

Abnormal Psychology (PSY404)

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Introduction to Abnormal Psychology

Topic: 1-3

Topic 01: Abnormal Psychology: An Introduction

Abnormal psychology can be defined in a number of ways. Many definitions of Abnormal Psychology have been proposed, but yet none has won total acceptance. It can be defined as per the following:

- Abnormal psychology is the scientific study of abnormal behavior.
- An effort to describe, predict, explain, and change abnormal patterns of human functioning.

“The Four Ds”:

Most of the definitions of abnormal psychology, although they are different, overlap in general and have certain features common in nature. Among those are the following four Ds.

Deviance

Deviance is to deviate, which is different, extreme, unusual, and perhaps even bizarre. This is a deviation from societal rules which are expected from members of society. Deviance from behaviors, thoughts, and emotions that differ markedly from a society's ideas about proper functioning and deviation from social norms i.e. stated and unstated rules for proper conduct. Judgments of abnormality vary from society to society as norms are culture-specific. One thing which is considered right in one society may be considered wrong in another. They also depend on specific circumstances as norms are different in each society. When a behavior deviates from the normal, it is labeled as abnormal.

Distress

Distress is a hallmark of psychological disorders. It is something that is unpleasant and upsetting to an individual. If a person is upset and agitated and is experiencing some distress, it may indicate the abnormality of certain behavior. Behavior, ideas, or emotions usually have to cause distress before they can be labeled abnormal. But it may not always be due to a psychological

problem as different other reasons may also cause distress for example toothache, pains, etc. Such surgical distresses will not be considered an abnormality.

Dysfunction

Another salient feature of abnormality is dysfunction. Abnormal behavior tends to be **dysfunctional** – it interferes with daily functioning. If a certain problem is interfering with the person's ability to conduct daily activities constructively, it shows that things with that person are not fine. For example, as a student, you cannot successfully carry out your educational tasks, and if you are employed somewhere, you cannot successfully do your official tasks. If someone has phobia, you will tend to avoid a certain situation, for example, a receptionist having social phobia may not be able to carry out his/her task of attending to people successfully.

Dysfunction alone does not necessarily indicate psychological abnormality as it could be for many other reasons. So an overall view of behavior must be taken to label it as abnormal.

Danger

Not necessarily in every behavior, but in many abnormal behaviors, the person tends to harm himself or the society. Abnormal behavior may become dangerous to oneself or others. Behavior may be consistently careless, hostile or confused. For example, abnormal behavior, a depressed individual may have suicidal ideation. Same as a patient may be homicidal i.e. causing danger for other people for example in schizophrenia and borderline personality.

DSM-5 Definition of Abnormal behavior:

DSM stands for Diagnostic and statistical manual for psychological disorders.

It defines abnormal behavior as:

“It is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in psychological, biological or developmental processes underlying mental functioning.”

Mental disorders are usually associated with significant disturbance in social, occupational, or other important activities.

Topic 02: Different Criteria of Abnormality

There are different criteria of abnormality that you may find overlapping with the definition of abnormal behavior. The following are four major criteria to label a behavior abnormal

Statistical Criteria

Under this definition of abnormality, a person's trait, thinking or behavior is classified as abnormal if it is rare or statistically unusual. Generally, it is considered that majority is right. But if there is a marked difference in behavior, thought and emotions from a society's idea about proper functioning, the person may be labeled as odd; as you are different from most of the people. This criterion has been criticized as it is not always necessary that all people who are on extreme sides of frequency curve can be labeled as abnormal.

Personal Distress

That is, a person's behavior may be classified as disordered if it causes him or her great distress. Behaviors, ideas, or emotions have to cause distress to be labeled as abnormal. Let's say, if you are afraid of something and it is not causing pathological stress, it will not be considered as abnormal. But there are certain distresses which are not because of psychological disorders and hence, the behavior will not be labeled as abnormal.

Dysfunction

Dysfunction occurs when an internal mechanism is unable to perform its natural functions. Abnormal behavior tends to interfere with the daily functioning, for example people cannot successfully carry out their tasks.

Violation of Social Norms

There are some standards set by a certain society and culture and if a person does not behave in accordance with those standards, his/her behavior is considered odd. There are different parameters. Social norms judge behaviors on such scales as:

- Good-bad
- Right-Wrong
- Justified-Unjustified
- Acceptable- unacceptable

Behaviors that violate social norms are considered abnormal or disordered.

Topic 03: Causes of Abnormality

There are different reasons of abnormal behavior. It includes two major clusters.

Biological Causes/Factors:

- **Genetic Factors** include problems are inherited from parents and genes play a significant role in such problems. Genetic and chromosomal issues are generally pronounced in closed cousin marriages because recessive genes get a chance to manifest themselves. Researchers have identified some genes related to certain disorders for example, genes have found to be contributors in intellectual disability, previously known as mental retardation. Genetic factors have also been found implicated in Schizophrenia and depression
- **Biochemical Imbalances** are imbalances, within the body or within the brain, also cause abnormality. Dues to imbalances of hormones of endocrine glands, an individual may experience some abnormality.
- **Changes to the Nervous System** play a major role in psychological functioning. As Central Nervous system works as a central processing unit for the human body, if it experiences any problem, it can have adverse effects on human functioning.
- There can be structural changes as well as functional changes in the nervous system. People experience certain psychological disorders if they experience any such changes.

Psychological Causes/Factors:

- **Defense Mechanisms, Intrapsychic Conflicts, Biological Instincts** to Freud, some intrapsychic conflict arises in the biological instincts because many needs/wish remains unfulfilled due to societal disapproval, which creates psychological disturbances.
- **Learned Response**

Children inherit certain abnormalities from their parents, some responses are learned also. Sometimes children learn to remain anxious if their parents are anxious. If parents, or any one of them, get gloomy and hopeless quickly, it is more likely that children with follow

them. Different agents of socialization may be modeled and their behavior are copied, which we call learned responses. They may also be a reason to one's psychological problem.

- **Negative Irrational Cognitions**

A person is very pessimistic towards life and always sees a negative aspect in everything; he/she is more likely to experience psychological problems. Irrational thinking may develop psychological disorders.

Sociocultural Factors:

Social circumstances, our vicinity, and the environment of a home also play a role in causing psychological problems. If the behavior around an individual is very critical, it may cause some distress leading to a psychological issue. Some factors in socio-cultural context for example poverty which causes frustration due to non-fulfillment of basic need can also be a major contributor. Similarly, if the society is very stringent, and tries to keep strict control over an individual, it can cause psychological problems. It is very important to first rule out biological/organic reasons for an abnormal behavior and then to look into psychological reasons as there are multiple causes of psychological problems.

Historical Perspective on Abnormal Behavior

Topic: 4-8

Topic 4: Ancient Views and Treatments

Ancient societies probably regarded abnormal behavior as the work of evil spirits. This view may have begun as far back as the Stone Age. It was thought that behaviors seemingly outside individual control were ascribed to supernatural causes. Human body and mind was viewed as battleground between external forces of good and evil. It was believed that abnormal behavior was caused due to friction of the good and evil.

Expelling the Evil Spirits:

The treatment for severe abnormality was to force the demons from the body through trephination and exorcism: the two major methods of treatment.

In **trephining**, a stone instrument, or trephine was used to cut away a circular selection of the skull to release the evil spirits.

Exorcism

There were different rituals which were performed for casting out of evil spirits:

- Prayer
- Nosie making
- Forcing the afflicted to drink terrible tasting brews
- Flogging was beating the clients
- Starvation

If we see in different regions of Asia, we can see that some of the exorcism techniques still exist such as in Pakistan.

Greek and Roman Views and Treatments:

500 B.C. to 500 A.D.

Greeks have a major contribution in medical science and in other different fields. Philosophers and physicians offered different explanations and treatments for abnormal behaviors in this era.

Hippocrates: Hippocrates has contributed immensely in different sciences, particularly in medical field. He believed and taught that illnesses had natural causes and it is not due to evil spirits. He looked to an unbalance of the four fluids, or **humors**. He suggested treatments attempted to “rebalance” those fluids or humors.

Europe in the Middle Ages: Demonology I:

500– 1350 A.D.

In the Middle Ages, from 500 – 1350 A.D. the concept of demonology re-emerged. The church rejected scientific forms of investigation, and it controlled all education. Many writings were burnt during this period as well. In this era religious beliefs were dominant and abnormality was seen as a conflict between good and evil. Some of the earlier demonological treatments re-emerged again e.g. exorcism. At the end of the middle Ages, demonology and its methods began to lose favor again.

Europe in the Middle Ages: Demonology II:

In this year, psychological dysfunction was seen as an evidence of Satan’s influence instead of evil spirits as the concepts got more connected to religion. Certain methods of treatment were employed in this era among which was Tarantism. In Tarantism, it was believed that an individual was possessed by a wolf or a spider (tarantula). The cure of the disorder was by performing a dance called Tarantella.

Topic 5: Islamic Perspective-Golden Period

There were different Muslim philosophers who contributed immensely in defining the abnormal behavior and its treatment.

Al-Razi (Rhazes) talked about rudimentary fear, shock, and introduced musical therapies for treating mental disorders.

Abu-Ali al-Husayn ibn Abdalah Ibn-Sina (980-1030), (Avicenna) in his book, *Teb al-Qonoon*, made some postulations concerning human emotional conditions and made suggestions

for their treatment. He posited that human emotions are very important and play a role in defining behavior. He used use of conditional therapy, centuries before the behavioral psychologists of the Twentieth Century.

Al-Ghazali (1058 - 1111CE), wrote the book “Ihya”, which pointed out that children were naturally egocentric. He believed that fear was a learned condition, either taught to children or gained through negative experiences. He was a firm believer that introspection and self-analysis were the keys to understanding mental issues and unlocking hidden reasons.

Najubud din Muhammed, wrote extensively about many mental disorders including depression, paranoia, persecution complex, sexual dysfunction and obsessional neuroses, amongst a host of other mental ailments.

Ibn-Khaldun (1332 - 1406CE) proposed that an individual's surroundings and local environment shaped their personality. He followed the lead of Aristotle and Ibn-Sina in believing that human behavior was shaped solely by experience and education. If we see now, behavioral school of thought is entirely based on the same proposition.

Topic 6: The Renaissance and the Rise of Asylums

The Renaissance period spans from 1400 to 1700 A.D. Islam came in 1400 and many concepts were changed. Parallel to the Islamic era, demonological views of abnormality continued to decline, the church started losing its control and there were many psychologists who played an active role in understanding the psychological problems.

German physician Johann Weyer believed that the mind was as susceptible to sickness as the body. Across Europe, religious shrines were devoted to the humane and loving treatment of people with mental disorders instead of pervious inhumane period. The care of people with mental disorders continued to improve in this atmosphere. This time also saw a rise of asylums-institutions whose primary purpose was care of the mentally ill.

Topic 7: Reform and Moral Treatment

1700 and onward, the moral treatment of mentally ill patients was started discarding the old concepts and methods of religious and inhumane treatments. As 1800 approached, the treatment

of people with mental disorders began to improve and moral treatment was initiated. Moral treatment refers to the care that emphasized moral guidance, humane and respectful techniques.

In the U.S., Benjamin Rush (father of American psychiatry) and Dorothea Dix (Boston schoolteacher) were the primary proponents of moral treatment

By the end of the nineteenth century, several factors led to a reversal of the moral treatment movement due to several reasons. There was a lot of money and staff shortages as number of patients and asylums increased with less resources. Another reason of reversal of moral treatment was declining recovery rates. Overcrowding was another major reason of this reversal. Emergence of prejudice also hindered moral treatments of mentally ill patients.

By the early years of the twentieth century, the moral treatment movement had ground to a halt; long-term hospitalization became the rule once again.

The Early Twentieth Century: Dual Perspectives:

As the moral movement was declining in the late 1800s, two opposing perspectives emerged:

The Somatogenic Perspective: This perspective posited that abnormal functioning has physical causes for example some head injury that may cause psychological disorder. Two factors were responsible for the rebirth of this perspective:

- Emil Kraepelin argued that physical factors (such as fatigue) are responsible for mental dysfunction
- Despite general optimism, biological approaches yielded mostly disappointing results throughout the first half of the 20th century, until a number of effective medications were finally discovered which started curing patients.

The Psychogenic Perspective: According to this perspective, abnormal functioning has psychological causes. The most primitive treatment according to the perspective was hypnotism which was introduced by Friedrich Mesmer for hysterical disorders. Based on neurological studies, Sigmund Freud's postulated theory of psychoanalysis. Freud offered treatment primarily to patients who did not require hospitalization now known as outpatient therapy.

Topic 8: Current Trends

If we talk about current trends that from twentieth century onwards, where we are standing, we shall see that the concept of mental illness is still vague. Peoples' behavior regarding psychological problems is still mixed. Some take it positively and some take it negatively. A survey was conducted regarding that and it was found that 43% of people surveyed believe that people bring mental disorders onto themselves and 35% consider mental health disorders to be caused by sinful behavior.

The past 50 years have brought major changes in the ways clinicians understand and treat abnormal behaviors.

Following are few current trends for treatment of mental disorders:

Psychotropic Medication: These are the medicines which are prescribed for an individual experiencing psychological problem. In the 1950s, researchers discovered a number of new psychotropic medications and patients started responding to those medicines. Antipsychotic drugs, antidepressant drugs and anti-anxiety drugs are few of them.

Deinstitutionalization: The discoveries led to deinstitutionalization and a rise in outpatient care. In modern societies, patients are not hospitalized and are kept in communities.

Community Mental Health Approach: By keeping the clients in communities instead of institutions, community mental health approach is being focused. So the clients may be kept and rehabilitated in the community.

Outpatient Treatment:

When patients do need institutionalization, it is usually short-term hospitalization, and then, ideally, outpatient psychotherapy and medication in the community settings.

Since the 1950s, outpatient care has continued to be the preferred mode of treatment for those with moderate disturbances.

Private Psychotherapy:

This type of care was once exclusively private psychotherapy. Currently there are many psychologists available in Pakistan also who provide mental health care to patients.

A Growing Emphasis on Preventing Disorders

The community mental health approach has given rise to the prevention movement. Many of today's programs aim to correct the social conditions that underlie psychological problems and help individuals at risk of developing disorders.

Promoting Mental Health

There are many campaigns run by different organization e.g. World Health Organization which promote mental health. Prevention programs have been further energized by the growing interest in positive psychology the study and enhancement of positive feelings, traits, and abilities

With all that, we still have a long way to go. Psychological patients must be treated the same way we treat physical ailments/disorders.

Diagnosis

Topic: 9-14

Topic 9: Diagnosis: Definition

To understand psychopathologies, it is very important to know how to diagnose a disorder.

Definition

“To determine that a person’s problem reflects a particular disorder or syndrome, a clinician attempts to make a diagnosis using informal, formal and clinical picture based on an existing classification system.”

There are different classification systems which help us in diagnosis. These classification systems are DSM (Diagnostic and statistical Manual published by American Psychological Association) and ICD (International classification of Disease, published by World Health Organization).

The diagnosis of the disorder is based on:

- Informal assessment
- Formal assessment
- DSM-5/ ICD 10 criteria for a specific disorder

The Diagnosis Process:

While diagnosing a client’s psychopathology, clinicians follow a process which consists of the following steps:

Clinical Interview: A clinical interview is a conversation between a clinician and a patient that is typically intended to develop a diagnosis. It is a "conversation with a purpose" that can be structured, semi-structured, or unstructured.

Subjective Ratings: Subjective rating is any rating that a person gives that is based on their subjective reaction or opinion, their feelings, desires, priorities, etc.

Preparing Baseline: It is a process of obtaining information about a participant's status for example, ability level, psychological well-being etc. before exposure to an intervention or treatment.

Behavioral Assessment: Behavioral assessment is a method used in the field of psychology to observe, describe, explain and predict behavior.

Formal Assessment using Psychological Tests: Administration of different standardized tests to assess true nature of client's pathology.

Consulting DSM 5/ ICD-10 Manual: The detailed classification system for mental disorders with detailed criteria of these disorders.

The Prognosis on the Basis of Diagnosis: Prognosis is predicting outcome of a particular treatment which depends on different factor

Topic 10: Assessment

Assessment is collecting relevant information to conclude. It is the main tool to reach the diagnosis. It is also used to evaluate the outcome of the treatment. If the assessment was done at the time of the onset of the disorder and a baseline was prepared, and then the therapy was started, then this is also important to see if there is any progress and the client is responding to the treatment. For this purpose, assessment is administered during the intervention.

Clinical assessment tools fall into three categories:

1. Behavioral observation
2. Clinical/case history interviews
3. Psychological tests

Clinical Interview

When a client reports the first contact with the psychologist or the mental health professional is interviewing the client. This interview is used to collect detailed information, especially personal history, history of disorder about the client to have background information of how the client's problem initiated and what is the nature of the problem. Interviews are flexible enough that they allow the interviewer to focus on whatever topics they consider most important for example

childhood history, adult history, premorbid personality, or any other important aspects which seems problematic. The interviews can be either structured or unstructured depending on the client's problem.

Limitations of Clinical Interview:

- Many clinical interviews lack validity and accuracy as it entirely depends upon the interviewer what kind of information he collects. He might ask some irrelevant questions and miss some important information.
- Interviews, particularly unstructured ones, may lack reliability because there are no certain kinds of question being asked from the client, so the conversation may lead into any direction.
- Individuals may be intentionally misleading so an expert interviewee must conduct initial interview and case history interview.
- Interviewers may be biased on may make mistakes in judgment because any one can be biased towards a certain race or an ethnic group.

Topic 11: Mental Status Examination

The Mental Status Exam (MSE) is the psychological equivalent of a physical exam that describes the mental state and behaviors of the person being seen. It includes both objective observations of the clinician and subjective descriptions given by the patient.

MSE is very important in assessment. It is a combination of formal and informal forms of assessment. There are different dimensions on which a clinical psychologist works upon.

General Appearance

- Appearance in relation to age
- Accessibility Friendly
- Body build
- Clothing
- Cosmetics

- Hygiene
- Odor
- Facial expressions

Psychomotor Behavior

- Gait
- Handshake
- Abnormal movements
- Rate of movements

Speech

- Rate of speech
- Intensity of volume
- Liveliness
- Quantity

Mood and Affect

- Appropriateness of affect
- Range of affect
- Stability of affect
- Attitude towards others during encounter
- Specific mood or feelings observed or reported

Cognition

- Cognition attention and concentration
- Memory
- Abstraction

- Insight into illness
- Orientation
- Judgement

Thought Pattern

- Clarity
- Relevance/logic
- Flow
- Content
- Level of consciousness

Topic 12: Formal Assessment

In formal assessment, different standardized tests are administered in order to get an insight that client has a certain problem or not and what is the problem's intensity. There are some specific characteristics of assessment tools which are discussed below.

Characteristics of a Psychological Test

Assessment tools must be standardized and it should have clear reliability and validity. Reliability is the quality of being trustworthy or of performing consistently well. It refers to the consistency of a test, i.e. it gives the same results if administered multiple times. Validity is the quality of being logically or factually sound. It means is the test really measuring what it intends to measure and really fulfilling the purpose for which it was developed.

Procedure:

Procedure of test administration is of utmost importance, and it included three following steps:

Administration: The test is administered on the client; the client fills it in.

Scoring: After the test administration, next step is scoring. Scoring is done on the basis of a certain procedure i.e. prescribed in manual or according to the given keys. Currently, computer assisted scoring is also prevalent.

Interpretation: The obtained scores are interpreted and the interpretation can be quantitative as well as qualitative.

Categories of Tests:

There are multiple types of tests which are used for assessment of a client. Following are few categories of tests employed for the purpose of assessment:

Intelligence Testing

An intelligence test is a questionnaire or a series of exercise designed to measure intelligence. It is always very important to know the intelligence level of the client. It is not necessary in all cases though, but its quite often that we needed to assess the IQ of an individual. Following are frequently employed intelligence tests:

- Salosson Intelligence Test
- Wechsler Adult Intelligence Scale (WAIS)
- Wechsler Intelligence Scale for Children (WISC)
- Stanford-Binet Intelligence Scales (these are the oldest one as compared to the others)

Stanford-Binet Intelligence Scales are the oldest one as compared to the others and most commonly used tests are WAIS and WISC.

Personality Testing

Personality tests consist of standardized tasks designed to determine various aspects of the personality or the emotional status of the individual. There are two categories of personality assessment:

Self-Report Tests

These are the measures in which respondents are asked to report directly on their own behaviors, beliefs, attitudes, or intentions. It is very important to know the premorbid personality of a client. So self-report measure helps in understanding the certain aspects of personality which may have played a role in client's psychopathology. Following are few commonly used self-report tests:

- Big Five Inventory

- Minnesota Multiphasic Personality Inventory (MMPI)
- Cattell's 16 Personality Factors Tests

Projective Tests

Any assessment procedure that consists of a series of relatively ambiguous stimuli and responses reflect the personality, cognitive style, and other psychological characteristics of the individual. This is assumed that the client projects his/her inner personality in response of these tests. Following are few commonly used personality tests:

- Rorschach Inkblot Test
- Thematic Apperception Test (For Adults)
- Child Apperception Test (For children)
- House Tree Person
- Rotter's Incomplete Sentence Blank (RISB) (considered as semi-projective and a test of maladjustment)

Ideally one projective test and one self-report measure be employed for a comprehensive understanding of client's personality.

Topic 13: Neuropsychological Assessment

Brain and behavior both go hand in hand and have an effect of each other, i.e. behavior will affect our brain and brain may affect our behavior. Sometimes biological conditions manifest them in psychological conditions. So it is very important to rule out such issues. Neuropsychological assessment is an in-depth assessment of skills and abilities linked to brain function. Following are few commonly used tests used in this category and a test is selected on the basis of client's problem:

- Benton Visual Retention Test
- Wisconsin Card Sorting Test
- Wechsler Memory Scale (WMS)

- Luria-Nebraska Neuropsychological battery
- Memory Assessment Scales (MAS)
- Bender Visual Motor Gestalt Tests
- Stroop Test
- Tower Test

Specific Disorder Related Tests

There are few tests which help in diagnostic assessment. If the client has a specific disorder, a suitable relevant test must be administered in order to get a clear picture of client's problem. There are specific tests for specific disorders among them following are few:

- Beck Depression Inventory (Depression)
- Beck Anxiety Inventory (Anxiety)
- Obsessive-compulsive Inventory (OCD)
- Positive and negative Symptoms Scale (PANAS) (Schizophrenia)

Behavioral Observation

Behavioral observation involves watching and recording the behavior of a person in particular settings. This is important for clinicians to record client's behavior on continuous basis throughout the assessment process. There are different ways of doing it among which one is method is systematic observations of behavior. This can be naturalistic as well as self-monitoring.

Clinical Observation

Along with behavioral observation, clinical observation is also very important. This could be done with multiple ways, for example, subjective Ratings of Symptoms and baseline charts etc.

Assessment Reports

Assessment report is brief description of results obtained by assessment inventories. This report included:

- Brief History of the Problem or illness
- Behavioral Observation
- Test Administration
- Quantitative Analysis of administered tests
- Qualitative Analysis of administered tests
- Conclusion

Topic 14: What is New in DSM-5?

The Diagnostic and Statistical Manual of Mental Disorders (DSM–5) contains descriptions, symptoms, and other criteria for diagnosing mental disorders. It has been published by American Psychological Association (APA). Its first version was published in 1962 and the current version i.e. DSM 5 was published in May, 2013 which is the latest version. It is a most widely used manual for diagnosing psychiatric illnesses as it encompasses detailed information about mental disorders listing approximately 400 disorders and it is revised on the basis on international research pool. It describes criteria for diagnoses, key clinical features, and related features that are often, but not always, present. Also, it helps clinicians to determine the severity of the problem.

What is the difference between DSM and ICD?

ICD is the international classification of diseases and the latest version is 10th version. DSM has been published by APA (American Psychiatric Association) whereas ICD has been published by WHO (World Health Organization). DSM is entirely based on psychiatric disorders while ICD included all other disease either physical or mental.

What is new in DSM-5?

DSM-5 has moved to non-axial documentation of diagnosis. Following previous versions of DSM, the client was rated on all Axes while diagnosing.

Not Otherwise Specified (NOS) language is eliminated in DSM-5. There are now options for designating “Unspecified” and “other specified” which will typically include a list of specifiers as to why the patient’s clinical condition doesn’t meet a more specific disorder.

The phrase “general medical condition” is replaced in DSM-5 with “another medical condition” where relevant across all disorders.

Contrary to previous versions of DSM, DSM-5 includes the ICD-10 (International classification of Diseases) diagnoses in parentheses.

Mental Retardation has been changed to Intellectual Disability.

The communication disorders, which are newly named from DSM-IV phonological disorder and stuttering, respectively, include: Language disorder (which combines the previous expressive and mixed receptive-expressive language disorders), Speech sound disorder (previously phonological disorder), Childhood-onset fluency disorder (previously stuttering) Also included is social (pragmatic) communication disorder, a new condition involving persistent difficulties in the social uses of verbal and nonverbal communication.

There is now a single condition called Autism Spectrum Disorder, which incorporates 4 previous separate disorders: autistic disorder (autism), Asperger's disorder, childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder not otherwise specified.

Specific learning disorder combines the DSM-IV diagnoses of reading disorder, mathematics disorder, disorder of written expression, and learning disorder not otherwise specified. Learning deficits in the areas of reading, written expression, and mathematics are coded as separate specifiers.

Attention deficit hyperactivity disorder (ADHD) has been modified somewhat, especially to emphasize that this disorder can continue into adulthood.

The following motor disorders are included in DSM-5: developmental coordination disorder, stereotypic movement disorder, Tourette's disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, other specified tic disorder, and unspecified tic disorder.

The tic criteria have been standardized across all of these disorders in this chapter.

Schizophrenia Spectrum and Other Psychotic Disorders, two changes were made to Criterion A for schizophrenia: The elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations. The addition of the requirement that at least one

of the Criterion A symptoms must be delusions, hallucinations, or disorganized speech. Criterion A for delusional disorder no longer has the requirement that the delusions must be non-bizarre; a specifier is now included for bizarre type delusions. Criteria for catatonia are described uniformly across DSM-5.

Bipolar disorders now include both changes in mood and changes in activity or energy.

A new diagnosis, disruptive mood dysregulation disorder, is included for children up to age 18 years. Persistent depressive disorder, which includes both chronic major depressive disorder and the previous dysthymic disorder. Premenstrual Dysphoric Disorder is a new addition in DSM 5. The exclusion of diagnosis of major Depressive Disorder in the first 2 months of grief has been removed in the DSM-5.

Major Neurocognitive Disorder now subsumes dementia and the amnesic disorder and a new disorder, Mild Neurocognitive Disorder.

The chapter "Obsessive-Compulsive and Related Disorders" is new in DSM-5. New disorders include OCD, hoarding disorder, excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition. The DSM-IV "with poor insight" specifier for obsessive-compulsive disorder has been refined to allow a distinction between individuals with good or fair insight, poor insight, and "absent insight/delusional" obsessive-compulsive disorder beliefs.

More attention is paid to behavioral symptoms that accompany PTSD in the DSM-5. It now includes four primary major symptom clusters: The diagnostic thresholds of Posttraumatic stress disorder have been lowered for children and adolescents. Furthermore, separate criteria have been added for children age 6 years or younger with this disorder. For a diagnosis of acute stress disorder, qualifying traumatic events are now explicit as to whether they were experienced directly, witnessed, or experienced indirectly. The DSM-IV Criterion A2 regarding the subjective reaction to the traumatic event has been eliminated.

Adjustment disorders are re-conceptualized as a heterogeneous array of stress-response syndromes that occur after exposure to a distressing (traumatic or non-traumatic) event.

Dissociative Disorders: De-realization is included in depersonalization disorder (depersonalization/de-realization disorder). Dissociative fugue is now a specifier of dissociative amnesia. The criteria for dissociative identity disorder have been changed to indicate that symptoms of disruption of identity may be reported as well as observed, and that gaps in the recall of events may occur for everyday and not just traumatic events. Also, experiences of pathological possession in some cultures are included in the description of identity disruption.

Somatoform disorders are now referred to as somatic symptom and related disorders. Hypochondriasis is changed to illness anxiety disorder. Illness anxiety disorder and factitious disorder are placed among the somatic symptom and related disorders.

Disruptive, Impulse-Control, and Conduct Disorders" is new to DSM-5 (includes disorders of "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence)

The DSM-IV category feeding disorder of infancy or early childhood has been renamed avoidant/restrictive food intake disorder. Binge eating disorder is now official, "real" diagnoses in the DSM-5.

In Sleep Disorders, primary insomnia has been renamed insomnia disorder to avoid the differentiation between primary and secondary insomnia. The use of the former "not otherwise specified" diagnoses in DSM-IV have been reduced by elevating rapid eye movement sleep behavior disorder and restless legs syndrome to independent disorders.

Sexual Disorders, In DSM-5, some gender-specific sexual dysfunctions have been added, and, for females, Genito-pelvic pain/penetration disorder has been added to DSM-5. The diagnosis of sexual aversion disorder has been removed due to rare use and lack of supporting research. Gender dysphoria is a new diagnostic class in DSM-5.

An overarching change from DSM-IV is the addition of the course specifiers "in a controlled environment" and "in remission" to the diagnostic criteria sets for all the paraphilic disorders.

DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Cannabis withdrawal and caffeine withdrawal are new disorders DSM-5 specifiers include "In a controlled environment" and "on maintenance therapy" as the situation warrants.

What is ICD-10?

International Classification of Diseases has been published by WHO (World Health Organization) and it all other disease either physical or mental among which one portion contains psychiatric disorders. The ICD has been revised periodically to incorporate changes in the medical field. It is mostly used by psychiatrist while psychologists usually use DSM for the diagnosis purpose

The ICD has been revised periodically to incorporate changes in the medical field. ICD-10 is printed in a three-volume set. It has alphanumeric categories. In the latest version of DSM, codes are from ICD-10.

Treatment

Topic: 15-16

Topic 15: Treatment

Treatment or therapy is a procedure designed to change abnormal behavior into more normal behavior. Once clinicians decide that a person is suffering from abnormality, they need to treat him/her. In this course, a clinical psychologist will employ a therapeutic intervention, but if the client needs some medication for a problem, he will be referred to a psychiatrist who will prescribe medicine for the client.

Planning a Treatment

All forms of therapy have three essential features:

1. A **sufferer /patient/client**, who seeks relief from the healer
2. A trained, socially accepted **healer/therapist**, whose expertise is accepted by the sufferer and his or her social group
3. A **series of contacts** between the healer and the sufferer, through which the healer tries to produce certain changes in the sufferer's emotional state, attitudes, and behavior.

Treatment Team

Treatment team includes the followings:

- Psychiatrist is a medical professional; they are trained doctors who prescribe medicines for the client
- Psychologists help in diagnosis, therapeutic intervention, and relapse prevention.
- Social worker follows up the social and familial problems of the client. After getting connected to family in natural settings, they bring back the information to the team.
- Helping Staff are psychiatric nurses who take care of psychiatric patients.

- Family/Informant plays an important role in treatment providing the adequate environment and helping the client to do as said by the psychologist/psychiatrist.

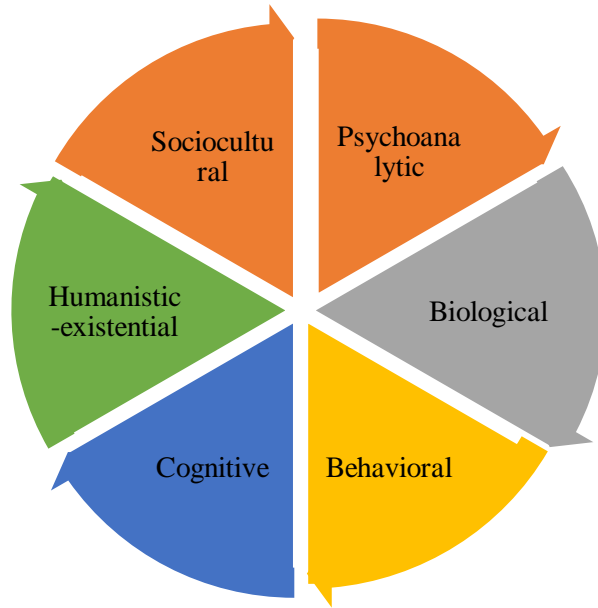
Topic 16: Modality of Treatment

Treatment decisions begin with assessment information and diagnostic decisions to determine a treatment plan using a combination of idiographic and nomothetic information. Other factors which may affect the treatment decisions are therapist's theoretical orientation, current research and general state of clinical knowledge, currently focusing on empirically supported, evidence-based treatment.

It generally begins with assessment information and diagnostic decisions to determine a treatment plan that either a client requires medicine, which is not necessary for all clients, or the client needs psychotherapy, a treatment using various therapeutic techniques which may be different for different clients. Moreover, some clients require a combination of both medication and therapy.

Following are today's leading theories and profession with reference to psychotherapy:

- Sociocultural (how can we focus on social and cultural aspects of client's problems)
- Psychoanalytic (Freudians and neo Freudians)
- Humanistic-existential
- Cognitive (REBT)
- Behavioral (behavior therapy, classical and operant condition and a mixture of those)
- Biological (pharmacological treatment)



A combination of all those may also be used for different clients.

