OCD: Compulsions

- **Four major categories**
  - Checking
  - Ordering
  - Arranging
  - Washing/cleaning

- **Association with obsessions**
  - Aggression/sex = checking
  - Symmetry = arranging or repeating
  - Contamination and germs = washing

- **Hoardung**

PANDAS
Baxter Article!

• One test question on what article is about.
• Take home message:
  – Psychological (social) therapies can actually change the functioning and structure/activity in the brain!
Obsessive-Compulsive Disorder

• Statistics
  – 1% (year)
  – Female > Male
    • Reversed in childhood
  – Chronic
  – Onset = depends
    • Male = 13 to 15
    • Female = 20 to 24
Obsessive-Compulsive Disorder: Causes

- Similar generalized biological vulnerability

- Specific psychological vulnerability
  - Early life experiences and learning
  - Thoughts are dangerous/unacceptable
  - Thought-action fusion

- Distraction temporarily reduces anxiety
  - Increases frequency of thought
Intrusive Thoughts Reported by Nonclinical samples without OCD

- Impulse to jump out a window
- Impulse to push someone in front of a train
- Wishing a person would die
- “If I say goodbye to someone, they will die”
- catch a disease from a public pool / toilet seat, etc.
- my hands are too dirty
- idea of swearing at my boss
- thoughts of blurting out something in church
- think I forgot to lock the house, turn off the iron, etc.
OCD: Treatment

• Medications
  – **SSRIs**
    • 60% benefit
  – **Psychosurgery (cingulotomy)**
    • Cingulate bundle lesion
    • 30% benefit

  – High relapse when d/c’d
OCD: Treatment

- **Cognitive-behavioral therapy**
  - Exposure
  - Response prevention
  - Reality testing
  - Highly effective
    - 86% benefit
  - No added benefit from combined treatment
    - Article: UCLA OCD Study
      - Metabolism changed the same way for both!
## Treatment of the Anxiety Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Anxiety的表现</th>
<th>Treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized Anxiety Disorder (GAD)</td>
<td>Future Anxiety</td>
<td>Expose/address and Gain Mastery; Challenge anxious thoughts</td>
</tr>
<tr>
<td>Panic</td>
<td>Physiological Arousal</td>
<td>Arousal + Relaxation; Challenge attributions</td>
</tr>
<tr>
<td>Social Phobia</td>
<td>Social Interaction</td>
<td>Graded exposure + Relaxation; Challenge Attributions</td>
</tr>
<tr>
<td>Simple Phobias</td>
<td>Object of Phobia</td>
<td>Graded exposure + Relaxation</td>
</tr>
<tr>
<td>PTSD</td>
<td>Thoughts of trauma</td>
<td>Safely re-enact trauma; gain mastery</td>
</tr>
<tr>
<td>OCD</td>
<td>Obsessive Thoughts</td>
<td>Prevention of compulsion</td>
</tr>
</tbody>
</table>
Mood Disorders and Suicide
• 1. Types and patterns and characteristics of affective disorders
• 2. Causes and treatments
• 3. Suicide
An Overview of Depression and Mania

- **Mood Disorders**
  - “Depressive disorders”
  - “Affective disorders”
  - “Depressive neuroses”
  - Gross deviations in mood
    - Depression
    - Mania
An Overview of Depression

• **Major depressive episode**
  – Extreme depression
  – 2 weeks
  – Cognitive symptoms
  – Physical dysfunction
  – Anhedonia
  – Duration - 4 to 9 months, untreated
An Overview of Mania

• **Manic episode**
  – Exaggerated elation, joy, euphoria
  – 1 week, or less
  – Cognitive symptoms
  – Physical dysfunction
  – Duration – 3 to 6 months, untreated

• **Hypomanic episode**
Structure of Mood Disorders

• **Unipolar disorders**
  – Depression or mania alone
  – Typically depression

• **Bipolar disorders**
  – Depression and mania
  – Mixed episodes
Structure of Mood Disorders

