**Prevalence-Lifetime (the chance that a person will develop this disorder in his lifetime) and Course**

**Psychotic Disorders 1.5% ( for all Psychotic Disorders)**

**Schizophrenia-** lifetime prevalence is between .5 and 1.5 % Course: Median age of onset is early to mid-20's for men, late 20's for women. The onset may be abrupt or insidious- but majority have prodromal symptoms ( social withdrawal, loss of interest in work/school, deterioration in hygiene, unusual behavior, outbursts of anger) Course is variable, complete remission is probably not common. Positive symptoms respond better to txt, and will typically diminish, but negative symptoms often persist in between episodes of positive symptoms.

**Schizoaffective Disorder**- Unknown, but lower then then the lifetime prevalence of Schizophrenia

Course: Typical age of onset is early adulthood, although onset can occur anywhere from adolescence to late in life. ( prognosis is somewhat better for Schizoaffective D/O then Schizophrenia, but considerably worse than the prognosis for Mood Disorders. The outcome for Schizoaffective D/O Bipolar type may be somewhat better than that for Schizoaffective D/O, Depressive type)

**Delusional Disorder-** population prevalence is .03%, lifetime morbidity risk between .05 and .1%

Course: Age of onset is variable, from adolescence to late in life, course quite variable- esp. in the Persecutory type, the disorder may be chronic, with a waxing and waning of the beliefs, or have full periods of remission with subsequent relapses, or it may remit in a few months with no further relapses.

**Brief Psychotic Disorder**- uncommon

**Shared Psychotic Disorder-** Unknown

**Mood Disorders 25%**

**Major Depressive Disorder** lifetime risk: women 10%-25%, men 5-12%

Course: May begin at any age, with average age of onset in the mid-20's. The number of prior episodes predicts the likelihood of developing subsequent episodes- At least 60% who have had single major depressive episode can be expected to have a second. Those who have had 2 episodes have a 70% chance of having a third, and those who have had 3 episodes have a 90% chance of having a fourth. Note- about 5%-10% of individuals with had a single episode will develop a manic episode.

( note: Major Depressive D/O recurrent means that the person has had at least 2 major depressive episodes. *Chronic is used to describe the current or most recent major depressive episode and indicated that criteria for the major depressive episode have been continuously met for at least 2 years*)

**Dysthymic Disorder**- lifetime prevalence 6%

Course: Often has an early and insidious onset in childhood, adolescence or early adult life as well as a chronic course. In clinical settings, individuals with Dysthymic Disorder usually have superimposed Major Depressive D/O- and if Dysthymic D/O precedes the onset of Major Depressive D/O, there is less likelihood that there will be spontaneous full interepisode recovery between Major Depressive episodes and a greater likelihood of having more frequent subsequent episodes.

**Cyclothymic Disorder**- lifetime prevalence from .4 to 1%

Course: Usually has an insidious onset and a chronic course. There is a 15-50% chance that the person will subsequently develop Bipolar I or II disorder. Usually begins in adolescence or early adult life. Onset of this disorder late in adult life may suggest a Mood Disorder Due to a Gen Med Condition such as Multiple Sclerosis.

**Bipolar I D/O** lifetime prevalence .4- 1.6%

Course: Average age of onset is 20 for both men and women. Bipolar I D/O is a recurrent disorder- more then 90 % of individuals who have a single Manic episode go on to have future episodes. Roughly 60-70% of Manic episodes occur immediately before or after a a Major Depressive episode. Manic episodes often precede or follow the Major Depressive episode in a characteristic pattern for a particular person. The number of lifetime episodes (both manic and major depressive) tend to be higher for Bipolar I D/O compared with Major Depressive D/O, recurrent. Studies on the course of Bipolar I D/O prior to lithium maintenance suggest that on average, 4 episodes occur in 10 years. ( note: mood stabilizers do not prevent further mood episodes- they decrease the frequency of these episodes) 5-15% of those with Bipolar I D/O have 4 or more mood episodes within a given year- this is noted by the specifier With Rapid Cycling. 20 to 30% continue to display mood lability and other residual mood symptoms between episodes. As many as 60% experience chronic interpersonal or occupational difficulties between acute episodes. Incomplete interepisode recovery is more common when the current episode is accompanied by mood-incongruent psychotic features.

