Treatise on Depression, Stress, Anxiety, & Suicide

The difference between arts and science is that science is exact and reproducible. For example, an object is considered to be metal if it meets certain criteria which can be measured and observed, regardless of where, or by whom, the observation have been conducted. If one mixes element A with element B and heat it to X degree centigrade, one will get compound Y and gas G. The outcome is totally predictable and reproducible every time.

Medicine strides the grey area between arts and science. Nothing is reproducible with certainty. The best one can do is, given a set of circumstance, to estimate the probability of a certain outcome based on currently available evidence, diagnostic criteria and treatment method. Looking back at the history of medical science, one can't help but notice that diagnostic criteria and treatment methods for many conditions shift continuously, like the moving stairs in the Hogwart's School of Wizardry.

Scientists try to bring some creditability back into medicine by trying to qualify and quantify every thing they can lay their hands on. Thus, surgeons can measure the size, shape, consistency, thickness, infiltration, and spread of a tumour and develop a set of diagnostic criteria from which the five year survival rate of the victim can be estimated with a modicum of certainty.

At the other end of the scale are the psychiatrists, and psychologists, who have the unenviable tasks of trying to make sense of the most complex and intangible domain of human emotions and behaviors. To this end, psychologists and psychiatrists have tried to develop all sorts of scales aimed at trying to qualify and quantify human emotions and behaviour, with the hope that these systems can then be used to predict how a person with a certain diagnosed condition will behave under a given set of circumstances.

Depression and anxiety are two of the most common and yet most nebulous psychiatric conditions to diagnose and manage. What exactly does one mean when one says a person is "depressed", "anxious" or "stressed"? To many, depression is synonymous with sadness, jealousy, anger, melancholy, despair, frustration, unhappiness, grief, anxiety, fear, compulsive obsessive behavior and all manners of negative emotions. The DASS 21 (ref 1) is a scale which has been developed by the University of NSW. It is supposed to be a "simple" guide to help the user distinguish between anxiety, depression and stress. On closer examination, it is obvious that the questions are very subjective and imprecise. e.g. How does one rate the dryness of one's mouth on a scale of 0-4 reliably? Would it make a difference if the person had just had two cups of tea before doing the test or if he had not had a drink for 5 hours before he takes the test? Multiply this ambiguity and subjectivity by 21 and then apply the equally subjective and ambiguous scoring system, you have a scale that is as useful as rolling a dice and as easy to operate as a Rubik's Cube. The DSM IV (ref 2) & ICD10 diagnostic systems are equally complex and ambiguous. One of the qualifying diagnostic criteria for depression is "being in a depressed mood most of the time". This is like trying to measure a slithering snake with a home-made ruler made of soft elastic. Two observers are unlikely to come up with the same answer. Likewise, clinicians can't really agree on, or define exactly what constitute depression, anxiety or stress, so they talk about these conditions as if they are the one and same condition. Most clinicians feel it is unnecessary to distinguish these conditions. These misconceptions and misunderstandings lead to confusion as to what cause depression, whether a person is indeed depressed, how to assess its severity and how best to help a person who is affected.

What is certain is that, judging by the plethora of diagnostic criteria and definitions available, it is obvious that the effort to quantify and diagnose these conditions are still continuing.

This is what compels me to propose my system of diagnosis for these conditions . It is simple, easy to understand, easy to apply, and above all, reproducible with a high degree of objectivity. The significance of my diagnostic system, the "Doug Lee Paradigm for depression, stress and anxiety" ,is that more than just being able to categorize and distinguish these conditions, it can be used to predict suicide risk.

I define **a person who is <u>depressed</u>** as a person who **has <u>lost hope</u> and interest**. He couldn't care less what happens to the world or to himself, and he couldn't care less if he lives or die.
A person who is <u>anxious</u> is <u>worried and fears</u> that something may happen to himself or to persons or objects he loves. He worries because he treasures life and is afraid of events that may threaten or endanger his happiness.
This is why depression and anxiety are actually mutually exclusive conditions
The condition loosely labeled as "stress" is the critical link which encompasses both these conditions.