• **Diagnostic considerations**
  – Accompanying symptoms
    • Overlap between disorders
  – Severity
  – **Course (Very important)**
    • Recurrent
    • Alternating
    • Seasonal
Depressive Disorders

• **Major Depressive Disorder**
  – No mania/hypomania
  – Single episode
    • Rare (85% have another one)
  – Recurrent
    • 4 episodes (lifetime)
    • Duration – 4 to 5 month

• Onset
  – Low until early teens
  – Mean age = 30
  – Becoming earlier!
Milder symptoms
- 2+ years
- Chronic
- Persistent

- Onset = early 20’s
- Early onset = before 21
  - Greater chronicity
  - Poor prognosis
  - Stronger familial component

- Median duration = 5 years
  - Depends on comorbidity
Dysthymic Disorder

- Patients with dysthymic disorder and major depressive disorder (N=46)
- Patients with pure dysthymic disorder (N=36)
- Patients with nonchronic major depressive disorder (N=38)

Score on Hamilton depression rating scale

Time (months)
Depressive Disorders: An Overview

• **Double Depression**
  – Major depressive episodes and dysthymic disorder
  – Dysthymia first
  – Severe psychopathology
  – Poor course
  – High recurrence rates
Grief and Depression

- Depression frequently follows loss
  - 62% after death have severe depression

- **Pathological or Complicated Grief**
  - Severity of symptoms
  - Dysfunction
  - Persistence of symptoms
  - After a year, change of recovering from grief is less.
  - For 10-20% this becomes a clinical disorder.
Review

• Is earlier onset dysthymia better or worse in terms of chronicity (how long it lasts), prognosis (response to treatment)?
  – Which kind is more hereditary?

• The onset age of depression is moving towards an earlier or later period world-wide?
Bipolar I Disorder: An Overview

- Alternating major depressive and manic episodes
- Single manic episode
- Recurrent
  - Symptom free for 2 months

**DSM-IV-TR**

**DSM TABLE 7.2 Criteria for Manic Episode**

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

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

C. The symptoms do not meet criteria for a mixed episode.

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

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

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

This is serious!

Suicide attempts: 17% Bipolar 1, 24% Bipolar 2, 12% unipolar
Bipolar I Disorder: An Overview

• Statistics
  – Onset = age 18
    • Childhood
    • Younger than MD
    • More acute onset
    • 1/3 or cases begin in adolescence
  – Chronic
  – Suicide
Bipolar II Disorder

• Alternating major depressive and hypomanic episodes (< 1 week, > 4 days)

• Statistics
  – Onset = age 19 to 22
    • Childhood
  – Chronic

---

**DSM TABLE 7.5** Diagnostic 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, schizoaffective 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.

Specify current or most recent episode:
- Hypomanic: If currently (or most recently) in a hypomanic episode
- Depressed: If currently (or most recently) in a major depressive episode

Specify (for current or most recent major depressive episode only if it is the most recent type of mood episode):
- Severity/psychotic/remission specifiers—Note: Fifth-digit codes specified cannot be used here because the code for bipolar II disorder already uses the fifth digit.
  - Chronic
    - With catatonic features
    - With melancholic features
    - With atypical features
    - With postpartum onset

Specify:
- Longitudinal course specifiers (with and without interepisode recovery)
- With seasonal pattern (applies only to the pattern of major depressive episodes)
- With rapid cycling

© Wadsworth, Cengage Learning
Cyclothymic Disorder

- Alternating manic and depressive episodes
  - Less severe
    - Definition: moodiness that interferes with functioning.
    - Persists longer

- Chronic symptoms
  - Adults = 2+ years
  - Children and adolescents = 1+ year
Cyclothymic Disorder

