Mood Disorders

I. Introduction
II. Unipolar Depression
III. Bipolar Depression
IV. Theories of Mood Disorders
V. Treatments for Mood Disorders
II. Unipolar Depression

• Major Depressive Disorder (MDD)
• Dysthymic Disorder
Major Depressive Episode
(5/9 for at least 2 weeks)

- Depressed mood
- Weight loss/gain
- Motor agitation or impairment
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Change in sleep
- Concentration impairment
- Thoughts of death or suicide
- Loss of interest in previously pleasurable activities
Major Depressive Disorder

- Occurrence of a major depressive episode
- No history of a manic or hypomanic episode
Subtypes of Depression

• Atypical (overeating & oversleeping)
• Melancholic (severe somatic symptoms)
• Chronic (symptoms for at least 2 years)
• Catatonic
• Psychotic (hallucinations & delusions)
• Postpartum onset (onset after childbirth)
Symptoms of Dysthymic Disorder

• Depressed mood for more days than not for at least 2 years
• Two of more of the following symptoms
  – Poor appetite
  – Insomnia/hypersomnia
  – Low energy/fatigue
  – Poor concentration/difficulty making decisions
  – Feelings of hopelessness
• No Major Depressive Episode for first 2 years
III. Bipolar Depression

- Bipolar Disorder I
- Bipolar Disorder II
- Cyclothymic Disorder
Manic Episode

• An elevated, expansive, or irritable mood for at least one week, plus at least three of these additional symptoms:
  – Inflated self-esteem or grandiosity
  – Decreased need for sleep
  – More talkative than usual/pressure to keep talking
  – Flight of ideas and racing thoughts
  – Distractibility
  – Increased goal-directed activity
  – Excessive involvement in dangerous activities
“Those? Oh, just a few souvenirs from my bipolar-disorder days.”
Bipolar I

• Occurrence of a manic episode
• (Major depressive episodes usually co-occur but aren’t required for the diagnosis)
Bipolar II

- Occurrence of a hypomanic episode
- Occurrence of a major depressive episode
Cyclothymic Disorder

• Occurrence of hypomanic symptoms and major depressive symptoms for at least 2 years

• No history of a manic episode, hypomanic episode, or major depressive episode
Figure 7.2  Mood disorders and specifiers for the most recent episode of the disorder.
IV. Theories of Mood Disorders
Figure 7.3  Co-occurrence of types of mood disorders in twins for Unipolar (UPD) and Bipolar (BPD) Affective Disorder (AD). (From “The Heritability of Bipolar Affective Disorder and the Genetic Relationship to Unipolar Depression” by P. McGuffin, F. Rijsdijk, M. Andrew, P. Sham, R. Katz, and A. Cardno from Archives of General Psychiatry, 60, pp. 497–502. Copyright © 2003 by the American Medical Association. Adapted with permission.)
"I FEEL BETTER TODAY TOO, BUT AROUND HERE I'VE LEARNED NOT TO BE TOO OPTIMISTIC."

(© 1998 Sidney Harris)
V. Treatments for Mood Disorders
Antidepressants

• Tricyclic antidepressants
  – Imipramine (Tofranil), Desipramine (Norpramin), Amitriptyline (Elavil)

• Monoamine Oxidase Inhibitors (MAOIs)
  – Phenelzine (Nardil), Tranylcypromine (Parnate)