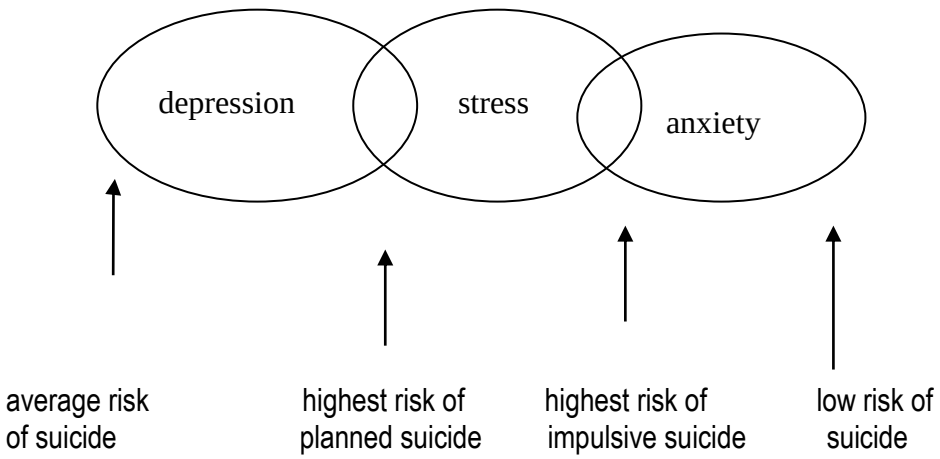
"Stress" is another term in psychology that is even more nebulous and harder to define than depression and anxiety. The government department "Comcare" flatly refuses to accept "stress" as a diagnosis on medical certificates from doctors, claiming that it is not a scientific term.

In the world of physics, a structure is said to be under "stress" if it is subjected to opposing forces acting on it without producing any movement or deformity. Similarly, if a person suffers from pressures from which there is no escape, he/she is under stress. If the structure is flexible, it will deform under stress and bounce back after the stress has passed (like a plank of timber). If the structure is not flexible (like a pane of glass) it will snap suddenly and catastrophically when the limit of stress is exceeded, likewise in human.

A person is under "<u>stress</u>" if he suffers from "<u>unbearable pain</u>" and "**<u>unachievable desire</u>**". "Pain" can be physical, psychological or emotional. "Desire" encompasses religious belief, infatuation, fantasy & cultural attitudes.

At first glance, it may seem to be a purely academic and rhetoric exercise to differentiate between these conditions . However, there is much more than academic value in making this distinction because, the diagnosis defines suicide risk.

The Doug Lee Paradigm



The media always associates this tragedy with depression. Whenever a person commits suicide, the paper will talk about depression. The truth is, a depressed person has lost hope and interest, but not necessarily the will to live. Plenty of examples can be found amongst the homeless and the vagrant population. They have no hope, no home, no love, and no one cares about them. Yet they keep living because , strange enough, they have no stress, i.e. they have no frustrated aspiration, therefore no unreachable desire, they have nothing further to lose, as long as they feel no pain, there is no stress and there is no reason to kill themselves. We all know people like that, the grumble bums, the kill joys, the Uncle Scrooge. The old man who can't stand the sound of happy children, the department manager who have no hope of further advancement and who make life miserable for all around them, the slaves who toil in the deep south cotton fields. Depressed people are like black holes. They can make a beautiful sunny day turn cloudy, they can drag you down into the dumps with them. When you are with a depressed person, you can feel your energy being drained and come away feeling awful. They keep making every one miserable but depression does not necessarily lead to suicide.

On the other end of the scale is anxiety. The anxious person makes you feel annoyed because he asks so many questions, explicit or implicit, many of them start with "what if…?" and "What about…?" "what if I miss a tablet? What if I drink alcohol with this medication? What if his temperature goes up? What if this doesn't work? What if his teacher does not like this colour? What if he start drinking again? What if we can't meet the repayment? What if he is he doesn't find me attractive anymore? What if your parents come home right now? What if the blood count keeps going down? What if my kidney function keep deteriorating? The anxious person is preoccupied with possibilities of harm and injuries to himself or his loved ones. He loves his life too much to commit suicide.

Pain is what causes a person to commit suicide. Pain of the loss of a loved one, pain of disastrous loss (stock market or gambling loss), pain of having one's reputation tarnished (people in high places who got news that they will be brought down by some unfavourable revelation), pain of not being allowed to see one's lover, pain of not being allowed to do what one wants, pain of terminal or chronic illness, pain of shame, pain of being violated, pain of not being able to practice one's religion / ideology/ political belief. The person who is both depressed (having no hope for a better tomorrow) as well as stressed (suffering from pain) is at the highest risk of committing suicide. These are the ones who plan and execute their suicide with precision, and often succeed. As they are depressed, they don't talk to any one, their stress often go unnoticed and this kind of suicide is hard to prevent. However if a person near to the victim is perceptive enough, he might have noticed that the victim is in a situation of suffering from pain, and catch the give away phrases (see table below) early enough, it may be prevented.