Theoretical Perspectives I

Topic: 17-21

Topic 17: Introducing Perspectives

In science, the perspectives/models or paradigms/theories attempt to explain events or behaviors. Each perspective spells out basic assumptions; and sets guideless for investigation. Today several models are used to explain and treat abnormal functioning. This variety has resulted both from shifts in values and beliefs over the past half-century and from improvements in clinical research. At one end of the spectrum is the biological model, which sees physical processes as key to human behavior. In the middle are three models that focus on more psychological and personal aspects of human functioning: The psychodynamic model looks at people's unconscious internal processes and conflicts; the cognitive-behavioral model emphasizes behavior, the ways in which it is learned, and the thinking that underlies behavior; and the humanistic-existential model stresses the role of values and choices. At the far end of the spectrum is the sociocultural model, which looks to social and cultural forces as the keys to human functioning. This model includes the family-social perspective, which focuses on an individual's family and social interactions, and the multicultural perspective, which emphasizes an individual's culture and the shared beliefs, values, and history of that culture.

Models' Influence

These models influence that that what specifically professionals/investigators are observing and how the questions are being asked on the basis of those observations. The information they seek, and how they interpret this information

Today, several models are used to explain and treat abnormal behavior. Each model focuses upon one aspect of humans. No single model can explain all aspects of abnormality

Topic 18: Biological Perspective

Adopting a medical perspective, biological theorists view abnormal behavior as an illness brought about by malfunctioning parts of the organism. Typically, they point to problems in brain anatomy, brain chemistry, and/or brain circuitry as the cause of such behavior.

Brain Anatomy and Abnormal Behavior

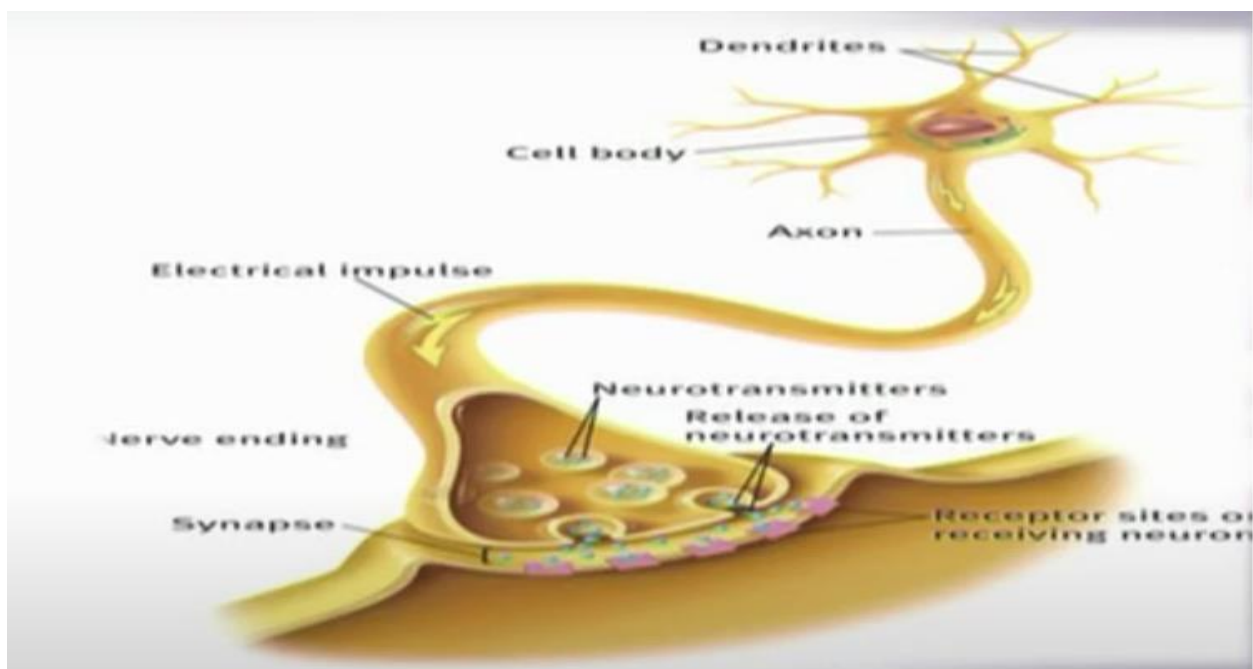
Brain is composed of 100 billion nerve cells called neurons and thousands of billions of support cells called glia/gliial cells. Within the brain large groups of neurons form distinct regions, or brain structures. Clinical researchers have sometimes discovered connections between particular psychological disorders and problems in specific structures of the brain. One such disorder is Huntington's disease, a disorder marked by violent emotional outbursts, memory loss, suicidal thinking, involuntary body movements, and absurd beliefs. This disease has been linked in part to a loss of cells in the basal ganglia and cortex.

Now there arises a question that either a structural change comes first or then the disorder come or vice versa. There is no conclusive evidence yet as the research is still going on.

Topic 19: Brain Chemistry and Abnormal Behavior

Biological researchers have also learned that psychological disorders can be related to problems in the transmission of messages from neuron to neuron. Information is communicated throughout the brain in form of electrical impulses that travel from one neuron to one (or more) others.

Structure of a Neuron:



- Dendrite
- Cell body
- Axon
- Electrical impulse
- Neurotransmitters
- Synapse

An impulse is first received by a neuron's dendrites, antenna-like extensions located at one end of the neuron. From there it travels down the neuron's axon, a long fiber extending from the neuron's body. Finally, it is transmitted through the nerve ending at the end of the axon to the dendrites of other neurons (See the above figure). Each neuron has multiple dendrites and a single axon. But that axon can be very long indeed, often extending all the way from one structure of the brain to another. Neurons are separated by a space (the synapse), across which a message moves.

A tiny space, called the synapse, separates one neuron from the next, and the message must somehow move across that space. When an electrical impulse reaches a neuron's ending, the nerve ending is stimulated to release a chemical, called a neurotransmitter, that travels across the synaptic space to receptors on the dendrites of the neighboring neurons. After binding to the receiving neuron's receptors, some neurotransmitters give a message to receiving neurons to "fire," that is, to trigger their own electrical impulse. Other neurotransmitters carry an inhibitory message; they tell receiving neurons to stop all firing. As you can see, neurotransmitters play a key role in moving information through the brain.

Topic 20: Neurotransmitters

Researchers have identified dozens of neurotransmitters in the brain e.g. serotonin, dopamine, and GABA and they have learned that each neuron uses only certain kinds. Studies indicate that abnormal activity by certain neurotransmitters is sometimes associated with mental disorders. Depression, for example, has been linked in part to low activity of the neurotransmitters

serotonin and norepinephrine. Anxiety has found to be having a relation with GABA. Schizophrenia is also linked with imbalances of dopamine

Endocrine Glands

Mental disorders are also found to be linked to abnormal chemical activity in the endocrine system. Endocrine glands, located throughout the body, work along with neurons to control such vital activities as growth, reproduction, sexual activity, heart rate, body temperature, energy, and responses to stress. The glands release chemicals called hormones into the bloodstream, and these chemicals then propel body organs into action. During times of stress, for example, the adrenal glands, located on top of the kidneys, secrete the hormone cortisol to help the body deal with the stress. Abnormal secretions of this chemical have been tied to anxiety and mood disorders i.e. depression or mania.

Genetic Factors

Genes on chromosomes control the characteristics and traits a person inherits. Studies suggest that inheritance plays a part in mood disorders, schizophrenia, Alzheimer's disease and other mental disorders. However, no specific gene in this regard has been identified though.

There is no exact information regarding to which extent genetic factors contribute to disorders. It appears that in most cases several genes combine to produce our actions and reactions.

Topic 21: Viral Infections

Under biological perspectives, another very important factor which may cause abnormal brain structure or biochemical dysfunction is infections, particularly viral infections e.g. schizophrenia and prenatal viral exposure or intellectual disability.

Treatment:

Biological practitioners attempt to identify physical source of dysfunction to determine the course of treatment. Once the clinicians have pinpointed physical sources of dysfunction, they are in a better position to choose a biological course of treatment. The three leading kinds of biological treatments used today are drug therapy, brain stimulation, and psychosurgery.

Drug Therapy/Psychotropic Medicines: These are the drugs that primarily affect the brain and reduce many symptoms of mental dysfunction. These drugs have greatly changed the outlook for

a number of mental disorders and today are used widely, either alone or with other forms of therapy. Drug therapy is by far the most common of three approaches.

Electroconvulsive Therapy: The oldest and most controversial approach, used primarily on severely depressed people, is electroconvulsive therapy (ECT). Two electrodes are attached to a patient's forehead, and an electrical current of 65 to 140 volts is passed briefly through the brain. The current causes a brain seizure that lasts up to a few minutes. After seven to nine ECT sessions, spaced two or three days apart, many patients feel considerably less depressed.

Neurosurgery: A third kind of biological treatment is psychosurgery, brain surgery for mental disorders.

Theoretical Perspectives II

Topic: 22-25

Psychodynamic & Behavioristic Perspective

Topic 21: Psychodynamic Perspective

Psychodynamic model IS the oldest and most famous of the modern psychological models. Psychodynamic theorists believe that a person's behavior, whether normal or abnormal, is determined largely by underlying psychological forces of which he or she is not consciously aware. These internal forces are described as dynamic that is, they interact with one another and their interaction gives rise to behavior, thoughts, and emotions. Abnormal symptoms are viewed as the result of conflicts between these forces. Sigmund Freud (1856-1939) was the founder of Psychodynamic theory and psychoanalytic therapy

Freud's Three Levels of Mind:

According to Freud there are three parts of mind each with their own roles and functions

Conscious: Conscious mind is comprised of all of the thoughts, memories, feelings, and wishes of which we are aware at any given moment. This is the aspect of our mental processing that we can think and talk about rationally.

Preconscious/Subconscious: This part consists of anything that could potentially be brought into the conscious mind.

Unconscious Mind: This is a reservoir of feelings, thoughts, urges, and memories that are outside of our conscious awareness. The unconscious contains contents that are unacceptable by the society or unpleasant, for example feelings of pain, anxiety, sexual urges or conflicts etc.

Structure of Personality:

Id: According to Freud, the psychological force that produces instinctual needs, drives, and impulses. The Id (instinctual Drives) unconsciously strive to satisfy basic sexual and aggressive drives. It operates on the pleasure principle, demanding gratification.

Ego: According to Freud, the psychological force that employs reason and operates in accordance with the reality principle. It functions as the “executive” and mediates the demands of the id and super ego.

Superego: According to Freud, the psychological force that represents a person’s values and ideals is superego. The superego provided standards for judgement (the conscience) and for future aspirations.

According to Freud, these three parts of the personality the id, the ego, and the superego—are often in some degree of conflict. A healthy personality is one in which an effective working relationship, an acceptable compromise, has formed among the three forces. If the id, ego, and superego are in excessive conflict, the person’s behavior may show signs of dysfunction

Development of Personality:

Freud believed that personality forms during the first few years of life, divided into psychosexual stages. According to him the personality develops in first three stages, and no substantial changes occur later. Freud proposed that at each stage of development, from infancy to maturity, new events challenge individuals and require adjustments in their id, ego, and superego. If the adjustments are successful, they lead to personal growth. If not, the person may become fixated, or stuck, at an early stage of development. Then all subsequent development suffers, and the individual may well be headed for abnormal functioning in the future. During these stages, the id’s pleasure seeking energies focus on pleasure sensitive body areas called erogenous zones.

Psychosexual Stages of Development:

- **Oral Stage: 0-18 months:** In this stage, pleasure centers on the mouth, sucking, biting chewing etc.
- **Anal Stage: (18-36 months):** Pleasure focuses upon bowel and bladder elimination and it helps coping with demands of control.
- **Phallic Stage (3-6 years):** Pleasure zone is genitals, coping with incestuous sexual feelings. Electra and Oedipus complex are salient features of this stage.

- **Latency Stage:** (6 to puberty): No further psychosexual development takes place during this stage and sexual feeling is dormant. Most sexual impulses are repressed during the latent stage, and sexual energy can be sublimated into other social activities.
- **Genital:** (Puberty to onwards): Maturation of sexual interests occurs in this stage.

Topic 23: Defense Mechanisms

According to psychoanalytic theory, strategies developed by the ego to control unacceptable id impulses and to avoid or reduce the anxiety they arouse are known as defense mechanisms. These are ego's protective methods of reducing anxiety by unconsciously distorting reality.

Following are few mechanisms:

Repression: It reduces anxiety arousing thoughts feelings and memories from consciousness. Person avoids anxiety by simply not allowing painful or dangerous thoughts to become conscious. For example, an executive's desire to run amok and attack his boss and colleagues at a board meeting is denied access to his awareness.

Regression: It leads to an infantile stage. Person retreats from an upsetting conflict to an early developmental stage in which no one is expected to behave maturely or responsibly for example, a boy who cannot cope with the anger he feels toward his rejecting mother regresses to infantile behavior, soiling his clothes and no longer taking care of his basic needs.

Reaction Formation: It causes the ego to unconsciously switch unacceptable impulses into their opposites. For example, treating someone you strongly dislike in an excessively friendly manner in order to hide your true feelings.

Projection: It leads people to disguise their own threatening impulses by attributing them to others. Person attributes his or her own unacceptable impulses, motives, or desires to other individuals. For example; the executive who repressed his destructive desires may project his anger onto his boss and claim that it is actually the boss who is hostile.

Rationalization: It offers self-justifying explanation. Person creates a socially acceptable reason for an action that actually reflects unacceptable motives. A student explains away poor grades by citing the importance of the "total experience" of going to college and claiming that too much emphasis on grades would actually interfere with a well-rounded education.

Displacement: It shifts sexual or aggressive impulses towards a more acceptable object. Person displaces hostility away from a dangerous object and onto a safer substitute. For example; after a perfect parking spot is taken by a person who cuts in front of your car, you release your pent-up anger by starting an argument with your roommate.

Normal/Abnormal Functioning:

According to Freud, a healthy personality is one in which compromise exists among the three forces i.e. Id, ego and super ego. If id, ego and superego are in excessive conflict, the person's behavior may show signs of dysfunction.

Topic 24: Therapeutic Techniques of Psychoanalytic Therapy

Psychodynamic therapies range from Freudian psychoanalysis to modern therapies based on self-theory or object relations theory. Psychodynamic therapists seek to uncover past traumas and the inner conflicts that have resulted from them. They try to help clients resolve, or settle, those conflicts and to resume personal development. According to most psychodynamic therapists, therapists must subtly guide therapy discussions so that the patients discover their underlying problems for themselves. Following techniques are employed in psychoanalysis:

Free Association: In psychodynamic therapies, the patient is responsible for starting and leading each discussion. The therapist tells the patient to describe any thought, feeling, or image that comes to mind, even if it seems unimportant. This practice is known as free association. The therapist expects that the patient's associations will eventually uncover unconscious events.

Resistance: Sometime it happens that during speaking sometimes there comes a blockade, or client takes more time, or resists to share some information. According to Freud, that particular area might be problematic and it must be analyzed.

Transference: Transference is client's unconscious positive or negative feeling redirection toward the therapist.

Dream Interpretation: Dreams, according to Freud, were a royal road to unconscious. He believed that through the analysis of dreams, we can gain some insight into a person's motivations and wishes. Manifest content of dreams and latent content of dreams both are analyzed while interpreting a dream.

Catharsis: Catharsis is the reliving of past repressed feelings in order to settle internal conflicts and overcome problems.

Post Freudians:

After Freud there were many other psychologists who contributed in his theoretical framework. Among them, following two were the eminent psychologists.

Carl Jung: Worked on analytical psychology. Jung's prominent concepts are archetypes, collective unconscious, extraversion and introversion and Word Association test

Alfred Adler: Adler is considered the founder of Individual Psychology. Inferiority complex and birth order are two distinctive concepts of his theory.

Topic 25: Behavioral Perspective

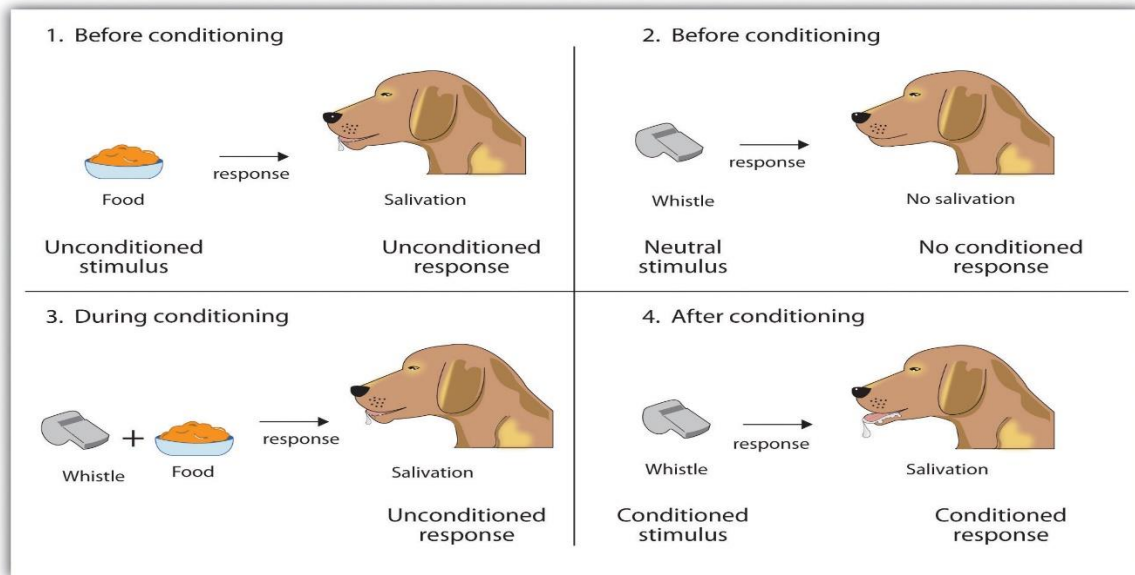
Basic Concepts

Behaviorists believe actions and behavior are determined largely by experiences in life and our experience is again determined by the environmental factors. Whatever happens around us, or the consequences of our own behavior determine how we will behave in future. Many learned behaviors help people to cope with daily challenges and to lead happy, productive lives. However, abnormal behaviors also can be learned. All explanations of behavior and treatment strategies of this school of thought are based on principles of learning.

Conditioning:

Learning principles are based on conditioning. Theorists have identified several forms of conditioning, and each may produce abnormal behavior as well as normal behavior. Following three have been discussed in this regard:

Classical Conditioning: It is a process of learning by temporal association in which two events that repeatedly occur close together in time become fused in a person's mind and produce the same response. Ivan Pavlov (1849-1936) is considered the father of classical conditioning. When two events occur close together in time, they become fused in the person's mind and subsequently, the person responds in the same way to both events.



In classical conditioning, for example, people learn to respond to one stimulus the same way they respond to another as a result of the two stimuli repeatedly occurring together close in time. If, say, a physician wears a white lab coat whenever she gives painful allergy shots to a little boy, the child may learn to fear not only injection needles, but also white lab coats. Many phobias are acquired by classical conditioning,

Operant Conditioning: B.F. Skinner is the main proponent of operant conditioning. It is a process of learning in which individuals come to behave in certain ways as a result of experiencing consequences of one kind or another whenever they perform the behavior.

Following are the principles of operant conditioning:

1. **Immediacy:** The reward of a behavior must be closed in time and space. For example, it should be immediate and not be delayed after a certain behavior has been shown.
2. **Consistency:** Consistency refers that a certain type of behavior must be reinforced/punished every time. If there is not consistency in reinforcement/punishment, the behavior will not be shaped.
3. **Reinforcement:** If the consequences of a behavior are satisfying, they are called reinforcers, and they serve to increase the likelihood of the person repeating the behavior in the future, it could be either positive or negative. A consequence is reinforcing when it

is pleasant (a reward, positive reinforcement) or when it removes an aversive state such as pain or fear (negative reinforcement).

4. **Punishment:** On the other hand, the consequences of a behavior are unsatisfying, they are called punishments, and they serve to decrease the likelihood of the person repeating the behavior in the future. Punishment can be positive or negative. A consequence is punishing when it is unpleasant (positive punishment) or when it takes away something pleasant (Negative punishment).

Modeling: It is a process of learning in which an individual acquires responses by observing and imitating others. Phobias can also be acquired by modeling. If a little girl observes her father become frightened whenever a dog crosses his path, she herself may develop a phobic fear of dogs.

Theoretical Perspectives III

Topic: 26-29

Cognitive, Humanistic & Sociocultural Perspectives

Topic 26: Cognitive Perspective

Basic Concepts

Cognition refers to thoughts and mental processes. It posits that our behavior depends upon on the way person attends to, interprets and uses available information. Every individual interprets a certain situation in a different manner, so this is mainly concerned with internal mental processes. It is a present focused approach. According to this paradigm, abnormal functioning can result from several kinds of cognitive problems. Some people may make assumptions and adopt attitudes that are disturbing and inaccurate so maladaptive thinking becomes the cause of maladaptive behavior. Faulty thinking, assumptions and attitudes are also a major cause of maladaptive behavior. Illogical thinking processes are another source of abnormal functioning, according to cognition-focused theorists.

There are two major proponents of this school of thought who presented their theories.

Beck's Cognitive Therapy

Aaron beck's theory was postulated first and on the basis of this theory, cognitive paradigm got evolved. The goal of this therapy is to help client recognize and restructure their thinking. If an individual rectifies his/her thought process, the behavior will automatically get rectified. Therapists also guide client to challenge their dysfunctional thoughts, try out new interpretations and apply new ways of thinking in their daily lives.

Albert Ellis' Rational Emotive Behavior Therapy

According to Ellis, we all have certain irrational beliefs that cause problems in our normal functioning. Ellis believed that through rational analysis and cognitive reconstructions, people could understand their self-defeating behaviors in light of their core irrational beliefs and then develop more rational constructs.

Topic 27: Humanistic Perspective

Basic Concepts

Humanists believe that human beings are born with a natural tendency to be friendly, cooperative, and constructive. People, these theorists propose, are driven to self-actualize that is, to fulfill their potential for goodness and growth. They can do so, however, only if they honestly recognize and accept their weaknesses as well as their strengths and establish satisfying personal values to live by. Humanists further suggest that self-actualization leads naturally to a concern for the welfare of others and to behavior that is loving, courageous, spontaneous, and independent. This paradigm recognizes and accepts the weaknesses as well as the strengths.

Roger's Humanistic Theory

According to Rogers, we all have a basic need to receive positive regard from the important people in our lives (primarily our parents). Those who receive unconditional (nonjudgmental) positive regard early in life are likely to develop unconditional self-regard. That is, they come to recognize their worth as persons, even while recognizing that they are not perfect. Such people are in a good position to actualize their positive potential. Unfortunately, some children repeatedly are made to feel that they are not worthy of positive regard. As a result, they acquire conditions of worth, standards that tell them they are lovable and acceptable only when they conform to certain guidelines.

Client Centered Therapy

Carl Rogers (1902–1987), often considered the pioneer of the humanistic perspective, developed client-centered therapy, a warm and supportive approach that in which clinicians try to help clients by conveying acceptance, accurate empathy, and genuineness.

Clinicians try to create a supportive climate in which clients feel able to look at themselves honestly and acceptingly. According to Rogers, the therapist must display three important qualities throughout the therapy:

- Unconditional positive regard (full and warm acceptance for the client)
- Accurate empathy (skillful listening and restating)

- Genuineness (sincere communication)

Topic 28: Sociocultural Perspective

Basic Concepts

According to the sociocultural model, abnormal behavior is best understood in light of the broad forces that influence an individual. What are the norms of the individual's society and culture? What roles does the person play in the social environment? What kind of family structure or cultural background is the person a part of? And how do other people view and react to him or her? Sometimes people adopt sick roles because of some social or family factors.

Family Social Treatments

The family-social perspective has helped spur the growth of several treatment approaches, including group, family, and couple therapy, and community treatment. Therapists of any orientation may work with clients in these various formats, applying the techniques and principles of their preferred models. However, more and more of the clinicians who use these formats believe that psychological problems emerge in family and social settings and are best treated in such settings, and they include special sociocultural strategies in their work.

Group Therapy: Group therapy is a therapy format in which a group of people with similar problems meet together with a therapist to work on those problems.

Family Therapy: In family therapy, a therapist meets with all members of a family, points out problem behaviors and interactions, and helps the whole family to change its ways (Goldenberg et al., 2016). Here, the entire family is viewed as the unit under treatment, even if only one of the members receives a clinical diagnosis.

Couple Therapy: In couple therapy, or marital therapy, the therapist works with two individuals who are in a long-term relationship. Often they are husband and wife, but the couple need not be married or even living together. Like family therapy, couple therapy often focuses on the structure and communication patterns in the relationship.

Community Treatment: Community mental health treatment programs allow clients, particularly those with severe psychological difficulties, to receive treatment in familiar social surroundings as they try to recover. Such community-based treatments, including community

day programs and residential services, seem to be of special value to people with severe mental disorders.

Topic 29: Other Perspectives

Biopsychosocial Model

Despite all their differences, the conclusions and techniques of the various models are often compatible. Certainly our understanding of abnormal behavior is more complete if we appreciate the biological, psychological, and sociocultural aspects of a person's problem rather than only one such aspect. Not surprisingly, then, many clinicians now favor explanations of abnormal behavior that consider more than one kind of cause at a time. These explanations, sometimes called biopsychosocial theories, state that abnormality results from the interaction of genetic, biological, emotional, behavioral, cognitive, social, cultural, and societal influence.

Diathesis Stress Theory

This theory posits that mental and physical disorders develop from a genetic or biological predisposition for that illness (diathesis) combined with stressful conditions that play a precipitating or facilitating role.

Integrative therapists are often called "eclectic" taking the strengths from each model and using them in combinations for treatment of a patient.

Summing Up:

Summing up, till now we have read all the following perspectives in detail:

1. Biological model
2. Psychodynamic model
3. Behavioral model
4. Cognitive model
5. Humanistic model
6. Sociocultural Perspectives
7. Biopsychosocial model

Neurodevelopmental Disorders I

Topic: 30-35

Topic 30: Introduction

Neurodevelopmental Disorders are a group of disabilities in the functioning of the brain that emerge at birth or during very early childhood and affect the individual's behavior, memory, concentration, and/or ability to learn. Some disorders first displayed during childhood subside as the person ages. However, the neurodevelopmental disorders often have a significant impact throughout the person's life

The onset of these disorders occurs before the children enter the school, these disorders are characterized by developmental deficits that cause impairment in personal, social, academic and/or occupational functioning. The range of developmental deficits varies from very specific limitations of learning, control of excessive function to global impairments of school skills or intelligence. Clinical presentation of these disorders includes symptoms of excess as well as deficits in achieving expected milestones

Topic 31: Intellectual Disability

The major disorder in category of neurodevelopmental disorder is intellectual disability, formerly known as mental Retardation in DSM IV-TR. The onset of this disorder occurs during the developmental period and includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. There are few distinct features of intellectual disability:

Deficits in intellectual functions such as deficits in reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience.

Deficits/impairments in adaptive functioning such as conceptual, social and practical domains. The individual fails to meet standards of personal independence and social responsibility in one or more aspects of daily life such as:

- Communication

- Social participation
- Academic or occupational functioning
- Personal independence at home or in community setting

The deficits begin during the developmental period (before the age of 18).

Topic 32: Intellectual Disability Diagnostic Criteria

The criteria might be overlapping but the following three criteria must be met to diagnose someone with intellectual disability:

1. Deficits in intellectual functions, confirmed by both clinical assessment and individualized, standardized intelligence testing
2. Deficits in adaptive functioning that fail to meet developmental and sociocultural standards for personal independence and social responsibility
3. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life:
 - Communication
 - Social participation
 - Independent living across multiple environments such as home, school work, and community

Topic 33: Intellectual Disability Specifiers/Diagnostic Criteria

In addition to the main criteria, few specifiers need to be addressed in the assessment. The severity of the disorder must be specified on the following levels:

- Mild
- Moderate
- Severe
- Profound

Levels of severity are defined based on adaptive functioning given in DSM 5 and not IQ scores because it is adaptive functioning that determines the level of supports required. Moreover, IQ measures are less valid in the lower end of the IQ range.

Global Developmental Delay

The clinical severity level cannot be reliably assessed during early childhood, under the age of 5 years. Sometimes an individual fails to meet developmental milestones in several areas of intellectual functioning but is unable to undergo systematic assess. So children who are too young to participate in standardized testing will be diagnosed as having global developmental delay but this category requires reassessment after some time.

Topic 34: Autism Spectrum Disorder

Autism spectrum disorder is marked by extreme unresponsiveness to other people, severe communication deficits, and highly rigid and repetitive behaviors, interests, and activities.

Diagnostic Criteria:

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history
 - 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
 - 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures: to a total lack of facial expressions and nonverbal communication.
 - 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity: Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

Topic 35: Autism Spectrum Disorder

Diagnostic Criteria (In continuation to the previous topic 34):

4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity: Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 2).

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life). D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- D. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Specify Current Severity:

Following parameters needs to be seen in this section:

- Severity is based on social communication impairments and restricted, repetitive patterns of behavior.
- Symptoms must be present in the early developmental period
- Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- These disturbances are not better explained by intellectual disability or global developmental delay.

It is also important to rule out and specify if the disorder is:

- With or without accompanying intellectual impairment
- With or without accompanying language impairment
- Associated with another medical or genetic condition or environmental factor

Neurodevelopmental Disorders II

Topic: 36-41

Topic 36: Specific Learning Disorder

Specific learning disorder, often referred to as learning disorder or learning disability, is a neurodevelopmental disorder that begins during school-age, although it may not be recognized until adulthood. This disorder is characterized by specific deficits in an individual's ability to perceive or process information efficiently and accurately. Learning disabilities refer to ongoing problems in one of three areas, i.e. reading, writing, and/or math, which is foundational to one's ability to learn. This disability has to be persistent and impairing to be diagnosed with specific learning disorder.

Diagnostic Criteria for Specific Learning Disorders:

- A. Difficulties learning and using academic skills, as indicated by the presence of at least one of the following symptoms that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:
1. Inaccurate or slow and effortful word reading (e.g., reads single words aloud incorrectly or slowly and hesitantly, frequently guesses words, has difficulty sounding out words).
 2. Difficulty understanding the meaning of what is read (e.g., may read text accurately but not understand the sequence, relationships, inferences, or deeper meanings of what is read).
 3. Difficulties with spelling (e.g., may add, omit, or substitute vowels or consonants).
 4. Difficulties with written expression (e.g., makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organization; written expression of ideas lacks clarity).
 5. Difficulties mastering number sense, number facts, or calculation (e.g., has poor understanding of numbers, their magnitude, and relationships; counts on fingers to add single-digit numbers instead of recalling the math fact as peers do; gets lost in the midst of arithmetic computation and may switch procedures).
 6. Difficulties with mathematical reasoning (e.g., has severe difficulty applying mathematical concepts, facts, or procedures to solve quantitative problems).

- B. The affected academic skills are substantially and quantifiably below those expected for the individual's chronological age, and cause significant interference with academic or occupational performance, or with activities of daily living, as confirmed by individually administered standardized achievement measures and comprehensive clinical assessment. For individuals age 17 years and older, a documented history of impairing learning difficulties may be substituted for the standardized assessment.
- C. The learning difficulties begin during school-age years but may not become fully manifest until the demands for those affected academic skills exceed the individual's limited capacities (e.g., as in timed tests, reading or writing lengthy complex reports for a tight deadline, excessively heavy academic loads).
- D. The learning difficulties are not better accounted for by intellectual disabilities, uncorrected visual or auditory acuity, other mental or neurological disorders, psychosocial adversity, lack of proficiency in the language of academic instruction, or inadequate educational instruction.

Note; The four diagnostic criteria are to be met based on a clinical synthesis of the individual's history (developmental, medical, family, educational), school reports, and psycho- educational assessment.

Topic 37: Specific Learning Disabilities

Diagnostic Criteria: (In continuation to the previous topic 36):

While diagnosing an individual we have to look at the specifiers and spicity if:

Reading Disability: With impairments in reading:

- Word reading accuracy
- Reading rate or fluency
- Reading comprehension

Note: Dyslexia is an alternative term used to refer to a pattern of learning difficulties characterized by problems with accurate or fluent word recognition, poor decoding, and poor spelling abilities. If dyslexia is used to specify this particular pattern of difficulties,

it is important also to specify any additional difficulties that are present, such as difficulties with reading comprehension or math reasoning.

Writing Disability: With impairment in the written expression:

- Spelling accuracy
- Grammar and punctuation accuracy
- Clarity or organization of written expression

Mathematical Disability: With impairments in mathematics

- Number sense
- Memorization of arithmetic facts
- Accurate or fluent calculation
- Accurate math reasoning

Note: Dyscalculia is an alternative term used to refer to a pattern of difficulties characterized by problems processing numerical information, learning arithmetic facts, and performing accurate or fluent calculations. If dyscalculia is used to specify this particular pattern of mathematic difficulties, it is important also to specify any additional difficulties that are present, such as difficulties with math reasoning or word reasoning accuracy.

We also need to specify current severity on the followings:

Mild: Some difficulties learning skills in one or two academic domains, but of mild enough severity that the individual may be able to compensate or function well when provided with appropriate accommodations or support services, especially during the school years.

Moderate: Marked difficulties learning skills in one or more academic domains, so that the individual is unlikely to become proficient without some intervals of intensive and specialized teaching during the school years. Some accommodations or supportive services at least part of the day at school, in the workplace, or at home may be needed to complete activities accurately and efficiently.