• Selective Serotonin Reuptake Inhibitors (SSRIs)
  – Fluoxetine (Prozac), Sertraline (Zoloft), Paroxetine (Paxil), Fluvoxamine (Luvox)
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<td>Phenelzine</td>
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<td>Amitriptyline</td>
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<td>Doxepin</td>
<td>Adapin; Sinequan</td>
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<td>Trimipramine</td>
<td>Surmontil</td>
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<td>Desipramine</td>
<td>Norpramin; Pertofran</td>
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<td>Nortriptyline</td>
<td>Aventil; Pamelar</td>
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<td>Protriptyline</td>
<td>Vivactil</td>
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<td>Maprotiline</td>
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<td>Amoxapine</td>
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<td>Trazodone</td>
<td>Desyrel</td>
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<td>Clomipramine</td>
<td>Anafranil</td>
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<td>Venlafaxine</td>
<td>Effexor</td>
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<td>Fluvoxamine</td>
<td>Generic only</td>
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<td>Nefazodone</td>
<td>Generic only</td>
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<td>Bupropion</td>
<td>Wellbutrin</td>
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<td>Mirtazapine</td>
<td>Remeron</td>
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<td>Citalopram</td>
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<td>Escitalopram</td>
<td>Lexapro</td>
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<td>Duloxetine</td>
<td>Cymbalta</td>
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<td>Reboxetine</td>
<td>Edronax</td>
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<td>Atomoxetine</td>
<td>Strattera</td>
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(Julien, 2008)
Schizophrenia

I. History
II. Symptoms
III. Other Psychotic Disorders
IV. Schizophrenia Subtypes
V. Prevalence
VI. Theories
VII. Treatments
I. History

- Emil Kraepelin
- Eugene Bleuler
II. Symptoms
Positive Symptoms

• Positive symptoms are defined by their presence or appearance

• Examples include:
  – Delusions
  – Hallucinations
  – Disorganized thought & Speech
  – Inappropriate Affect

• Type I Schizophrenia
“And only you can hear this whistle?”
Negative Symptoms

• Negative symptoms are defined by their absence or disappearance

• Examples include:
  – Alogia
  – Affective flattening
  – Avolition
  – Social withdrawal
  – Anhedonia

• Type II Schizophrenia
Other Symptoms

• Catatonia
• Attention deficits
DSM Checklist

SCHIZOPHRENIA

1. At least two of the following symptoms, each present for a significant portion of time during a one-month period:
   (a) Delusions.
   (b) Hallucinations.
   (c) Disorganized speech.
   (d) Grossly disorganized or catatonic behavior.
   (e) Negative symptoms.

2. Functioning markedly below the level achieved prior to onset.

3. Continuous signs of the disturbance for at least six months, at least one month of which includes symptoms in full and active form (as opposed to attenuated form).

Based on APA, 2000.
Other Symptoms

• Prodromal & residual symptoms
### III. Other Psychotic Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Key Features</th>
<th>Duration</th>
<th>Lifetime Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>Various psychotic symptoms such as delusions, hallucinations, disorganized speech, flat or inappropriate affect, and catatonia</td>
<td>6 months or more</td>
<td>1.0%</td>
</tr>
<tr>
<td>Brief psychotic disorder</td>
<td>Various psychotic symptoms such as delusions, hallucinations, disorganized speech, flat or inappropriate affect, and catatonia</td>
<td>Less than 1 month</td>
<td>Unknown</td>
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<tr>
<td>Schizophréniform disorder</td>
<td>Various psychotic symptoms such as delusions, hallucinations, disorganized speech, flat or inappropriate affect, and catatonia</td>
<td>1 to 6 months</td>
<td>0.2%</td>
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<tr>
<td>Schizoaffective disorder</td>
<td>Marked symptoms of both schizophrenia and a mood disorder</td>
<td>6 months or more</td>
<td>Unknown</td>
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<tr>
<td>Delusional disorder</td>
<td>Persistent delusions that are not bizarre and not due to schizophrenia; persecutory, jealous, grandiose, and somatic delusions are common</td>
<td>1 month or more</td>
<td>0.1%</td>
</tr>
<tr>
<td>Shared psychotic disorder</td>
<td>Person adopts delusions that are held by another individual, such as a parent or sibling; also known as folie à deux</td>
<td>No minimum length</td>
<td>Unknown</td>
</tr>
<tr>
<td>Psychotic disorder due to a general medical condition</td>
<td>Hallucinations or delusions caused by a medical illness or brain damage</td>
<td>No minimum length</td>
<td>Unknown</td>
</tr>
<tr>
<td>Substance-induced psychotic disorder</td>
<td>Hallucinations or delusions caused directly by a substance, such as an abused drug</td>
<td>No minimum length</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
IV. Schizophrenia Subtypes

- Paranoid
- Disorganized
- Catatonic
- Undifferentiated
- Residual
V. Prevalence

![Bar chart showing annual prevalence of schizophrenia by economic status.]

