2005). Individuals who experience bipolar disorder, rapid cycling are at higher risk of suicide than others with bipolar disorder, and also of a longer duration of the disorder (Gigante et al., 2016).

Cyclothymic Disorder

Cyclothymic disorder is characterized by alternations between dysphoria and briefer, less intense, and less disruptive euphoric states called hypomanic episodes. People with this disorder have met the criteria for a hypomanic episode many times over a span of at least 2 years (1 year in children and adolescents) and also experience numerous periods of depressive symptoms but never meet the criteria for a major depressive episode. During their respective time frames, adults, children, or adolescents have never been without these symptoms for more than 2 months at a time.

cyclothymic disorder

A mood disorder with symptoms that are more chronic and less severe than those of bipolar disorder.

7.3 Theories and Treatment of Depressive and Bipolar Disorders

Biological Perspectives

Long aware of the tendency for mood disorders to occur more frequently among biologically related family members, researchers working within the biological perspective are attempting to pinpoint genetic contributors to these disorders. However, multiple genes interact with environmental risk factors in complex ways, with epigenetics playing a significant role (Walker et al., 2016).

Biological Theories Supporting the role of genetics, it has long been known that first-degree relatives of people with major depressive disorder are 15 to 25 percent more likely to have the disorder than are people who do not have this close biological relationship. Based on the existing literature, major depressive disorder has an estimated



Antidepressant medication is commonly prescribed to individuals who suffer from major depressive disorder.

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heritability of 37 percent (Sullivan, Neale, & Kendler, 2000), with rates higher in women than men (approximately 40 percent for women vs. 30 percent for men) (Flint & Kendler, 2014). The age at onset of first major depressive episode also appears to have a genetic component (Ferentinos et al., 2015). Compared to major depressive disorder, bipolar disorder has an even stronger pattern of genetic inheritance, with an estimated heritability of 60 to as high as 85 percent (Berrettini & Lohoff, 2017).

Moving from genetics to the biochemical abnormalities, increasing evidence points to the role of altered serotonin and norepinephrine levels in causing the mood changes associated with major depressive disorder. However, not everyone with genetic predisposition shows these mood-changing alterations in neurotransmitter levels. If exposed as adults to life stressors and other environmental factors, the genetically predisposed can experience a series of changes in the neural pathways active in regulating mood. Contributing further to their chances of developing depression are abnormalities in brain-derived neurotrophic factor (BDNF), a protein

that helps keep neurons alive and able to adapt and change in response to experience (Naoui, Maruyama, & Shamoto-Nagai, 2018).

These alterations in neurotransmitters can further influence the mood of individuals with major depressive disorder by causing activation within the brain's internally based attentional circuits. Rather than focus their attention outward, individuals with major depressive disorder become overly preoccupied with their thoughts and feelings (Kaiser, Andrews-Hanna, Wager, & Pizzagalli, 2015). Because areas within the brain's inner network responsible for emotional processing are also disrupted, this set of changes causes the depressed person to turn those thoughts and feelings in a negative direction (Guo et al., 2015).

Brain scan and neuropsychological testing of individuals with bipolar disorder suggest that they have difficulties in attention, memory, and executive function consistent with abnormalities in the prefrontal lobe (Abé et al., 2015). These changes may have their origins in altered genetics which, in turn, place individuals at risk when they are exposed to life stressors, particularly early in life (Pfaffenseller, Kapczinski, Gallitano, & Klamt, 2018).

Antidepressant Medications At present, biological interventions for mood disorders target not the genetic abnormalities themselves but the effect of those abnormalities on neurotransmitters. Therefore, antidepressant medication is the most common form of biologically based treatment for people with major depressive disorder. Clinicians prescribe antidepressants from four major categories: selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs).

The choice of antidepressant depends primarily on the clinician's preference for a particular class of medications. Ultimately, the medications the individual receives may be selected by trial and error as the clinician attempts to identify which work best and produce the fewest side effects.

SSRIs block the uptake of serotonin, making more of this crucial neurotransmitter available to act at the receptor sites of receiving neurons. SSRIs include fluoxetine (Prozac), citalopram (Celexa), escitalopram (Lexapro), paroxetine (Paxil), and sertraline (Zoloft). Balancing their positive effects on mood are their side effects. The most commonly reported are nausea, agitation, and sexual dysfunction. A newer class of antidepressants are serotonin modulators (such as vortioxetine) that target the postsynaptic serotonin receptors rather than the reuptake of serotonin in the synapse. These medications were approved for use in the United States in 2013, and results are still coming in on whether they will prove to be as effective as, but with fewer side effects than, other classes of antidepressants (Nishimura et al., 2018).



Psychotherapeutic medication offers relief to many individuals who suffer from mood disorders and is often used in combination with other modes of treatment, such as psychotherapy, to help patients manage their symptoms.

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SNRIs increase both norepinephrine and serotonin levels by blocking their reuptake. They include duloxetine (Cymbalta), venlafaxine (Effexor), and desvenlafaxine (Pristiq). These medications also carry with them a number of undesirable side effects including suicidal thoughts or attempts as well as allergic symptoms, gastrointestinal disturbances, weakness, nausea, vomiting, confusion, memory loss, irritability, and panic attacks, among others. Compared to SSRIs, the SNRIs show statistically significant effects in experimental studies, but clinically they seem to hold no advantages. If anything, SNRIs bring a higher risk of adverse reactions than SSRIs (Machado & Einarson, 2010).