Severe: Severe difficulties learning skills, affecting several academic domains, so that the individual is unlikely to learn those skills without ongoing intensive individualized and specialized teaching for most of the school years. Even with an array of appropriate accommodations or services at home, at school, or in the workplace, the individual may not be able to complete all activities efficiently

Topic 38: Communication Disorders

A communication disorder is any disorder that affects an individual's ability to comprehend, detect, or apply language and speech to engage in discourse effectively with others. Following are types of communication disorders:

- Language Disorder
- Speech Sound disorders
- Social communication disorder
- Childhood-onset fluency disorder (stuttering & stammering)

Language Disorder

Language disorder is characterized by persistent difficulties in the acquisition and use of language due to comprehension or production.

Diagnostic Criteria:

Following is the diagnostic criteria of language disorders:

- A. Persistent difficulties in the acquisition and use of language across modalities (i.e., spoken, written, sign language, or other) due to deficits in comprehension or production that include the following:
 1. Reduced vocabulary (word knowledge and use).
 2. Limited sentence structure (ability to put words and word endings together to form sentences based on the rules of grammar and morphology).
 3. Impairments in discourse (ability to use vocabulary and connect sentences to explain or describe a topic or series of events or have a conversation).

- B. Language abilities are substantially and quantifiably below those expected for age, resulting in functional limitations in effective communication, social participation, academic achievement, or occupational performance, individually or in any combination.
- C. Onset of symptoms is in the early developmental period.
- D. The difficulties are not attributable to hearing or other sensory impairment, motor dysfunction, or another medical or neurological condition and are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

Topic 39: Speech Sound Disorders

Speech sound disorders is an umbrella term referring to any difficulty or combination of difficulties with perception, motor production, or phonological representation of speech sounds and speech segment.

Diagnostic Criteria:

Following is the diagnostic criteria of speech sound disorders:

- A. Persistent difficulty with speech sound production that interferes with speech intelligibility or prevents verbal communication of messages.
- B. The disturbance causes limitations in effective communication that interfere with social participation, academic achievement, or occupational performance, individually or in any combination.
- C. Onset of symptoms is in the early developmental period.
- D. The difficulties are not attributable to congenital or acquired conditions, such as cerebral palsy, cleft palate, deafness or hearing loss, traumatic brain injury, or other medical or neurological conditions.

Topic 40: Childhood-Onset Fluency Disorder (Stuttering)

Childhood-onset fluency disorder is a communication disorder in which there is a disturbance in the flow and timing of speech.

Diagnostic Criteria:

Following is the diagnostic criteria of childhood-onset fluency disorder:

- A. Disturbances in the normal fluency and time patterning of speech that are inappropriate for the individual's age and language skills, persist over time, and are characterized by frequent and marked occurrences of one (or more) of the following:
1. Sound and syllable repetitions.
 2. Sound prolongations of consonants as well as vowels.
 3. Broken words (e.g., pauses within a word).
 4. Audible or silent blocking (filled or unfilled pauses in speech).
 5. Circumlocutions (word substitutions to avoid problematic words).
 6. Words produced with an excess of physical tension.
 7. Monosyllabic whole-word repetitions (e.g., "I-I-I-I see him").
- B. The disturbance causes anxiety about speaking or limitations in effective communication, social participation, or academic or occupational performance, individually or in any combination.
- C. The onset of symptoms is in the early developmental period. (Note: Later-onset cases are diagnosed as 307.0 [F98.5] adult-onset fluency disorder.)
- D. The disturbance is not attributable to a speech-motor or sensory deficit, dysfluency associated with neurological insult (e.g., stroke, tumor, trauma), or another medical condition and is not better explained by another mental disorder.

Topic 41: Social Communication Disorder

The social communication disorder is characterized by difficulties with the use of verbal and nonverbal language for social purposes. Individual faces difficulties in understanding what is not explicitly stated. Individual experiences functional limitations in:

- Effective communication
- Social participation
- Social relationships
- Academic or occupational performance

Diagnostic Criteria:

Following is the diagnostic criteria of social communication disorder:

- A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:
 - 1. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.
 - 2. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on a playground, talking differently to a child than to an adult, and avoiding use of overly formal language.
 - 3. Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction.
 - 4. Difficulties understanding what is not explicitly stated (e.g., making inferences) and nonliteral or ambiguous meanings of language (e.g., idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).
- B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.
- C. The onset of the symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities).
- D. The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.

Neurodevelopmental Disorders III

Topic: 42-45

Topic 42: Attention Deficit Hyperactivity Disorder (ADHD)

Children with attention-deficit/hyperactivity disorder (ADHD) have great difficulty attending to tasks or behave over actively and impulsively, or both. About half of the children with ADHD also have learning or communication problems; many perform poorly in school; a number have difficulty interacting with other children, and about 80 percent misbehave, often quite seriously. The children may also have great difficulty controlling their emotions, and some have anxiety or mood problems

There are two features of ADHD:

1. Inattention and Disorganization Entail:

- Inability to stay on task, seemingly not to listen
- Losing materials
- At levels that are inconsistent with age or developmental level

2. Hyperactivity-Impulsivity Entails:

- Over-activity
- Fidgeting,
- Inability to stay seated, particularly in a structured environment
- Intruding into other people's activities
- Inability to wait
- Symptoms that are excessive for age

If all the symptoms interfere with functioning or development, as characterized by Inattention and/or 6 (or more) symptoms for at least 6 months, the individual will be diagnosed with ADHD. ADHD is a difficult disorder to assess properly. Ideally, the child's behavior should be observed

in several environments (school, home, with friends) because the symptoms of hyperactivity and inattentiveness must be present across multiple settings for ADHD to be diagnosed.

It negatively impacts directly on social and occupational functioning and academic functioning of the child.

Diagnostic Criteria:

Following is the diagnostic criteria of Attention Deficit Hyperactivity Disorder (ADHD):

- A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

Topic 43: Attention Deficit Hyperactivity Disorder (ADHD)

Diagnostic Criteria: (In continuation to the previous topic 42):

- 1. Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

- a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
- b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
- c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
- d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
- e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).

- f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
- g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
- h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
- i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

Topic 44: Attention Deficit Hyperactivity Disorder (ADHD)

Diagnostic Criteria: (In continuation to the previous topic 43):

2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

- a. Often fidgets with or taps hands or feet or squirms in seat.
- b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
- c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
- d. Often unable to play or engage in leisure activities quietly.
- e. Is often “on the go,” acting as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- f. Often talks excessively.
- g. Often blurts out an answer before a question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation).

- h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
- i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

Topic 45: Attention Deficit Hyperactivity Disorder (ADHD)

Diagnostic Criteria: (In continuation to the previous topic 44):

- B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
- C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
- D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

Other than the previously discussed symptoms i.e. inattention and hyperactivity, duration and age of onset, the following must also be looked upon:

We need to specify if:

- The child is with combined presentation i.e. both attention deficit and hyperactivity
- The child is with predominantly inattentive presentation
- The child is with predominantly hyperactive/impulsive presentation

It also needs to be specified if the condition/disorder is in partial remission. When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.

Severity:

Along with all previously discussed elements, the severity of the problems also needs to be specified as per followings:

- **Mild:** Few, if any, symptoms are there
- **Moderate:** Symptoms between “mild” and “severe” are present
- **Severe:** Many symptoms are present

Neurodevelopmental Disorders IV

Topic: 46-50

Topic 46: Motor Disorder

Motor disorders are disorders of the nervous system that cause abnormal and involuntary movements. Following disorders fall in this category:

- Developmental coordination disorder
- Stereotypic movement disorder
- Tic disorders.

Developmental Coordination Disorder

Diagnostic Criteria:

- A. The acquisition and execution of coordinated motor skills is substantially below that expected given the individual's chronological age and opportunity for skill learning and use. Difficulties are manifested as clumsiness (e.g., dropping or bumping into objects) as well as slowness and inaccuracy of performance of motor skills (e.g., catching an object, using scissors or cutlery, handwriting, riding a bike, or participating in sports).
- B. The motor skills deficit in Criterion A significantly and persistently interferes with activities of daily living appropriate to chronological age (e.g., self-care and self-maintenance) and impacts academic/school productivity, prevocational and vocational activities, leisure, and play.
- C. Onset of symptoms is in the early developmental period.
- D. The motor skills deficits are not better explained by intellectual disability (Intellectual developmental disorder) or visual impairment and are not attributable to a neurological condition affecting movement (e.g., cerebral palsy, muscular dystrophy, degenerative disorder)

Topic 47: Stereotypic Movement Disorder

Diagnostic Criteria:

- A. Repetitive, seemingly driven, and apparently purposeless motor behavior (e.g., hand shaking or waving, body rocking, head banging, self-biting, hitting own body).
- B. The repetitive motor behavior interferes with social, academic, or other activities and may result in self-injury.
- C. Onset is in the early developmental period.
- D. The repetitive motor behavior is not attributable to the physiological effects of a substance or neurological condition and is not better explained by another neurodevelopmental or mental disorder (e.g., trichotillomania [hair-pulling disorder], obsessive-compulsive disorder).

Topic 48: Stereotypic Movement Disorder

Diagnostic Criteria: (In continuation to the previous topic 47):

With all the above mention features of this disorder, it is very important for the diagnosis of stereotypic movement that you specify if the movements are:

- With self-injurious behavior(or behavior that would result in an injury if preventive measures were not used)
- Without self-injurious
- Associated with a known medical or genetic condition, neurodevelopmental disorder, or environmental factors

It is also important to specify the current severity level as per followings:

Mild: Symptoms are easily suppressed by sensory stimulus or distraction

Moderate: Symptoms require explicit protective measures and behavioral modification

Severe: Continuous monitoring and protective measures are required

Topic 49: Tic Disorders

A tic is a sudden, rapid, recurrent, non-rhythmic motor movement or vocalization for example muscle twitching, excessive blinking of eyes, or some specific vocal sounds. Tics are often classified not as involuntary movements but as “involuntary movements”. This means that

people can suppress their actions for a time. The suppression, though, results in discomfort that grows until it is relieved by performing the tic.

Tourette's Disorder

Diagnostic Criteria:

In important disorder in tic disorder is Tourette's Disorder.

- A. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently.
- B. The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset.
- C. Onset is before age 18 years.
- D. The disturbance is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington's disease, post viral encephalitis).

Topic 50: Persistent (Chronic) Motor or Vocal Tic Disorder

Diagnostic Criteria:

This disorder is diagnosed when:

- A. Single or multiple motor or vocal tics have been present during the illness, but not both motor and vocal.
- B. The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset.
- C. Onset is before age 18 years.
- D. The disturbance is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington's disease, post-viral encephalitis).
- E. Criteria have never been met for Tourette's disorder.

It is important to know that Persistent (Chronic) Motor or Vocal Tic Disorder will be diagnosed if the criteria have never been met for Tourette's disorder.

While diagnosing Persistent (Chronic) Motor or Vocal Tic Disorder we need to specify if it is:

- With motor tics only
- With vocal tics only
- With both

Schizophrenia spectrum & other Psychotic Disorders I

Topic 51-56

Topic 51

The broad category of schizophrenia includes a set of disorders in which individual experience distorted perception of reality and impairment in thinking, behavior, affect, and motivation. Schizophrenia is a serious mental illness, given its potentially broad impact on an individual's ability to live a productive and fulfilling life. Although a significant number of people with schizophrenia eventually manage to live symptom-free lives, in some ways, all must adapt their lives to the reality of the illness.

For years, Schizophrenia was a “wastebasket category” for diagnosticians as the label was at times assigned to anyone who acted unpredictably or strangely. The disorder is defined more precisely today, but still its symptoms vary greatly, and so do its triggers, course, and responsiveness to treatment.

In fact, most of today's clinicians believe that schizophrenia is actually a group of distinct disorders that happen to have some features in common. Regardless of whether schizophrenia is a single disorder or several disorders, the lives of people who struggle with its symptoms are filled with pain and turmoil.

Following disorders fall in this category:

1. Schizophrenia
2. Schizophreniform Disorder
3. Schizoaffective Disorder
4. Delusional Disorder
5. Brief Psychotic Disorder
6. Substance/Medication-Induced Psychotic Disorder
7. Psychotic Disorder Due to another Medical Condition
8. Catatonia Disorder Associated with Another Mental Disorder (Catatonia Specifier)

9. Catatonic Disorder Due to another Medical Conditions

Schizophrenia

Schizophrenia is a severe mental disorder in which reality is abnormally interpreted. The symptoms of schizophrenia can be grouped into three categories:

Positive Symptoms: Positive symptoms are those symptoms which adds into one's behavior for example, excesses of thought, emotion, and behavior. Positive symptoms are "pathological excesses," or bizarre additions, to a person's behavior. Delusions, disorganized thinking and speech, heightened perceptions and hallucinations, and inappropriate affect are the ones most often found in schizophrenia.

- **Delusions:** Many people with schizophrenia develop delusions, ideas that they believe wholeheartedly but that have no basis in fact. The deluded person may consider the ideas enlightening or may feel confused by them. Some people hold a single delusion that dominates their lives and behavior; others have many delusions.
- **Hallucinations:** Another kind of perceptual problem in schizophrenia consists of hallucinations, perceptions that a person has in the absence of external stimuli. People who have auditory hallucinations, by far the most common kind in schizophrenia, hear sounds and voices that seem to come from outside their heads. Hallucinations can also involve any of the other senses. Tactile hallucinations may take the form of tingling, burning, or electric-shock sensations. Somatic hallucinations feel as if something is happening inside the body, such as a snake crawling inside one's stomach. Visual hallucinations may produce vague perceptions of colors or clouds or distinct visions of people or objects. People with gustatory hallucinations regularly find that their food or drink tastes strange, and people with olfactory hallucinations smell odors that no one else does, such as the smell of poison or smoke.

Negative Symptoms: Negative symptoms are those that seem to be "pathological deficits," characteristics that are lacking in a person. Poverty of speech, blunted and flat affect, loss of volition, and social withdrawal are commonly found in schizophrenia. Such deficits greatly affect one's life and activities.

Psychomotor Symptoms: People with schizophrenia sometimes experience psychomotor symptoms. Many move relatively slowly, and a number make awkward movements or repeated grimaces and odd gestures that seem to have a private purpose perhaps ritualistic or magical.

Some people with schizophrenia are more dominated by positive symptoms and others by negative symptoms, although most tend to have both kinds of symptoms to some degree.

Diagnostic Criteria

- A. Two (or more) of the following, each present for a significant portion of time during a 1 - month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
 - 1. Delusions: A delusion is a strange false belief firmly held despite evidence to the contrary. There are many types of schizophrenia. It is one of the major features of schizophrenia.
 - 2. Hallucinations: Hallucinations refer to experiencing of sights, sounds, or other perceptions in the absence of external stimuli.
 - 3. Disorganized speech: It refers to a disorganized pattern of speech which includes rapid shift of topics, irrelevant and incoherent conversation, neologisms i.e. made up words etc. or phrases.
 - 4. Grossly disorganized or catatonic behavior: Catatonic behavior is remaining in one posture for long hours.
 - 5. Negative symptoms: deficits in behavior
- B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).
- C. Continuous signs of the disturbance persist for at least 6 months (Duration). This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

Topic 52: Schizophrenia (In continuation to the previous topic 51)

- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

Specify if:

The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

- **First episode, currently in acute episode:** First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled.
- **First episode, currently in partial remission:** Partial remission is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.
- **First episode, currently in full remission:** Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present.
- **Multiple episodes, currently in acute episode:** Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).
- **Multiple episodes, currently in partial remission**
- **Multiple episodes, currently in full remission**

- **Continuous:** Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.
- **Unspecified**

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Note: Diagnosis of schizophrenia can be made without using this severity specifier.

Topic 53: Schizophreniform Disorder

Schizophreniform Disorder is a type of schizophrenia but there are slight differences between the two i.e. the time duration.

- A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
1. Delusions.
 2. Hallucinations.
 3. Disorganized speech (e.g., frequent derailment or incoherence).
 4. Grossly disorganized or catatonic behavior.
 5. Negative symptoms (i.e., diminished emotional expression or avolition).
- B. An episode of the disorder lasts at least 1 month but less than 6 months. When the diagnosis must be made without waiting for recovery, it should be qualified as “provisional.”
- C. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred

concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

- D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify if:

With good prognostic features: This specifier requires the presence of at least two of the following features: onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning; confusion or perplexity; good premorbid social and occupational functioning; and absence of blunted or flat affect.

Without good prognostic features: This specifier is applied if two or more of the above features have not been present.

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Note: Diagnosis of schizophreniform disorder can be made without using this severity specifier.

Topic 54: Schizoaffective Disorder

Schizoaffective Disorder, as the name indicates, is characterized by mainly symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder i.e. mania and depression.

Diagnostic Criteria

- A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.

Note: The major depressive episode must include Criterion A1: Depressed mood.

- B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.
- C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.
- D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify whether:

Bipolar type: This subtype applies if a manic episode is part of the presentation. Major depressive episodes may also occur.

Depressive type: This subtype applies if only major depressive episodes are part of the presentation.

Specify if:

With catatonia

Specify if:

The following course specifiers are only to be used after a 1 -year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

- **First episode, currently in acute episode:** First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled.
- **First episode, currently in partial remission:** Partial remission is a time period during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

- **First episode, currently in full remission:** Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present.
- **Multiple episodes, currently in acute episode:** Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).
- **Multiple episodes, currently in partial remission**
- **Multiple episodes, currently in full remission**
- **Continuous:** Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.
- **Unspecified**

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Note: Diagnosis of schizoaffective disorder can be made without using this severity specifier.

Topic 55: Delusional Disorder

Delusional disorder, formerly known as paranoid disorder, is characterized of delusions.

Diagnostic Criteria

- A. The presence of one (or more) delusions with a duration of 1 month or longer.
- B. Criterion A for schizophrenia has never been met.

Note: Hallucinations, if present, are not prominent and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).

- C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.

- D. If manic or major depressive episodes have occurred; these have been brief relative to the duration of the delusional periods.
- E. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

Specify whether:

We need to specify the type of delusion whether it is:

Erotomaniac Type: This subtype applies when the central theme of the delusion is that another person is in love with the individual.

Grandiose Type: This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery.

Jealous Type: This subtype applies when the central theme of the individual's delusion is that his or her spouse or lover is unfaithful.

Persecutory Type: This subtype applies when the central theme of the delusion involves the individual's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals.

Somatic Type: This subtype applies when the central theme of the delusion involves bodily functions or sensations.

Mixed Type: This subtype applies when no one delusional theme predominates.

Unspecified Type: This subtype applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).

Specify if:

With bizarre content: Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., an individual's belief that a stranger has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars).

Topic 56: Delusional Disorder

Specifier:

In diagnosis of delusional disorder, following specifiers are to be used only after a 1-year duration of the disorder:

- First episode, currently in acute episode
- First episode, currently in partial remission
- First episode, currently in full remission
- Multiple episodes, currently in acute episode
- Multiple episodes, currently in partial remission
- Multiple episodes, currently in full remission
- Continuous
- Unspecified

Specify current severity:

Current Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including:

- Delusions
- Hallucinations
- Disorganized speech
- Abnormal psychomotor behavior,
- Negative symptoms.

Diagnosis of delusional disorder can be made without using this severity specifier.

Schizophrenia & other Psychotic Disorders II

Topic 57-62

Topic 57: Brief Psychotic Disorder

This disorder is characterized of a sudden and temporary period of psychotic behavior for example, delusions and hallucinations. As the term implies, brief psychotic disorder is a diagnosis that clinicians use when an individual develops symptoms of psychosis that do not persist past a short period of time.

Diagnostic Criteria

- A. Presence of one (or more) of the following symptoms. At least one of these must be (1), (2), or (3):
- Delusions.
 - Hallucinations.
 - Disorganized speech (e.g., frequent derailment or incoherence).
 - Grossly disorganized or catatonic behavior.

Note: Do not include a symptom if it is a culturally sanctioned response.

- B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.
- C. The disturbance is not better explained by major depressive or bipolar disorder with psychotic features or another psychotic disorder such as schizophrenia or catatonia, and is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify if:

With marked stressor(s) (brief reactive psychosis): If symptoms occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual's culture.

Without marked stressor(s): If symptoms do not occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual's culture.

With postpartum onset: If onset is during pregnancy or within 4 weeks postpartum.

Specify if: With catatonia

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Note: Diagnosis of brief psychotic disorder can be made without using this severity specifier.

Substance /Medicine Induces Psychotic Disorder/same discussion in next module, so part of next module.

Topic 58: Substance /Medicine Induced Psychotic Disorder

Substance/medicine induced psychotic disorder is characterized by hallucinations and/or delusions due to the direct effects of a substance or withdrawal from a substance in the absence of delirium. It is any psychotic episode that is related to the abuse of an intoxicant.

Diagnostic Criteria

Substance /Medicine Induced Psychotic Disorder will be diagnosed if

A. Presence of one or both of the following symptoms:

1. Delusions.

2. Hallucinations.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.

2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by a psychotic disorder that is not substance/medication-induced. Such evidence of an independent psychotic disorder could include the following:

The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence of an independent non-substance/medication-induced psychotic disorder (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

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

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

Specifiers:

While diagnosing Substance /Medicine Induced Psychotic Disorder we need to specify if it is:

- With onset during intoxication
- With onset during withdrawal

Severity:

The current severity of the symptoms also needs to be specified according to Clinician-Rated Dimensions of Psychosis Symptom

Topic 59: Psychotic Disorders Due to another Medical Condition

Psychotic disorder due to another medical condition is characterized by hallucinations or delusions that are caused by another medical disorder such as tumors, infections, migraines, strokes etc. Following are the prominent symptoms of this disorder:

- A. Prominent hallucinations or delusions.
- B. The disturbance is the direct pathophysiological consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder.
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Specifiers:

It is important to specify whether predominant symptoms are:

- With delusions
- With hallucinations

Severity:

The current severity of the symptoms also needs to be specified through formally formulated tools for this purpose, however, diagnosis of Psychotic Disorder Due to Another Medical Condition disorder can be made without using this severity specifier.

Topic 60: Catatonia Associated with another Mental Disorder

The psychomotor symptoms of schizophrenia may take certain extreme forms, collectively called catatonia. Catatonia, as discussed earlier refers to abnormality of movement and behavior caused due to disturbed mental state generally schizophrenia. It is characterized by repetitive or purposeless over activity, or catalepsy, resistance to passive movement, and negativism.

Catatonia Associated with another Mental Disorder will be diagnosed if the clinical picture is dominated by three (or more) of the following symptoms:

- **Stupor:** It refers to unresponsiveness as individuals stop responding to their environment, remaining motionless and silent for long stretches of time.
- **Catalepsy:** Individual remains in a trance or seizure like state, maintain a rigid, upright posture for hours and resist efforts to be moved.
- **Waxy flexibility:** In such state, individuals allow themselves to be moved into new positions and get back to that position again, but do not move on their own.
- **Mutism:** Individuals in this state do not utter a word, and remain silent.
- **Negativism:** Individuals keep on negating everything and keep do contrary to what is told to them. They do not comply to anything other than they want to do.
- **Posturing:** Individuals remain in one posture for longer periods of time and does not change it.
- **Mannerism:** Mannerism is behaving in a certain manner.
- **Stereotypy:** This is repetition of an act purposelessly for example a certain movement.
- **Agitation:** It refers to restlessness which is not influenced by external stimuli.
- **Grimacing:** Grimacing refers to an emotionless smile
- **Echolalia:** it is repetition of others' words.
- **Echopraxia:** It refers to imitation of others' movements

Followings must be kept in mind:

- The disturbance is the direct physiological consequence of another medical condition.
- The disturbance is not better explained by another mental disorder.
- The disturbance does not occur exclusively during the course of a delirium (incoherence due to intoxication, fever and other disorders).
- Clinically significant distress or impairment in different areas of functioning

Unspecified Catatonia:

This is used when the symptoms of catatonia are causing significant stress or are affecting the person's activities or relationships with others. It is diagnosed when:

- Either the nature of the underlying mental disorder or other medical condition is unclear
- Full criteria for catatonia are not met
- There is insufficient information to make a more specific diagnosis

Topic 61: Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Unspecified Schizophrenia Spectrum and Other Psychotic Disorder is diagnosed when symptoms characteristic of a schizophrenia spectrum and other psychotic disorder predominate but do not meet the full criteria such as combination, duration, or severity for any of the disorders in the category of schizophrenia spectrum and other psychotic disorders.

Etiology of Schizophrenia and other psychotic Disorder:

Researches have indicated a number of factors which can cause schizophrenia. Following are few of them.

Genetic Factors

Following the principles of the diathesis stress perspective, genetic researchers believe that some people inherit a biological predisposition to schizophrenia and develop the disorder later when they face extreme stress, usually during late adolescence or early adulthood.

- Relatives of people with schizophrenia are at increased risk of developing the disorder. Family pedigree studies have found repeatedly that schizophrenia and schizophrenia-like brain abnormalities are more common among relatives of people with the disorder. And the more closely related the relatives are to the person with schizophrenia, the more likely they are to develop the disorder.
- It has also been found by researches that those with schizophrenia in their family histories have more negative symptoms as negative systems may have a stronger genetic as compared to positive symptoms.
- The concordance rate / risk for identical twins is greater than that for fraternal twins. Twins, who are among the closest of relatives, have in particular been studied by schizophrenia researchers. If both members of a pair of twins have a particular trait, they are said to be concordant for that trait. If genetic factors are at work in schizophrenia, identical twins (who

share all their genes) should have a higher concordance rate for schizophrenia than fraternal twins (who share only some genes). This expectation has been supported consistently by research.

- The risk for adoptees that had a biological mother with schizophrenia is higher than those who do not have a biological parent with schizophrenia. Adoption studies look at adults with schizophrenia who were adopted as infants and compare them with both their biological and their adoptive relatives. Because they were reared apart from their biological relatives, similar symptoms in those relatives would indicate genetic influences. Conversely, similarities to their adoptive relatives would suggest environmental influences. Researchers have repeatedly found that the biological relatives of adoptees with schizophrenia are more likely than their adoptive relatives to develop schizophrenia or another schizophrenia spectrum disorder

Familial High-Risk Studies

Few studies have been done on families to identify the risk factors which subsequently lead to higher probability of schizophrenia. It has been found that:

- People with negative symptoms had a history of pregnancy and birth complications.
- People with predominantly positive symptoms had a history of family instability, such as separation from parents and placement in orphanages / institutions

Topic 62: Etiology of Schizophrenia and other psychotic Disorder

Psychological Factors

Other than all above mentioned factors, few psychological factors have also been found to be playing a significant role in development of schizophrenia.

- We all face different kinds of stressors in our lives and deal with it but people with schizophrenia appear to be very reactive to the stressors encountered in daily living.
- Though schizophrenia is seen across all socio-economic status, across all genders, across all races but the highest rates of schizophrenia are found in urban areas inhabited by people of the lowest socioeconomic status.

- Term schizophrenogenic mother was coined in 1959 for the supposedly cold and dominant, conflict-inducing parent who was said to produce schizophrenia in her offspring.
- Vague communication and high conflict in family also increases the risk of schizophrenia.
- If the child who has been reared in a disturbed family environment, he is at higher risk on developing schizophrenia.
- Patients with schizophrenia having families with High Expressed Emotion (EE) (critical comments, hostility, and emotional over-involvement) have more chances of relapse.

Developmental Factors

Another set of factors which are associated with development of schizophrenia which are developmental factors. In this regard many retrospective studies have found that:

- Children who later developed schizophrenia had lower IQs and were more often delinquent and withdrawn than other members
- Boys who later developed schizophrenia were rated by teachers as disagreeable, whereas girls were rated as passive
- Low IQ and cognitive deficits in childhood predicted the onset of schizophrenia in young adulthood, even after controlling for low socioeconomic status.

Depressive Disorders

Topic 63-69

Topic 63

Whenever we feel particularly unhappy, we are likely to describe ourselves as “depressed.” In all likelihood, we are merely responding to sad events, fatigue, or unhappy thoughts. All of us experience dejection from time to time, but only some experience a depressive disorder. Depressive disorders bring severe and long-lasting psychological pain that may intensify as time goes by. Those who suffer from such disorders may lose their will to carry out the simplest of life’s activities; some even lose their will to live. Earlier known as mood/affective disorders and mood disorders, depressive disorders are a wide range of disorders. Following disorders come under umbrella of depressive disorders:

1. Disruptive Mood Dysregulation Disorder
2. Major Depressive Disorder
3. Persistent Depressive Disorders (Dysthymia)
4. Substance/Medication-Induced Depressive Disorders
5. Depressive Disorder Due to Another Medical Condition
6. Other Specified Depressive Disorders

Disruptive Mood Dysregulation Disorder

Disruptive Mood Dysregulation Disorder is a disorder that starts in developmental phase, and is characterized by a persistently irritable/angry mood and recurrent temper outbursts that are out of proportion to the situation in hand and considerably more severe than the typical reaction of same-aged peers in children and adolescents. This disorder is diagnosed when:

- A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
- B. The temper outbursts are inconsistent with developmental level.

- C. The temper outbursts occur, on average, three or more times per week.
- D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).
- E. Criteria A-D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A-D.
- F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
- G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
- H. By history or observation, the age at onset of Criteria A-E is before 10 years.
- I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.

- J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).
- K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Topic 64: Major Depressive Disorder

Major depressive disorder, also known as clinical depression, is characterized of low mood and intense feelings of sadness for extended period of time.

Following is the diagnostic criteria of MDD:

- 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.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)
 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).
 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 gain.)
 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 cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

- D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

If five (or more) symptoms of the symptoms persist for 2-weeks period

1. At least one of the symptoms is either
 - Depressed mood or
 - Loss of interest or pleasure
2. Significant weight loss or weight gain
3. Insomnia or hypersomnia
4. Psychomotor agitation or retardation
5. Fatigue or loss of energy
6. Diminished ability to think or concentrate
7. Recurrent suicidal ideation

MDD will be diagnosed if the symptoms cause clinically significant distress or impairment in different areas of functioning. The diagnosis is not attributable to the physiological effects of a substance or to another medical condition. The symptoms are not better explained by another mental disorder (Psychotic, Manic etc.)

Specifiers:

Course: We need to specify if it is Single episode or Recurrent episode

We also need to specify the severity on the followings with the help of different diagnostic scales as well as clinical observation:

- Mild
- Moderate

- Severe
- With psychotic features
- In partial / Full remission
- Unspecified

Topic 65: Persistent Depressive Disorders (Dysthemia)

Persistent Depressive Disorders is very much like major depressive disorders but with slight differences. As the name indicates that problems remain for the longer period of time i.e. depressed mood present for at least 2 years. In addition to that in children and adolescents, mood can be irritable instead of being low and duration must be at least 1 year.

Diagnostic Criteria:

- A. Depressed mood for most of the day, for more days than not, as indicated by either 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 1 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 individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

- D. Criteria for a major depressive disorder may be continuously present for 2 years.

- E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.
- F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
- G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g. hypothyroidism).
- H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for a major depressive episode include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for persistent depressive disorder. If full criteria for a major depressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

Severity:

We also need to specify the current severity of the disorder on the following:

- Mild
- Moderate
- Severe

Topic 66: Substance/Medication-Induced Depressive Disorders

In Substance/Medication-Induced Depressive Disorders the symptoms start during or soon after a certain substance/medication has been taken.

Following is the diagnostic criteria of Substance/Medication-Induced Depressive Disorders:

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by a depressive disorder that is not substance/medication-induced. Such evidence of an independent depressive disorder could include the following:
- The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced depressive disorder (e.g., a history of recurrent non substance/medication-related episodes).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specifiers:

While diagnosing Substance/Medication-Induced Depressive Disorders we need to specify if the onset is during:

- intoxication
- withdrawal

Topic 67: Depressive Disorder Due to Another Medical Condition

Depression can be caused by general medical conditions that affect the body's systems or from long-term illnesses that cause ongoing pain. Although the symptoms are similar to those of depressive disorders, it is important to determine if the person has a non-neuropsychiatric medical condition.

Depressive Disorder Due to Another Medical Condition is diagnosed when there is:

- A. A prominent and persistent period of depressed mood or markedly diminished interest or pleasure in all, or almost all, activities that predominates in the clinical picture.
- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder (e.g., adjustment disorder, with depressed mood, in which the stressor is a serious medical condition).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specifiers:

While diagnosing Depressive Disorder Due to Another Medical Condition, it needs to be specified if it is:

- With depressive features
- With major depressive-like episode
- With mixed feature

Other Specified Depressive Disorders

These disorders are diagnosed when symptoms of depressive disorder that cause clinically significant distress or impairment predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class. This category is used in situations in which

the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific depressive disorder.

Examples of presentations that can be specified using the “other specified” designation include the following:

- Recurrent brief depression
- Short-duration depressive episode
- Depressive episode with insufficient symptoms

Topic 68: Etiology of Depressive Disorders

There are multiple factors which can be attributed to the development of depressive disorders.