**Bipolar II D/O**- lifetime prevalence of .5%

Course: Roughly 60-70% of the Hypomanic episodes in Bipolar II D/O occur immediately before or after a Major Depressive episode. Hypomanic episodes often precede or follow the Major Depressive episodes in a characteristic pattern for a particular person. The number of lifetime episodes (both Hypomanic and Major Depressive) tend to be higher for Bipolar II D/O compared with Major Depressive D/O, recurrent. Approx. 5-15% of individuals with Bipolar II D/O have multiple (four or more) mood episodes that occur within a given year. Approx. 15% continue to display mood lability and interpersonal or occupational difficulties between episodes. Psychotic symptoms do not occur in hypomanic episodes, and they appear to be less frequent in the Major Depressive episodes in Bipolar II D/O than is the case for Bipolar I D/O. Over 5 years, about 5-15% of individuals with Bipolar II D/O will develop a Manic episode.

*Rapid Cycling specifier- can be applied to either Bipolar I or II- At least 4 episodes of a mood disturbance in the previous 12 months that meet criteria for a Major Depressive, Manic, Mixed or Hypomanic episode- episodes are demarcated by partial or full remission for at least 2 months or a switch to an episode of opposite polarity.*

**Anxiety Disorders 35%**

**Panic Disorder with/without agoraphobia-** lifetime prevalence between 1 and 2 %

Course: Age at onset varies considerably, but is most typically between late adolescence and the mid-30s. There may be a bimodal distribution, with one peak in late adolescence and a second smaller peak in the mid-30's. A small number begin in childhood, and onset after 45 is unusual but can occur. Usual course is chronic but waxing and waning. Some individuals may have episodic outbreaks with years of remission in between, and others may have continuous severe symptomatology. Limited symptom attacks may come to be experienced with greater frequency if the course is chronic. Onset of Agoraphobia is usually within the first year of occurrence of recurrent panic attacks, and its relationship to the course of Panic Attacks are variable.

**Specific Phobia**- lifetime prevalence 7.2%- 11.3%

Course: Usually occur in childhood or early adolescence and may occur at a younger age for women then men. Mean age at onset varies according to the type of Specific Phobia. Age at onset for Specific Phobia, Situational Type, tends to be bimodally distributed- with a peak in childhood and a second peak in the mid- 20's. Specific Phobias, Natural Environment Type ( eg- heights) tend to begin primarily in childhood, although many new cases of height phobia develop in early adulthood. Phobias that result from a traumatic event or from unexpected Panic Attacks tend to be particularly acute in their development and do not have a characteristic age of onset. Specific phobias that persist into adulthood remit only infrequently.

**Social Phobi**a- lifetime prevalence 3%-13%

Course: Onset typically in the mid-teens, sometimes emerging out of a childhood history of social inhibition or shyness. Some report an onset in early childhood. Onset may abruptly begin after a stressful experience, or it may be insidious. Course is often continuous, and the duration is frequently lifelong. May fluctuate with life stressors and demands.

**OCD**- lifetime prevalence of 2.5%

Course: Usually begins in adolescence or early adulthood, it may begin in childhood. Modal age of onset is earlier in males than in females: between ages 6 and 15 years for males and between ages 20 and 29 years for females. For the most part, onset is gradual, but an acute onset has been seen in some cases. Majority have a chronic waxing and waning course, with exacerbation of symptoms related to stress. About 15% show progressive deterioration in occupational and social functioning. About 5 % have an episode course with minimal or no symptoms between episodes.

**PTSD**- lifetime prevalence 8%, studies of at-risk individuals yield variable findings- with the highest rates (ranging from 1/3 to over half of those exposed) found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide.

Course: Can occur at any age, including childhood. Symptoms usually begin within the first three months after the trauma, although there may be a delay of months or years before symptoms appear. Thee symptoms and the relative predominance of reexperiencing, avoidance, and hyperarousal symptoms may vary over time. Complete recovery occurs within three months for approx. half of cases, with many others having persisting symptoms for longer than 12 months after the trauma. In some cases, the course is waxing and waning. Symptom reactivation may occur in response to reminders of the original trauma, life stressors, or new traumatic events. The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder.

**GAD**- Lifetime prevalence was 5%

Course: Many individuals with this disorder report that they have felt anxious and nervous all their lives. Over half report onset in childhood or adolescence, onset occurring after age 20 is not uncommon. The course is chronic but fluctuating- and often worsens during times of stress.