- **Lower**: 1.90%
- **Lower-middle**: 1.30%
- **Middle**: 0.90%
- **Upper-middle**: 0.80%
- **Upper**: 0.40%
Life Circumstance of People with Schizophrenia

- Unsupervised living: 34%
- Living with family member: 25%
- Supervised living (e.g., halfway house): 18%
- Nursing homes: 8%
- Jails and prisons: 6%
- Hospitals: 5%
- Homeless: 5%
VI. Theories
Brain Abnormalities
Disorganization in the Hippocampus
The Seasonality Effect

Number of schizophrenic births (per 10,000 live births)
Adjusted Seasonality Effect
Expressed Emotion & Relapse
(Bebbington & Kuipers, 1994)

Percentage of Patients Relapsed

<table>
<thead>
<tr>
<th></th>
<th>High Contact</th>
<th>Low Contact</th>
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<tbody>
<tr>
<td>Family High in EE</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Family Low in EE</td>
<td>15%</td>
<td>25%</td>
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VII. Treatments
## Antipsychotic Drugs

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<thead>
<tr>
<th>Class/Generic Name</th>
<th>Trade Name</th>
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<tbody>
<tr>
<td><strong>Conventional antipsychotics</strong></td>
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<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
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<tr>
<td>Trifluromazine</td>
<td>Vesprin</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>Mellaril</td>
</tr>
<tr>
<td>Mesoridazine</td>
<td>Serentil</td>
</tr>
<tr>
<td>Trifluoperazine</td>
<td>Stelazine</td>
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<tr>
<td>Fluphenazine</td>
<td>Prolixin, Permitil</td>
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<tr>
<td>Perphenazine</td>
<td>Trilafon</td>
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<tr>
<td>Acetophenazine</td>
<td>Tindal</td>
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<tr>
<td>Chlorpromazine Hydrochloride</td>
<td>Taractan</td>
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<tr>
<td>Thiothixene</td>
<td>Navane</td>
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<tr>
<td>Haloperidol</td>
<td>Haldol</td>
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<tr>
<td>Loxapine</td>
<td>Loxitane</td>
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<tr>
<td>Molindone Hydrochloride</td>
<td>Moban, Lidone</td>
</tr>
<tr>
<td>Pimozide</td>
<td>Orap</td>
</tr>
<tr>
<td><strong>Atypical antipsychotics</strong></td>
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<tr>
<td>Risperidone</td>
<td>Risperdal</td>
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<tr>
<td>Clozapine</td>
<td>Clozaril</td>
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<tr>
<td>Olanzapine</td>
<td>Zyprexa</td>
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<tr>
<td>Quetiapine</td>
<td>Seroquel</td>
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<tr>
<td>Ziprasidone</td>
<td>Geodon</td>
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<tr>
<td>Aripiprazole</td>
<td>Abilify</td>
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</tbody>
</table>
Chlorpromazine

• A.k.a. Thorazine
• One of the first antipsychotic medications
• Works by blocking D1 & D2 dopamine receptors
• Side effects/drawbacks
  – Impairs motor activity (~Parkinson’s)
  – Involuntary movements of the tongue and face (tardive dyskinesia)
  – Not everyone responds
Clozapine

- Considered an “atypical” antipsychotic
- Works by blocking D4 dopamine receptors
- Also influences levels of serotonin, acetylcholine, epinephrine, & histamine
- A bit more effective at treating both positive and negative symptoms
Effects of Psychosocial Intervention (with Medication) on Relapse Rates. In one study, patients with schizophrenia who received social skills training, family therapy, or both in addition to medication had much lower relapse rates in the first year after treatment than did patients who received only medication.