Neurobiological Factors:

- Monozygotic twins (identical) and Dizygotic (fraternal) twins yield heritability. Studies have found that there is higher concordance in Monozygotic than dizygotic twins for developing major depressive disorder
- Genetic vulnerabilities express themselves more when there the certain environmental factors facilitate them. These environmental such as deprived environment, abusive surroundings or stressful situations, influence expression of genetic vulnerabilities
- Adoption studies also support the modest heritability of depressive disorder.
- There are certain neuro-chemical changes in brain. In this regard, neurotransmitters have been studied the most in terms of their possible role in mood disorders: norepinephrine, dopamine, and serotonin. Each of these neurotransmitters is present in many different areas of the brain.
- Depressive disorders have also been associated with changes in many of the brain areas involved in experiencing and regulating emotion: the subgenual anterior cingulate; the hippocampus, and the dorsolateral prefrontal cortex.

Social Factors:

- Those who experience stressful life events involving loss i.e. financial loss or of significant others', and humiliation, may develop depression.
- Diathesis–Stress Model considers both preexisting vulnerabilities (diatheses) and stressors. We all have vulnerabilities, and this vulnerability causes us to get stressed when faced with any stressor.
- Diatheses (preexisting vulnerabilities) could be biological, social, or psychological.
- Low social support is another very important social factor which may lessen a person's ability to handle stressful life events.
- Relapse of depression is more common in patients who have family members with high expressed emotions i.e. a family member's critical or hostile comments toward personality and disorder related behavior of patient or emotional over involvement with the person to trigger depression.
- Interpersonal problems can trigger the onset of depressive symptoms and vice versa.

Topic 69: Etiology of Depressive Disorders

Psychological Factors

Neuroticism is a personality trait that refers to a person who is anxiety prone. Neuroticism is a vulnerability factor and predicts the onset of depression. Several longitudinal studies suggest that neuroticism, a personality trait that involves the tendency to react to events with greater-than-average negative affect, predicts the onset of depression

Cognitive Biases:

In cognitive theories, negative thoughts and beliefs are seen as major causes of depression. Pessimistic and self-critical thoughts can torture the person with depression. According to Aron Beck, cognitive bias is very common among patients of depression. He postulated that:

- People with depression are overly attentive to negative feedback about themselves.
- They hold biased view of others as they focus more on negative aspects filtering the positive ones.

- Selective perception

Negative Triad:

Aaron Beck (1967) argued that depression is associated with a negative triad: negative views of the self, the world, and the future. The “world” part of the depressive triad refers to the person’s own corner of the world the situations he or she faces. For example, people might think “I cannot possibly cope with all these demands and responsibilities” as opposed to worrying about problems in the broader world outside of their life.

According to this model, in childhood, people with depression acquired negative schema through experiences such as loss of a parent, the social rejection of peers, or the depressive attitude of a parent. Schemas are different from conscious thoughts they are an underlying set of beliefs that operate outside of a person’s awareness to shape the way a person makes sense of his or her experiences. The negative schema is activated whenever the person encounters situations similar to those that originally caused the schema to form. Once activated, negative schemas are believed to cause cognitive biases, or tendencies to process information in certain negative ways. That is, Beck suggested that people with depression might be overly attentive to negative feedback about themselves.

Rumination

While Beck’s theory and the hopelessness model tend to focus on the nature of negative thoughts, Susan Nolen-Hoeksema (1991) has suggested that a specific way of thinking called rumination may increase the risk of depression. Rumination is defined as a tendency to repetitively dwell on sad experiences and thoughts, or to chew on material again and again. The most detrimental form of rumination may be a tendency to brood or to regretfully ponder why an episode happened.

Bipolar and Related Disorders

Topic 70-76

Topic 70: Bipolar Disorders

According to DSM 5, Bipolar disorders are a group of disorders that cause extreme fluctuation in a person's mood, energy, and ability to function. Such conditions feature extreme shifts in mood and fluctuations in energy and activity levels. Previously known as manic depressive disorder, it has been termed as Bipolar and Related Disorders in DSM 5.

Bipolar disorder is a category that includes three different conditions:

1. Bipolar I disorder
2. Bipolar II disorder
3. Cyclothymic disorder

If any of these disorders are left untreated, it can adversely affect relationships, undermine career prospects, and has serious effect on academic performance. Moreover, in some cases, it can lead to suicide. Diagnosis of these disorders most commonly occurs between the ages of 15 and 25 years, but it can happen at any age. It affects males and females equally.

In bipolar disorders, we have to know about three types of episodes:

- Manic Episode
- Hypomanic Episode
- Depressive Episode

Manic Episode

As opposed to depression, mania is the other pole of mood. A manic episode is not a disorder in and of itself, but rather is diagnosed as a part of a condition called bipolar disorder. Individuals in a state of mania typically experience dramatic and inappropriate rises in mood. The symptoms of mania span the same areas of functioning i.e. emotional, motivational, behavioral, cognitive,

and physical as those of depression, but mania affects those areas in an opposite way. A person experiencing a manic episode is usually engaged in significant goal-directed activity beyond their normal activities.

Distinctive Features

- The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.
- A distinct period of abnormally and persistently elevated, expansive, or irritable mood
- Abnormally and persistently increased activity or energy

Duration: Duration of the manic episode to be diagnosed must be 1 week and present most of the day, nearly every day.

Topic 71: Diagnostic Criteria of Manic Episode

According to DSM-5, it is necessary to meet the following criteria for a manic episode.

- A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
- B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
 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), as reported or observed.
 6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e. purposeless non-goal-directed activity).

7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

Topic 72: Hypomanic Episode

Hypo- comes from the Greek for “under”; hypomania is “under”, less extreme than, mania. Although mania involves significant impairment, hypomania does not. Rather, hypomania involves a change in functioning that does not cause serious problems. The person with hypomania may feel more social, flirtatious, energized, and productive.

It is a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy

Duration: Duration of the manic episode to be diagnosed must at least 4 consecutive days and present most of the day, nearly every day.

Diagnostic Criteria

- A. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, 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), as reported or observed.

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
 7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
- B. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
 - C. The disturbance in mood and the change in functioning are observable by others.
 - D. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
 - E. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Topic 73: Bipolar I Disorder

Bipolar I disorder is a manic-depressive disorder that can exist both with and without psychotic episodes. A person affected by bipolar I disorder has had at least one manic episode in his or her life. Most people with bipolar I disorder also suffer from episodes of depression. Often, there is a pattern of cycling between mania and depression. In between episodes of mania and depression, many people with bipolar I disorder can live normal lives.

Following is the diagnostic criteria of Bipolar I disorder according to DSM-5:

- A. Criteria have been met for at least one manic episode
- B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic

Severity:

We need to specify the current severity of the disorder on the following:

- Mild

- Moderate
- Severe

Specify:

While diagnosing bipolar disorder we need to specify if it is:

- Unspecified
- with psychotic features
- With anxious distress
- With mixed features
- With rapid cycling
- With melancholic features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With péri-partum onset
- With seasonal pattern

Topic 74: Bipolar II Disorder

Bipolar II disorder is characterized by cycles of depressive episodes followed by hypomanic periods. Bipolar II symptoms are very much similar with Bipolar I disorder but, in bipolar II, elevated moods never reach full-blown mania. The less-intense elevated moods in bipolar II disorder are called hypomanic episodes, or hypomania.

Diagnostic Criteria:

Following is the diagnostic criteria of Bipolar II disorder:

- Criteria have been met for at least one hypomanic episode and at least one major depressive episode
- There has never been a manic episode.

- The symptoms are not better explained by psychotic disorder or any other medical condition
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify:

We need to specify current or most recent episode as per the following phases:

- Hypomanic
- Depressed

It is also needed to be specified it is:

- With anxious distress
- With mixed features
- With rapid cycling
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- With péri-partum onset
- With seasonal pattern

We also need to specify if the course if full criteria for a mood episode are not currently met:

- In partial remission
- In full remission

We need to specify the current severity of the disorder on the following:

- Mild
- Moderate
- Severe

Topic 75: Cyclothymic Disorder

Cyclothymic disorder is a cyclic disorder that causes brief episodes of hypomania and depression. It is diagnosed when symptoms are not sufficient to be a major depressive episode or a hypomanic episode.

Following is the diagnostic criteria of Cyclothymic Disorder as per DSM 5:

- A. For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.
- B. During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.
- C. Criteria for a major depressive, manic, or hypomanic episode have never been met.
- D. The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
- E. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify:

While diagnosing, it needs to be specified if it is:

- With anxious distress
- Substance/medication induced

Topic 76: Substance/Medication Induced Bipolar Disorder

These disorders are classified as mania, hypomania or a major depressive episode directly caused by a substance/medication. The symptoms must start during or soon after the substance/medication was taken, or during withdrawal.

Following is the diagnostic criteria of Cyclothymic Disorder as per DSM 5:

- A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by elevated, expansive, or irritable mood, with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all, activities.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by a bipolar or related disorder that is not substance/medication-induced. Such evidence of an independent bipolar or related disorder could include the following:
 - The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced bipolar and related disorder (e.g., a history of recurrent non-substance/medication-related episodes).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify:

We need to specify the current severity of the disorder on the following parameters:

- With use disorder, mild
- With use disorder, moderate
- With use disorder, severe

It also needs to be specified if:

- With onset during intoxication
- With onset during withdrawal

Bipolar and Related Disorders II

Topic 77-81

Topic 77: Suicide

Suicide is defined as an intentioned death, a self-inflicted death in which one makes an intentional, direct, and conscious effort to end one's life. Suicide is a very negative outcome of any mental disorder, particularly depression. It is the act of killing oneself, most often as a result of depression or other mental illness. Suicide is a step taken to deal with intolerable mental anguish and pain, fear or despair that overwhelms an individual. Suicide is not officially classified as a mental disorder, although DSM-5's framers have proposed that a category called suicidal behavior disorder be studied for possible inclusion in future revisions of DSM-5.

There could be multiple causes of suicide and it should not be attributed to any one single cause. It is not necessary that all who die by suicide have been diagnosed with a mental illness or all having a mental illness end their lives by suicide. People who experience suicidal thoughts experience tremendous emotional pain and overwhelming feelings of hopelessness, despair, and helplessness.

Regardless of whether suicidal acts themselves represent a distinct disorder, psychological dysfunction, a breakdown of coping skills, emotional turmoil, a distorted view of life, usually plays a role in such acts. Suicidal acts may be connected to recent events or current conditions in a person's life. Although such factors may not be the basic motivation for the suicide, they can precipitate it. Common triggering factors include stressful events, mood and thought changes, alcohol and other drug use, mental disorders, and modeling.

Suicide is not about a moral weakness or a character flaw. People who considering suicide feel as if their pain will never end and that suicide is the only way to stop their suffering. Several Factors can contribute to suicide such as:

- Loss

- Addictions
- Childhood trauma or other forms of trauma
- Depression
- Psychotic disorder
- Serious physical illness
- Major life changes

All of the above mentioned can make one feel overwhelmed and unable to cope. It is important to remember that it isn't necessarily the nature of the loss or stressor that is as important as the individual's experience of these things feeling unbearable. Any intentions, no matter how small, must not be ignored.

Topic 78: Etiological Factors of Bipolar and Related disorders

There are multiple etiological factors that are attributed to development of bipolar and related disorders. We will discuss the following in this regard:

Neurobiological and Genetic or Chromosomal Factors:

Bipolar disorder is among the most heritable of disorders. Much of the evidence for this comes from studies of twins.

Adoption studies also confirm the importance of heritability in bipolar disorder. Bipolar II disorder is also highly heritable. Genetic models, however, do not explain the timing of manic symptoms. Other factors likely serve as the immediate triggers of symptoms.

There is a huge amount of interest in finding the specific genes involved in mood disorders through molecular genetics research. Molecular biologists have identified genes associated with unipolar depression. Unipolar depression may be tied to chromosomes 1,4,9-14, 17,18,20,21,22 and X. Gene 5-HTT located at chromosome 17 is associated with unipolar depression as 5-HTT is responsible for production of serotonin.

Depression is also associated with low levels of norepinephrine. Mania is associated with high levels of norepinephrine and dopamine levels. Mania and depression both are associated with low serotonin levels. Reward system in brain is believed to guide pleasure, motivation, and energy. Dopamine plays a major role in the sensitivity of the reward system in the brain, which is believed to guide pleasure, motivation, and energy in the context of opportunities to obtain rewards. Some research suggests that diminished function of the dopamine system could help explain the deficits in pleasure, motivation, and energy in major depressive disorder. Among people with bipolar disorder, several different drugs that increase dopamine levels have been found to trigger manic symptoms. One possibility is that dopamine receptors may be overly sensitive in bipolar disorder.

Endocrinal System is also very important in this regard. Unipolar depression is also associated with high level of cortisol, released in stress by adrenal gland. Cortisol dysregulation also predicts a more severe course of mood symptoms over time. Melatonin, also called Dracula hormone as it gets released only in dark, is also associated with depression. If we talk about seasonal depression, it is usually seen in areas where there is less sunny and they see dark weather quite often. One cause may be this; they develop more melatonin which causes depression.

Topic 79: Psychological Factors

Many different psychological factors may play a role in depressive disorders. The triggers of depressive episodes in bipolar disorder appear similar to the triggers of major depressive episodes such as:

- Losses in earlier life
- Negative life events
- Neuroticism
- Negative cognitive styles etc.
- Number of rewards received during life time
- Social rewards (social support)

Cognitive View

In cognitive theories, negative thoughts and beliefs are seen as major causes of depression. Pessimistic and self-critical thoughts can torture the person with depression. If you always think negative, it causes the same emotions in your personality.

Cognitive Triade: (Aaron Beck)

As discussed in etiology of depressive disorder, Aron Beck talks of cognitive Triad. It consists of three forms of negative thinking towards self, towards others and towards future.

There are also errors in thinking/ logic which cause depression. For instance, some people have an inclination to develop arbitrary inferences i.e. negative conclusion based on insufficient evidence. Selectively negative things are filtered from situation ignoring the positive one. In studies of how people process information, depression is associated with a tendency to stay focused on negative information once it is initially noticed. For example, if shown pictures of negative and positive facial expressions, those with depression tend to look at the negative pictures for longer than they look at the positive pictures. People with depression also tend to remember more negative than positive information.

Automatic thoughts refer to images or mental activity that occurs as a response to a trigger. They are automatic and 'pop up' or 'flash' in your mind without conscious thought. People who develop depression usually experience these negative automatic thoughts.

Topic 80: Psychological Factors

Cognitive View

Irrational Thinking (Albert Ellis):

Ellis believed that a large number of psychological problems are due to patterns of irrational thought. He proposed that people interpret what is happening around them, that sometimes these interpretations can cause emotional turmoil. Ellis used to list a number of irrational beliefs that people can harbor. He later shifted from a cataloguing of specific beliefs to the more general concept of “demandingness,” that is, the musts or should that people impose on themselves and on others. Thus, instead of wanting something to be a certain way, feeling disappointed, and then perhaps engaging in some behavior that might bring about the desired outcome, the person

demands that it be so. Ellis hypothesized that it is this unrealistic, unproductive demand that creates the kind of emotional distress and behavioral dysfunction that bring people to therapists.

Learned Helplessness (Seligman)

Postulated by Seligman, learned helplessness refers to the perception, based on past experiences, that one has no control over one’s reinforcements. People in this state typically accept that bad things will happen and that they have little control over them. They are unsuccessful in resolving issues even when there is a potential solution. This thinking leads to negative thinking, eventually causing depression.

Attribution-Learned helplessness:

Attributions refer to the explanations a person forms about why a stressor has occurred. The model places emphasis on two key dimensions of attributions.

1. Stable (permanent) versus unstable (temporary) causes
2. Global (relevant to many life domains) versus specific (limited to one area) causes

Following is an example of attribution style:

Event: I failed my test today

	Internal		External	
	Stable	Unstable	Stable	Unstable
Global	I have a problem with test anxiety	Having argument with my sister spoiled my whole day	Written tests are not good way to assess knowledge	If the tests are given after vacation no one does better
Specific	I just have no grasp over subject	I got confused and forgot as I could not do first question right	The professor gives difficult tests	The professor did not prepare test properly due to his other engagements

People with depression attribute present loss of control to some internal cause which is both global and stable. People whose attributional style leads them to believe that negative life events are due to stable and global causes are likely to become hopeless and this hopelessness will set the stage for depression. They may feel helpless to prevent future negative outcomes.

Topic 81: Environmental Causes

Socio-environmental models focus on the role of negative life events, lack of social support, and family criticism as triggers for episodes but also consider ways in which a person with depression may elicit negative responses from others. People with less social skill and those who tend to seek excessive reassurance are at elevated risk for the development of depression. Few of the environmental factors which play a role in bipolar disorder are as follows:

- Abuse
- Mental stress
- A significant loss
- Some other traumatic event may contribute to or trigger bipolar disorder.

It is always important to see that many people experience such bad socio-environmental challenges but not all of them develop mental disorders. There is a possibility that those with a genetic predisposition for bipolar disorder may not have noticeable symptoms until an environmental factor triggers it.

Anxiety Disorders I

Topic 82-88

Topic 82: General Features 1248/394

Anxiety is defined as apprehension over an anticipated problem. Anxiety is the main feature of anxiety disorders.

- Anxiety is manifested through excessive fear and anxiety related behavioral disturbances
- Many of the anxiety disorders develop in childhood and tend to persist if not treated
- Anxiety disorders are diagnosed when there is no other alternate explanation of fear / anxiety
- Anxiety disorder occurs more frequently in females as compared to males.

Any time you face what seems to be a serious threat to your well-being, you may react with the state of immediate alarm known as fear. Sometimes you cannot pinpoint a specific cause for your alarm, but still you feel tense and edgy, as if you expect something unpleasant to happen. The vague sense of being in danger is usually called anxiety, and it has the same features, the same increases in breathing, muscular tension, perspiration, and so forth, as fear.

Fear	Anxiety
Emotional response to real or perceived imminent	Anticipation of future threat
Autonomic arousal necessary for fight or flight	Muscle tension
Thoughts of immediate danger	Preparation for future danger
Escape behaviors	Cautious or avoidant behaviors

All of us face some fear and anxiety, and differentiate it with pathological fear and anxiety

1. Normal Fear/Anxiety is consistent with developmental age. It is brief and for shorten span of time. As long as fearful stimulus disappears, the fear/anxiety also disappears.
2. On the contrary, pathological Fear / Anxiety is characterized by excessive or Persistent beyond developmentally appropriate periods, as in phobias, individual seems to be

disproportionality afraid of even a snake toy. Such fear/anxiety often lasts for 6 months or more.

Types of Anxiety Disorders

Following disorders fall under the category of anxiety disorders:

- Separation anxiety disorder
- Selective Mutism
- Specific phobia
- Social anxiety disorder
- Panic disorder
- Agoraphobia
- Generalized anxiety disorder
- Substance/medication-induced anxiety disorder

Topic 83: Separation Anxiety Disorder

Individuals with separation anxiety disorder feel extreme anxiety, often panic, whenever they are separated from home or from key people/significant others in their lives. Children with separation anxiety disorder have great trouble traveling away from their family, and they often refuse to visit friends' houses, go on errands, or attend camp or school. Many cannot stay alone in a room and cling to their parents around the house. Some also have temper tantrums, cry, or plead to keep their parents from leaving them. The children may fear that they will get lost when separated from their parents or that the parents will meet with an accident or illness. As long as the children are near their parents, they may function quite normally. At the first hint of separation, however, the dramatic pattern of symptoms may be set in motion. Separation anxiety disorder is one of the most common psychological disorders among the young. In fact, for years, clinicians believed that the disorder is developed only by children or adolescents. DSM-5 determined that the disorder can also develop in adulthood, particularly after adults have experienced traumas such as the death of a spouse or child, a relationship break-up, separation caused by military service etc.

Such individuals may become consumed with concern about the health, safety, or well-being of a significant other, their spouse, a surviving child, or another important person in their life. They

may constantly and excessively try to be with the other individual, check on the other's whereabouts, protect the other person, and restrict the person's activities and travels. Their extreme anxiety and invasive demands cause them severe distress and can greatly damage their social and occupational lives.

Diagnostic Criteria:

A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.

Topic 84: Diagnostic Criteria: (In continuation to the previous module)

4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
 5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
 6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
 7. Repeated nightmares involving the theme of separation.
 8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.
- A. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.
- B. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

- C. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder.

Topic 85: Selective Mutism

In selective mutism, children consistently fail to speak in certain social situations, but show no difficulty at all speaking in others. Child with this disorder may have no problem talking, laughing, or singing at home with family members, but will offer absolutely no words in other key situations, such as the classroom. Some go an entire school year without speaking a word to their teacher or classmates. Many have a special friend in the classroom to whom they will discreetly whisper important things to be communicated to the class, such as answers to a teacher's questions or the need to use the restroom. People who only see a selectively mute child at school often find it hard to believe that the child is an absolute chatterbox at home.

Many researchers believe that selective mutism is an early version of social anxiety disorder, appearing in children before they have fully developed the cognitive capacities to worry about future embarrassment or anticipate potential judgment from others

Diagnostic Criteria:

- A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.
- B. The disturbance interferes with educational or occupational achievement or with social communication.
- C. The duration of the disturbance is at least 1 month (not limited to the first month of school).
- D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- E. The disturbance is not better explained by a communication disorder (e.g., childhood onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

Topic 86: Specific Phobia

A specific phobia is a disproportionate fear caused by a specific object or situation, such as fear of flying, fear of snakes, and fear of heights. The person recognizes that the fear is excessive but still goes to great lengths to avoid the feared object or situation. The names for these fears consist of a Greek word for the feared object or situation followed by the suffix -phobia (derived from the name of the Greek god Phobos, who frightened his enemies).

Diagnostic Criteria:

A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.

B. The phobic object or situation almost always provokes immediate fear or anxiety.

C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.

D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.

E. **Duration:** The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

Specify if:

While diagnosing we need to specify the specific type of phobia:

- Animal (e.g., spiders).

- Natural environment (e.g., heights).
- Blood-injection-injury (e.g., needles).
- Situational (e.g., airplanes).
- Other (e.g., situations that may lead to choking or vomiting: in children, (e.g., loud sounds).

Topic 87: Social Anxiety Disorder

Social anxiety disorder is a persistent, unrealistically intense fear of social situations that might involve being scrutinized by, or even just exposed to, unfamiliar people. Although this disorder is labeled social phobia in the DSM-IV-TR, the term social anxiety disorder is proposed in the DSM-5 because the problems caused by it, tend to be much more pervasive and to interfere much more with normal activities than the problems caused by other phobias. People with social anxiety disorder usually try to avoid situations in which they might be evaluated, show signs of anxiety, or behave in embarrassing ways. The most common fears include public speaking, speaking up in meetings or classes, meeting new people, and talking to people in authority. Although this may sound like shyness, people with social anxiety disorder avoid more social situations, feel more discomfort socially, and experience these symptoms for longer periods of their life than people who are shy. They often fear that they will blush or sweat excessively. Speaking or performing in public, eating in public, using public restrooms, or engaging in virtually any activity in the presence of others can cause extreme anxiety. People with social anxiety disorder often work in occupations far below their talents because of their extreme social fears. Many would rather work in an unrewarding job with limited social demand than deal with social situations every day.

Diagnostic Criteria:

- A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

- B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing: will lead to rejection or offend others).
- C. The social situations almost always provoke fear or anxiety.
Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.
- D. The social situations are avoided or endured with intense fear or anxiety.
- E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
- F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
- J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

While diagnosing we need to specify if it is:

Performance only: If the fear is restricted to speaking or performing in public.

Duration: Duration of symptoms must be more than 6 months

Topic 88: Agoraphobia

Agoraphobia is defined by anxiety about situations in which it would be embarrassing or difficult to escape if anxiety symptoms occurred. Commonly feared situations include crowds and crowded places such as grocery stores, malls, and churches. Sometimes the situations are those that are difficult to escape from, such as trains, bridges, or long road trips. Many people with agoraphobia are virtually unable to leave their house, and even those who can leave do so only with great distress. Researches prove that The disorder also is twice as common among women as men and among poor people as wealthy people. Many people with agoraphobia have extreme

and sudden explosions of fear, called panic attacks, when they enter public places, a problem that may have first set the stage for their development of agoraphobia. Such individuals may receive two diagnoses, agoraphobia and panic disorder, an anxiety disorder that will be discussed next, because their difficulties extend considerably beyond an excessive fear of venturing away from home into public places.

Diagnostic Criteria:

A. Marked fear or anxiety about two (or more) of the following five situations:

1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
3. Being in enclosed places (e.g., shops, theaters, cinemas).
4. Standing in line or being in a crowd.
5. Being outside of the home alone.

B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence).

C. The agoraphobic situations almost always provoke fear or anxiety.

D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder for example, the symptoms are not confined to specific phobia, situational type; do not involve only social situations (as in social anxiety disorder): and are not related exclusively to obsessions (as in obsessive-compulsive disorder), perceived defects or flaws in physical appearance (as in body dysmorphic disorder), reminders of traumatic events (as in posttraumatic stress disorder), or fear of separation (as in separation anxiety disorder).

Note: Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual's presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

Anxiety Disorders II

Topic 89-95

Topic 89: Panic Disorder

Panic disorder is characterized by frequent panic attacks that are unrelated to specific situations and by worry about having more panic attacks. A panic attack is a sudden attack of intense apprehension, terror, and feelings of impending doom, accompanied by at least four other symptoms. Physical symptoms can include labored breathing, heart palpitations, nausea, upset stomach, chest pain, feelings of choking and smothering, dizziness, lightheadedness, sweating, chills, heat sensations, and trembling. Other symptoms that may occur during a panic attack include depersonalization, a feeling of being outside one's body; de-realization, a feeling of the world's not being real; and fears of losing control, of going crazy, or even of dying. Not surprisingly, people often report that they have an intense urge to flee whatever situation they are in when a panic attack occurs. The symptoms tend to come on very rapidly and reach a peak of intensity within 10 minutes.

Panic attacks that occur unexpectedly are called uncued attacks. Panic attacks that are clearly triggered by specific situations, such as seeing a snake, are referred to as cued panic attacks.

Diagnostic Criteria:

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur;

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.

7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or “going crazy.”
13. Fear of dying.

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, car-diopulmonary disorders).

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder: in response to circumscribed phobic objects or situations, as in specific phobia: in response to obsessions, as in obsessive-compulsive disorder: in response to reminders of traumatic events, as in posttraumatic stress disorder: or in response to separation from attachment figures, as in separation anxiety disorder).

Topic 90: Generalized Anxiety Disorder

The central feature of generalized anxiety disorder (GAD) is worry. People with GAD are persistently worried, often about minor things. The term worry refers to the cognitive tendency to chew on a problem and to be unable to let go of it. Often, worry continues because a person cannot settle on a solution to the problem. Most of us worry from time to time, but the worries of people with GAD are excessive, uncontrollable, and long-lasting.

GAD is not diagnosed if a person worries only about concerns driven by another psychological disorder; for example, a person with claustrophobia who only worries about being in closed spaces would not meet the criteria for GAD. The worries of people with GAD are similar in focus to those of most people: they worry about relationships, health, finances, and daily hassles, but they worry more about these issues, and these persistent worries interfere with daily life. Other symptoms of GAD include difficulty concentrating, tiring easily, restlessness, irritability, and muscle tension.

Diagnostic Criteria:

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months);

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Topic 91: Substance/Medication-Induced Anxiety Disorder

Substance or medication-induced anxiety disorder is the diagnostic name for severe anxiety or panic which is caused by taking or stopping any drug.

Diagnostic Criteria:

A. Panic attacks or anxiety is predominant in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by an anxiety disorder that is not substance/medication-induced. Such evidence of an independent anxiety disorder could include the following:

- The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced anxiety disorder (e.g., a history of recurrent non substance/medication-related episodes).

- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Topic 92: Anxiety Disorder Due to another Medical Condition

Anxiety disorder due to a medical condition includes symptoms of intense anxiety or panic that are directly caused by a physical health problem. When a person suffers from anxiety disorder due to another medical condition, the presence of that medical condition leads directly to the anxiety experienced.

Diagnostic Criteria:

- A. Panic attacks or anxiety is predominant in the clinical picture.
- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder.
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Topic 93: Etiology of Anxiety Disorders

Separation Anxiety Disorder:

Genetics plays a role in anxiety among children, however, genes do their work via the environment, with genetics playing a stronger role in separation anxiety in the context of more negative life events experienced by a child for example loss of a significant other or a primary care giver.

Parenting practices play a role in childhood anxiety. Specifically, parental control and overprotectiveness, more than parental rejection, is associated with childhood anxiety. Other psychological factors that predict anxiety symptoms among children and adolescents include emotion-regulation problems and insecure attachment in infancy.

Etiology of Selective Mutism:

If an individual has traits of Negative affectivity (neuroticism) or behavioral inhibition, it may lead to selective mutism. Parental history of shyness, social isolation, and social anxiety also leads to this problem. Parental overprotection, as discussed earlier, also plays a role in developing this problem.

Etiology of Specific Phobia:

In the behavioral model, phobias are seen as a conditioned response that develops after a threatening experience (classical conditioning) and is sustained by avoidant behavior (Operant conditioning). Behavioral theory suggests that phobias could be conditioned by direct trauma, modeling, or verbal instruction.

Topic 94: Etiology of Social Anxiety Disorder

Behavioral Factors: Conditioning of Social Anxiety Disorder Behavioral perspectives on the causes of social anxiety disorder are similar to those on specific phobias, insofar as they are based on a two-factor conditioning model. That is, a person could have a negative social experience (directly, through modeling, or through verbal instruction) and become classically conditioned to fear similar situations, which the person then avoids. Through operant conditioning, this avoidance behavior is maintained because it reduces the fear the person experiences.

Cognitive Perspective:

The theory focuses on several different ways in which cognitive processes might intensify social anxiety. First, people with social anxiety disorders appear to have unrealistically negative beliefs about the consequences of their social behaviors, for example, they may believe that others will reject them if they blush or pause while speaking. Second, they attend more to how they are doing in social situations and their own internal sensations than other people do. Instead of attending to their conversation partner, they are often thinking about how others might perceive them (e.g., “He must think I’m an idiot”). They often form powerful negative visual images of how others will react to them. The resultant anxiety interferes with their ability to perform well socially, creating a vicious circle, for example, the socially anxious person doesn’t pay enough

attention to others, who then perceive the person as not interested in them. Such people set unrealistically high social standards and view themselves as unattractive and socially unskilled.

Such people anticipate that social disasters will occur so they perform “avoidance” and “safety” behaviors. After a social event, they review the details and overestimate how poorly things went or what negative results will occur.

Topic 95: Etiology of Panic Disorder

Biological Perspective:

A panic attack seems to reflect a misfire of the fear circuit, with a concomitant surge in activity in the sympathetic nervous system. The fear circuit appears to play an important role in many of the anxiety disorders. The locus ceruleus is the major source of the neurotransmitter norepinephrine in the brain, and norepinephrine plays a major role in triggering sympathetic nervous system activity. Changes in level of norepinephrine are associated with panic attacks. Amygdala is associated with panic attacks also.

Researches prove that genetic and chromosomal factors also play a role in panic attacks. It has been seen that close relatives have higher rates of panic disorder than more distant.

Cognitive Factor:

Cognitive perspectives focus on catastrophic misinterpretations of somatic changes. According to this model, panic attacks develop when a person interprets bodily sensations as signs of impending doom. For example, the person may interpret the sensation of an increase in heart rate as a sign of an impending heart attack. Obviously, such thoughts will increase the person’s anxiety, which produces more physical sensations, creating a vicious circle. This proneness is due to reason that they experienced more traumatic events over the course of their lives.

Etiology of Generalized Anxiety Disorder:

Psychodynamic Perspective:

According to Freud, early developmental experiences may produce an unusually high level of anxiety in certain children. Say that a boy is spanked every time he cries for milk as an infant,

messes his pants as a 2-year-old, and explores his genitals as a toddler. He may eventually come to believe that his various id impulses are very dangerous, and he may feel overwhelming anxiety whenever he has such impulses, setting the stage for generalized anxiety disorder.

Alternatively, a child's ego defense mechanisms may be too weak to cope with even normal levels of anxiety. Overprotected children, shielded by their parents from all frustrations and threats, have little opportunity to develop effective defense mechanisms. When they face the pressures of adult life, their defense mechanisms may be too weak to cope with the resulting anxieties. Adults, who as children suffered extreme punishment for expressing id impulses, have higher levels of anxiety later in life.

Cognitive Perspective:

According to cognitive perspective, psychological disorders are often caused by dysfunctional ways of thinking. When people who make these assumptions are faced with a stressful event, such as an exam or a first date, they are likely to interpret it as dangerous, to overreact, and to feel fear. As they apply the assumptions to more and more events, they may begin to develop generalized anxiety disorder.

Obsessive Compulsive and Related Disorders I

Topic 96-102

Topic 96

OCD is characterized by the presence of obsessions and/or compulsions. The main features of obsessive and compulsive disorders are obsessions and compulsions. Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. Some other obsessive-compulsive and related disorders are also characterized by preoccupations and by repetitive behaviors or mental acts in response to the preoccupations. Other obsessive-compulsive and related disorders are characterized primarily by recurrent body-focused repetitive behaviors (e.g., hair pulling, skin picking) and repeated attempts to decrease or stop the behaviors.