TCAs, which derive their name from the fact that they have a three-ring chemical structure, include amitriptyline (Elavil, Endep), desipramine (Norpramin), imipramine (Tofranil), and nortriptyline (Aventyl, Pamelor). These medications are particularly effective in alleviating depression in people who have some of the more common biological symptoms, such as disturbed appetite and sleep. Although the exact process by which TCAs work remains unclear, we do know that they block the premature reuptake of biogenic amines back into the presynaptic neurons, thus increasing their excitatory effects on the postsynaptic neurons.

The antidepressant effects of MAOIs, such as phenelzine (Nardil) and tranylcypromine (Parnate), prolong the life of serotonin and norepinephrine in the synapse, thereby increasing their actions in the central nervous system. MAOIs are particularly effective in treating chronic depression in people who have not responded to other medications. However, they have serious side effects that can be life-threatening when people taking them are also on allergy medications or ingest foods or beverages such as beer, cheese, and chocolate, all of which are high in a substance called tyramine. As a result, clinicians do not prescribe MAOIs as commonly as other types of antidepressant medications.

Antidepressant medications take time to work, requiring 2 to 6 weeks to take effect. Once the depression has subsided, the clinician will urge the client to remain on the medication for 4 or 5 additional months, and much longer for people with a history of

What's in the *DSM-5*

Depressive and Bipolar Disorders

Modifications to the category of mood disorders in the *DSM-5* were intended to provide greater precision in the diagnosis by refining the criteria for major depressive episode, manic episode, and hypomanic episode. One of the major problems in the *DSM-IV-TR* was a failure to differentiate these episodes from a person's typical level of activity, sadness, or disturbance. In particular, the failure to distinguish bipolar disorder from attention-deficit/hyperactivity disorder might, in turn, have led to overdiagnosis of children and adolescents with bipolar disorder. Thus, the changes represent a slight but important improvement and will lead to greater specificity.

A highly controversial decision in the *DSM-5* was the addition of premenstrual dysphoric disorder (PMDD). As you have learned, this change was met with criticism for pathologizing normal experiences in women. Similarly, critics argue that disruptive mood dysregulation disorder pathologizes children's normal experience of temper tantrums. The rationale for proposing this new diagnosis, however, was that it would reduce the frequency of bipolar disorder diagnoses in children. Separating severe chronic irritability from bipolar disorder, the authors argued, means that children will not be misdiagnosed.

Finally, the *DSM-5* authors angered many critics when they decided to leave out the "bereavement exclusion" present in *DSM-IV-TR*. This change means that an individual who meets the criteria for a major depressive episode and who has lost a loved one in the past 2 months (which was the bereavement exclusion) can receive a psychiatric diagnosis. Thus, prior to the *DSM-5*, losing a loved one in the past 2 months excluded people from receiving this diagnosis. The argument in favor of making this change was that, in a vulnerable individual, bereavement could trigger a major depressive episode that would be appropriate to diagnose. Moreover, in a lengthy note of clarification, the *DSM-5* authors maintain that the grief associated with normal bereavement is different from the symptoms that occur in individuals who develop a true depressive disorder.

recurrent, severe depressive episodes. It is best for the clinician and client to work together to develop therapeutic programs that include regular visits early in treatment, expanded educational efforts that focus on the medications, and continued monitoring of treatment compliance.

Even though these medications can be effective, especially for certain clients, researchers are concerned that studies of antidepressants suffer from the "file drawer problem"—the fact that investigators are likely to file away, and not even submit for publication, studies that fail to establish significant benefits. In one analysis of 74 FDA-registered studies on antidepressants, 31 percent, accounting for 3,349 study participants, were not published. On the other hand, in the published studies, 94 percent of the medication trials reported positive findings. This bias toward publishing only positive results severely limits our ability to evaluate the efficacy of antidepressants because we are seeing only a slice of the actual data (Turner et al., 2008).

Adding further complications, some researchers have questioned

whether people with less-than-severe depression might experience positive results because of the so-called placebo effect, in which they get better because they expect to get better (Kirsch et al., 2008).

Medication is certainly one route for the clinician to follow in treating individuals with major depressive disorder. However, increasing attention is being given to the possibility that psychotherapy can be equally effective (Farabaugh et al., 2015). Psychotherapy also carries fewer risks and adverse side effects than medication use. Over the long term, it could therefore be a better treatment route with more enduring effects than medication (Hollon, 2016). This is possible in part because, through therapy, individuals can work through some of their underlying issues and also learn skills for managing their symptoms that they can continue using on their own.

Bipolar Medications The traditional treatment for bipolar disorder is lithium carbonate, referred to as lithium, a naturally occurring salt found in small amounts in drinking water that, when used medically, replaces sodium in the body. Clinicians advise people who have frequent manic episodes (two or more a year) to remain on lithium continuously as a preventive measure. The drawback is that, even though lithium is a natural substance in the body, it can have side effects. These include mild central nervous system disturbances, gastrointestinal upsets, and more serious cardiac effects. As a consequence, people who experience manic episodes may be reluctant or even unwilling to take lithium continuously.

From the client's perspective, lithium can be seen to interfere with the euphoria that can accompany the beginnings of a manic episode. Consequently, people with this disorder who enjoy those pleasurable feelings may resist taking the medication. Unfortunately, by the time their euphoria escalates into a full-blown episode, it is often too late because their judgment

has been clouded by their manic symptoms of grandiosity and elation. To help overcome this dilemma, clinicians may advise their clients to participate in lithium groups, in which members who use the medication on a regular basis provide support to each other and reinforce the importance of staying on the medication.