Source: Hogarty et al., 1986.
Dissociative Disorders

I. Introduction
II. Dissociative Identity Disorder (DID)
III. Dissociative Fugue
IV. Dissociative Amnesia
I. Introduction
II. Dissociative Identity Disorder (DID)
Symptoms of DID

• The presence of two or more distinct identities or personality states
• Control of the person’s behavior recurrently taken by at least two of these identities or personality states
• An inability to recall important personal information that is too extensive to be explained by ordinary forgetfullness
Entries from subject number six's diaries

Satan again that hat door for the people that wronged me!!!

Prison—sitting in a jail cell/Sitting in a jail cell for a crime someone else has done I guess that happened. Just on the names that I use actually belong to people I know...

Letters from subject number 10

Heir to (surname 61-year-old in the January—six Atlanta Journal of 810 ladson) is person in your leadership keep off thing first 4 I killed 61 year old Anna Mae Chiaia on Dec. 19, 1977. I was person from Aug. 24—Dec. 1, 1977. What about rest??

I also have the letter from the YWCA in Rochester and the Bureau of Vital Statistics.

Once him in a cell in Youthide & Special Handling Unit. His crime submitted Aug. 9, 1977. Plaintiff is in jail. Claimant lost ten of the time his right is under the 6th.

Figure 7.2 Handwriting samples from DID cases. From
Somatoform Disorders

I. Introduction

II. Conversion Disorder

III. Somatization Disorder

IV. Pain Disorder

V. Hypochondriasis

VI. Body Dysmorphic Disorder
I. Introduction
II. Conversion Disorder
III. Somatization Disorder
IV. Pain Disorder
V. Hypochondriasis
VI. Body Dysmorphic Disorder
Personality Disorders

I. Introduction

II. Cluster A: Odd-Eccentric Personality Disorders

III. Cluster B: Dramatic-Emotional Personality Disorders

IV. Cluster C: Anxious-Fearful Personality Disorders

V. Criticisms of Personality Disorders
I. Introduction
II. Odd-Eccentric Personality Disorders

- Paranoid P. D.
- Schizoid P. D.
- Schizotypal P. D.
Cluster A Personality Disorders & Schizophrenia
(adapted from Siever, 1992)

<table>
<thead>
<tr>
<th></th>
<th>“Positive” symptoms: ideas of reference, magical thinking, &amp; perceptual distortions</th>
<th>“Negative” symptoms: social isolation, poor rapport, &amp; constricted affect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid P. D.</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Schizoid P. D.</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Schizotypal P. D.</td>
<td>Yes</td>
<td>Yes</td>
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</tbody>
</table>
III. Dramatic-Emotional Personality Disorders

• Antisocial P. D.
• Borderline P. D.
• Histrionic P. D.
• Narcissistic P. D.
Ted Bundy & Jeffrey Dahmer
Antisocial P. D. & Rehabilitation (Rice et al., 1997)

Rate of Violent Recidivism

- Therapeutic Community
- Prison

Psychopaths

Nonpsychopaths
Narcissistic Personality Disorder
"IT MAKES ME REALIZE HOW INSIGNIFICANT MOST PEOPLE ARE."
IV. Anxious-Fearful Personality Disorders

- Avoidant P. D.
- Dependent P. D.
- Obsessive-Compulsive P. D.
V. Criticisms of Personality Disorders
<table>
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<th><strong>PERSONALITY DISORDER</strong></th>
<th>Paranoia</th>
<th>Schizoid</th>
<th>Schizotypal</th>
<th>Antisocial</th>
<th>Borderline</th>
<th>Histrionic</th>
<th>Narcissistic</th>
<th>Avoidant</th>
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**FEATURES**

- Central Feature
- Prominent Feature