In DSM 5, following disorders come under category of Obsessive Compulsive and Related Disorders:

- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder
- Hoarding Disorder
- Trichotillomania Disorder
- Excoriation Disorder
- Substance/Medication-Induced OC and Related Disorders
- Obsessive Compulsive and Related Disorder Due to Another Medical Condition
- Other specified Obsessive Compulsive and related Disorder
- Unspecified Obsessive Compulsive and related Disorder (e.g. body focused repetitive behavior disorder, obsessional jealousy)

DSM IV TR to DSM-5:

In DSM IV TR this category did not exist. Obsessive-Compulsive Disorder was placed under anxiety disorders. Body dysmorphic disorder was placed in Somatoform disorder earlier but is now falls under this category. Hoarding Disorder, Trichotillomania Disorder and Excoriation Disorder are newly added disorders which did not exist in previous versions of DSM.

Topic 97: Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is characterized by obsessions or compulsions. Of course, most of us have unwanted thoughts from time to time, like an advertising jingle that gets stuck in our mind. And most of us also have urges now and then to behave in ways that would be embarrassing or dangerous. But few of us have thoughts or urges that are persistent and intrusive enough to qualify us for a diagnosis of OCD.

Obsessions are intrusive and recurring thoughts, images, or impulses that are persistent and uncontrollable (i.e., the person cannot stop the thoughts) and that usually appear irrational to the person experiencing them. For people with OCD obsessions have such force and frequency that they interfere with normal activities. The most frequent foci for obsessions include fears of contamination, sexual or aggressive impulses, body problems, religion, and symmetry or order.

General Features of OCD:

- Thoughts feel both intrusive and align to the person
- People are quite aware that their thoughts are excessive.
- The often take form of: wishes (e.g. repeated wish that someone very close will die)
- Impulses (repeated urge to do something socially inappropriate)
- Images (stuck vision of something obscene)
- Ideas (notion that germs are everywhere)
- There are certain themes around obsessions e.g. dirt or contamination, violence, aggression, orderliness, religion and sexuality

Topic 98

Compulsions are repetitive, clearly excessive behaviors or mental acts that the person feels driven to perform to reduce the anxiety caused by obsessive thoughts or to prevent some calamity from occurring. Commonly reported compulsions include the following:

- Pursuing cleanliness and orderliness, sometimes through elaborate rituals
- Performing repetitive, magically protective acts, such as counting or touching a body part
- Repetitive checking to ensure that certain acts are carried out, for example, returning seven or eight times in a row to see that lights, stove burners, or faucets were turned off, windows fastened, and doors locked

Compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. Repetitive Behaviors can take different forms e.g. hand washing, ordering or Mental acts e.g. praying, counting etc. That an individual feels driven to perform in response to an obsession. Most of the individuals recognize it unreasonable, but they believe at the same time that something terrible will happen if they do not perform the compulsions. After performing the act, they feel less anxious for a short while.

Many people with OCD perform rituals i.e. must to do something the same way every time, according to certain rules for example, arranging things in a certain manner. Compulsions can take various forms e.g. cleaning compulsions, checking compulsions, seek order or balance, touching, verbal and counting. Anxiety has a major role to play in compulsions, produced by obsessions. The obsessions cause intense anxiety, while the compulsions are aimed at reducing anxiety. Moreover, anxiety increases if a person tries to resist his or her obsessions or compulsions. But the relieved anxiety due to compulsions is very short lived and individual start performing the same ritual again after sometime.

Topic 99: Diagnostic Criteria of Obsessive Compulsive Disorder

According to DSM 5, following is the diagnostic criteria of OCD:

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling disorder]; skin picking, as in excoriation [skin-picking] disorder; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Specify if:

With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight: The individual thinks obsessive-compulsive disorder beliefs are probably true.

With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

Specify if:

Tic-related: The individual has a current or past history of a tic disorder.

Topic 100: Body Dysmorphic Disorder

People with body dysmorphic disorder (BDD) are preoccupied with an imagined or exaggerated defect in their appearance. Although people with BDD may appear attractive to others, they perceive themselves as ugly or even “monstrous” in their appearance. Women tend to focus on their skin, hips, breasts, and legs, whereas men are more likely to focus on their height, penis size, or body. Some men suffer from the preoccupation that their body is small or insufficiently muscular, even when others would not share this perception.

Like persons with OCD, people with BDD find it very hard to stop thinking about their concerns. Also like people with OCD, people with BDD find themselves compelled to engage in certain behaviors. In BDD, the most common compulsive behaviors include checking their appearance in the mirror, comparing their appearance to that of other people, asking others for reassurance about their appearance, or using strategies to change their appearance or camouflage disliked body areas (grooming, tanning, exercising, changing clothes, and applying makeup). While many spend hours a day checking their appearance, some try to avoid being reminded of their perceived flaws by avoiding mirrors, reflective surfaces, or bright lights. While most of us do things to feel better about our appearance, people with this disorder spend an inordinate amount of time and energy on these endeavors.

Diagnostic Criteria:

A. Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.

B. At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g., comparing his or her appearance with that of others) in response to the appearance concerns.

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

D. The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet diagnostic criteria for an eating disorder.

Specify:

We need to specify if it is:

With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.

Specify if:

We also need to indicate degree of insight regarding body dysmorphic disorder beliefs (e.g., “I look ugly” or “I look deformed”).

1. **With good or fair insight:** The individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true.
2. **With poor insight:** The individual thinks that the body dysmorphic disorder beliefs are probably true.
3. **With absent insight/delusional beliefs:** The individual is completely convinced that the body dysmorphic disorder beliefs are true.

Topic 101: Hoarding Disorder

Hoarding was not recognized as a diagnosis until the DSM-5. Hoarding disorder is characterized by a persistent difficulty discarding or parting with belongings because of a perceived need to save them. Collecting is a favorite hobby for many people. What distinguishes the common fascination with collections from the clinical disorder of hoarding? For people with hoarding

disorder, the need to acquire is only part of the problem. The bigger problem is that they abhor parting with their objects, even when others cannot see any potential value in them. Most typically, collections of clothes, tools, or antiques may be gathered along with old containers, bottle caps, and sandwich wrappers. People with hoarding disorder are extremely attached to their possessions, and they are very resistant to efforts to get rid of them. The consequences of hoarding can be quite severe. The accrual of objects often overwhelms the person's home. The pattern often results in fire hazards, unhealthy sanitation, or other dangers

Diagnostic Criteria:

- A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.
- B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
- C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).
- D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).

Topic 102: Hoarding Disorder

Diagnostic Criteria

(In continuation to the previous topic#101)

- E. The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome).
- F. The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder).

Specify:

We need to specify if it is:

With excessive acquisition: If difficulty discarding possessions is accompanied by excessive acquisition of items that are not needed or for which there is no available space.

It also needs to be specified if the disorder is:

With good or fair insight: The individual recognizes that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.

With poor insight: The individual is mostly convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

With absent insight/delusional beliefs: The individual is completely convinced that hoarding-related beliefs and behaviors (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.

Obsessive Compulsive and Related Disorders II

Topic 103-108

Topic 103: Trichotillomania (Hair-Pulling Disorder)

People with trichotillomania, also known as hair-pulling disorder, repeatedly pull out hair from their scalp, eyebrows, eyelashes, or other parts of the body. The disorder usually centers on just one or two of these body sites, most often the scalp. Typically, those with the disorder pull one hair at a time. It is common for anxiety or stress to trigger or accompany the hair-pulling behavior. Some sufferers follow specific rituals as they pull their hair, including pulling until the hair feels “just right” and selecting certain types of hairs for. Because of the distress, impairment, or embarrassment caused by this behavior, the individuals often try to reduce or stop the hair-pulling.

Diagnostic Criteria:

- A. Recurrent pulling out of one’s hair, resulting in hair loss.
- B. Repeated attempts to decrease or stop hair pulling.
- C. The hair pulling causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).
- E. The hair pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder).

Excoriation (Skin-Picking) Disorder:

People with excoriation (skin-picking) disorder keep picking at their skin, resulting in significant sores or wounds. Like those with hair pulling disorder, they often try to reduce or stop the behavior. Most sufferers pick with their fingers and center their picking on one area, most often the face. Other common areas of focus include the arms, legs, lips, scalp, chest, and extremities

such as fingernails and cuticles. The behavior is typically triggered or accompanied by anxiety or stress.

Diagnostic Criteria:

According to DSM 5, following is the diagnostic criteria to be diagnosed with Excoriation Disorder:

- A. Recurrent skin picking resulting in skin lesions.
- B. Repeated attempts to decrease or stop skin picking.
- C. The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).
- E. The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in non-suicidal self-injury).

Topic 104: Substance/Medication-Induced OC and Related Disorders

Substance/medication-induced obsessive-compulsive or related disorder is diagnosed in patients with obsessions and compulsions characteristic of OCD, but that develop during or after substance intoxication or withdrawal or after exposure to medications.

Diagnostic Criteria:

- A. Obsessions, compulsions, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of the obsessive-compulsive and related disorders predominate in the clinical picture.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by an obsessive-compulsive and related disorder that is not substance/medication-induced. Such evidence of an independent obsessive-compulsive and related disorder could include the following:

The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced obsessive-compulsive and related disorder (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

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

Note: This diagnosis should be made in addition to a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant clinical attention.

Topic 105: Obsessive-Compulsive and Related Disorder Due to Another Medical Condition

This disorder is diagnosed when obsessions, compulsions, and/or body-focused repetitive behaviors are the direct effect of a medical condition.

Diagnostic Criteria:

- A. Obsessions, compulsions, preoccupations with appearance, hoarding, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of obsessive-compulsive and related disorder predominate in the clinical picture.
- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder.

D. The disturbance does not occur exclusively during the course of a delirium.

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

Specify:

While diagnosing we need to specify if:

- **With Obsessive-Compulsive Disorder-like symptoms:** If obsessive-compulsive disorder-like symptoms predominate in the clinical presentation.
- **With appearance preoccupations:** If preoccupation with perceived appearance defects or flaws predominates in the clinical presentation.
- **With hoarding symptoms:** If hoarding predominates in the clinical presentation.
- **With hair-pulling symptoms:** If hair pulling predominates in the clinical presentation.
- **With skin-picking symptoms:** If skin picking predominates in the clinical presentation.

Topic 106: Other Specified Obsessive-Compulsive and Related Disorder

This category applies to presentations in which symptoms characteristic of an obsessive compulsive and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders diagnostic class. The other specified obsessive-compulsive and related disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific obsessive-compulsive and related disorder. Clinicians record “other specified obsessive-compulsive and related disorder” followed by the specific reason (e.g. Body dysmorphic-like disorder without repetitive behaviors).

Unspecified Obsessive-Compulsive and Related Disorder

This category applies to presentations in which symptoms characteristic of an obsessive compulsive and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the obsessive-compulsive and related disorders diagnostic class. The unspecified obsessive-compulsive and related disorder category is used in situations in

which the clinician chooses not to specify the reason that the criteria are not met for a specific obsessive-compulsive and related disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Topic 107

Obsessive-compulsive disorder, body dysmorphic disorder and hoarding disorder share some overlap in etiology.

Etiology of Obsessive Compulsive Disorder

Genetic and Physiological Factors

Research has found moderate genetic contribution in development of obsessive compulsive disorder. Brain-imaging studies indicate that three closely related areas of the brain are unusually active in people with OCD:

1. The orbitofrontal cortex (an area of the medial prefrontal cortex located just above the eyes)
2. The anterior cingulate cortex
3. The caudate nucleus, striatum, (part of the basal ganglia)

When people with OCD are shown objects that tend to provoke symptoms (such as a soiled glove for a person who fears contamination), activity in these three areas increases

Environmental Factors:

Physical and sexual abuse has been associated with development of obsessive compulsive disorder. Stressful or traumatic life events can also result into OCD.

Temperamental/Personal Factors:

People with OCD have greater internalizing symptoms for example, they will blame themselves, if they remained victim of any abuse etc. instead of seeing external factors. People with OCD also have higher negative emotionality i.e. that are more triggered towards negative emotions instead of positive emotions.

Consider for a moment how we know to stop thinking about something, to stop cleaning, or to quit studying for a test or organizing our desk. There is no absolute signal from the environment.

Rather, most of us stop when we have the sense of “that is enough.” **Yedasentience** is defined as this subjective feeling of knowing. Just like you have a signal that you have eaten enough food, yedasentience is an intuitive signal that you have thought enough, cleaned enough, or in other ways done what you should to prevent chaos and danger. One theory suggests that people with OCD suffer from a deficit in yedasentience. Because they fail to gain the internal sense of completion, they have a hard time stopping their thoughts and behaviors. Objectively, they seem to know that there is no need to check the stove or wash their hands again, but they suffer from an anxious internal sense that things are not complete.

Behavioral Explanations:

Behavioral models emphasize operant conditioning of compulsions. That is, compulsions are reinforced because they reduce anxiety. For example, compulsive handwashing would provide immediate relief from the anxiety associated with obsessions about germs. Similarly, checking the stove may provide immediate relief from the anxiety associated with the thought that the house will catch fire. Consistent with this view, after compulsive behavior, self-reported anxiety and even psychophysiological arousal drop.

Topic 108: Etiology of Body Dysmorphic Disorder

Genetic and Physiological Factors:

It has been seen that if first-degree relatives of an individual have obsessive-compulsive disorder (OCD), there will be high perseverance in individual to develop body dysmorphic disorder. Moreover, all disorders of this category have a high concordance rate in first degree relatives.

Environmental Factors:

Childhood experiences are of utmost important in developing some certain mental disorders. If the child has been neglected or abused in childhood, it will may later manifest in for of body dysmorphic disorder in later stage of life.

Currently media projections are also very important in setting certain physical standards which seems perfect. People start comparing themselves to those models and start relating themselves to those and set the same body standards. This might lead to development of body dimorphic disorder.

Etiology of Hoarding Disorder:

Genetic Factors:

As all other disorders of this category, hoarding disorder has also genetic role. There are familiar patterns, that if there is a trend in a family, children tend to do the same.

Environmental Factors:

Stressful/traumatic life events preceded onset or exacerbation of disorder.

Temperamental Factor:

Indecisiveness has found to be a prominent feature of individuals with hoarding disorders.

Cognitive Behavioral Model:

According to the cognitive behavioral model, hoarding is related to poor organizational abilities, unusual beliefs about possessions, and avoidance behaviors. Several different types of cognitive problems interfere with organizational abilities among. People with hoarding disorder. Many people with hoarding disorder demonstrate difficulties with attention. They also find it difficult to categorize objects. When asked to sort objects into categories, hoarders tend to be slow, to generate many more categories than others do, and to find the process much more anxiety-provoking. Beyond these difficulties with organizational skills, the cognitive model focuses on the unusual beliefs that people with hoarding disorder hold about their possessions. Almost by definition, hoarders demonstrate an extreme emotional attachment to their possessions. They report feeling comforted by their objects, being frightened by the idea of losing an object, and seeing the objects as core to their sense of self and identity. These beliefs about the importance of each and every object interfere with any attempts to tackle the clutter. In the face of the anxiety of all these decisions, avoidance is common many people with this disorder feel that it is better to pause than to make the wrong decision or to lose a valued object

Etiology of Trichotillomania and Excoriation Disorder

Genetic and Physiological Factors

Both disorders are more common in individuals with OCD and their first-degree family members than in the general population.

Trauma and Stress Related Disorders I

Topic 109-118

Topic 109: Introduction

Extraordinary stress and trauma play an even more central role in certain psychological disorders. In these disorders, the reactions to stress become severe and debilitating, linger for a long period of time, and may make it impossible for the individual to live a normal life.

We all feel stress when are faced with a situation that demands some change and change is always demanding. We always need some resources to cope with that change. Any change/event, that may challenge one's individual or environmental resources, could be stressful. The state of stress has two components:

1. **Stressor:** Stressor is an event that creates demand of evaluation/utilization of available resources causing pressure and stress
2. **Stress Response:** It is a reaction to the stressor experienced by the individual

Broadly, stress can be conceptualized as the subjective experience of distress in response to perceived environmental problems. Life stressors can be defined as the environmental problems that trigger the subjective sense of stress. Life stressors can be of many kinds ranging from daily hassles e.g. traffic jams to major life difficulties i.e. financial setbacks, migration or death of loved ones. These stressors exert a psychological pressure on Individual to use their available resources to cope up with the situations.

Then there are certain traumatic events which we met, though not very often, in our live such as manmade e.g. terror attacks, assaults or natural disasters e.g. floods, accidents, tornados earthquakes etc. Such traumatic events induce a lot of stress on individual which ultimately causes post traumatic reactions in many of them. Researchers have found that physical or psychological abuses and terminal illness also cause post traumatic reactions in individual.

To fully understand these various stress-related disorders, it is important to appreciate the precise nature of stress and how the brain and body typically react to stress. The features of arousal are set in motion by the brain structure called the hypothalamus. When our brain interprets a

situation as dangerous, neurotransmitters in the hypothalamus are released, triggering the firing of neurons throughout the brain and the release of chemicals throughout the body. Actually, the hypothalamus activates two important systems the autonomic nervous system and the endocrine system.

Autonomic Nervous System:

Autonomic nervous system generates a fight or flight response in certain traumatic situations. This system is based on two following systems:

Sympathetic Nervous System: when we face a dangerous situation, the hypothalamus first excites the sympathetic nervous system, a group of ANS fibers that work to quicken our heartbeat and produce the other changes that we come to experience as fear or anxiety.

Parasympathetic Nervous System: When the perceived danger passes, a second group of autonomic nervous system fibers, called the parasympathetic nervous system, helps return our heartbeat and other body processes to normal.

Together the sympathetic and parasympathetic nervous systems help control our arousal reactions.

Endocrine Glands: Pituitary & Adrenal:

The second brain body pathway by which arousal is produced is the hypothalamic-pituitary-adrenal (HPA) pathway. When we are faced by stressors, the hypothalamus also signals the pituitary gland, which lies nearby, to secrete the adrenocorticotropic hormone (ACTH), sometimes called the body's "major stress hormone". ACTH, in turn, stimulates the outer layer of the adrenal glands, an area called the adrenal cortex, triggering the release of a group of stress hormones called corticosteroids, including the hormone cortisol. These corticosteroids travel to various body organs, where they further produce arousal reactions

General Features of Trauma and Stress Related Disorders

1. Exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion
2. The most prominent clinical characteristics are Anhedonic (lack of interest in pleasurable activities) and dysphoric (depressive mood, feeling sad or gloomy) symptoms
3. Externalizing angry and aggressive symptoms, or

4. Dissociative symptoms: De-realization & Depersonalization

Types of Trauma and Stress Related Disorders

Following disorders fall under this category:

1. Reactive Attachment Disorder
2. Disinhibited Social Engagement Disorder
3. Posttraumatic Stress Disorder (PTSD)
4. Acute Stress Disorder (ASD)
5. Adjustment Disorder

Reactive Attachment Disorder and Disinhibited Social Engagement Disorder are commonly found in children.

Topic 110: Reactive Attachment Disorder

Reactive Attachment Disorders are limited to the child, before the age of five. The child does not reciprocate, or does not seek for any emotional support in the times of need. Reactive attachment disorder (RAD) is a condition in which an infant or young child does not form a secure, healthy emotional bond with his/her primary caretakers. Such children often have trouble managing their emotions and struggle to form meaningful connections with others. Children with RAD show consistent patterns of these behaviors.

Diagnostic Criteria:

A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:

1. The child rarely or minimally seeks comfort when distressed.
2. The child rarely or minimally responds to comfort when distressed.

B. A persistent social and emotional disturbance characterized by at least two of the following:

1. Minimal social and emotional responsiveness to others.
2. Limited positive affect.
3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:

1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

Topic 111: Reactive Attachment Disorder

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).

E. The criteria are not met for autism spectrum disorder.

F. The disturbance is evident before age 5 years.

G. The child has a developmental age of at least 9 months.

Specify:

We need to specify if it is:

Persistent: The disorder has been present for more than 12 months.

Specify Current Severity:

Reactive attachment disorder is specified as severe when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Topic 112: Disinhibited Social Engagement Disorder

This disorder is opposite to the Reactive Attachment Disorder in which children are not able to form any bonds or do not show any emotional attachment towards their caregivers. In Disinhibited Social Engagement Disorder (DSED), or Disinhibited Attachment Disorder, a child may actively approach and interact with unfamiliar adults. It may develop when a child lacks appropriate nurturing and affection from parents for any number of reasons. As a

result of these unfulfilled needs, the child is not closely bonded to parents and is as comfortable with strangers as they are with their primary caregivers.

Diagnostic Criteria:

A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:

1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.
2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
4. Willingness to go off with an unfamiliar adult with minimal or no hesitation.

B. The behaviors in Criterion A are not limited to impulsivity (as in attention-deficit/hyperactivity disorder) but include socially dis-inhibited behavior.

Topic 113: Disinhibited Social Engagement Disorder

(In continuation to the pervious topic 112)

C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:

1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).

D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g.: the disturbances in Criterion A began following the pathogenic care in Criterion C).

E. The child has a developmental age of at least 9 months.

Specify:

We need to specify if it is:

Persistent: The disorder has been present for more than 12 months.

Specify Current Severity:

Disinhibited social engagement disorder is specified as severe when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Topic 114: Posttraumatic Stress Disorder (PTSD)

When we confront stressful situations, we feel aroused psychologically and physically and experience a growing sense of fear. If the stressful situation is perceived as extraordinary and/or unusually dangerous, we may temporarily experience levels of arousal, fear, and depression that are beyond anything we have ever known. For most people, such reactions subside soon after the danger passes. For others, however, the symptoms of arousal, anxiety, and depression, as well as other kinds of symptoms, persist well after the upsetting situation is over. These people may be suffering from posttraumatic stress disorder, patterns that arise in reaction to a psychologically traumatic event.

Posttraumatic stress disorder (PTSD) entails an extreme response to a severe stressor, including increased anxiety, avoidance of stimuli associated with the trauma, and symptoms of increased arousal. Diagnoses of these disorders are considered only in the context of serious traumas; the person must have experienced or witnessed an event that involved actual or threatened death, serious injury, or sexual violation.

Diagnostic Criteria:

Note: The following criteria apply to adults, adolescents, and children older than 6 years (For children 6 years and younger, see corresponding criteria below)

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.

3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

Topic 115: Posttraumatic Stress Disorder (PTSD)

In the DSM-5, the symptoms for PTSD are grouped into four major categories:

Intrusively re-experiencing the traumatic event. The person may have repetitive memories or nightmares of the event. The person may be intensely upset by or show marked physiological reactions to reminders of the event (e.g., helicopter sounds that remind a veteran of the battlefield; darkness that reminds a woman of a rape).

Avoidance of stimuli associated with the event. Some may try to avoid all reminders of the event. For example, a Turkish earthquake survivor stopped sleeping indoors after he was buried alive at night. Other people try to avoid thinking about the trauma; some may remember only disorganized fragments of the event. These symptoms may seem contradictory to re-experiencing symptoms; although the person is using avoidance to try to prevent reminders, the strategy often fails, and so re-experiencing occurs.

Other signs of mood and cognitive change after the trauma. These can include inability to remember important aspects of the event, persistently negative cognition, blaming self or others for the event, pervasive negative emotions, lack of interest or involvement in significant activities, feeling detached from others, or inability to experience positive emotions.

Symptoms of increased arousal and reactivity. These symptoms include irritable or aggressive behavior, reckless or self-destructive behavior, difficulty falling asleep or staying asleep, difficulty concentrating, hypervigilance, and an exaggerated startle response. Laboratory studies

have confirmed that people with PTSD demonstrate heightened arousal, as measured by physiological responses to trauma-relevant images.

Diagnostic Criteria: (In continuation to the previous topic 114)

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Topic 116: Posttraumatic Stress Disorder (PTSD)

Diagnostic Criteria: (In continuation to the previous topic 115)

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Topic 117: Posttraumatic Stress Disorder (PTSD)

Diagnostic Criteria: (In continuation to the previous topic 116)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. **Duration** of the disturbance (Criteria B, C, D, and E) is more than 1 month. (if the symptoms are from 3-30 day, it will be diagnosed as Acute stress disorder, and if the symptoms remain for more than a month, it will be diagnosed as PTSD)

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Topic 118: Posttraumatic Stress Disorder (PTSD)

Diagnostic Criteria: (In continuation to the pervious topic 117)

Along with the mentioned cluster of symptoms, but along with all those a person may possess dissociative symptoms also so we need to:

Specify Whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly). It is floating, dreamlike state, in which you see yourself as an outsider.
2. **De-realization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify:

While diagnosing we need to specify if it is:

With Delayed Expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Trauma and Stress Related Disorders II

Topic 119-124

Topic 119: Acute Stress Disorder

In many terms Acute stress disorder and Post traumatic disorders share many similarities. Acute stress Disorder is a disorder in which fear and related symptoms are experienced soon after a traumatic event and last less than a month.

Diagnostic Criteria:

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the event(s) occurred to a close family member or close friend.

Note: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).

Note: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms

6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
12. Hypervigilance
13. Problems with concentration.

14. Exaggerated startle response.

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Topic 120: Adjustment Disorder

Adjustment disorder is characterized by excessive and extended feelings of anxiety, depressed mood, or antisocial behavior in response to life stressors. The symptoms of an adjustment disorder are not as severe as those in PTSD or in anxiety disorders, but they do cause individuals considerable stress and may interfere with their job, schoolwork, or social life. In Acute stress disorder and Post traumatic stress disorder, a traumatic event causes the problem, but in adjustment disorder, a significant stressor must be there.

Diagnostic Criteria:

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:

1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
2. Significant impairment in social, occupational, or other important areas of functioning.

C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.

D. The symptoms do not represent normal bereavement.

E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Specify:

We need to specify if it is:

- With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant.
- With anxiety: Nervousness, worry, jitteriness, or separation anxiety is predominant.

Topic 121: Adjustment Disorder

Diagnostic Criteria: (In continuation to the previous topic 120)

Specify if it is:

- With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant.
- With disturbance of conduct: Disturbance of conduct is predominant.
- With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.
- Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

Topic 122: Etiology of Trauma and Stress Related Disorders

Clearly, extraordinary trauma can cause a stress disorder. The stressful event alone, however, may not be the entire explanation. Anyone who experiences an unusual trauma will be affected by it, but only some people develop a stress disorder. To understand the development of these disorders more fully, researchers have looked at different factors among which few will be discussed here.

1. Pre-trauma factors

2. Peri-trauma factors
3. Post trauma factors

Pre-Trauma Factors:

A Pre-trauma factor is defined as a vulnerability factor can be defined as an enduring, endogenous trait inherent in the individual that serves to increase the likelihood of developing a particular disorder

Temperamental Factors:

Childhood emotional problems/disturbance by the age 6 years e.g., externalizing or anxiety problems can make a child vulnerable to cope with the life stressors.

Prior mental disorders e.g., panic disorder, depressive disorder increases the probability for a disorder to be developed in an individual.

Moreover, Research suggests that people with certain personalities, attitudes, and coping styles are particularly likely to develop posttraumatic stress disorder

Environmental Factors:

Researchers have found that certain childhood experiences increase a person's risk for later PTSD. People whose childhoods were marked by poverty appear more likely to develop the disorder in the face of later trauma. So do people whose childhoods included an assault, abuse, or a catastrophe; multiple traumas; parental separation or divorce; or living with family members suffering from psychological disorders. Childhood adversities e.g. economic adversities play an important role in this regard.

Genetic and Physiological Factors:

Investigators have linked posttraumatic stress disorder to several biological factors. Female gender is more prone and vulnerable to develop stress related disorders. Moreover, age is also important in this regard that if adult females experience a trauma at a younger age, they are more likely to develop the disorder. Moreover, there are certain genotypes may either be protective or increase risk of PTSD after exposure to a trauma.

Topic 123: Peri-Traumatic Factors

Peri-traumatic factors refer to those factors which play a role during a traumatic event is taking place.

Environmental Factors:

The severity of the trauma influences whether or not a person will develop PTSD. The greater the magnitude of trauma, the greater is the likelihood of PTSD development. Perceived life death and personal injury are also likely to cause stress ultimately developing PTSD. Interpersonal violence particularly trauma perpetrated by a caregiver can also lead to development of this disorder. Along with that, being a perpetrator could also cause stress.

Temperamental Factors:

These factors include negative appraisals, inappropriate coping strategies, and development of acute stress disorder. Appraisal is of two kinds i.e. primary appraisal and secondary appraisal. Primary appraisal is an assessment of how significant an event is for a person, including whether it is a threat or opportunity. Secondary appraisal then considers one's ability to cope or take advantage of the situation. If a person negatively appraises a situation, then likelihood of developing Post traumatic disorder increases. Along with that, coping strategies are also very important. Coping strategies are the specific efforts, both behavioral and psychological, that people use to control, tolerate, reduce, or minimize stressful events. There are two types of coping strategies i.e. emotion focused coping and problem focused coping. Emotion-focused coping is a type of stress management strategy that attempts to reduce negative emotional responses that occur due to exposure to stressors. Problem-focused coping is that kind of coping aimed at resolving the stressful situation or event or altering the source of the stress. Maladaptive patterns of emotional focused strategies also cause stress and lead to development of such disorders.

Topic 124: Post Trauma Factors

These refer to the factors which play a role after a specific trauma.

Environmental Factors:

When individual experiences a trauma, and copes well, when they experience a subsequent exposure to trauma it leads to development of PTSD. Moreover, subsequent adverse life events, such financial or other trauma-related losses also very important in this regard.

Social support including family stability, children, a network of friends all are a protective factor that moderates outcome after trauma. Those who do not find this support after a trauma, are at higher risk of developing PTSD.

Neurobiological Factors

As with other anxiety disorders, PTSD appears to be related to greater activation of the amygdala and diminished activation of the medial prefrontal cortex, regions that are integrally involved in learning and extinguishing fears. Although these two regions seem involved in many of the anxiety disorders, PTSD appears uniquely related to the function of the hippocampus.

The hippocampus is known for its role in memory, particularly for memories related to emotions. Brain-imaging studies show that among people with PTSD, the hippocampus has a smaller volume than among people who do not have PTSD.

Personal Factors:

Personal factors also play a major in development of PTSD. Selective attention causes people to feel a prey to stress who only focus on the negative aspects of a situation. Neuroticism is another major factor in this regard. For example, a classic study conducted after the monster 1989 storm, Hurricane Hugo, revealed that children who had been highly anxious before the storm were more likely than other children to develop severe stress reactions. Negative effectivity is another important factor. It has been seen that people who generally view life's negative events as beyond their control tend to develop more severe stress symptoms after traumatic events than people who feel that they have more control over their lives. Similarly, people who generally find it difficult to derive anything positive from unpleasant situations adjust more poorly after traumatic events than other people. People with avoidance coping are more likely to develop PTSD. People with low level of intelligence, who are not effectively able to solve their problems are also at a risk of developing trauma and stress related disorders subsequent to a trauma.

Dissociative Disorders I

Topic 125-131

Topic 125:

As discussed in previous lectures, a number of people with acute and posttraumatic stress disorders have symptoms of dissociation along with their other symptoms. They may, for example, feel dazed, have trouble remembering things, or have a sense of depersonalization or derealization. Symptoms of this kind are also on display in dissociative disorders, another group of disorders triggered by traumatic events. The memory difficulties and other dissociative symptoms found in these disorders are particularly intense, extensive, and disruptive. Moreover, in such disorders, dissociative reactions are the main or only symptoms. People with dissociative disorders do not typically have the significant arousal, negative emotions, sleep difficulties, and other problems that characterize acute and posttraumatic stress disorders. Nor are there clear physical factors at work in dissociative disorders.

Most of us experience a sense of wholeness and continuity as we interact with the world. We perceive ourselves as being more than a collection of isolated sensory experiences, feelings, and behaviors. In other words, we have an *identity*, a sense of who we are and where we fit in our environment. *Memory* is a key to this sense of identity, the link between our past, present, and future. Without a memory, we would always be starting over; with it, our life and our identity move forward. In dissociative disorders, one part of a person's memory or identity becomes dissociated, or separated, from other parts of his or her memory or identity. These disorders are characterized by Major disruption of memory, identity, or consciousness.

Individuals with these disorders may not remember new or old information. One part of the person's memory typically seems dissociated from the rest without any biological, medical or age related reasons. Such changes in memory, are called "Dissociative Disorders".

Dissociative disorders are characterized by a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior. Dissociative symptoms can potentially disrupt every area of psychological functioning.

Topic 126:

Dissociative symptoms are experienced as a) unbidden intrusions into awareness and behavior, with accompanying losses of continuity in subjective experience (i.e., "positive" dissociative symptoms such as fragmentation of identity, depersonalization, and derealization) and/or b) inability to access information or to control mental functions that normally are readily amenable to access or control (i.e., "negative" dissociative symptoms such as amnesia).

The dissociative disorders are frequently found in the aftermath of trauma, and many of the symptoms, including embarrassment and confusion about the symptoms or a desire to hide them, are influenced by the proximity to trauma. In DSM-5, the dissociative disorders are placed next to, but are not part of, the trauma- and stressor-related disorders, reflecting the close relationship between these diagnostic classes. Both acute stress disorder and posttraumatic stress disorder contain dissociative symptoms, such as amnesia, flashbacks, numbing, and depersonalization/derealization.

This category includes the following disorders:

1. Dissociative Identity Disorder (Previously known as Multiple Personality Disorder)
2. Dissociative Amnesia
3. Depersonalization/ Derealization Disorder
4. Other Specified Dissociative Disorder
5. Unspecified Dissociative Disorder

Topic 127: Dissociative Identity Disorder

Dissociative identity disorder, once known as multiple personality disorder, is characterized by the presence of two or more distinct personality states or an experience of possession and recurrent episodes of amnesia. These personalities may not always be aware of each other's memories, thoughts, feelings, and behavior.