Because of the variable nature of bipolar disorder, other medications can be beneficial in treating symptoms apart from the mania itself. For example, people in a depressive episode may need to take an antidepressant medication in addition to the lithium for the duration of the episode. However, this can be problematic for a person who is prone to developing mania, because an antidepressant might provoke hypomania or mania. Those who have psychotic symptoms may benefit from taking antipsychotic medication such as clozapine (Li, Tang, Wang, & de Leon, 2015). People who experience rapid cycling present a challenge for clinicians because of the sudden changes that take place in their emotions and behavior.

Psychopharmacologists report that rapid cyclers, especially those for whom lithium has not been sufficient, seem to respond positively to prescriptions of anticonvulsant medication, such as carbamazepine (Tegretol) or valproate (Depakote), although these alone are not as effective as lithium (Kessing et al., 2011; Zivanovic, 2017).

Alternative Biologically Based Treatments For some clients with mood disorders, medication is either ineffective or slow in alleviating symptoms that are severe and possibly life-threatening. Even with the best treatment, between 60 and 70 percent of individuals with major depressive disorder do not achieve symptom relief (Rush et al., 2006). A combination of genetic, physiological, and environmental factors govern the response to medication. Researchers hope to improve the efficacy of medications through **pharmacogenetics**, the use of genetic testing to identify who will improve with a particular medication, including antidepressants (Crisafulli et al., 2011) and lithium (McCarthy, Leckband, & Kelsoe, 2010).

Clinicians, at present, have several somatic alternatives to medication for treatment-resistant depression. As we discussed in the chapter “Theoretical Perspectives,” one

pharmacogenetics

The use of genetic testing to identify who will and will not improve with a particular medication.



Once a risky and controversial procedure, electroconvulsive therapy is now a highly regulated and safe procedure available for individuals with severe depression who have not responded to other treatment options.

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circadian rhythms

Biological clocks that set patterns of sleepfulness and wakefulness on approximately a 24-hour basis.

alternative is electroconvulsive therapy (ECT) (Lisanby, 2007). Clinicians and clients are not sure exactly how ECT works, but most current hypotheses center on ECT-induced changes in neurotransmitter receptors and in the body's natural opiates which, in turn, cause structural changes in the brain (Yroni et al., 2018). As we discussed in the chapter "Theoretical Perspectives," deep brain stimulation (DBS) is another somatic treatment clinicians use to target major depressive disorder (as well as obsessive-compulsive disorder and movement disorders).

Based on the hypothesis that at least some mood disorders reflect a disruption in daily biological clocks known as **circadian rhythms**, researchers are proposing the use of treatments that "reset" the individual's bodily clock. Such treatments include light therapy, in which the individual is seated in front of a bright light for a period of time, such as 30 minutes in the morning. One distinct advantage of light therapy is that its side effects are minimal and almost entirely disappear after the dosage is reduced or treatment discontinued (Pail et al., 2011). Researchers also believe lithium may work on at least some individuals with bipolar disorder by resetting their circadian rhythms (McClung, 2007).

Psychological Perspectives

Psychodynamic Approaches Early psychoanalytic theories based on the psychodynamic approach proposed that people with depressive disorders had suffered a loss early in their lives that affected them at a deep, intrapsychic level (Abraham, 1911/1968). It was attachment theory, however, that focused attention on people's feelings of security or insecurity arising from the way their caregivers reared them in childhood. Bowlby (1980) proposed that people with an insecure attachment style have a greater risk for developing a depressive disorder in adulthood. Following up on Bowlby's ideas, Bemporad (1985) proposed that insecurely attached children become preoccupied with the need to be loved by others. As adults, they form relationships in which they overvalue the support of their partners. When such relationships end, they become overwhelmed with feelings of inadequacy and loss.

Psychoanalytic explanations of bipolar disorder propose that manic episodes are defensive responses through which individuals stave off feelings of inadequacy, loss, and helplessness. Clients are thought to develop feelings of grandiosity and elation or become hyperenergetic as an unconscious defense against sinking into a state of gloom and despair. Supporting this interpretation, researchers report a positive relationship between use of denial and narcissistic defense mechanisms and the extent of manic symptoms (Sharma & Sinha, 2010).

Contemporary approaches to treatment within the psychodynamic perspective focus on helping individuals manage their symptoms rather than attempting to repair the core of the individual's disturbed attachment. These approaches consist of short (8- or 10-session), focused treatments. A review of eight studies comparing short-term psychodynamic therapy to other methods showed this method to be as least as effective as CBT in the treatment of major depressive disorder (Lewis, Dennerstein, & Gibbs, 2008).

Behavioral and Cognitive-Behavioral Approaches One of the earliest behavioral formulations of theories of depression regards the symptoms of depression as resulting from lack of positive reinforcement (Lazarus, 1968; Skinner, 1953). According to this view, depressed people withdraw from life because they no longer have incentives to be active. Contemporary behaviorists base their approach on Lewinsohn's (1974) model. Lewinsohn maintained that depressed people have a low rate of what he termed "response contingent positive reinforcement behaviors," which increase in frequency as the result of performing actions that produce pleasure. According to the behaviorist point of view, the lack of positive reinforcement elicits the symptoms of low self-esteem, guilt, and pessimism.

In the method known as **behavioral activation** for depression, based on these behaviorist principles, the clinician helps the client identify activities associated with positive mood. The client keeps a record of the frequency of engaging in these rewarding activities and sets small weekly goals that gradually increase in frequency and duration. These activities are preferably consistent with the client's core values. Some clients may prefer to explore the arts, whereas others spend time in physical activity. Behavioral activation seems particularly well suited for clients who are not "psychologically minded," for group therapy, and for settings such as hospitals, nursing homes, and substance-abuse treatment centers (Sturmey, 2009).