The type of suicide that is most tragic are the ones who are suffering from anxiety (fear, e.g. stolen money from the firm and some one is making inquiry) as well as pain (lost the money in ambling) and unachievable desire (finding two $2 million back before Monday, when the auditor arrives). They decide to avert the pain and escape the fear on the spur of the moment, jumping off a building, slitting the wrist, without the opportunity to talk through the consequence with someone. If one can show the prospective victim a possible way out (your rich aunty may soon be leaving you all her money) the person may change his mind.

For a person who has suffered severe pain or grief from loss of body parts, loved ones, job, reputation, fortune etc., if one can somehow convince the person to transform his grief to love for some one else (there are other starfish in the sea) or some thing else (take up a hobby building model railway etc) or love for higher purpose (e.g. forming a group or working to raise fund for a group dedicated to helping other victims who have suffered similar misfortunes), one may be able to prevent the tragedy.

I have developed a simplified system which can help lay persons to understand and distinguish these distinctive and different conditions. It also offers advice on how one can provide initial assistance to victims before seeking professional help.

Applying my simple diagnostic criteria, one can easily diagnose and identify the person with the highest suicide risk and offer appropriate assistance.

The information in this article is only meant as a guide for the diagnosis and preliminary intervention of three commonly encountered emotional affliction.

It must be emphasized that there are a lot more kinds of mental illnesses other than depression, stress and anxiety. If you come across someone who is drowning, you shouldn't jump in unless you are strong enough and have had appropriate life saving training, otherwise you are likely to become the second victim and double the tasks of the professional rescuer. Likewise,it is important that if you are concerned about a person because he or she is unusually sad, distressed, upset or unhappy about something, you should encourage the person to seek professional help as soon as possible.

The Doug Lee Paradigm for diagnosing Depression Stress & Anxiety

	Depression	Stress	Anxiety
Definition:	**Lost of hope & interest**	**Unavoidable pain** (physical or emotional, real or perceived, immediate or forthcoming) **Unachievable desires**	**Fear** of injury, harm or death
It is a state of mind caused by having….	no desire, despair, nothing to look forward to,	insufficient means to achieve what one desires (or to avoid what one does not desire)	fear of losing what one desires (e.g. good health, happiness)
Patient feels…	Hopeless Disinterested Couldn't be bothered	Unable to find relief, Unable to do anything about the situation and Unable to escape	Surrounded by possibilities of injury or harm to himself or loved ones
Patient asks… (This is the main diagnostic feature)	no question, but, instead, make negative statements (see below) *If you talk to a person for 15 minutes and he hasn't asked a single question, he IS depressed.	What should I do? What more can I do? (seek guidance)	Excessive amount of questions What if…? What about …? (seek reassurance)
Pt says… (these are the "diagnostic phrases")	What's the point/use.. I can't see any point… It won't work….	I can't cope anymore I can't take this anymore I can't bear this Its too much… I feel trapped I'm stuck with …	What if ….. What about ….
Suicide risk	Medium	Highest	low
Reason	Can't be bothered	Can't stand the pain (physical or psychological) because : What he desires is unattainable or What he cherishes will soon be taken from him	Life is too precious
Think of	Eyore	Romeo & Juliet	Piglet
Caused by	(lost of **Hope**, or inability to perceive & appreciate **joy**)	Inability to escape or withstand **Pain & suffering** (mental or physical, real or perceived)	Inability to overcome **fear**
Treatment principle	Bestow Hope If you can just hang on, there is light at the end of the tunnel	Introduce victim to Love (universally & broadly) Look beyond your own pain, find some one else (e.g. a foster child in a 3rd world country), something else (e.g. a hobby, a noble course) to love	Help victim to find Faith & belief in destiny e.g.Believe in the love of God, believe what will be will be, acquire knowledge & skill to deal with what one fears most e.g. learning to fly to overcome fear of flying.