• **Statistics**
  
  – **Onset** = age 12 or 14
    
    If it has not already appeared, it is unlikely to after 40
  
  – **Chronic**
  
  – **Lifelong**
  
  – **Female > Male**
  
  – **Risks for Bipolar I/II**
• What is the difference between Bipolar I and II
• How long do the symptoms have to occur for to be a full manic vs. a hypomanic episode?
• What is cyclothymic disorder?
• How long does someone have to be down, most of the day, nearly every day for it to be considered a full depressive episode?
Additional Defining Criteria

- **Symptom Specifiers (know each)**
  - Atypical
    - Most severe symptoms
      - And suicide attempts
  - Melancholic
  - Chronic
    - \( \geq 2 \) years (not dysthymia)
  - Catatonic
    - Rare!
  - Psychotic
    - More common than you would guess
      - 18% of those meeting criteria for Unipolar depression have this on some Level.
    - Mood congruent/ incongruent
  - Postpartum
Police Suspect Superior Mother Killed Infant

SUPERIOR, Colo. (CBS) — A Superior woman is under arrest and accused in the death of her 6-month-old son.

Stephanie Rochester, 34, is being held in the Boulder County Jail.

The Denver Post reported that she is a mental health counselor at Children's Hospital in Aurora.

Boulder County investigators say they have evidence that the baby's death was intentional. Rochester and her husband brought the baby into a Louisville hospital Tuesday morning, saying he was unresponsive in his crib. So far, no autopsy results have been released.

"From our investigation we determined that there was probable cause to arrest the mother, Stephanie Rochester, for first-degree murder and child abuse resulting in the death of the child," Rick Brough with the Boulder County Sheriff's Department said.

Some neighbors said Rochester had been experiencing some post-partum depression but that she adored her baby.

"She loved that baby every day of its life. She stayed home with him, she cared about him, he was her everything," a neighbor said. "He was very sweet, he was really chill, he was really mellow, very observant."

Neighbors say Rochester recently obtained medication for post-partum depression.

"She wasn't sleeping very well and she was just feeling a little disconnected in her head and she mentioned that she had been crying," the neighbor said.

Neighbors are coming together to support the family, including Rochester, who they say is not a villain.

"We want her to know that she can come home and we'll hug her and we'll love her and we're not mad at her and hope the whole world will take care of her," the neighbor said. "Don't judge her, don't persecute her, help her."

Officials are still waiting on autopsy results to find out how the baby died.

Rochester is being held on a $750,000 bond.

The baby's father, who had just returned from Sweden and is also married to Rochester, has not been charged.
Additional Defining Criteria

- **Course Specifiers (know each)**
  - Longitudinal course
  - Rapid cycling pattern
    - At least 4 manic or DP Episodes in a year.
      = poor responders, high suicide rate.
  - Seasonal pattern
    - Late fall-early spring – CABIN FEVER
    - Depression (2.7%!) vs. mania
    - Regional (e.g., 2% FL vs Fairbanks 9%)
    - Too much Melatonin production
      - Melatonin is secreted by the pineal gland to help Regulate sleep. Light suppresses it so winter is bad for vulnerable folks.
    - Phototherapy
      Most common symptoms
      sleep and weight gain.
Prevalence of Mood Disorders

TABLE 7.2 Prevalence of Affective Disorders Reported in Epidemiological Surveys Conducted Since 1980*

<table>
<thead>
<tr>
<th>Disorder</th>
<th>6 Months to 1 Year</th>
<th>Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression</td>
<td>6.5 (2.6 to 9.8)</td>
<td>16.1 (4.4 to 18.0)</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>3.3 (2.3 to 4.6)</td>
<td>3.6 (3.1 to 3.9)</td>
</tr>
<tr>
<td>Bipolar</td>
<td>1.1 (1.0 to 1.7)</td>
<td>1.3 (0.6 to 3.3)</td>
</tr>
</tbody>
</table>

*Surveys used research diagnostic criteria (RDC); the third edition or third edition, text revision, of the Diagnostic and Statistical Manual (DSM-III or DSM-III-R); or International Classification of Diseases, 10th edition (ICD-10), criteria.