Clinicians are increasingly integrating behavioral with cognitive approaches that focus on the role of dysfunctional thoughts as causes of, or at least contributors to, mood disorders. People with depressive disorders, according to the cognitive-behavioral perspective, think in repetitively negative ways that perpetuate their negative emotions. Beck (1967) defined these depressive thoughts as the **cognitive triad**—that is, a negative view of the self, the world, and the future.

These negative views lead depressed individuals, in turn, to experience a profound loss of self-esteem, convinced they will never have what they need to feel good about themselves. They assume they are worthless and helpless and that their efforts to improve their lives are doomed to fail. In the course of their daily experiences, the depressed, in this perspective, make faulty interpretations that keep alive the cycle of negative thoughts and emotions (Beck, Rush, Shaw, & Emery, 1979; Beck & Weishaar, 1989). Each of these faulty interpretations, or cognitive distortions, has its own unique qualities (see Table 3), but they share a failure to draw logical conclusions from the individual's experiences.

Behavioral therapy with clients who have depressive disorders follows the general principles that we outlined in the chapter "Theoretical Perspectives" in which clinicians help their clients develop more positively reinforcing experiences. In this approach, clinicians begin with a careful assessment of the frequency, quality, and range of activities and social interactions in their client's life, focusing on sources of positive and negative reinforcement. Based on this analysis, the clinicians work with their clients to institute changes in their environments while also teaching them social skills to improve the quality and number of their positive interactions. An important focus of the work

behavioral activation

Behavioral therapy for depression in which the clinician helps the client identify activities associated with positive mood.

cognitive triad

According to the cognitive theory of depression, the view that a depressed person's dysphoria results from a negative view of the self, the world, and the future.

TABLE 3 Examples of Cognitive Distortions

Type of Distortion	Definition	Example
Overgeneralizing	If it's true in one case, it applies to any case that is even slightly similar.	"I failed my first English exam, so I'm probably going to fail all of them."
Using selective abstraction	Taking seriously only events that represent failures, deprivation, loss, or frustration.	"Even though I won the election for the student senate, I'm not really popular because not everyone voted for me."
Taking excessive responsibility	Feeling responsible for all bad things that happen to you or to others to whom you are close.	"It's my fault that my friend didn't get the internship—I should've warned her about how hard the interview would be."
Assuming temporal causality	Assuming that if it has been true in the past, it's always going to be true.	"My last date was a wipeout, my next date will probably hate me too."
Making excessive self-references	Feeling at the center of everyone else's attention and assuming everyone can see your flaws and errors.	"When I tripped over the branch in the sidewalk, everyone could see how clumsy I am."
Catastrophizing	Always thinking the worst and being certain that it will happen.	"Because I failed my accounting exam, I will never make it in the business world."
Engaging in dichotomous thinking	Seeing everything as either one extreme or another rather than as mixed or in between.	"I can't stand people who are liars because I can never trust them."

SOURCE: Adapted from A. T. Beck, A. J. Rush, B. F. Shaw, & G. Emery in *Cognitive Therapy of Depression*.

done by behaviorally oriented clinicians is to encourage clients to increase their participation in activities they find inherently rewarding. These rewarding activities, in turn, can help boost the client's mood.

Behaviorally oriented clinicians also believe that education is an essential component of therapy. They regard individuals with depressive disorders as perpetuating their negative emotions by setting unrealistic goals, which they are then unable to achieve. To counteract these, clinicians working in the behavioral perspective assign homework exercises that encourage clients to make gradual behavioral changes, which will increase the probability that they can achieve their goals and thus feel rewarded.

Another technique used by the behavioral clinician combines behavioral contracting with self-reinforcement. For example, the clinician and client may agree that a client would benefit from the opportunity to socialize outside the home more often. Together, they would then set up a schedule of rewards in which they pair the social activity with something the client identifies as a desirable reward compatible with the goals of treatment (the clinician would not recommend that the client use the rewards of alcohol, drugs, or online gambling). Other methods the behaviorally oriented clinician would use include more extensive instruction, modeling, coaching, role playing, rehearsal, and perhaps working with the client in a real-world setting.

The focus of cognitive-behavioral therapy (CBT) is on helping clients try to change their dysfunctional thought processes that in turn will improve their mood. Like behaviorally oriented therapy, CBT requires an active collaboration between the client and the clinician. In contrast to behaviorally oriented therapy, however, CBT also focuses on the client's dysfunctional thoughts and how to modify them through cognitive restructuring. Mindfulness training, as an additional component of a cognitive-behavioral intervention, can help clients develop a greater sense of self-efficacy, an added boost to its positive effects on mood (Eisendrath et al., 2015). Another CBT technique known as mood monitoring can further help clients learn ways to track their mood over time and look for patterns in mood fluctuation. This is particularly helpful in the case of clients with bipolar disorder, who through the mood monitoring technique become more self-aware of when their symptoms might be worsening, so they can intervene using skills or other methods to avoid a full-blown manic or depressive episode.

Clinicians treating people with bipolar disorder customarily turn first to pharmacological interventions. However, psychological interventions can be beneficial in helping clients develop better coping strategies in an effort to minimize the likelihood of relapse. As we mentioned earlier, people who have experienced a manic episode may be tempted to forgo taking their medication because they wish to reexperience the exciting highs of a manic episode. If they can develop insight into the risks of noncompliance, however, and gain an improved understanding of medications such as lithium, they are more likely to adhere to the treatment program.