Diagnostic Criteria:

According to DSM 5, Following is the diagnostic criteria of Dissociative Identity Disorder:

- A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

- B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The disturbance is not a normal part of a broadly accepted cultural or religious practice.

Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

- E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Topic 128:

In dissociative personality disorder, there are multiple personalities in one individual. According to the proposed DSM-5, a diagnosis of dissociative identity disorder (DID) requires that a person have at least two separate personalities, or alters i.e. different modes of being, thinking, feeling, and acting that exist independently of one another and that emerge at different times. Each determines the person's nature and activities when it is in command. The primary alter may be totally unaware that the other alters exist and may have no memory of what those other alters do and experience when they are in control. Each alter may be quite complex, with its own behavior patterns, memories, and relationships. Usually the personalities of the different alters are quite different from one another, even polar opposites.

How Do Subpersonalities Differ?

These sub-personalities often exhibit dramatically different characteristics and may differ in features as basic as age, sex, race, and family history. They also may have **physiological differences**, such as differences in autonomic nervous system activity, blood pressure levels, and allergies to different substances. A pioneering study looked at the brain activities of different subpersonalities by measuring their evoked potentials, that is, brain-response patterns recorded on an electroencephalograph. It is not uncommon for different sub-personalities to have different **abilities**, including being able to drive, speak a foreign language, or play an instrument. Their handwriting can also differ. In addition, the subpersonalities usually have different tastes in food, friends, music, and literature.

The transition from one sub-personality to the next ("switching") is usually sudden and may be dramatic.

Topic 129: How Do Subpersonalities Interact?

How subpersonalities relate to or recall one another varies from case to case. Generally, however, there are three kinds of relationships:

In **mutually amnesic relationships**, the subpersonalities have no awareness of one another. Conversely, in **mutually cognizant patterns**, each subpersonality is well aware of the rest. They may hear one another's voices and even talk among themselves. Some are on good terms, while others do not get along at all. In **one-way amnesic relationships**, the most common relationship pattern, some subpersonalities are aware of others, but the awareness is not mutual. Those who are aware, called coconscious subpersonalities, are "quiet observers" who watch the actions and thoughts of the other subpersonalities but do not interact with them. Sometimes while another subpersonality is present, the coconscious personality makes itself known through indirect means, such as auditory hallucinations (perhaps a voice giving commands) or "automatic writing" (the current personality may find itself writing down words over which it has no control).

Investigators used to believe that most cases of dissociative identity disorder involved two or three subpersonalities. Studies now suggest, however, that the average number of subpersonalities per patient is much higher, 15 for women and 8 for men. In fact, there have been cases in which 100 or more subpersonalities were observed. Often the subpersonalities emerge in groups of 2 or 3 at a time.

Topic 130: Dissociative Amnesia

The person with dissociative amnesia is unable to recall important personal information, usually information about some traumatic experience. The holes in memory are too extensive to be explained by ordinary forgetfulness. The information is not permanently lost, but it cannot be retrieved during the episode of amnesia, which may last for as short a period as several hours or as long as several years. The amnesia usually disappears as suddenly as it began, with complete recovery and only a small chance of recurrence.

Most often the memory loss involves information about some part of a traumatic experience, such as witnessing the sudden death of a loved one. More rarely the amnesia is for entire events during a circumscribed period of distress. During the period of amnesia, the person's behavior is otherwise unremarkable, except that the memory loss may cause some disorientation.

Diagnostic Criteria:

- A. An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.

Note: Dissociative amnesia most often consists of localized or selective amnesia for a specific event or events; or generalized amnesia for identity and life history.

- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Autobiographical Information should be successfully stored in memory and ordinarily would be readily remembered).
- C. The disturbance is not attributable to the physiological effects of a substance (e.g., alcohol or other drug of abuse, a medication) or a neurological or other medical condition (e.g., partial complex seizures, transient global amnesia, sequelae of a closed head injury/traumatic brain injury, other neurological condition).
- D. The disturbance is not better explained by dissociative identity disorder, posttraumatic stress disorder, acute stress disorder, somatic symptom disorder, or major or mild neurocognitive disorder.

Topic 131: Dissociative Amnesia

Types of Amnesia:

Dissociative amnesia has different types.

In **localized amnesia**, the most common type of dissociative amnesia, a person loses all memory of events that took place within a limited period of time, almost always beginning with some very disturbing occurrence. A soldier, for example, may awaken a week after a horrific combat battle and be unable to recall the battle or any of the events surrounding it. She may remember everything that happened up to the battle, and may recall everything that has occurred over the past several days, but the events in between remain a total blank. The forgotten period is called the amnesic episode.

People with **selective amnesia**, the second most common form of dissociative amnesia, remember some, but not all, events that took place during a period of time. If the combat soldier mentioned in the previous paragraph had selective amnesia, she might remember certain interactions or conversations that occurred during the battle, but not more disturbing events such as the death of a friend or the screams of enemy soldiers.

In some cases, the loss of memory extends back to times long before the upsetting period. In addition to forgetting battle-linked events, the soldier may not remember events that occurred earlier in her life. In this case, she would have what is called **generalized amnesia**. In extreme cases, she might not even recognize relatives and friends.

In the forms of dissociative amnesia just discussed, the period affected by the amnesia has an end. In **continuous amnesia**, however, forgetting continues into the present. The soldier might forget new and ongoing experiences as well as what happened before and during the battle. It is quite rare in cases of dissociative amnesia.

In **systematized amnesia** (a specific category), patients forget specific categories of information, such as all information about an individual or their family.

Permanent amnesia is forgetting the information on permanent basis.

Dissociative Fugue

In a more severe subtype of amnesia called fugue (from the Latin fugere, “to flee”), the memory loss is more extensive. The person not only becomes totally amnesic but suddenly leaves home and work and assumes a new identity. Sometimes the person takes on a new name, a new home, a new job, and even a new set of personality characteristics. The person may even succeed in establishing a fairly complex social life. More often, however, the new life does not crystallize to this extent, and the fugue is of relatively brief duration, consisting for the most part of limited but apparently purposeful travel, during which social contacts are minimal or absent. As in other forms of amnesia, recovery is usually complete, although it takes varying amounts of time; after recovery, people are fully able to remember the details of their life and experiences, except for those events that took place during the fugue. Fugues tend to end abruptly. In some cases, the person “awakens” in a strange place, surrounded by unfamiliar faces, and wonders how he or she got there. In other cases, the lack of personal history may arouse suspicion. Perhaps a traffic accident or legal problem leads police to discover the false identity; at other times friends search for and find the missing person.

The majorities of people who go through a dissociative fugue regain most or all of their memories and never have a recurrence. Since fugues are usually brief and totally reversible, those who have experienced them tend to have few aftereffects. People who have been away for months or years, however, often do have trouble adjusting to the changes that took place during their flight.

Dissociative Disorders II

Topic 132-138

Topic 132: Depersonalization/Derealization Disorder

In depersonalization/derealization disorder, the person's perception of the self or surroundings is disconcertingly and disruptively altered. The altered perceptions are usually triggered by stress. This disorder usually begins in adolescence, and it can start either abruptly or more insidiously. Once it begins, it has a chronic course, that is, it lasts a long time.

Depersonalization:

People with this condition feel as though they have become separated from their body and are observing themselves from outside. This sense of unreality can extend to other sensory experiences and behavior (e.g., unreal self).

Derealization:

Derealization is the feeling that the external world, too, is unreal and strange e.g., individuals or objects are experienced as unreal, fog, and dream.

Topic 133: Depersonalization/Derealization Disorder

Diagnostic criteria:

According to DSM 5, following the diagnostic criteria of Depersonalization/Derealization Disorder:

- A. The presence of persistent or recurrent experiences of depersonalization, derealization, or both:
1. **Depersonalization:** Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions (e.g., perceptual alterations, distorted sense of time, unreal or absent self, emotional and/ or physical numbing).
 2. **Derealization:** Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike, foggy, lifeless, or visually distorted).
- B. During the depersonalization or derealization experiences, reality testing remains intact.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, medication) or another medical condition (e.g., seizures).

E. The disturbance is not better explained by another mental disorder, such as schizophrenia, panic disorder, major depressive disorder, acute stress disorder, posttraumatic stress disorder, or another dissociative disorder.

Specify:

While diagnosing, we need to specify if Depersonalization/Derealization is:

With Dissociative Fugue: Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.

Topic 134: Other Specified Dissociative Disorders

This category applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class. The other specified dissociative disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific dissociative disorder. This is done by recording “other specified dissociative disorder” followed by the specific reason (e.g., “dissociative trance”).

Topic 135: Unspecified Dissociative Disorders

This category applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class. The unspecified dissociative disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific dissociative disorder, and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Topic 136: Etiology of Dissociative Disorders

Psychodynamic Theory:

Psychodynamic theorists believe that these dissociative disorders are caused by *repression*, the most basic ego defense mechanism: people fight off anxiety by unconsciously preventing painful memories,

thoughts, or impulses from reaching awareness. Everyone uses repression to a degree but people with dissociative amnesia and dissociative identity disorder are thought to repress their memories excessively. There is another phenomenon related to this i.e. *suppression*. In suppression, one consciously tries to stop himself from thinking or feeling something. On the contrary in repression, it happens unconsciously.

In the psychodynamic view, dissociative amnesia is a single episode of massive repression. A person unconsciously blocks the memory of an extremely upsetting event to avoid the pain of facing it. Repressing may be his or her only protection from overwhelming anxiety. In contrast, dissociative identity disorder is thought to result from a lifetime of excessive repression. Psychodynamic theorists believe that this continuous use of repression is motivated by traumatic childhood events, particularly abusive parenting.

Children who experience such traumas may come to fear the dangerous world they live in and take flight from it by pretending to be another person who is looking on safely from afar. Abused children may also come to fear the impulses that they believe are the reasons for their excessive punishments. Whenever they experience “bad” thoughts or impulses, they unconsciously try to disown and deny them by assigning them to other personalities.

Topic 137: Etiology of Dissociative Disorders

Behavioral Theory:

According to behaviorists, dissociation grows from normal memory processes such as drifting of the mind or forgetting. If people learn something when they are in a particular situation or state of mind, they are likely to remember it best when they are again in that same condition. According to them, there is nothing unconscious, but the individual does not want to register anything via memory process. Specifically, they hold that dissociation is a response learned through operant conditioning.

People who experience a traumatic event may later find temporary relief when their mind drifts to other subjects. For some, this momentary forgetting, leads to a drop in anxiety, and increases the likelihood of future forgetting. They are reinforced for the act of forgetting and learn without being aware that they are learning that such acts help them escape anxiety.

Topic 138: Etiology of Dissociative Disorders

Environmental Factors:

1. Dissociative disorders have been classified in DSM 5 as trauma related disorders, so traumatic events play a very important role.

2. Trauma can differ from e.g. physical and sexual abuse
3. Avoidance of emotions experienced during a traumatic event tend to play a major role in development of dissociative disorders.
4. As discussed earlier, adverse childhood experiences can also lead to development of these disorders, as they seek shelter as being someone else.

Personal Factors:

1. There are many of us who are problem solvers and many of us are harm-avoidant. This harm-avoidant temperament individuals are more vulnerable to develop these disorders as they are unable to face traumatic situations.
2. People with immature defenses also tend to develop of these disorders as their coping styles are not very mature.
3. People have already preconceived ideas about certain situations. Thus cognitive disconnection and over connection schemata also lead to the avoidance.

Psychological Factors:

Severe psychological stresses and conflicts in an individual's life also predisposes him/her to develop dissociative disorders.

Feeding and Eating Disorders I

Topic 139-144

Topic 139: General Features

Many cultures are preoccupied with food. In many different areas of the world, new restaurants abound, and numerous magazines, websites, and television shows are devoted to food preparation. At the same time, many people are overweight. Dieting to lose weight is common, and the desire of many people, especially women, to be thinner has created a multibillion-dollar-a-year business. Given this intense interest in food and eating, it is not surprising that this aspect of human behavior is subject to disorder.

Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Strong association has been found between obesity and mental disorders. Side effects of some psychotropic medications contribute to the development of obesity, and obesity may be a risk factor for the development of some mental disorders (e.g., depressive disorders).

Following disorders fall under the category of feeding and eating disorders:

1. Pica
2. Rumination Disorder
3. Avoidant/Restrictive Food Intake Disorder
4. Anorexia Nervosa
5. Bulimia Nervosa
6. Binge-eating Disorder
7. Other Specified Feeding and Eating Disorder
8. Unspecified Feeding and Eating Disorder

Topic 140: Pica

Pica is an eating disorder that involves eating items that are not typically thought of as food and that do not contain significant nutritional value, such as hair, dirt, and flakes of dried paint etc. This disorder can occur in any age but it mostly occurs in children and pregnant women. It's usually temporary. This is a serious disorder because even one incidence can cause the child to experience significant medical consequences due to lead poisoning or injury to the gastrointestinal tract. Pica is the most serious cause of self-injury to occur in people with intellectual developmental disabilities.

Diagnostic Criteria:

- A. Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
- B. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.
- C. The eating behavior is not part of a culturally supported or socially normative practice.
- D. If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Rumination Disorder:

Rumination Disorder usually happens in children. In this disorder, individual brings back up and re-chews partially digested food that has already been swallowed. Mostly, the re-chewed food is swallowed again; but occasionally, the spitted out.

- A. Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out.
- B. The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis).
- C. The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.
- D. If the symptoms occur in the context of another mental disorder (e.g., intellectual disability [Intellectual developmental disorder] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Specify:

While diagnosing, we need to specify if the disorder is:

In remission: After full criteria for rumination disorder were previously met, the criteria have not been met for a sustained period of time.

Topic 141: Avoidant/Restrictive Food Intake Disorder

Avoidant/Restrictive Food Intake Disorder is an eating disorder characterized by highly selective eating habits, disturbed feeding patterns or both. It often results in significant nutrition and energy deficiencies, and for children, failure to gain weight.

- A. An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by

persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
 2. Significant nutritional deficiency.
 3. Dependence on enteral feeding or oral nutritional supplements.
 4. Marked interference with psychosocial functioning.
- B. The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
- C. The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
- D. The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Specify:

While diagnosing, we need to specify if the disorder is:

In remission: After full criteria for avoidant/restrictive food intake disorder were previously met, the criteria have not been met for a sustained period of time.

Topic 142: Anorexia Nervosa

The term anorexia refers to loss of appetite, and nervosa indicates that the loss is due to emotional reasons. The term is something of a misnomer because most people with anorexia nervosa actually do not lose their appetite or interest in food. On the contrary, while starving themselves, most people with the disorder become preoccupied with food; they may read cookbooks constantly and prepare gourmet meals for their families.

Diagnostic Criteria:

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Coding note: The ICD-9-CM code for anorexia nervosa is 307.1, which is assigned regardless of the subtype. The ICD-10-CM code depends on the subtype (see below).

Topic 143:

Specify:

It needs to be specified if it is:

Restricting Type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

Binge-eating/purging Type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

It also needs to be specified if it is:

In partial remission: After full criteria for anorexia nervosa were previously met. Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify Current Severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The

level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

- Mild: BMI > 17 kg/m²
- Moderate: BMI 16-16.99 kg/m²
- Severe: BMI 15-15.99 kg/m²
- Extreme: BMI < 15 kg/m²
- Specify whether:

Topic 144: Bulimia Nervosa

People with bulimia nervosa, a disorder also known as binge-purge syndrome, engage in repeated episodes of uncontrollable overeating, or binges. A binge episode takes place over a limited period of time, often two hours, during which the person eats much more food than most people would eat during a similar time span (APA, 2013). In addition, people with this disorder repeatedly perform inappropriate compensatory behaviors, such as forcing themselves to vomit; misusing laxatives, diuretics, or enemas; fasting; or exercising excessively.

Like anorexia nervosa, bulimia nervosa usually occurs in females. It begins in adolescence or young adulthood (most often between 15 and 20 years of age) and often lasts for years, with periodic letup. The weight of people with bulimia nervosa usually stays within a normal range, although it may fluctuate markedly within that range. Some people with this disorder, however, become seriously underweight and may eventually qualify for a diagnosis of anorexia nervosa instead.

Diagnostic Criteria:

According to DSM, following the diagnostic criteria of Bulimia Nervosa:

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

- C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify:

We need to specify if the disorder is:

- **In partial remission:** After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time.
- **In full remission:** After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify Current Severity:

The minimum level of severity is based on the frequency of inappropriate compensatory behaviors (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- **Mild:** An average of 1-3 episodes of inappropriate compensatory behaviors per week.
- **Moderate:** An average of 4-7 episodes of inappropriate compensatory behaviors per week.
- **Severe:** An average of 8-13 episodes of inappropriate compensatory behaviors per week.
- **Extreme:** An average of 14 or more episodes of inappropriate compensatory behaviors per week.

Feeding and Eating Disorders II

Topic 145-150

Topic 145: Binge-Eating Disorder

Like those with bulimia Nervosa, people with binge-eating disorder engage in repeated eating binges during which they feel no control over their eating. However, they do not perform inappropriate compensatory behavior. As a result of their frequent binges, around half of people with binge-eating disorder become overweight or even obese. A person with a BMI greater than 30 is considered obese.

Binge-eating disorder was first identified 60 years ago as a pattern common among many overweight people. It is important to recognize, however, that most overweight people do not engage in repeated binges; their weight results from frequent overeating and/or a combination of biological, psychological, and sociocultural factors. Like people with bulimia nervosa or anorexia nervosa, those with binge-eating disorder typically are preoccupied with food, weight, and appearance; base their evaluation of themselves largely on their weight and shape; misperceive their body size and are extremely dissatisfied with their body; struggle with feelings of depression, anxiety, and perfectionism; and may abuse substances.

Diagnostic Criteria:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. The binge-eating episodes are associated with three (or more) of the following:

1. Eating much more rapidly than normal.
2. Eating until feeling uncomfortably full.
3. Eating large amounts of food when not feeling physically hungry.
4. Eating alone because of feeling embarrassed by how much one is eating.
5. Feeling disgusted with oneself, depressed, or very guilty afterward.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Topic 146:

Specify:

While diagnosing it needs to be specified if it is:

In Partial Remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.

In Full Remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify Current Severity:

Current severity also needs to be specified. The minimum level of severity is based on the frequency of episodes of binge eating. The level of severity may be increased to reflect other symptoms and the degree of functional disability.

- **Mild:** 1-3 binge-eating episodes per week.
- **Moderate:** 4-7 binge-eating episodes per week.
- **Severe:** 8-13 binge-eating episodes per week.
- **Extreme:** 14 or more binge-eating episodes per week.

Topic 147: Other specified Feeding and Eating Disorders

This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The other specified feeding or eating disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific feeding and eating disorder. This is done by recording “other specified feeding or eating disorder” followed by the specific reason (e.g., “bulimia nervosa of low frequency”).

Examples of presentations that can be specified using the “other specified” designation include the following:

1. **Atypical Anorexia Nervosa:** All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.
2. **Bulimia Nervosa (of low frequency and/or limited duration):** All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
3. **Binge-Eating Disorder (of low frequency and/or limited duration):** All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.
4. **Purging Disorder:** Recurrent purging behavior to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
5. **Night Eating Syndrome:** Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

Unspecified Feeding and Eating Disorders

This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The unspecified feeding and eating disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific feeding and eating disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Topic 148: Etiological Factors of Pica

If a child is not getting care or affection and are continuously neglected, they may indulge in such behaviors.

lack of supervision also leads to such problems. If child remains neglected and is not being supervised that what are they eating, such behaviors may get reinforced and children get accustomed to eating such stuff.

Developmental delays are also a major cause of it. If a child achieves developmental milestone i.e. physical, psychological, social, late, are more prone to develop pica.

Etiology of Rumination Disorder

Many psychosocial problems have been identified which play a role in development of Rumination Disorder. If there is lack of stimulation and child does not get very stimulating environment, it may lead to this disorder. As mentioned above, neglect is another factor which leads to development of this disorder. Clinicians have observed that the parents of teenagers with eating disorders do tend to define their children's needs rather than allow the children to define their own needs. If an individual is faced with stressful life situations throughout the life span, it causes development of eating disorder. Problems in the parent-child relationship also contribute a lot in this regard.

Etiology of Avoidant/Restrictive Disorder:

Avoidant/Restrictive Disorder can occur in comorbidity with different childhood disorders such as anxiety disorders, autism spectrum disorder, obsessive compulsive disorder, Attention deficit hyperactivity disorder. Familial anxiety may also increase risk of the disorder. Other than the above mentioned, there are some biological causes also which may lead to development of these disorders. History of gastrointestinal conditions, even if it has been recovered, may cause this problem as an individual develops an aversion with the food. Other medical conditions can also contribute in development of Avoidant/Restrictive Disorder.

Topic 149: Etiology of Anorexia Nervosa

Studies have found that individuals who develop anxiety disorders or display obsessional traits in childhood are at increased risk of developing anorexia nervosa. Throughout history, the standards societies have set for the ideal body, especially the ideal female body, have varied greatly. The sociocultural ideal of thinness is a likely vehicle through which people learn to fear being or even feeling fat, as obese people are viewed by others as less smart and are stereotyped as lonely, shy, and greedy for the affection of others. There are certain cultures where thinness is valued, so people tend to be following those standards. Same as, Occupations and vocations that encourage thinness, such as modeling.

An increased risk of anorexia nervosa and bulimia nervosa among first-degree biological relatives of individuals with the disorder. Both anorexia nervosa and bulimia nervosa run in families. First-degree relatives of young women with anorexia nervosa are more than ten times more likely than average to have the disorder themselves. Twin studies of eating disorders also suggest a genetic influence. Most studies of both anorexia and bulimia report higher MZ than DZ concordance rates.

Topic 150: Etiology of Bulimia Nervosa

There are some causes of bulimia and anorexia nervosa. Some of these are as follows:

- Weight concerns play a major role in development of eating disorders.
- People with low self-esteem are more vulnerable to cause eating disorders
- Sometimes, there is masked depression and these depressive symptoms lead to eating disorders.
- People with social anxiety disorder at a higher risk for developing anorexia/bulimia nervosa
- Overanxious disorder of childhood can predispose somebody to bulimia nervosa.
- Internalization of a thin body ideal increase risk for developing weight concerns, which in turn increase risk for the development of bulimia nervosa.
- Childhood is very important in this regard. If a person had a rough childhood in which he/she had adverse stressful experiences such as particularly parent-child relationship or the child gets sexually or physically abuse, it makes him/her vulnerable to develop psychological disorders, particularly eating disorders.
- Childhood obesity is another risk factor that a person may develop eating disorders.
- Early pubertal maturation also exposes the person to develop eating disorders
- Familial transmission of bulimia nervosa is also very important in this regard as an individual may internalize the family patterns.
- There are genetic vulnerabilities for the disorder. For bulimia nervosa, first-degree relatives of women with bulimia nervosa are about four times more likely than average to have the disorder.

Etiology of Binge-Eating Disorder

As there are shared causes of eating disorders, there is one specific element found for binge-eating disorder. It appears to run in families, which may reflect additive genetic influences.

Sleep-Wake Disorders I

Topic 151-158

Topic 151:

Sleep disorders are among the most common clinical problems encountered in medicine and psychiatry. Sleep disorders involve problems with the quality, timing and amount of sleep, which cause problems with functioning and distress during the daytime. Inadequate or nonrestorative sleep can markedly impair a patient's quality of life. Sleep disorders are often accompanied by depression, anxiety, and cognitive changes that must be addressed in treatment planning and management.

Following disorders fall under this category:

1. Insomnia Disorder
2. Hyper-somnolence Disorder (formally called hypersomnia)
3. Narcolepsy
4. Breathing-related Sleep Disorders
 - Obstructive Sleep Apnea Hypopnea
 - Central Sleep Apnea
 - Sleep-Related Hypoventilation
5. Circadian Rhythm Sleep-wake Disorders
6. Parasomnias
 - Non-Rapid Eye Movement (NREM) Sleep Arousal Disorders
 - Nightmare Disorder
 - Rapid Eye Movement (REM) Sleep Behavior Disorder
 - Restless Legs Syndrome
7. Substance/Medication-induced Sleep Disorder

Topic 152: Insomnia Disorder

Insomnia is a common sleep disorder that can make it hard to fall asleep, hard to stay asleep, or cause you to wake up too early and not be able to get back to sleep. It is characterized by severe difficulty falling asleep or maintaining sleep at least three nights per week. The condition can be short-term (acute) or can last a long time (chronic). It may also come and go.

Diagnostic Criteria:

Following is the diagnostic criteria of insomnia disorder:

- A. A predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms:
 1. Difficulty initiating sleep. (In children, this may manifest as difficulty initiating sleep without caregiver intervention.)
 2. Difficulty maintaining sleep, characterized by frequent awakenings or problems returning to sleep after awakenings. (In children, this may manifest as difficulty returning to sleep without caregiver intervention.)
 3. Early-morning awakening with inability to return to sleep.
- B. The sleep disturbance causes clinically significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
- C. The sleep difficulty occurs at least 3 nights per week.
- D. The sleep difficulty is present for at least 3 months.
- E. The sleep difficulty occurs despite adequate opportunity for sleep.
- F. The insomnia is not better explained by and does not occur exclusively during the course of another sleep-wake disorder (e.g., narcolepsy, a breathing-related sleep disorder, a circadian rhythm sleep-wake disorder, a parasomnia).
- G. The insomnia is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- H. Coexisting mental disorders and medical conditions do not adequately explain the pre-dominant complaint of insomnia.

Specify:

While diagnosing we need to specify if it is with:

- With non-sleep disorder mental comorbidity, including substance use disorders
- With other medical comorbidity
- With other sleep disorder

We also need to specify if it is:

- **Episodic:** Symptoms last at least 1 month but less than 3 months.
- **Persistent:** Symptoms last 3 months or longer.
- **Recurrent:** Two (or more) episodes within the space of 1 year.

Topic 153: Hyper-Somnolence Disorder

Hyper-somnolence is a condition where a person experiences significant episodes of sleepiness, even after having 7 hours or more of quality sleep. One remains extremely drowsy or sleepy during the day even though he/she has slept for what should be long enough to feel refreshed.

Diagnostic Criteria:

- A. Self-reported excessive sleepiness (hyper-somnolence) despite a main sleep period lasting at least 7 hours, with at least one of the following symptoms:
 - 1. Recurrent periods of sleep or lapses into sleep within the same day.
 - 2. A prolonged main sleep episode of more than 9 hours per day that is nonrestorative (i.e., unrefreshing).
- 3. Difficulty being fully awake after abrupt awakening.

- B. The hyper-somnolence occurs at least three times per week, for at least 3 months.
- C. The hyper-somnolence is accompanied by significant distress or impairment in cognitive, social, occupational, or other important areas of functioning.
- D. The hyper-somnolence is not better explained by and does not occur exclusively during the course of another sleep disorder (e.g., narcolepsy, breathing-related sleep disorder, circadian rhythm sleep-wake disorder, or a parasomnia).
- E. The hyper-somnolence is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- F. Coexisting mental and medical disorders do not adequately explain the predominant complaint of hyper-somnolence.

Specify:

While diagnosing we need to specify if it is:

- With mental disorder, including substance use disorders
- With medical condition
- With another sleep disorder

We also need to specify if it is:

- **Acute:** Duration of less than 1 month.
- **Subacute:** Duration of 1-3 months.
- **Persistent:** Duration of more than 3 months.

Specify Current Severity:

Specify severity based on degree of difficulty maintaining daytime alertness as manifested by the occurrence of multiple attacks of irresistible sleepiness within any given day occurring, for example, while sedentary, driving, visiting with friends, or working.

- **Mild:** Difficulty maintaining daytime alertness 1-2 days/week.
- **Moderate:** Difficulty maintaining daytime alertness 3-4 days/week.
- **Severe:** Difficulty maintaining daytime alertness 5-7 days/week.

Similar Criteria for Insomnia & Hyper-somnolence Disorder:

Insomnia & Hyper-somnolence Disorder both has the similar criteria in common:

1. Cause significant distress or impairment in all important areas of functioning.
2. Not better explained by / do not occur exclusively during the course of another sleep-wake disorder
3. Not attributable to the physiological effects of a substance.
4. Coexisting mental disorders and medical conditions do not adequately explain them

Topic 154: Narcolepsy

Narcolepsy is characterized by a repeated sudden and irrepressible need to sleep during waking hours. People with this disorder may also suddenly fall asleep at any time, during any type of activity. Type 1 narcolepsy comes with a sudden loss of muscle tone that causes weakness and makes you unable to control your muscles (cataplexy). Type 2 is narcolepsy without cataplexy.

Diagnostic Criteria:

- A. Recurrent periods of an irrepressible need to sleep, lapsing into sleep, or napping occurring within the same day. These must have been occurring at least three times per week over the past 3 months.
- B. The presence of at least one of the following:
 1. Episodes of cataplexy, defined as either (a) or (b), occurring at least a few times per month:
 - a. In individuals with long-standing disease, brief (seconds to minutes) episodes of sudden bilateral loss of muscle tone with maintained consciousness that are precipitated by laughter or joking.
 - b. In children or in individuals within 6 months of onset, spontaneous grimaces or jaw-opening episodes with tongue thrusting or a global hypotonia, without any obvious emotional triggers.
 2. Hypocretin deficiency, as measured using cerebrospinal fluid (CSF) hypocretin-1 immunoreactivity values (less than or equal to one-third of values obtained in healthy subjects tested

using the same assay, or less than or equal to 110 pg/mL). Low CSF levels of hypocretin-1 must not be observed in the context of acute brain injury, inflammation, or infection.

3. Nocturnal sleep polysomnography showing rapid eye movement (REM) sleep latency less than or equal to 15 minutes, or a multiple sleep latency test showing a mean sleep latency less than or equal to 8 minutes and two or more sleep-onset REM periods.

Specify Current Severity:

- **Mild:** Infrequent cataplexy (less than once per week), need for naps only once or twice per day, and less disturbed nocturnal sleep.
- **Moderate:** Cataplexy once daily or every few days, disturbed nocturnal sleep, and need for multiple naps daily.
- **Severe:** Drug-resistant cataplexy with multiple attacks daily, nearly constant sleepiness, and disturbed nocturnal sleep (i.e., movements, insomnia, and vivid dreaming)

Topic 155: Breathing-related Sleep Disorders

Sleep-related breathing disorders or sleep-disordered breathing are characterized by abnormal respiration during sleep. This category encompasses three relatively distinct disorders:

1. Obstructive sleep apnea hypopnea
2. Central sleep apnea
3. Sleep-related hypoventilation

Obstructive Sleep Apnea Hypopnea:

Obstructive sleep apnea-hypopnea is characterized by repetitive episodes of airflow reduction (hypopnea) or cessation (apnea) due to upper airway collapse during sleep.

Diagnostic Criteria:

- A. Either (1) or (2):
 1. Evidence by polysomnography of at least five obstructive apneas or hypopneas per hour of sleep and either of the following sleep symptoms:
 - a. Nocturnal breathing disturbances: snoring, snorting/gasping, or breathing pauses during sleep.
 - b. Daytime sleepiness, fatigue, or unrefreshing sleep despite sufficient opportunities to sleep that is not better explained by another mental disorder (including a sleep disorder) and is not attributable to another medical condition.

2. Evidence by polysomnography of 15 or more obstructive apneas and/or hypopneas per hour of sleep regardless of accompanying symptoms.

Specify Current Severity:

- **Mild:** Apnea hypopnea index is less than 15.
- **Moderate:** Apnea hypopnea Index is 15-30.
- **Severe:** Apnea hypopnea index is greater than 30.

Central Sleep Apnea:

Central sleep apnea is a disorder in which your breathing repeatedly stops and starts during sleep. It is characterized by frequent awakenings each night due to periodic deprivation of oxygen to the brain during sleep.

Diagnostic criteria:

- A. Evidence by polysomnography of five or more central apneas per hour of sleep.
- B. The disorder is not better explained by another current sleep disorder.

Topic 156: Sleep-Related Hypoventilation

Hypoventilation disorders involve abnormally slow breathing during sleep, also known as respiratory depression. Breathing is restricted in someone with sleep-related hypoventilation, leading to low levels of oxygen or elevated levels of carbon dioxide in the blood.

Diagnostic Criteria:

- A. Polysomnography demonstrates episodes of decreased respiration associated with elevated CO₂ levels. (Note: In the absence of objective measurement of CO₂, persistent low levels of hemoglobin oxygen saturation unassociated with apneic/hypopneic events may indicate hypoventilation.)
- B. The disturbance is not better explained by another current sleep disorder.

Circadian Rhythm Sleep-Wake Disorders

This disorder is characterized by a mismatch between a person's sleep-wake pattern and the sleep-wake schedule of most other people.

Diagnostic Criteria:

- A. A persistent or recurrent pattern of sleep disruption that is primarily due to an alteration of the circadian system or to a misalignment between the endogenous circadian rhythm and the sleep-wake schedule required by an individual's physical environment or social or professional schedule.
- B. The sleep disruption leads to excessive sleepiness or insomnia, or both.

C. The sleep disturbance causes clinically significant distress or impairment in social, occupational, and other important areas of functioning.