TABLE 7.3 Lifetime Prevalence of Mood Disorder Subtypes by Age, Sex, and Ethnicity

<table>
<thead>
<tr>
<th>Lifetime Prevalence %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar I</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>18–29</td>
</tr>
<tr>
<td>30–44</td>
</tr>
<tr>
<td>45–64</td>
</tr>
<tr>
<td>65+</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Men</td>
</tr>
<tr>
<td>Women</td>
</tr>
<tr>
<td>Ethnicity</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
</tbody>
</table>

Note: Significant variation within groups, adjusted for age, sex, or ethnicity.
Prevalence of Mood Disorders

• Children and Adolescents
  – Symptom presentations
    • Not as episodic
    • Less imbalance in gender
      – Slightly more in boys!
    • Bipolar is rare in childhood but increases in adolescence.

  – Misdiagnosis
    • ADHD
      – Because of aggression and destructiveness
    • Conduct disorder
Aspects of Mood Disorder Criteria that differ in Children

• Major Depressive Disorder
  – lower prevalence
  – Irritability instead of depressed mood
  – Eating: failure to achieve weight gain
  – Stronger association with aggression

• Bipolar Disorder
  – Chronic
  – Explosiveness
  – Most commonly similar to mixed state
  – Is this bipolar disorder?
Review

• Describe the changing gender balance in depression rates in children vs. adolescents vs. adults vs. elderly.

• How are symptoms different in children than adults for bipolar disorder?

• What symptoms characterize later onset depression in the elderly?
Among the creative

- Higher prevalence
  - Melancholia
  - Mania

- Manic and creativity or.. Genes that predispose to bipolar are in some way related to creativity (reciprocal Gene x environment model).

**Prevalence of Mood Disorders**

<table>
<thead>
<tr>
<th>Poet</th>
<th>Pulitzer Prize in Poetry</th>
<th>Treated for Major Depressive Illness</th>
<th>Treated for Mania</th>
<th>Committed Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hart Crane (1899–1932)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Theodore Roethke (1908–1963)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Delmore Schwartz (1913–1966)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>John Berryman (1914–1972)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Randall Jarrell (1914–1965)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Robert Lowell (1917–1977)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Anne Sexton (1928–1974)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sylvia Plath* (1932–1963)</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

*Plath, although not treated for mania, was probably bipolar II.*
# Review

## Table 11.1: Mood Disorders

<table>
<thead>
<tr>
<th>Mood Disorder</th>
<th>Symptoms</th>
<th>Lifetime Prevalence (%)</th>
<th>Gender Difference</th>
<th>Age of Onset</th>
</tr>
</thead>
</table>
| Major Depressive Disorder | • Single episode: Single, major depressive episode  
                           | • Recurrent: Two or more major depressive episodes | 8.0–19.0                  | Much higher in females             | Any age; average age in 20s         |
| Dysthymic Disorder     | • Depressed mood that is chronic and relatively continual in nature       | 6.0                      | Much higher in females    | Often starts in childhood or adolescence |
| Bipolar I Disorder     | • Single manic episode  
                           | • Most recent episode hypomanic  
                           | • Most recent episode manic  
                           | • Most recent episode mixed  
                           | • Most recent episode depressed  
                           | • More recent episode unspecified | 0.4–1.6                  | No major difference                     | Any age; usually in early 20s             |
| Bipolar II Disorder    | • Recurrent major depressive episodes with hypomania                    | 0.5                      | Higher in females         | Any age                             |
| Cyclothymic Disorder   | • Manic and depressed moods that are chronic and relatively continual in nature | 0.4–1.0                  | No difference             | Often starts in adolescence         |
Links

• http://www.youtube.com/watch?v=3JMYWiAaiQs

• http://www.youtube.com/watch?v=kKm526pnMSg&feature=related

• http://www.youtube.com/watch?v=FkBq0KZiKRA

• http://www.5min.com/Video/The-Relationship-Between-Creativity-and-Depression-303383930