Psychoeducation is an especially important aspect of treating people with bipolar disorder to help them understand its nature, as well as the reasons medication is so important in controlling symptoms (Bond & Anderson, 2015). Moreover, CBT can also be an effective intervention for clients with bipolar disorder to help them cope with the periods in which their symptoms are beginning to emerge but are not yet full-blown (Driessen & Hollon, 2010). Rather than using one therapeutic approach, then, clinicians currently recommend the use of a combination of methods ranging from traditional psychotherapeutic medications to mindfulness training, and even nutritional supplements and hormone therapy. They are also now turning to cognitive remediation therapy, based on the findings in the literature of cognitive abnormalities in memory, inhibitory control, and attention (Dean et al., 2018).

Interpersonal therapy (IPT)

A time-limited form of psychotherapy for treating people with major depressive disorder, based on the assumption that interpersonal stress induces an episode of depression in a person who is genetically vulnerable to this disorder.

Interpersonal Approaches Developed as a brief intervention, **interpersonal therapy (IPT)** is a focused approach intended to last between 12 and 16 weeks. In IPT, clients are helped to manage the interpersonal stress associated with their depressive episodes, which themselves are seen as a function of genetic predisposition. Administered

according to a set of guidelines, interpersonal therapy provides clinicians with a clear model to follow so that treatment can proceed within the scheduled time frame. The IPT manual has the additional advantage of ensuring some consistency across therapists, making it possible to evaluate its effectiveness empirically.

Clinicians administer interpersonal therapy in three broad phases. In the first phase, the clinician assesses the magnitude and nature of the individual's depression using quantitative assessment measures and semistructured interviews. Depending on the type of depressive symptoms the individual shows, the therapist may consider combining treatment with antidepressant medications along with psychotherapy.

In the second phase, the therapist and the client collaborate on formulating a treatment plan that focuses on the primary problem. Typically, these problems are related to grief, interpersonal disputes, role transitions, and problems in interpersonal relationships stemming from inadequate social skills.

The therapist then carries out the treatment plan in the third phase, varying the methods according to the precise nature of the client's primary problem. The IPT approach encourages clinicians to combine such techniques as encouraging self-exploration, providing support, educating the client on the nature of depression, and offering feedback on the client's ineffective social skills. A primary focus of therapy is on the here and now, rather than on past childhood or developmental issues.

For clients who cannot take antidepressant medications or for whom it is impractical to use medications, IPT is an especially valuable intervention in that nonmedical staff can administer it, or clients, with instruction, can learn it themselves (Weissman, 2007). A large-scale analysis of studies conducted over 30 years showed that interpersonal therapy was significantly more effective than cognitive-behavioral therapy or medications (Bowden, 2005).

Interpersonal and social rhythm therapy (IPSRT) (Frank, 2007) is a biopsychosocial approach to treating people with bipolar disorder that incorporates the concepts of stressful life events and disturbances in circadian rhythms (such as altered sleep/wake cycles, appetite, and energy level) into a focus on the individual's personal relationships. According to the IPSRT model, mood episodes are likely to emerge from medication nonadherence, stressful life events, and disruptions in social rhythms.

Clinicians who use IPSRT focus on educating clients about medication adherence, giving them a forum to explore their feelings about the disorder, and helping them develop insight about the ways in which the disorder has altered their lives. Clients learn to pay careful attention to the regularity of daily routines (including the timing of events and the stimulation that occurs with these events), and the extent to which life events, positive as well as negative, influence daily routines. The goal of IPSRT is to increase the stability of a client's social rhythms.

Reducing interpersonal stress for clients with bipolar disorder is important for several reasons. First, stressful life events heighten the arousal of the individual's autonomic nervous system and hence alter circadian rhythms. Helping clients cope with stress helps adjust these rhythms. Second, many life events, whether perceived as stressful or not, themselves cause changes in daily routines that in turn create more stress. Third, major life stressors affect a person's mood and also lead to significant changes in social



An interpersonal therapist carefully collaborates with each client to generate a unique treatment plan, based on the client's symptoms and particular areas of concern.

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Interpersonal and social rhythm therapy incorporates biological approaches to treatment such as light therapy to regulate an individual's circadian rhythms.

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routines (Frank, 2007). As clients stabilize their social rhythms and routines while improving their interpersonal relationships, their stress levels decline accordingly. Researchers employing IPSRT support its use on an outpatient and inpatient basis (Swartz et al., 2011). However, in comparing IPT with IPSRT, a randomized clinical treatment study showed that the two were equally effective (Inder et al., 2015).

Looking across the results of virtually all published studies on interventions for mood disorders, Hollon and Ponniah (2010) concluded that cognitive-behavioral and behavioral therapy meet the criteria for evidence-based treatments, receiving strong support particularly for individuals with less severe or chronic depression. A review of randomized clinical trials comparing CBT with IPT shows both to be equally effective in treating major depressive disorder for at least 1 year post-treatment (Lemmens et al., 2015). Individuals with more severe depressive or bipolar disorders also benefit from cognitive-behavioral, interpersonal, and behaviorally oriented therapy above and beyond the effects of medication, and perhaps even instead of medication entirely, particularly over the long term (McHugh et al., 2013).

Sociocultural Perspectives

According to the sociocultural perspective, individuals develop depressive disorders in response to external life circumstances. These circumstances can be specific events such as sexual victimization, chronic stress such as poverty and single parenting, or episodic stress such as bereavement or job loss. Women are more likely to be exposed to these stressors than are men, a fact that may account, at least in part, for the higher frequency in the diagnosis of depressive disorders in women (Hammen, 2005).