Topic 157: Delayed Sleep Phase Type

One more type of Circadian Rhythm Sleep-Wake Disorder is Delayed Sleep Phase Type. It is diagnosed when a person's sleep is delayed by two hours or more beyond what is considered an acceptable or conventional bedtime. This delay occurs when one's internal sleep clock (circadian rhythm) is shifted later at night and later in the morning. But once sleep occurs, the sleep is generally normal.

Diagnostic Features:

The delayed sleep phase type is based primarily on a history of a delay in the timing of the major sleep period (usually more than 2 hours) in relation to the desired sleep and wake-up time, resulting in symptoms of insomnia and excessive sleepiness. When allowed to set their own schedule, individuals with delayed sleep phase type exhibit normal sleep quality and duration for age. Symptoms of sleep-onset insomnia, difficulty waking in the morning, and excessive early day sleepiness are prominent.

Associated Features Supporting Diagnosis

Common associated features of delayed sleep phase type include a history of mental disorders or a concurrent mental disorder. Extreme and prolonged difficulty awakening with morning confusion is also common. Psychophysiological insomnia may develop as a result of maladaptive behaviors that impair sleep and increase arousal because of repeated attempts to fall asleep at an earlier time.

Irregular Sleep-Wake Type

Irregular sleep-wake rhythm is a rare form of circadian rhythm sleep disorder. It is characterized by frequent naps throughout the day with no main nighttime sleep episode.

Diagnostic Features:

The diagnosis of irregular sleep-wake type is based primarily on a history of symptoms of insomnia at night (during the usual sleep period) and excessive sleepiness (napping) during the day. Irregular sleep-wake type is characterized by a lack of discernable sleep-wake circadian rhythm. There is no major sleep period, and sleep is fragmented into at least three periods during the 24-hour day.

Associated Features Supporting Diagnosis:

Individuals with irregular sleep-wake type typically present with insomnia or excessive sleepiness, depending on the time of day. Sleep and wake periods across 24 hours are fragmented, although the

longest sleep period tends to occur between 2:00 A.M. and 6:00 A.M. and is usually less than 4 hours. A history of isolation or reclusion may occur in association with the disorder and contribute to the symptoms via a lack of external stimuli to help entrain a normal pattern. Individuals or their caregivers report frequent naps throughout the day. Irregular sleep-wake type is most commonly associated with neurodegenerative disorders, such as major neurocognitive disorder, and many neurodevelopmental disorders in children.

Topic 158: Non-24-Hour Sleep-Wake Type

The diagnosis of non-24-hour sleep-wake type is based primarily on a history of symptoms of insomnia or excessive sleepiness related to abnormal synchronization between the 24-hour light-dark cycle and the endogenous circadian rhythm. Individuals typically present with periods of insomnia, excessive sleepiness, or both, which alternate with short asymptomatic periods. Starting with the asymptomatic period, when the individual's sleep phase is aligned to the external environment, sleep latency will gradually increase and the individual will complain of sleep-onset insomnia. As the sleep phase continues to drift so that sleep time is now in the daytime, the individual will have trouble staying awake during the day and will complain of sleepiness. Because the circadian period is not aligned to the external 24-hour environment, symptoms will depend on when an individual tries to sleep in relation to the circadian rhythm of sleep propensity.

Associated Features Supporting Diagnosis

Non-24-hour sleep-wake type is most common among blind or visually impaired individuals who have decreased light perception. In sighted individuals, there is often a history of delayed sleep phase and of decreased exposure to light and structured social and physical activity. Sighted individuals with non-24-hour sleep-wake type also demonstrate increased sleep duration.

Shift Work Type

Shift work sleep disorder occurs in individuals who work nontraditional hours like split shift, graveyard shifts, early morning shifts, or rotating shifts. It's characterized by excessive sleepiness, lack of refreshing sleep, and drowsiness.

Diagnostic Features

Diagnosis is primarily based on a history of the individual working outside of the normal 8:00 A.M. to 6:00 P.M. daytime window (particularly at night) on a regularly scheduled (i.e., non-overtime) basis. Symptoms of excessive sleepiness at work, and impaired sleep at home, on a persistent basis are prominent. Presence of both sets of symptoms are usually required for a diagnosis of shift work type.

Typically, when the individual reverts to a day- work routine, symptoms resolve. Although the etiology is slightly different, individuals who travel across many time zones on a very frequent basis may experience effects similar to those experienced by individuals with shift work type who work rotating shifts.

Sleep-Wake Disorders II

Topic 159-163

Topic 159: Parasomnias

Parasomnias are disorders characterized by abnormal behavioral, experiential, or physiological events occurring in association with sleep, specific sleep stages, or sleep-wake transitions. The most common parasomnias, non-rapid eye movement (NREM) sleep arousal disorders and rapid eye movement (REM) sleep behavior disorder, represent a mixtures of wakefulness and NREM sleep and wakefulness and REM sleep, respectively. These conditions serve as a reminder that sleep and wakefulness are not mutually exclusive and that sleep is not necessarily a global, whole-brain phenomenon.

Non-Rapid Eye Movement Sleep Arousal Disorders

Non-rapid eye movement sleep arousal disorders refer to the repeated episodes of incomplete awakening from sleep that include behaviors such as sleepwalking and sleep terrors.

Diagnostic Criteria:

- A. Recurrent episodes of incomplete awakening from sleep, usually occurring during the first third of the major sleep episode, accompanied by either one of the following:
 - **Sleepwalking:** Repeated episodes of rising from bed during sleep and walking about. While sleepwalking, the individual has a blank, staring face; is relatively unresponsive to the efforts of others to communicate with him or her; and can be awakened only with great difficulty.
 - **Sleep terrors:** Recurrent episodes of abrupt terror arousals from sleep, usually beginning with a panicky scream. There is intense fear and signs of autonomic arousal, such as mydriasis, tachycardia, rapid breathing, and sweating, during each episode. There is relative unresponsiveness to efforts of others to comfort the individual during the episodes.
- B. No or little (e.g., only a single visual scene) dream imagery is recalled.
- C. Amnesia for the episodes is present.
- D. The episodes cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- F. Coexisting mental and medical disorders do not explain the episodes of sleepwalking or sleep terrors.

Specify:

While diagnosing we specify whether it sleepwalking type

We also need to specify if it is:

- With sleep-related eating
- With sleep-related sexual behavior (sexsomnia)
- Sleep terror type

Topic 160: Nightmare Disorder

- A. Repeated occurrences of extended, extremely dysphoric, and well-remembered dreams that usually involve efforts to avoid threats to survival, security, or physical integrity and that generally occur during the second half of the major sleep episode.
- B. On awakening from the dysphoric dreams, the individual rapidly becomes oriented and alert.
- C. The sleep disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The nightmare symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- E. Coexisting mental and medical disorders do not adequately explain the predominant complaint of dysphoric dreams.

Specify:

We need to specify if it was during sleep onset

- We also need to specify if it is:
- With associated non-sleep disorder, including substance use disorders
- With associated other medical condition
- With associated other sleep disorder

We also need to specify of it is:

- **Acute:** Duration of period of nightmares is 1 month or less.
- **Subacute:** Duration of period of nightmares is greater than 1 month but less than 6 months.
- **Persistent:** Duration of period of nightmares is 6 months or greater.

Specify current severity:

Severity can be rated by the frequency with which the nightmares occur:

- **Mild:** Less than one episode per week on average.
- **Moderate:** One or more episodes per week but less than nightly.

- **Severe:** Episodes nightly

REM Sleep Behavior Disorder

Rapid eye movement (REM) sleep behavior disorder is a sleep disorder in which you physically act out vivid, often unpleasant dreams with vocal sounds and sudden, often violent arm and leg movements during REM sleep.

Diagnostic Criteria:

- A. Repeated episodes of arousal during sleep associated with vocalization and/or complex motor behaviors.
- B. These behaviors arise during rapid eye movement (REM) sleep and therefore usually occur more than 90 minutes after sleep onset, are more frequent during the later portions of the sleep period, and uncommonly occur during daytime naps.
- C. Upon awakening from these episodes, the individual is completely awake, alert, and not confused or disoriented.
- D. Either of the following:
 1. REM sleep without atonia on polysomnographic recording.
 2. A history suggestive of REM sleep behavior disorder and an established synucleinopathy diagnosis (e.g., Parkinson's disease, multiple system atrophy).
- E. The behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (which may include injury to self or the bed partner).
- F. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- G. Coexisting mental and medical disorders do not explain the episodes.

Topic 161: Restless Legs Syndrome

Restless legs syndrome (RLS) is generally a long-term disorder that causes a strong urge to move one's legs. There is often an unpleasant feeling in the legs that improves somewhat by moving them. This is often described as aching, tingling, or crawling in nature.

Diagnostic Criteria:

- A. An urge to move the legs, usually accompanied by or in response to uncomfortable and unpleasant sensations in the legs, characterized by all of the following:
 1. The urge to move the legs begins or worsens during periods of rest or inactivity.
 2. The urge to move the legs is partially or totally relieved by movement.

3. The urge to move the legs is worse in the evening or at night than during the day, or occurs only in the evening or at night.
- B. The symptoms in Criterion A occur at least three times per week and have persisted for at least 3 months.
- C. The symptoms in Criterion A are accompanied by significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
- D. The symptoms in Criterion A are not attributable to another mental disorder or medical condition (e.g., arthritis, leg edema, peripheral ischemia, leg cramps) and are not better explained by a behavioral condition (e.g., positional discomfort, habitual foot tapping).
- E. The symptoms are not attributable to the physiological effects of a drug of abuse or medication (e.g., akathisia).

Similar Criteria for Nightmare, NREM, REM, Sleep Disorder& Restless Legs Syndrome:

Following are some similar criteria for Nightmare, NREM, REM, Sleep Disorder& Restless Legs Syndrome:

1. These disorders cause significant distress or impairment in all important areas of functioning.
2. Symptoms of these disorders are not attributable to the physiological effects of a substance.
3. Coexisting mental disorders and medical conditions do not adequately explain them.

Topic 163: Substance/Medication-Induced Sleep Disorder

Substance or medication-induced sleep disorder is the official diagnostic name for insomnia and other sleep problems which are caused by the use of alcohol, drugs, or taking certain medications.

Diagnostic Criteria:

- A. A prominent and severe disturbance in sleep.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
 1. The symptoms in Criterion A developed during or soon after substance intoxication or after withdrawal from or exposure to a medication.
 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by a sleep disorder that is not substance/medication-induced. Such evidence of an independent sleep disorder could include the following:

The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-

substance/medication-induced sleep disorder (e.g., a history of recurrent non-substance/medication-related episodes).

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

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Topic 164: Etiology of Sleep-wake disorders

Different factors that can cause sleep problems, which include as given below.

- People may experience disturbed because of certain physical disturbances e.g. pain from ulcers etc. which may lead to development of certain sleep-wake disorders.
- In many sleep-wake disorder, individual experiences breathing problems and such medical issues e.g., asthma may elevate sleep disturbances.
- Psychiatric disorders e.g., depression, anxiety disorders etc. also play a major role in development of these disorders as sleeplessness in a significant symptom in many psychological disorders.
- For a peaceful sleep, environment counts a lot. If an individual's environment is inadequate, and there are different environmental issues e.g., alcohol use or other environmental stressors play an important role in developing sleep related disorders.
- Researchers have found genetic basis for sleep issues like narcolepsy.
- Working the night shift: People who work at night often experience sleep disorders because their activities run contrary to their "biological clocks".
- Different medicines can also interfere with sleep so it could be major reason that predisposes people to different sleep related disorders.
- Aging is another major factor which increases the risk of sleep related disorders. About half of all adults over the age of 65 have some sort of sleep disorder. But this is unclear if it's a usual part of aging or a result of medicines older persons may be using for other physiological or psychological problems.

Disruptive, Impulse Control and Conduct Disorders I

Topic 164-168

Topic 164:

Disruptive, impulse-control, and conduct disorders include conditions involving problems in the self-control of emotions and behaviors. While other disorders in DSM-5 may also involve problems in emotional and/or behavioral regulation, the disorders in this chapter are unique in that these problems are manifested in behaviors that violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or authority figures. The underlying causes of the problems in the self-control of emotions and behaviors can vary greatly across the disorders in this chapter and among individuals within a given diagnostic category.

These disorders are more common in males than in females and tend to have first onset in childhood or adolescence. It is very rare for either conduct disorder or oppositional defiant disorder to first emerge in adulthood. In most cases of conduct disorder previously would have met criteria for oppositional defiant disorder, at least in those cases in which conduct disorder emerges prior to adolescence.

Following disorders fall under this category:

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder (to be discussed later in Personality Disorders)
- Pyromania
- Kleptomania
- Other Specified Disruptive, Impulse-Control, and Conduct Disorders

- Unspecified Disruptive, Impulse-Control, and Conduct Disorders

Topic 165: Oppositional Defiant Disorder

Children and adolescents with oppositional defiant disorder display angry or irritable mood, argumentative or defiant behavior, and vindictiveness that results in significant family or school problems. This disorder is much more extreme than the typical childhood or adolescent rebelliousness, and it is more than a phase. Youths with this disorder repeatedly lose their temper, argue, refuse to do what they are told, and deliberately annoy other people. They are touchy, resentful, belligerent, spiteful, and self-righteous. Rather than seeing themselves as the cause of their problems, they blame other people or insist that they are victims of circumstances. Some young people who behave in this way are more oppositional with their parents than with outsiders, but most have problems in every sphere. To the extent that their behavior interferes with their school performance and social relationships, they lose the respect of teachers and the friendship of peers. These losses can lead them to feel inadequate and depressed. Oppositional defiant disorder typically becomes evident between ages 8 and 12. Pre-adolescent boys are more likely to develop this disorder than are girls of the same age, but after puberty it tends to be equally common in males and females.

Diagnostic Criteria:

- A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry/Irritable Mood

1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful.

Argumentative/Defiant Behavior

4. Often argues with authority figures or, for children and adolescents, with adults.
5. Often actively defies or refuses to comply with requests from authority figures or with rules.
6. Often deliberately annoys others.
7. Often blames others for his or her mistakes or misbehavior.

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past 6 months.

Topic 166: Oppositional Defiant Disorder

Diagnostic Criteria: (In continuation to the previous topic 166)

Note: The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A5). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture.

B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

C. The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.

Specify Current Severity:

- **Mild:** Symptoms are confined to only one setting (e.g., at home, at school, at work, with peers).
- **Moderate:** Some symptoms are present in at least two settings.
- **Severe:** Some symptoms are present in three or more settings.

Topic 167: Intermittent Explosive Disorder

People with intermittent explosive disorder are unable to hold back their urges to express strong angry feelings and associated violent behaviors. They can have angry outbursts that are either verbal (temper tantrums, tirades, arguments) or physical outbursts in which individuals become assaultive or destructive in ways that are out of proportion to any stress or provocation. These physical outbursts, on at least three occasions in a 12-month period, may cause damage to the individual, other people, or property. However, even if individuals show verbal or physical aggression without causing harm, they may still receive this diagnosis. The rage shown by people with this disorder is out of proportion to any particular provocation or stress, and their actions are not premeditated. Afterward, they feel either significantly distressed, suffer interpersonal or occupational consequences, or may suffer financial or legal consequences. The magnitude of their aggressive outbursts is out of proportion to the provocation for their anger. In addition, the outbursts are not premeditated.

Diagnostic Criteria:

- A. Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following;
1. Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of 3 months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals.
 2. Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.

Topic 168: Intermittent Explosive Disorder

Diagnostic Criteria: (In continuation to the previous topic 167)

B. The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors.

C. The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/or anger based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation).

D. The recurrent aggressive outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences.

E. Chronological age is at least 6 years (or equivalent developmental level).

F. The recurrent aggressive outbursts are not better explained by another mental disorder (e.g., major depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, a psychotic disorder, antisocial personality disorder, borderline personality disorder) and are not attributable to another medical condition (e.g., head trauma, Alzheimer's disease) or to the physiological effects of a substance (e.g., a drug of abuse, a medication). For children ages 6-18 years, aggressive behavior that occurs as part of an adjustment disorder should not be considered for this diagnosis.

Note: This diagnosis can be made in addition to the diagnosis of attention-deficit/hyper-activity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder when recurrent impulsive aggressive outbursts are in excess of those usually seen in these disorders and warrant independent clinical attention.

Disruptive, Impulse Control and Conduct Disorders II

Topic 169-174

Topic 169: Conduct Disorder

Children with conduct disorder, a more severe problem, repeatedly violate the basic rights of others. They are often aggressive and may be physically cruel to people or animals, deliberately destroy other people's property, steal or lie, skip school, or run away from home. Many threaten or harm their victims, committing such crimes as fire setting, shoplifting, forgery, breaking into buildings or cars, mugging, and armed robbery. As they get older, their acts of physical violence may include rape or, in rare cases, homicide. Conduct disorder usually begins between 7 and 15 years of age. Between 5 and 10 percent of children, three-quarters of them boys qualify for this diagnosis. Children with a relatively mild conduct disorder often improve over time, but a severe case may continue into adulthood and develop into antisocial personality disorder, another psychological problem, and/or a criminal lifestyle. Usually, the earlier the onset of the conduct disorder, the poorer the eventual outcome. Research indicates that more than 80 percent of those who develop this disorder first display a pattern of oppositional defiant disorder.

Topic 170: Conduct Disorder

Diagnostic Criteria:

- A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:

Aggression to People and Animals

1. Often bullies, threatens, or intimidates others.

2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
7. Has forced someone into sexual activity.

Destruction of Property

8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others' property (other than by fire setting).

Topic 171: Conduct Disorder

Diagnostic Criteria (In continuation to the previous topic 170):

Deceitfulness or Theft

10. Has broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).

Serious Violations of Rules

13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
15. Is often truant from school, beginning before age 13 years.

Topic 172: Conduct Disorder

Diagnostic Criteria (In continuation to the previous topic 171):

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.

Specify whether the disorder is:

Childhood-Onset Type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years.

Adolescent-Onset Type: Individuals show no symptom characteristic of conduct disorder prior to age 10 years.

Unspecified Onset: Criteria for a diagnosis of conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years.

Specify Current Severity:

Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying, truancy, staying out after dark without permission, other rule breaking).

Moderate: The number of conduct problems and the effect on others are intermediate between those specified in “mild” and those in “severe” (e.g., stealing without confronting a victim, vandalism).

Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).

It can be found in diagnostic category of “Personality Disorders”. Since this disorder is closely connected to the spectrum of "externalizing" conduct disorders, therefore it has dual coding.

Externalizing disorders are characterized by more outward-directed behaviors, such as aggressiveness, noncompliance, over activity, and impulsiveness; the category includes attention deficit/hyperactivity disorder, conduct disorder, and oppositional defiant disorder. Internalizing disorders are characterized by more inward-focused experiences and behaviors, such as depression, social withdrawal, and anxiety; the category includes childhood anxiety and mood disorders.

Topic 173: Pyromania

People with pyromania deliberately set fires, feeling tension and arousal before they commit the act. They are fascinated with and curious about fire and its situational contexts, and derive pleasure, gratification, or relief when setting or witnessing fires or while participating in their aftermath. To be diagnosed with pyromania, the individual must not set fires for monetary reasons or have other medical or psychiatric conditions. Arson, by contrast, is deliberate fire setting intended to produce financial gain, and an arsonist does not experience the relief shown by people with pyromania. The majority of people with pyromania are male.

Diagnostic Criteria:

- A. Deliberate and purposeful fire setting on more than one occasion.
- B. Tension or affective arousal before the act.
- C. Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences).
- D. Pleasure, gratification, or relief when setting fires or when witnessing or participating in their aftermath.
- E. The fire setting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one’s living circumstances, in response

to a delusion or hallucination, or as a result of impaired judgment (e.g., in major neurocognitive disorder, intellectual disability [intellectual developmental disorder], substance intoxication).

- F. The fire setting is not better explained by conduct disorder, a manic episode, or antisocial personality disorder.

Topic 174: Kleptomania

People with the impulse-control disorder kleptomania are driven by a persistent urge to steal. Unlike shoplifters or thieves, they don't actually wish to have the object, or the money that it's worth. Instead, they seek excitement from the act of stealing. Despite this, people with kleptomania would rather not be driven to this behavior and feel that their urge is unpleasant, unwanted, intrusive, and senseless. Because they don't really want or need the items that they steal, these people don't have specific uses for them and may give or throw them away.

Diagnostic Criteria:

- A. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.
- B. Increasing sense of tension immediately before committing the theft.
- C. Pleasure, gratification, or relief at the time of committing the theft.
- D. The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination.
- E. The stealing is not better explained by conduct disorder, a manic episode, or antisocial personality disorder.

Disruptive, Impulse Control and Conduct Disorders III

Topic 175-178

Topic 175: Other Specified Disruptive, Impulse-Control, and Conduct Disorder

This category applies to presentations in which symptoms characteristic of a disruptive, impulse-control, and conduct disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the disruptive, impulse-control, and conduct disorders diagnostic class. The other specified disruptive, impulse-control, and conduct disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific disruptive, impulse-control, and conduct disorder. This is done by recording “other specified disruptive, impulse-control, and conduct disorder” followed by the specific reason (e.g., “recurrent behavioral outbursts of insufficient frequency”).

Unspecified Disruptive, Impulse-Control, and Conduct Disorder

This category applies to presentations in which symptoms characteristic of a disruptive, impulse-control, and conduct disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the disruptive, impulse-control, and conduct disorders diagnostic class. The unspecified disruptive, impulse-control, and conduct disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific disruptive, impulse-control, and conduct disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Topic 176: Etiology of Disruptive, Impulse-Control, and Conduct Disorders:

Conduct Disorders:

Many cases of conduct disorder, particularly those marked by destructive behaviors, have been linked to genetic and biological factors. Many cases of conduct disorder, particularly those marked by destructive behaviors, have been linked to genetic and biological factors. A number of cases have also been tied to drug abuse, poverty, traumatic events, and exposure to violent peers or community violence. In addition, conduct disorder is often related to troubled parent–child relationships, inadequate parenting, family conflict, marital conflict, and family hostility. Children, whose parents reject, leave, coerce, or abuse them or fail to provide appropriate and consistent supervision are apparently more likely to develop conduct problems. Children also seem more prone to this disorder when their parents themselves are antisocial, display excessive anger, or have substance use, mood, or schizophrenic disorders.

Topic 177: Etiology of Oppositional Defiant Disorder

There are multiple causes of Oppositional Defiant Disorder. Few of them are discussed below:

- **Personal Factors:** If individual has problems with emotional regulation, it may lead to development of this disorder. Such persons are not able to regulate their emotions as to when to be happy or when to show anger. They have high levels of emotional reactivity i.e. reacting to a situation in a very heightened manner, thus being prone to develop oppositional defiant disorder.
- **Environmental Factors:** Parenting, again, is very important as many of the other psychological disorders. If there is harsh or inconsistent child rearing practices may lead to development of this disorder.
- **Genetic and Physiological Factors:** Genetic and physiological factors have also been identified in development of oppositional defiant disorder. Abnormalities in the prefrontal cortex and amygdala are seen in the individuals with this disorder.

Etiology of Intermittent Explosive Disorder

- **Environmental Factors:** History of physical and emotional trauma during the first two decades of life increases the risk intermittent explosive disorder.
- **Genetic and Physiological:** Substantial genetic influence for impulsive aggression has been found. If first degree relatives or parents have tendencies of the disorder, it increases the likelihood that the next generation may develop intermittent explosive disorder.

Etiology of Conduct Disorder:

- **Personal:** If an individual's infant temperament was difficult to control, i.e. he had temperamental issues right from the beginning, there is a likelihood for him/her to develop conduct disorder. People with lower-than-average intelligence, particularly with regard to verbal IQ, are more prone to develop this disorder.

Topic 178: Etiology of Conduct Disorder

(In continuation to the previous topic 177):

- **Family Factors:** Perhaps more than any other childhood disorder, conduct disorder is defined by the impact of the child's behavior on people and surroundings. So family is of utmost importance in this regard. Parental rejection/neglect, inconsistent child-rearing practices, harsh discipline, physical/sexual abuse, lack of supervision, early institutional living, Frequent changes of caregivers, large family size, parental criminality and familial psychopathology all are contributors in increasing the likelihood of conduct disorder.
- **Community Factors:** Community factors are as important as family factors as it strongly impacts one wellbeing and mental health. Peer rejection and maltreatment, delinquent peer group, and neighborhood, exposure to violence usually lead to development of this order.

- It is important to mention that both types of risk factors i.e. family and community, tend to be more common and severe among individuals with the childhood-onset subtype of conduct disorder
- **Genetic and Physiological Factors:** Predisposing conditions to the development of conduct disorder include being raised in harsh environments involving trauma, abuse, and neglect but Genetic vulnerability may further exacerbate the risk of growing up in such households. Biological or adoptive parent or a sibling with conduct or ADHD disorder increases the risk of conduct disorder. There is a great risk for the offspring for developing the disorder if biological parents are with severe alcohol use disorder, depressive and bipolar disorders, or schizophrenia.

Etiology of Conduct Disorder:

Etiology of Kleptomania

Researcher have found that first-degree relatives of individuals with kleptomania may have higher rates of obsessive-compulsive disorder and substance use disorders, including alcohol use disorder than the general population.

Personality Disorders I

Topic 179-184

Topic 179:

Each of us has a personality, a set of uniquely expressed characteristics that influence our behaviors, emotions, thoughts, and interactions. Our particular characteristics, often called personality traits, lead us to react in fairly predictable ways as we move through life. Yet our personalities are also flexible. We learn from experience. As we interact with our surroundings, we try out various responses to see which feel better and which are more effective. This is a flexibility that people who suffer from a personality disorder usually do not have.

A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible. People with a personality disorder display an enduring, rigid pattern of inner experience and outward behavior that impairs their sense of self, emotional experiences, goals, capacity for empathy, and/or capacity for intimacy. Put another way, they have personality traits that are much more extreme and dysfunctional than those of most other people in their culture, leading to significant problems and psychological pain for themselves or others.

Personality disorders have an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. These disorders are among the most difficult psychological disorders to treat. Many people with the disorders are not even aware of their personality problems and fail to trace their difficulties to their maladaptive style of thinking and behaving.

It is common for a person with a personality disorder to also suffer from another disorder, a relationship called *comorbidity*

DSM-5 identifies 10 personality disorders; often these disorders are separated into three groups, or clusters.

Cluster A: Individuals in this cluster often appear odd or eccentric, it includes:

- Paranoid Personality disorder
- Schizoid Personality disorder
- Schizotypal Personality disorder

Cluster B: Individuals with these disorders often appear dramatic, emotional, or erratic. it includes:

- Antisocial Personality disorder
- Borderline Personality disorder
- Histrionic Personality disorder
- Narcissistic Personality disorder

Cluster C: Individuals with these disorders often appear anxious or fearful. This cluster includes:

- Avoidant Personality disorder
- Dependent Personality disorder
- Obsessive Compulsive Personality disorder

Topic 180: Common Diagnostic criteria of Personality Disorder

- A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
 2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
 3. Interpersonal functioning.
 4. Impulse control.

Topic 181: Common Diagnostic criteria of Personality Disorder

(In continuation to the previous topic 180)

- B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The pattern is stable and of long duration, and Its onset can be traced back at least to adolescence or early adulthood.
- E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.
- F. The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).

Topic 182: Cluster A

The cluster of “odd” personality disorders consists of the paranoid, schizoid, and schizotypal personality disorders. People with these disorders typically have odd or eccentric behaviors that are similar to but not as extensive as those seen in schizophrenia, including extreme suspiciousness, social withdrawal, and peculiar ways of thinking and perceiving things. Directly related or not, people with an odd-cluster personality disorder often qualify for an additional diagnosis of schizophrenia or have close relatives with schizophrenia

Paranoid Personality Disorder:

People with paranoid personality disorder deeply distrust other people and are suspicious of others’ motives. Because they believe that everyone intends them harm, they shun close relationships. Ever on guard and cautious and seeing threats everywhere, people with this disorder continually expect to be the targets of some trickery. They find “hidden” meanings, which are usually belittling or threatening, in

everything. Quick to challenge the loyalty or trustworthiness of acquaintances, people with paranoid personality disorder remain cold and distant. Although inaccurate and inappropriate, their suspicions are not usually delusional; the ideas are not so bizarre or so firmly held as to clearly remove the individuals from reality.

Diagnostic Criteria:

- A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
1. Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
 2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
 3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
 4. Reads hidden demeaning or threatening meanings into benign remarks or events.
 5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
 6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
 7. Have recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.
- B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, or another psychotic disorder and is not attributable to the physiological effects of another medical condition.

Note: If criteria are met prior to the onset of schizophrenia, add “premorbid,” i.e., “paranoid personality disorder (premorbid).”

Topic 183: Schizoid Personality Disorder

People with schizoid personality disorder persistently avoid and are removed from social relationships and demonstrate little in the way of emotion. Like people with paranoid personality disorder, they do not have close ties with other people. The reason they avoid social contact, however, has nothing to do with paranoid feelings of distrust or suspicion; it is because they genuinely prefer to be alone.

People with these traits, often described as “loners,” make no effort to start or keep friendships, take little interest in having sexual relationships, and even seem indifferent to their families. They seek out jobs that require little or no contact with others. When necessary, they can form work relations to a degree, but they prefer to keep to themselves. Many live by themselves as well. Not surprisingly, their social skills tend to be weak. If they marry, their lack of interest in intimacy may create marital or family problems.

People with schizoid personality disorder focus mainly on themselves and are generally unaffected by praise or criticism. They rarely show any feelings, expressing neither joy nor anger. They seem to have no need for attention or acceptance; are typically viewed as cold, humorless, or dull; and generally succeed in being ignored. Men are slightly more likely to experience it than are women, and men may also be more impaired by it.

Diagnostic Criteria:

- A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
 - 1. Neither desires nor enjoys close relationships, including being part of a family.
 - 2. Almost always chooses solitary activities.
 - 3. Has little, if any, interest in having sexual experiences with another person.
 - 4. Takes pleasure in few, if any, activities.
 - 5. Lacks close friends or confidants other than first-degree relatives.

6. Appears indifferent to the praise or criticism of others.
 7. Shows emotional coldness, detachment, or flattened affectivity.
- B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder and is not attributable to the physiological effects of another medical condition.

Topic 184: Schizotypal Personality Disorder

People with schizotypal personality disorder display a range of interpersonal problems marked by extreme discomfort in close relationships, very odd patterns of thinking and perceiving, and behavioral eccentricities. Anxious around others, they seek isolation and have few close friends.

Some feel intensely lonely. The disorder is more severe than the paranoid and schizoid personality disorders.

The thoughts and behaviors of people with schizotypal personality disorder can be noticeably disturbed. These symptoms may include ideas of reference i.e. beliefs that unrelated events pertain to them in some important way—and bodily illusions, such as sensing an external “force” or presence. A number of people with this disorder see themselves as having special extrasensory abilities, and some believe that they have magical control over others. Examples of schizotypal eccentricities include repeatedly arranging cans to align their labels, organizing closets extensively, or wearing an odd assortment of clothing. The emotions of these individuals may be inappropriate, flat, or humorless.

People with schizotypal personality disorder often have great difficulty keeping their attention focused. Correspondingly, their conversation is typically digressive and vague, even sprinkled with loose associations. They tend to drift aimlessly and lead an idle, unproductive life. They are likely to choose undemanding jobs in which they can work below their capacity and are not required to interact with other people.

Diagnostic Criteria:

- A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
1. Ideas of reference (excluding delusions of reference).
 2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or “sixth sense”: in children and adolescents, bizarre fantasies or preoccupations).
 3. Unusual perceptual experiences, including bodily illusions.
 4. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped).
 5. Suspiciousness or paranoid ideation.
 6. Inappropriate or constricted affect.
 7. Behavior or appearance that is odd, eccentric, or peculiar.
 8. Lack of close friends or confidants other than first-degree relatives.
 9. Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.
- B. Does not occur exclusively during the course of schizophrenia, a bipolar disorder or depressive disorder with psychotic features, another psychotic disorder, or autism spectrum disorder.

Personality Disorders II

Topic 185-191

Topic 185: Cluster B

The cluster of “dramatic” personality disorders includes the antisocial, borderline, histrionic, and narcissistic personality disorders. The behaviors of people with these problems are so dramatic, emotional, or erratic that it is almost impossible for them to have relationships that are truly giving and satisfying. These personality disorders are more commonly diagnosed than the others. However, only the antisocial and borderline personality disorders have received much study, partly because they create so many problems for other people.

Antisocial Personality Disorder:

Sometimes described as “psychopaths” or “sociopaths,” people with antisocial personality disorder persistently disregard and violate others’. Aside from substance use disorders, this is the disorder most closely linked to adult criminal behavior. DSM-5 stipulates that a person must be at least 18 years of age to receive this diagnosis; however, most people with antisocial personality disorder displayed some patterns of misbehavior before they were 15, including truancy, running away, cruelty to animals or people, and destroying property.

People with antisocial personality disorder lie repeatedly. Many cannot work consistently at a job; they are absent frequently and are likely to quit their jobs altogether. Usually they are also careless with money and frequently fail to pay their debts. They are often impulsive, taking action without thinking of the consequences. Correspondingly, they may be irritable, aggressive, and quick to start fights. Many travel from place to place.

Recklessness is another common trait: people with antisocial personality disorder have little regard for their own safety or for that of others, even their children. They are self-centered as well, and are likely to have trouble maintaining close relationships. Usually they develop a knack for gaining personal profit at the expense of other people.