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Ref (1) The DASS21 system of diagnosing depression, stress and anxiety

DASS21	*Name:*	*Date:*

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3	S
2	I was aware of dryness of my mouth	0	1	2	3	A
3	I couldn't seem to experience any positive feeling at all	0	1	2	3	D
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3	A
5	I found it difficult to work up the initiative to do things	0	1	2	3	D
6	I tended to over-react to situations	0	1	2	3	S
7	I experienced trembling (eg, in the hands)	0	1	2	3	A
8	I felt that I was using a lot of nervous energy	0	1	2	3	S
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3	A
10	I felt that I had nothing to look forward to	0	1	2	3	D
11	I found myself getting agitated	0	1	2	3	S
12	I found it difficult to relax	0	1	2	3	S
13	I felt down-hearted and blue	0	1	2	3	D
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3	S
15	I felt I was close to panic	0	1	2	3	A
16	I was unable to become enthusiastic about anything	0	1	2	3	D
17	I felt I wasn't worth much as a person	0	1	2	3	D
18	I felt that I was rather touchy	0	1	2	3	S
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3	A
20	I felt scared without any good reason	0	1	2	3	A
21	I felt that life was meaningless	0	1	2	3	D

DASS 21 SCORE:

	DEPESSION SCORE	ANXIETY SCORE	STRESS SCORE
_____	[D]	[A]	[S]

	Depression	Anxiety	Stress
Normal	**0 – 4**	0 – 3	0 - 7
Mild	**5 – 6**	4 – 5	8 – 9
Moderate	**7 – 10**	6 – 7	10 – 12
Severe	**11 – 13**	8 – 9	13 – 16
Extremely Severe	**14+**	10+	17+

Normal	supportive Counselling – No Clinical Treatment
Mild	Clinical Treatment – CBT indicated + Possible Pharmacology Treatment
Moderate	Clinical Treatment – CBT indicated + Pharmacology Treatment
Severe	Clinical Treatment – CBT indicated + Pharmacology Treatment + referral
Extremely severe	Clinical Treatment -- Pharmacology Treatment + urgent Referral suggested

Ref 2

Depression
*According to DSM-IV**

DSM-IV, Diagnostic and Statistical Manual of Mental Disorders (4th ed.) , American Psychiatric Association.

Major Depressive Episode	Manic Episode	Mixed Episode
Hypomanic Episode	Major Depressive Disorder	Dysthymic Disorder
Bipolar I Disorder	Bipolar II Disorder	Cyclothymic Disorder

Criteria for Major Depressive Episode

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

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). NOTE: In children and adolescents, irritability may be observed.

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

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

(4) insomnia or hypersomnia nearly every day

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

(6) fatigue or loss of energy nearly every day

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

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

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

B. The symptoms do not meet criteria for a Mixed Episode.

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

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

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

Criteria for Manic Episode

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

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

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode.

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

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

NOTE: Manic-like episodes caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Criteria for Mixed Episode

A. The criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day during at least a 1-week period.

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

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism) NOTE: Mixed-like episodes caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Criteria for Hypomanic Episode

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

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

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

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

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

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

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

NOTE: Hypomanic-like episodes caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.

Criteria for Major Depressive Disorder

NOTE: There are two listings for Major Depressive Disorder, Single Episode and Recurrent. Recurrent information is in parenthesis.

A. Presence of a single (two or more) Major Depressive Episode.

B. The Major Depressive Episode (Episodes) is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

NOTE: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

Criteria for Dysthymic Disorder

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. NOTE: In children and adolescents, mood can be irritable and duration must be at least one year.

B. Presence, while depressed, of two (or more) of the following:

(1) poor appetite or overeating

(2) insomnia or hypersomnia

(3) low energy or fatigue

(4) low self-esteem

(5) poor concentration or difficulty making decisions

(6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic

Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

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

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

Criteria for Bipolar I Disorder (Most Recent Episode Unspecified)

A. Criteria, except for duration, are currently (or most recently) met for a Manic, a Hypomanic, a Mixed, or a Major Depressive Episode.

B. There has previously been at least one Manic Episode or Mixed Episode.

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

D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, SchizophreniformDisorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

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

Criteria for Bipolar II Disorder

A. Presence (or history) of one or more Major Depressive Episodes.

B. Presence (or history) of at least one Hypomanic Episode.

C. There has never been a Manic Episode or a Mixed Episode.

D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

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

Criteria for Cyclothymic Disorder

A. For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a Major Depressive Episode.

NOTE: In children and adolescents, the duration must be at least 1 year.

B. During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.

C. No Major Depressive Episode,Manic Episode, or Mixed Episode has been present during the first 2 years of the disturbance.

D. The symptoms in Criterion A are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

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

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