However, acute and chronic stressors seem to play a differential role in predisposing an individual to experiencing depressive symptoms. Exposure to an acute stress such as the death of a loved one or an automobile accident could precipitate a major depressive episode. However, exposure to chronic strains from poor working conditions, health or interpersonal problems, or financial adversity can interact with genetic predisposition and personality to lead certain individuals to experience more persistent feelings of hopelessness. Moreover, once activated, an individual's feelings of depression and hopelessness can exacerbate the effects of exposure to stressful environments, which, in turn, can further increase the individual's feelings of chronic strain (Brown & Rosellini, 2011).

On the positive side, strong religious beliefs and spirituality may combine with the social support that membership in a religious community provides to lower an individual's chances of developing depression, even among those with high risk. Among the adult children of individuals with major depressive disorder, those with the strongest religious beliefs were less likely to experience a recurrence over a 10-year period (Miller et al., 2011).

7.4 Suicide

Although not a diagnosable disorder, suicidality is one potential diagnostic feature of a major depressive episode. The definition of suicide is "a fatal self-inflicted destructive act with explicit or inferred intent to die" (Goldsmith, Pellman, Kleinman, & Bunney, 2002, p. 27). Suicidal behavior runs along a continuum of thinking about ending one's life ("suicidal ideation"), to developing a plan, to undertaking nonfatal suicidal behavior ("suicide attempt"), to actually ending one's life ("suicide") (Centers for Disease Control and Prevention, 2011b).

The rate of completed suicide in the United States is far lower than the rates of other reported causes of death, amounting to slightly over 44 per 100,000 deaths in 2015 (Murphy et al., 2017). However, underreporting is likely, due to the difficulty of establishing cause of death as intentional rather than unintentional harm. The highest suicide rates by age are for people 45 to 54 years old (20.3 per 100,000). Individuals 85 and older have the next highest

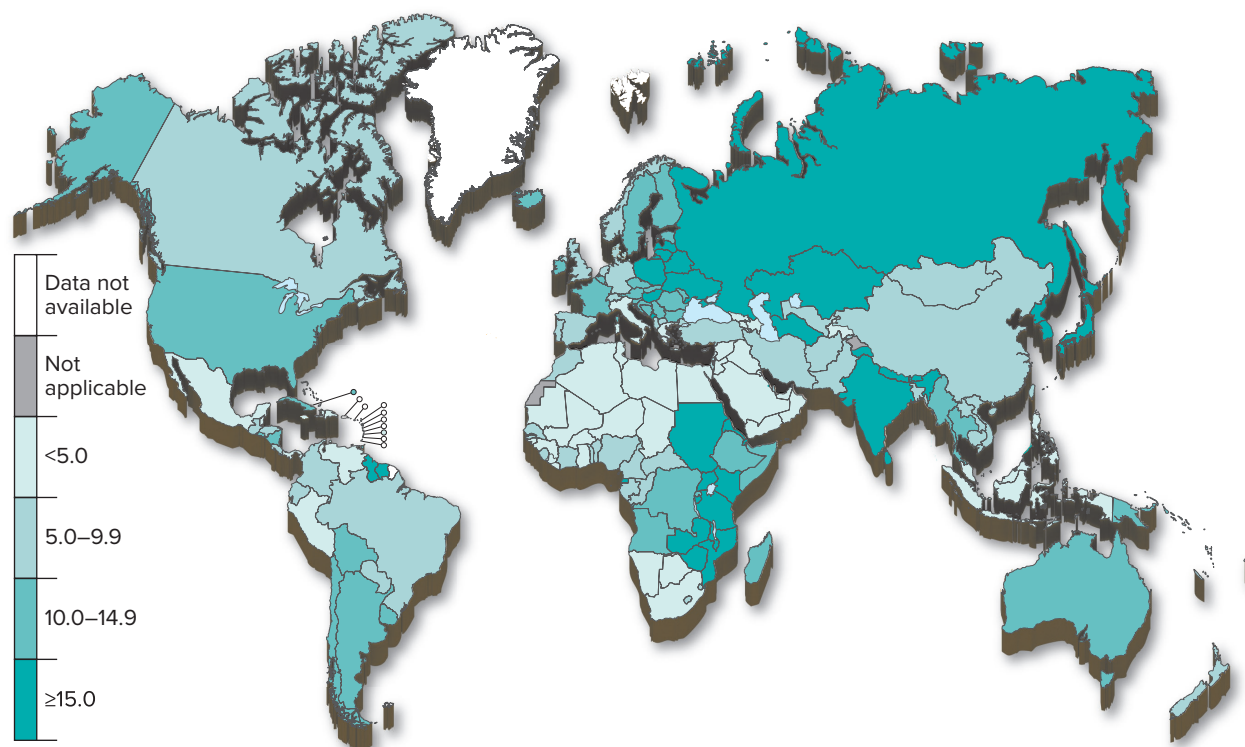


FIGURE 3 Map of Suicide Rates

SOURCE: Age-standardized suicide rates (per 100,000 population), both sexes, 2012 World Health Organization.

rates (19.4) as well as the highest rates of suicide by discharge of firearms (13.7). Within the United States, white men are much more likely than are nonwhite men to commit suicide.

Around the world, there are approximately 1 million suicides each year, with a global mortality rate of 16 per 100,000. The highest global suicide rates are for males in Lithuania (61.3 per 100,000) and for females in South Korea (22.1 per 100,000), and the lowest rates (near 0) for several Latin American and Caribbean countries, Jordan, and Iran (see Figure 3).

Young adults are at highest risk of suicide in many countries outside the United States. In Europe and North America, depression and alcohol-use disorders are major psychological risk factors for suicide. In the United States, more than 90 percent of suicides occur in people with a psychological disorder (Goldsmith et al., 2002). In contrast, impulsiveness plays a higher role in the suicides of people from Asian countries (World Health Organization, 2011).

The biopsychosocial perspective is particularly appropriate for understanding why people commit suicide and in many ways parallels the understanding gleaned from an integrative framework for major depressive disorders. Biological theories emphasize the genetic and physiological contributions that also contribute to the causes of mood disorders. Psychological theories focus on distorted cognitive processes and extreme feelings of hopelessness that characterize suicide victims. From a sociocultural perspective, the variations between and within countries suggest contributions relating to an individual's religious beliefs and values and the degree to which the individual is exposed to life stresses.

The perspective of positive psychology provides a framework for understanding why individuals who are at high risk for the reasons above nevertheless do not commit suicide.

You Be the Judge

Do-Not-Resuscitate Orders for Suicidal Patients

The question whether physicians should assist patients in ending their own lives, a process known as physician-assisted suicide, came to public attention in the 1990s when Dr. Jack Kevorkian, a Michigan physician, began providing terminally ill patients with the means to end their lives through pharmacological injections. Kevorkian's very public involvement sprang from what he saw as a righteous campaign to alleviate people's suffering and allow them to "die with dignity." He was imprisoned for 8 years following the televised assisted suicide he performed on a man with amyotrophic lateral sclerosis (ALS), a terminal nervous system disease.

Medical professionals encourage (or sometimes require) patients, terminally ill or not, to direct them—in an "advance directive" or "living will"—by stating whether they wish to have artificial life support should they be unable to survive on their own. The advance directive often includes a DNR or "do not resuscitate" order in which the patient specifies that no heroic life-support measures should be taken to prolong life with, for example, life-support machines. Medical professionals respect the conditions of the DNR when they must make life-and-death decisions. In contrast, when individuals who have psychological disorders and wish to end their lives embark upon the same plans as a medical patient with a life-threatening illness, clinicians treat them to prevent them from committing suicide. The treatment may include involuntary hospitalization.

The obligation to respect end-of-life wishes may present an ethical conflict for mental health professionals when treating suicidal individuals who complete a DNR stating that they do not wish to be given life support. The question is whether having a serious psychological disorder that is incapacitating, resistant to treatment, and debilitating is any different from having a similarly untreatable and painful medical illness.

Q: *You be the judge:* Does the individual's right to autonomy, respected with a DNR, differ in this type of case (Cook, Pan, Silverman, & Soltys, 2010)?

The buffering hypothesis of suicidality (Johnson et al., 2011) describes resilience as a separate dimension from risk. You may be at risk of committing suicide, but if you are high on resilience, you are unlikely to do so. The statistically higher risk you may face due to living in a stressful environment may not translate into higher suicidality if you feel you can cope successfully with these circumstances.

The factors that seem to contribute to high resilience include the ability to make positive assessments of your life circumstances and to feel in control over these circumstances. Additional buffers to suicide risk are a number of psychosocial factors such as being able to solve problems, having high self-esteem, feeling supported by family and significant others, and being securely attached. People who do not believe suicide is an acceptable option to stress are also better able to overcome high risk. On the negative side, low resilience occurs with high levels of perfectionism and hopelessness (Hewitt, Caelian, Chen, & Flett, 2014). Having friends or family members who attempted suicide represents another risk factor (Mueller, Abrutyn, & Stockton, 2015).

Interventions based on the resilience model would not only address the individual's specific risk factors, then, but also assess and then strengthen the individual's feelings of personal control and perceived abilities to handle stress. CBT is one such intervention shown to be effective on reducing suicide attempts in populations such as adolescents (Ougrin et al., 2015) and members of the military with a history of suicide attempts (Rudd et al., 2015).

7.5 Depressive and Bipolar Disorders: The Biopsychosocial Perspective

The disorders we covered in this chapter span a range of phenomena, from chronic but distressing sad moods to rapidly vacillating alternations between mania and depression. Although these disorders clearly indicate disturbances in neurotransmitter functioning, they also reflect the influences of cognitive processes and sociocultural factors. Because individuals may experience the symptoms of depressive disorders for many years, clinicians are increasingly turning to nonpharmacological interventions, particularly for cases in which individuals have mild or moderate symptoms. The situation for clients with bipolar disorder is more complicated, because lifelong maintenance therapy on medication is more likely necessary. Nevertheless, these individuals can benefit from psychological interventions to help keep their symptoms monitored and under control.

Even individuals whose mood disorder symptoms reflect a heavy influence of biology, however, should have access to a range of therapeutic services. With the development of evidence-based approaches, which integrate interventions across the individual's multiple domains of functioning, the chances are good that people with these disorders will increasingly have the ability to obtain treatment that allows them to regulate their moods and lead more fulfilling lives.

Return to the Case: Janice Butterfield

After several weeks in therapy, Janice's depression had started to show improvement. Once her depression remitted, however, she discontinued taking her medication. As she discussed in her initial therapy session, Janice found it important to appear strong to her family and associated psychological problems with weakness. Despite her concerns about admitting her psychological struggles, Janice continued to come to her weekly psychotherapy, and the sessions focused on her feelings about her diagnosis and the importance of taking her medication to prevent future mood swings, though she felt stable at the time. Reminded of examples of the past consequences of her mood swings, however, Janice was slowly able to better understand that the impact on her family would be far worse should she continue to go through mood cycles than if she worked at maintaining stability.

Dr. Tobin's reflections: Though it is a natural reaction to feel down when faced with a challenge such as losing a job and having to find a way to support your family, Janice's response went beyond the typical depression most people feel, and she met diagnostic criteria for major depressive episodes. Janice's description of her past depressive episodes was also consistent with this diagnosis. It was also

revealed that Janice experienced manic episodes in the past that had not only greatly affected her life but had put her family at great financial risk. Unfortunately, it wasn't until Janice had attempted suicide that she finally sought the help she needed. It is not unusual for individuals with bipolar disorder to be noncompliant with medication, because they go through long periods of feeling "normal" or being at their baseline. This was especially true of Janice, who had gone her entire life without seeking treatment and had difficulty understanding the need to take medication when she was not feeling depressed or manic.

Janice described experiencing a worsening of her mood episodes over time. This is typical for individuals with bipolar disorder who go without treatment for many years. Though she has been hesitant to talk about her problems with her family, it will be important to include them in her treatment because they can help Janice understand when her mood may start to shift. Individuals with bipolar disorder may struggle to be aware of these changes in mood. Over time, it will be important for Janice to continue to explore her concerns about the stigma of mental health treatment, given that this had been a major barrier to her reaching out for help in the past.

SUMMARY

- Depressive and bipolar disorders reflect a disturbance in a person's emotional state or mood. People can experience this disturbance in the form of extreme depression, excessive elation, or a combination of these emotional states. An episode is a time-limited period during which specific intense symptoms of a disorder are evident.
 - Major depressive disorder is characterized by acute but time-limited episodes of depressive symptoms, such as feelings of extreme dejection, a loss of interest in previously pleasurable aspects of life, bodily symptoms, and disturbances in eating and sleeping behavior. Individuals with major depressive disorder also have cognitive symptoms, such as a negative self-view, feelings of guilt, inability to concentrate, and indecisiveness. Depressive episodes can be melancholic or seasonal. Persistent depressive disorder consists of depression that is not as deep or intense as that experienced in major depressive disorder but has a longer-lasting course. People with persistent depressive disorder have, for at least 2 years, depressive symptoms such as low energy, low self-esteem, poor concentration, decision-making difficulty, feelings of hopelessness, and disturbances of appetite and sleep. Disruptive mood dysregulation disorder consists of chronic and severe irritability, and premenstrual dysphoric disorder occurs in women prior to their monthly menstrual periods.
 - Bipolar disorder is characterized by an intense and highly disruptive experience of extreme elation, or euphoria, called a manic episode, which manifests in abnormally heightened levels of thinking, behavior, and emotionality that cause significant impairment. Bipolar episodes in which both mania and depression are displayed can be labeled with specifiers to indicate mixed symptoms. Cyclothymic disorder consists of a vacillation between dysphoria and briefer, less intense, and less disruptive states called hypomanic episodes.
 - Clinicians have explained depressive and bipolar disorders in terms of biological, psychological, and sociocultural approaches. The most compelling evidence supporting a biological model relies on the role of genetics; it has been well established that these disorders run in families. Biological theories focus on neurotransmitter and hormonal functioning.
- Psychological theories have moved from early psychoanalytic approaches to more contemporary viewpoints that emphasize the behavioral, cognitive, and interpersonal aspects of mood disturbance. The behavioral viewpoint assumes that depression is the result of a reduction in positive reinforcements, deficient social skills, or the disruption caused by stressful life experiences. According to the cognitive perspective, depressed people react to stressful experiences by activating a set of thoughts called the cognitive triad: negative views of the self, the world, and the future. Cognitive distortions are errors people make in the way they draw conclusions from their experiences, applying illogical rules such as arbitrary inferences and overgeneralizing. Interpersonal theory posits a model of understanding depressive and bipolar disorders that emphasizes disturbed social functioning.
- Clinicians also base depressive and bipolar disorder treatments on biological, psychological, and sociocultural perspectives. Antidepressant medication is the most common form of somatic treatment for people who are depressed, and lithium carbonate is the most widely used medication for people who have bipolar disorder. In cases of incapacitating depression and some extreme cases of acute mania, the clinician may recommend electroconvulsive therapy. The psychological interventions most effective for treating people with depressive and bipolar disorders are those rooted in the behavioral and cognitive approaches. Sociocultural and interpersonal interventions focus on the treatment of mood symptoms within the context of an interpersonal system, such as an intimate relationship.
 - Although no formal diagnostic category specifically applies to people who commit suicide, many suicidal people have depressive or bipolar disorders, and some suffer from other serious psychological disorders. Clinicians explain the dramatic act of suicide from biological, psychological, and sociocultural perspectives. The treatment of suicidal clients varies considerably, depending on the context, intent, and lethality. Most intervention approaches incorporate support and direct therapy.

KEY TERMS

Behavioral activation

Bipolar disorder

Bipolar disorder, rapid cycling

Circadian rhythms

Cognitive triad

Cyclothymic disorder

Depressive disorder

Disruptive mood dysregulation
disorder

Dysphoria

Euphoria

Hypomanic episode

Interpersonal therapy (IPT)

Major depressive disorder

Major depressive episode

Manic episode

Persistent depressive disorder
(dysthymia)

Pharmacogenetics

Premenstrual dysphoric disorder
(PMDD)