Diagnostic Criteria:

- A. A pervasive pattern of disregard for and violation of the rights of others, occurring since age 15 years, as indicated by three (or more) of the following:
 - 1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
 - 2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
 - 3. Impulsivity or failure to plan ahead.
 - 4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
 - 5. Reckless disregard for safety of self or others.
 - 6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
 - 7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
- B. The individual is at least age 18 years.
- C. There is evidence of conduct disorder with onset before age 15 years.
- D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or bipolar disorder.

Topic 186: Borderline Personality Disorder

People with borderline personality disorder display great instability, including major shifts in mood, an unstable self-image, and impulsivity. These characteristics combine to make their relationships very

unstable as well. People with borderline personality disorder swing in and out of very depressive, anxious, and irritable states that last anywhere from a few hours to a few days or more. Their emotions seem to be always in conflict with the world around them. They are prone to bouts of anger, which sometimes result in physical aggression and violence. Just as often, however, they direct their impulsive anger inward and inflict bodily harm on themselves. Many seem troubled by deep feelings of emptiness.

Diagnostic Criteria:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Topic 187: Histrionic Personality Disorder

People with histrionic personality disorder, once called hysterical personality disorder, are extremely emotional; they are typically described as “emotionally charged”, and continually seek to be the center of attention.

People with histrionic personality disorder are always “on stage,” using theatrical gestures and mannerisms and grandiose language to describe ordinary everyday events. Like chameleons, they keep changing themselves to attract and impress an audience, and in their pursuit they change not only their surface characteristics—according to the latest fads—but also their opinions and beliefs. In fact, their speech is actually scanty in detail and substance, and they seem to lack a sense of who they really are. Approval and praise are their lifeblood; they must have others present to witness their exaggerated emotional states. Vain, self-centered, demanding, and unable to delay gratification for long, they overreact to any minor event that gets in the way of their quest for attention. Some make suicide attempts, often to manipulate others. People with histrionic personality disorder may draw attention to themselves by exaggerating their physical illnesses or fatigue

Diagnostic Criteria:

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Is uncomfortable in situations in which he or she is not the center of attention.
2. Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
3. Displays rapidly shifting and shallow expression of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.

7. Is suggestible (i.e., easily influenced by others or circumstances).
8. Considers relationships to be more intimate than they actually are.

Topic 188: Narcissistic Personality Disorders

People with narcissistic personality disorder are generally grandiose, need much admiration, and feel no empathy with others. Convinced of their own great success, power, or beauty, they expect constant attention and admiration from those around them. They exaggerate their achievements and talents, expecting others to recognize them as superior, and often appear arrogant. They are very choosy about their friends and associates, believing that their problems are unique and can be appreciated only by other “special,” high-status people. Because of their charm, they often make favorable first impressions, yet they can rarely maintain long-term relationships. People with narcissistic personality disorder are seldom interested in the feelings of others. They may not even be able to empathize with such feelings. Many take advantage of other people to achieve their own ends, perhaps partly out of envy; at the same time, they believe others envy them. Though grandiose, some react to criticism or frustration with bouts of rage, humiliation, or embitterment. Others may react with cold indifference. And still others become extremely pessimistic and filled with depression. They may have periods of zest that alternate with periods of disappointment.

Diagnostic Criteria:

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.

3. Believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations).
6. Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends).
7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors or attitudes.

Topic 189: Cluster C

The cluster of 'anxious' personality disorders includes the avoidant, dependent and obsessive-compulsive personality disorders. People with these patterns typically display anxious and fearful behavior. Although many of the symptoms of these personality disorders are similar to those of the anxiety and depressive disorders, researchers have not found direct links between this cluster and those disorders.

Avoidant Personality Disorder

People with avoidant personality disorder are very uncomfortable and inhibited in social situations, overwhelmed by feelings of inadequacy, and extremely sensitive to negative evaluation. They are so fearful of being rejected that they give no one an opportunity to reject them—or to accept them either.

Such Individuals actively avoid occasions for social contact. At the center of this withdrawal lies not so much poor social skills as a dread of criticism, disapproval, or rejection. They are timid and hesitant in social situations, afraid to say something foolish or to embarrass themselves by blushing or acting nervous. Even in intimate relationships they express themselves very carefully, afraid of being shamed or ridiculed.

People with this disorder believe themselves to be unappealing or inferior to others. They exaggerate the potential difficulties of new situations, so they seldom take risks or try out new activities. They usually have few or no close friends, though they actually yearn for intimate relationships, and frequently feel depressed and lonely. As a substitute, some develop an inner world of fantasy and imagination.

Diagnostic Criteria:

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1. Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.
2. Is unwilling to get involved with people unless certain of being liked.
3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed. '
4. Is preoccupied with being criticized or rejected in social situations.
5. Is inhibited in new interpersonal situations because of feelings of inadequacy.
6. Views self as socially inept, personally unappealing, or inferior to others.
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Topic 190: Dependent Personality Disorder

People with dependent personality disorder have a pervasive, excessive need to be taken care of. As a result, they are clinging and obedient, fearing separation from their parent, spouse, or other person with whom they are in a close relationship. They rely on others so much that they cannot make the smallest decision for themselves. It is normal and healthy to depend on others, but those with dependent personality disorder constantly need assistance with even the simplest matters and have extreme feelings of inadequacy and helplessness. Afraid that they cannot care for themselves, they cling desperately to

friends or relatives. As discussed previously, people with avoidant personality disorder have difficulty initiating relationships. In contrast, people with dependent personality disorder have difficulty with separation. They feel completely helpless and devastated when a close relationship ends, and they quickly seek out another relationship to fill the void. Many cling persistently to relationships with partners who physically or psychologically abuse them. Lacking confidence in their own ability and judgment, people with this disorder seldom disagree with others and allow even important decisions to be made for them. Their fear of separation and their feelings of helplessness may leave them particularly prone to suicidal thoughts, especially when they believe that a relationship is about to end.

Diagnostic Criteria:

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
2. Needs others to assume responsibility for most major areas of his or her life.
3. Has difficulty expressing disagreement with others because of fear of loss of support or approval.
(Note: Do not include realistic fears of retribution.)
4. Has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy).
5. Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
6. Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
7. Urgently seeks another relationship as a source of care and support when a close relationship ends.

8. Is unrealistically preoccupied with fears of being left to take care of himself or herself.

Topic 191: Obsessive-Compulsive Personality Disorder

People with obsessive-compulsive personality disorder are so preoccupied with order, perfection, and control that they lose all flexibility, openness, and efficiency. Their concern for doing everything “right” impairs their productivity. When faced with a task, people with obsessive-compulsive personality disorder may become so focused on organization and details that they fail to grasp the point of the activity. As a result, their work is often behind schedule (some seem unable to finish any job), and they may neglect leisure activities and friendships.

People with this personality disorder set unreasonably high standards for themselves and others. Their behaviors extend well beyond the realm of conscientiousness. They can never be satisfied with their performance, but they typically refuse to seek help or to work with a team, convinced that others are too careless or incompetent to do the job right. They also tend to be rigid and stubborn, particularly in their morals, ethics, and values.

Diagnostic Criteria:

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- a. Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
- b. Shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met).
- c. Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).

- d. Is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
- e. Is unable to discard worn-out or worthless objects even when they have no sentimental value.
- f. Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
- g. Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
- h. Shows rigidity and stubbornness

Personality Disorders III

Topic 192-196

Topic 192: Personality Change Due to another Medical Condition

Personality change due to another medical condition is a persistent personality disturbance that is judged to be due to the direct physiological effects of a medical condition (e.g., frontal lobe lesion).

Diagnostic Criteria:

- A. A persistent personality disturbance that represents a change from the individual's previous characteristic personality pattern.

Note: In children, the disturbance involves a marked deviation from normal development or a significant change in the child's usual behavior patterns, lasting at least 1 year.

- B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- C. The disturbance is not better explained by another mental disorder (including another mental disorder due to another medical condition).
- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Topic 193: Etiology of Personality Disorders

Clinicians have learned much about the symptoms of personality disorders but have not been so successful in determining their causes. Origin of these disorders is a matter of considerable controversy to different theorists. They find it difficult to explain personality disorder e.g. theorists belonging to

behavioristic school of thought do not believe in personality rather they believe in behavior that it gets changed in relation to the environment we live in.

Traditional thinking holds dysfunctional early environments that prevent the evolution of adaptive patterns of perception, response, and defense leads of development of these disorders.

Pathophysiology Factors: In people with personality disorders, abnormalities may be seen in the frontal, temporal, and parietal lobes. If there are any structural and functional changes in these lobes, they can cause personality changes. These abnormalities may be caused by perinatal injury, trauma, or genetics. Diminished monoamine oxidase (MAO), an enzyme involved in the degradation process for various monoamines released by neurons and glia cells and imbalances serotonin levels are also connected to personality disorders. However, the relationships of anatomy, receptors, and neurotransmitters to personality disorders are purely speculative at this point.

Genetic Factors: Though no clear cut gene has been identified in this regard, it has been found that first-degree biological relatives of individuals with schizophrenia are more vulnerable to develop personality disorder than among the general population.

Topic 194: Etiology of Antisocial Personality Disorder

Genetic Factors: Genetic contribution is strongly supported in development of antisocial personality disorder. Adoption studies reveal a higher-than-normal prevalence of antisocial behavior in adopted children of biological parents with APD and substance abuse. Neuro brain chemistry and neuro brain chemical changes i.e. Serotonergic dysregulation in the septohippocampal system have also been found contributing in this regard. There may also be developmental or acquired abnormalities in the prefrontal brain systems and reduced autonomic activity. This may underlie the low arousal, poor fear conditioning, and decision-making deficits described in antisocial personality disorder.

Etiology of Borderline Personality Disorder:

Psychosocial Factors:

People with BPD are much more likely to report a history of parental separation, verbal abuse, and emotional abuse during childhood than are people diagnosed with other personality disorders. Early abuse (sexual, physical, and emotional) and borderline syndrome is often formulated as a variant of posttraumatic stress disorder.

Genetic Factors: Mood disorders in first-degree relatives are strongly linked to development of Borderline Personality Disorder. Biological factors, such as abnormal monoaminergic functioning and prefrontal neuropsychological dysfunction, have been implicated in this regard but have not been well established by research.

Topic 195: Etiology of Histrionic Personality Disorder

Genetic Factors: There is very little research evidence to determine the biologic sources of this disorder. The psychodynamic perspective was originally developed to help explain cases of hysteria so it is no surprise that psychodynamic theorists continue to have a strong interest in histrionic personality disorder and psychoanalytic theories incriminate seductive and authoritarian attitudes by fathers of these patients. Most psychodynamic theorists believe that as children, people with this disorder had cold and controlling parents who left them feeling unloved and afraid of abandonment. To defend against deep-seated fears of loss, the children learned to behave dramatically, inventing crises that would require other people to act protectively.

Etiology of Narcissistic Personality Disorder:

As with histrionic personality disorder, no data on biological features of development of this disorder is available. Psychodynamic theorists more than others have theorized about narcissistic personality disorder, and they again propose that the problem begins with cold, rejecting parents.

They argue that some people with this background spend their lives defending against feeling unsatisfied, rejected, unworthy, ashamed, and wary of the world. They do so by repeatedly telling themselves that they are actually perfect and desirable, and also by seeking admiration from others. So, narcissism functions as a defense against awareness of low self-esteem.

More modern psychodynamic models postulate that this disorder can arise from an imbalance between positive mirroring of the developing child and the presence of an adult figure who can be idealized.

Topic 196: Etiology of Avoidant Personality Disorder

No data on biological causes of avoidant personality disorder is available. Theorists often assume that avoidant personality disorder has the same causes as anxiety disorders, such as early traumas, conditioned fears, upsetting beliefs, or biochemical abnormalities. However, with the exception of social anxiety disorder, research has not clearly tied the personality disorder directly to the anxiety disorders. So people with Extreme traits of introversion and neuroticism are more likely to develop borderline personality disorder.

Etiology of dependent personality Disorder:

No studies of genetics or of biological traits related to this disorder are available. Psychodynamic explanations for dependent personality disorder are very similar to those for depression. Psychodynamic theorists focus mainly on the general feelings of shame and insecurity that people with avoidant personality disorder have. Avoidant personality disorder is caused due to an insecure form of attachment to others, which may be the result of clinging parental behavior.

Etiology of Obsessive-compulsive Personality Disorder:

Modest evidence points toward the heritability of this disorder.

Freudian theorists suggest that people with obsessive-compulsive personality disorder are anal retentive. That is, because of overly harsh toilet training during the anal stage, they become filled with anger, and

they remain fixated at this stage. To keep their anger under control, they persistently resist both their anger and their instincts to have bowel movements. In turn, they become extremely orderly and restrained; many become passionate collectors. Other psychodynamic theorists suggest that any early struggles with parents over control and independence may ignite the aggressive impulses at the root of this personality disorder. Psychodynamically, these patients are viewed as needing control as a defense against shame or powerlessness.

Psychosexual Disorders/ Paraphilic disorders I

Topic 197-201

Topic 197:

Sexuality is one of the most personal areas of life. Each of us is a sexual being with preferences and fantasies that may surprise or even shock us from time to time. Usually these are part of normal sexual functioning. But when our fantasies or desires begin to affect us or others in unwanted or harmful ways, they begin to qualify as abnormal.

When it comes to sexuality, deciding which patterns of behavior represent psychological disorders becomes more complicated, perhaps, than in other areas of human behavior. When evaluating the “normality” of a given sexual behavior, the context is extremely important, as are customs and mores, which change over time. Attitudes and behaviors related to sexuality are continually evolving.

Sexual dysfunctions are a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure.

There are two major categories of this group of disorders:

1. Paraphilic Disorders
2. Gender dysmorphic Disorder

Paraphilic Disorders:

This is a group of disorders recurrent sexual attraction to an unusual objects or sexual activities lasting at least 6 months. DSM differentiates the paraphilias based on the source of sexual satisfaction.

The term paraphilia (para meaning “faulty” or “abnormal” and philia meaning “attraction”) literally means a deviation involving the object of a person’s sexual attraction. Paraphilias are behaviors in which an individual has recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving (1) nonhuman objects, (2) children or other non-consenting persons, or (3) the suffering or humiliation of self or partner. Clinicians diagnose Paraphilic disorder when the paraphilia causes intense distress and impairment. Thus, a person’s “non-normative” (i.e., unusual) sexual behavior is not pathological in and of itself. Only when these fantasies, urges, or behaviors involve “recurrent and intense sexual arousal” that cannot be achieved in another fashion are they regarded as symptoms of a psychological disorder.

The essential feature of a Paraphilic disorder, then, is that people with one of these disorders are so psychologically dependent on the target of their desire that they are unable to experience sexual arousal unless this target is present in some form. Even if people with these disorders do not actually fulfill their urges or fantasies, they are obsessed with thoughts about carrying them out. Their attraction can become so strong and compelling that they lose sight of any goals other than achieving sexual fulfillment in this specific way. During periods in which the individual feels especially stressed, the symptoms may become more intense.

Following disorders fall under this category of disorders:

1. Voyeuristic Disorder
2. Exhibitionistic Disorder
3. Frotteuristic Disorder
4. Sexual Masochism
5. Sexual Sadism Disorder
6. Pedophilic Disorder
7. Fetishistic Disorder
8. Transvestic Disorder

Common Diagnostic Criteria for the above mentioned disorders:

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from any source in the process of disrobing, or engaging in sexual activity and manifested by fantasies, urges, or behaviors.
- B. The individual has acted on these sexual urges with a non-consenting person,
- C. the sexual urges or fantasies cause clinically significant distress or impairment in all important areas of functioning

Topic 198: Voyeuristic Disorder

In this disorder, and individual derive sexual pleasures from observing nudity or sexual activity of others. Voyeuristic disorder involves an intense and recurrent desire to obtain sexual gratification by watching unsuspecting others in a state of undress or having sexual relations. For some men with this disorder, voyeurism is their only sexual activity; for others, it is preferred but not absolutely essential for sexual arousal

Diagnostic Criteria:

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, as manifested by fantasies, urges, or behaviors.
- B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The individual experiencing the arousal and/or acting on the urges is at least 18 years of age.

Specify:

We need to specify if the disorder is:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in voyeuristic behavior are restricted.

In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Exhibitionistic Disorder:

Exhibitionistic disorder is a recurrent, intense desire to obtain sexual gratification by exposing one's genitals to an unwilling stranger, sometimes a child. It typically begins in adolescence. As with voyeuristic disorder, there is seldom an attempt to have actual contact with the stranger. The urge to expose seems overwhelming and virtually uncontrollable to the exhibitionist and is apparently triggered by anxiety and restlessness as well as by sexual arousal. Because of the compulsive nature of the urge, the exposures may be repeated often and even in the same place and at the same time of day. At the time of the act, the social and legal consequences are far from exhibitionists' minds.

Diagnostic Criteria:

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges, or behaviors.
- B. The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify whether:

Sexually aroused by exposing genitals to pre-pubertal children

Sexually aroused by exposing genitals to physically mature individuals

Sexually aroused by exposing genitals to pre-pubertal children and to physically mature individuals

Specify if;

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to expose one's genitals are restricted.

In full remission: The individual has not acted on the urges with a non-consenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Frotteuristic Disorder:

Frotteuristic disorder involves the sexually oriented touching of an unsuspecting person. The frotteur may rub his penis against a woman's thighs or buttocks or fondle her breasts or genitals.

These attacks typically occur in places such as a crowded bus or sidewalk that provide an easy means of escape. Frotteuristic disorder has not been studied very extensively. It typically occurs along with other paraphilias. Most men who engage in frotteurism report doing so dozens of times.

Diagnostic Criteria:

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from touching or rubbing against a non-consenting person, as manifested by fantasies, urges, or behaviors.
- B. The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to touch or rub against a nonconsenting person are restricted.

In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Topic 199: Sexual Masochism Disorder

Sexual masochism disorder is defined by an intense and recurrent desire to obtain or increase sexual gratification through being subjected to pain or humiliation. This arousal may take such forms as fantasies, urges, or behaviors. Many people have fantasies of being forced into sexual

acts against their will, but only those who are very distressed or impaired by the fantasies receive this diagnosis. Some people with the disorder act on the masochistic urges by themselves, perhaps tying, sticking pins into, or even cutting themselves. Others have their sexual partners restrain, tie up, blindfold, spank, paddle, whip, beat, electrically shock, “pin and pierce,” or humiliate them.

Diagnostic Criteria:

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors.
- B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify:

We need to specify if the disorder is:

With asphyxiophilia: If the individual engages in the practice of achieving sexual arousal related to restriction of breathing.

We also need to specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in masochistic sexual behaviors are restricted.

In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment.

Sexual Sadism Disorder:

Sexual sadism disorder is defined by an intense and recurrent desire to obtain or increase sexual gratification by inflicting pain or psychological suffering (such as humiliation) on another. This arousal

may be expressed through fantasies, urges, or behaviors, including acts such as dominating, restraining, blindfolding, cutting, strangling, mutilating, or even killing the victim.

Diagnostic Criteria:

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors.
- B. The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in sadistic sexual behaviors are restricted.

In full remission: The individual has not acted on the urges with a non-consenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Pedophilic Disorder:

This disorder is diagnosed when adults derive sexual gratification through sexual contact with pre-pubertal or pubescent children, or when they experience recurrent, intense, and distressing desires for sexual contact with pre-pubertal or pubescent children. Those with the disorder may be attracted to prepubescent children (classic type), early pubescent children (hebephilic type), or both (pedohebephilic type).

Some people with pedophilic disorder are satisfied by child pornography or seemingly innocent material such as children's underwear ads; others are driven to actually watch, touch, fondle, or engage in sexual intercourse with children. Some people with the disorder are attracted only to children; others are attracted to adults as well.

Diagnostic Criteria:

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).
- B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

- C. The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

Specify whether:

- Exclusive type (attracted only to children)
- Nonexclusive type

Specify if:

- Sexually attracted to males
- Sexually attracted to females
- Sexually attracted to both

Specify if:

- Limited to incest

Topic 200: Fetishistic Disorder

One relatively common paraphilic disorder is fetishistic disorder. Key features of this disorder are recurrent intense sexual urges, sexually arousing fantasies, or behaviors that involve the use of a nonliving object or no genital body part, often to the exclusion of all other stimuli. Usually the disorder, which is far more common in men than in women, begins in adolescence. Almost anything can be a fetish; women's underwear, shoes, and boots are particularly common. Some people with this disorder steal in order to collect as many of the desired objects as possible. The objects may be touched, smelled, worn, or used in some other way while the person masturbates, or the person may ask a partner to wear the object when they have sex.

Diagnostic Criteria:

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on non-genital body part(s), as manifested by fantasies, urges, or behaviors.
- B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The fetish objects are not limited to articles of clothing used in cross-dressing (as in transvestic disorder) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator).

Specify:

Body part(s)

Nonliving object(s)

Other

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in fetishistic behaviors are restricted.

In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment.

Transvestic Disorder:

A person with transvestic disorder, also known as transvestism or cross-dressing, feels recurrent and intense sexual arousal from dressing in clothes of the opposite gender—arousal expressed through fantasies, urges, or behaviors.

Diagnostic Criteria:

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviors.
- B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

With fetishism: If sexually aroused by fabrics, materials, or garments.

Specify if:

With autogynephilia: If sexually aroused by thoughts or images of self as female.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to cross-dress are restricted,

In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment.

Topic 201: Etiology of Paraphilic Disorders

Neurobiological Factors: Because the overwhelming majority of people with paraphilias are men, there has been speculation that androgens (hormones like testosterone) play a role. Androgens regulate sexual desire, and sexual desire appears to be atypically high among people with paraphilias. Nonetheless, men with paraphilias do not appear to have high levels of testosterone or other androgens. If biology turns out to be important, it most likely will be but one factor in a complex network of causes that includes experience as a major player.

Psychological Factors: Most psychological theories of the paraphilias involve a set of risk factors.

Dominant models emphasize conditioning experiences, relationship histories, abuse, and cognition. Some behavioral theorists view the cause of paraphilias as classical conditioning that by chance has linked sexual arousal with unusual or inappropriate stimuli. From an operant conditioning perspective, some paraphilias, such as exhibitionistic disorder and pedophilic disorder, are considered an outcome of inadequate social skills. Evidence does indicate that men with pedophilic disorder often have poor social skills. These paraphilias may thus be activities that substitute for more conventional relationships and sexual activity. On the other hand, the fact that many pedophiles and exhibitionists have conventional social and sexual relationships indicates that the issue is more complex than a simple absence of non-deviant sexual outlets.

Other Risk Factors: The childhood histories of people with paraphilias reveal that often they were exposed to physical abuse, sexual abuse, and poor parent–child relationships. In studies of adult offenders, rates of sexual abuse are more than threefold higher among sexual offenders compared to those charged with nonsexual offenses and are particularly high among those charged with sexual offenses against children.

Some research suggests that alcohol and negative affect are often the immediate triggers of incidents of pedophilic, voyeuristic, and exhibitionistic disorders. This is consistent with evidence that alcohol decreases inhibition. Deviant sexual activity, like alcohol use, may be a means of escaping from negative affect. Moreover, there is a connection between paraphilic disorders and anti-social personality.

Psychosexual Disorders II

Topic 202-205

Topic 202: Gender Dysphoria

Previously known as gender identity disorder, the term gender dysphoria refers to distress that may accompany the incongruence between a person's experienced or expressed gender and that person's assigned gender. Before getting into the details of the disorder, we need to get familiarized with the following few terminologies:

Transgender:

It refers to the broad spectrum of individuals who transiently or persistently identifies with a gender different from their natal gender.

Transsexual

This denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery i.e. *Reassignment Surgery*.

Gender Dysphoria

It is an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category.

Not everyone experiences distress as the result of this incongruence but, importantly, many people are distressed if they are unable to receive treatment through hormones and/or surgery. Thus, in the current criteria for disorder, the individual experiences identification with the other sex. The feeling that they are "in the wrong body" causes feelings of discomfort and a sense of inappropriateness about their assigned gender. Both of these conditions must be present for a clinician to assign the diagnosis. Thus, the clinical problem is the dysphoria, not the individual's gender identity.

Topic 203: Gender Dysphoria

Similar Diagnostic Criteria for Children & Adults:

- A. A marked incongruence between one's experienced / expressed gender and assigned gender, of at least 6 months' duration.

- B. Causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender Dysphoria in Children Diagnostic Criteria:

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 3. A strong preference for cross-gender roles in make-believe play or fantasy play.
 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
 5. A strong preference for playmates of the other gender.
 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
 7. A strong dislike of one's sexual anatomy.
 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Topic 204: Gender Dysphoria in Adolescents and Adults Diagnostic Criteria

- i. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- ii. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

Topic 205: Etiology of Gender Dysphoria

Although such features of dysphoria have been documented, the cause of gender dysphoria has been hard to sort out. The causes of gender dysphoria are currently unknown, but genes, hormonal influences in the womb, and environmental factors are all suspected to be involved.

Psychological Factors: Early-onset gender dysphoria develops in early preschool age. A high degree of atypicality may develop gender dysphoria and its persistence into adolescence and adulthood is more likely.

Environmental Factors: Males with gender dysphoria (in both childhood, adolescence) commonly have older brothers than do males without the condition. Surveys reveal that 90 percent of transgender persons experience at least a moderate degree of distress or dysfunction at home, school, or work, or in social relationships, especially during adolescence.

Environmental Factors: Habitual fetishistic transvestism developing into autogynephilia (i.e., sexual arousal associated with the thought or image of oneself as a woman).

Neurocognitive Disorders I

Topic 206-211

Topic 206:

The brain's functioning affects our abilities to think, remember, and pay attention. There are many sources of insults or injuries that can affect an individual's brain, including trauma, disease, or exposure to toxic substances, including drugs. As the seat of all thoughts, actions, motivations, and memories, the brain, when damaged, can cause a variety of symptoms.

Neurocognitive Disorders are a group of disorders in which the primary clinical deficit is in cognitive function, and they are acquired rather than developmental. Impaired cognition has not been present since birth or very early life, and thus represents a decline from a previously attained level of functioning. Although cognitive deficits are present in many mental disorders (e.g., schizophrenia, bipolar disorders), only disorders whose core features are cognitive are included in the NCD category.

Clinicians use neuropsychological testing and neuroimaging techniques, as well as an individual's medical history, to decide whether an individual's symptoms fall into the category of a cognitive disorder.

In previous versions of DSM, NCDs were referred to as Dementia, Delirium, Amnesic and Other Cognitive Disorder. Dementia was a major category among them and it was confined to old age. NCDs Begin with Delirium (confused state of mind), followed by the syndromes of major and mild NCD, and their etiological subtypes.

Topic 207:

In DSM V, the mild or major Neurocognitive Disorders subtypes are:

- Neurocognitive Disorders with Lewy bodies
- Vascular Neurocognitive Disorders
- Fronto-temporal Neurocognitive Disorders
- Substance/medication-induced Neurocognitive Disorders

Mild or Major Neurocognitive Disorders are due to:

- Alzheimer's disease
- Traumatic brain injury
- HIV infection

- Parkinson's disease
- Huntington's disease
- Another medical condition
- Multiple etiologies
- Unspecified NCD.

Delirium:

Delirium is a major disturbance in attention and orientation to the environment. As the person's focus becomes less clear, he or she has great difficulty concentrating and thinking in an organized way, leading to misinterpretations, illusions, and on occasion, hallucinations. Sufferers may believe that it is morning in the middle of the night or that they are home when actually they are in a hospital room. This state of massive confusion typically develops over a short period of time, usually hours or days. Delirium may occur in any age group, including children, but is most common in elderly people.

Diagnostic Criteria:

- i. A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment).
- ii. The disturbance develops over a short period of time (usually hours to a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day.
- iii. An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception).
- iv. The disturbances in Criteria A and C are not better explained by another preexisting, established, or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal, such as coma.
- v. There is evidence from the history, physical examination, or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal (i.e., due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple etiologies.

Specify whether:

Substance intoxication delirium: This diagnosis should be made instead of substance intoxication when the symptoms in Criteria A and C predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

Topic 208: Similar diagnostic Criteria for NSDs

- A. Evidence of cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:
 - 1. Concern of the individual, a knowledgeable informant, or clinician that there has been decline in cognitive function
 - 2. Impairment in cognitive performance, preferably documented by standardized Neuropsychological testing or another quantified clinical assessment.
- B. The cognitive deficits affects everyday activities.
- C. Do not occur exclusively in the context of a delirium.
- D. Are not better explained by another mental disorder.

Topic 209:

(Similar diagnostic Criteria for NSDs:

In continuation to the previous topic 208)

- E. The criteria are met for major or mild neurocognitive disorder.
- F. There is insidious onset and gradual progression of impairment in one or more cognitive domains (for major neurocognitive disorder, at least two domains must be impaired)

Specify:

Without behavioral disturbance: If the cognitive disturbance is not accompanied by any clinically significant behavioral disturbance.

With behavioral disturbance: If the cognitive disturbance is accompanied by a clinically significant behavioral disturbance (e.g. psychotic symptoms).

Specify Current Severity:

Mild: Difficulties with instrumental activities of daily living (e.g., housework).

Moderate: Difficulties with basic activities of daily living (e.g., feeding).

Severe: Fully dependent.

Topic 210: Neurocognitive disorders due to Alzheimer's Disease

Neurocognitive disorder due to Alzheimer's disease is a neurocognitive disorder associated with progressive, gradual declines in memory, learning, and at least one other cognitive domain. The first symptoms of memory loss precede a cascade of changes that eventually end in death due to a complication such as pneumonia.

Diagnostic Criteria:

- A. The criteria are met for major or mild neurocognitive disorder.
- B. There is insidious onset and gradual progression of impairment in one or more cognitive domains (for major neurocognitive disorder, at least two domains must be impaired).
- C. Criteria are met for either probable or possible Alzheimer's disease as follows:

For major neurocognitive disorder:

Probable Alzheimer's disease is diagnosed if either of the following is present; otherwise, **possible Alzheimer's disease** should be diagnosed.

1. Evidence of a causative Alzheimer's disease genetic mutation from family history or genetic testing.
2. All three of the following are present:
 - a. Clear evidence of decline in memory and learning and at least one other cognitive domain (based on detailed history or serial neuropsychological testing).
 - b. Steadily progressive, gradual decline in cognition, without extended plateaus.
 - c. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline).

For Mild Neurocognitive Disorder:

Probable Alzheimer's disease is diagnosed if there is evidence of a causative Alzheimer's disease genetic mutation from either genetic testing or family history.

Possible Alzheimer's disease is diagnosed if there is no evidence of a causative Alzheimer's disease genetic mutation from either genetic testing or family history, and all three of the following are present:

1. Clear evidence of decline in memory and learning.

2. Steadily progressive, gradual decline in cognition, without extended plateaus.
3. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological or systemic disease or condition likely contributing to cognitive decline).

D. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

Frontotemporal Neurocognitive Disorder:

As suggested by the name, the problems are caused by a loss of neurons in frontal and temporal regions of the brain. The neuronal deterioration of FTD occurs predominantly in the anterior temporal lobes and prefrontal cortex. This problem typically begins in the mid- to late 50s, and it progresses rapidly; death usually occurs within 5–10 years of the diagnosis.

Diagnostic Criteria:

A. The criteria are met for major or mild neurocognitive disorder.

B. The disturbance has insidious onset and gradual progression.

C. Either (1) or (2);

1. Behavioral variant;

a. Three or more of the following behavioral symptoms:

- I. Behavioral disinhibition.
- II. Apathy or inertia.
- III. Loss of sympathy or empathy.
- IV. Perseverative, stereotyped or compulsive/ritualistic behavior.
- V. Hyperorality and dietary changes.

b. Prominent decline in social cognition and/or executive abilities.

2. Language variant:

- a. Prominent decline in language ability, in the form of speech production, word finding, object naming, grammar, or word comprehension.

D. Relative sparing of learning and memory and perceptual-motor function.

E. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

Topic 211: Neurocognitive disorders due to Lewy Bodies

Neurocognitive disorder with Lewy bodies, which researchers first identified in 1961, is similar to Alzheimer's disease, with progressive loss of memory, language, calculation, and reasoning, as well as other higher mental function. However, the progress of the illness may be more rapid than what we see in Alzheimer's disease. Lewy bodies are tiny, spherical structures consisting of protein deposits in dying nerve cells found in damaged regions deep within the brains of people with Parkinson's disease. A clinician diagnoses this condition when Lewy bodies are more diffusely dispersed throughout the brain.

Diagnostic Criteria:

- A. The criteria are met for major or mild neurocognitive disorder.
- B. The disorder has an insidious onset and gradual progression.
- C. The disorder meets a combination of core diagnostic features and suggestive diagnostic features for either probable or possible neurocognitive disorder with Lewy bodies.

For probable major or mild neurocognitive disorder with Lewy bodies, the individual has two core features, or one suggestive feature with one or more core features.

For possible major or mild neurocognitive disorder with Lewy bodies, the individual has only one core feature, or one or more suggestive features.

1. Core diagnostic features:

- a. Fluctuating cognition with pronounced variations in attention and alertness.
- b. Recurrent visual hallucinations that is well formed and detailed.
- c. Spontaneous features of parkinsonism, with onset subsequent to the development of cognitive decline.

2. Suggestive diagnostic features;

- a. Meets criteria for rapid eye movement sleep behavior disorder.
- b. Severe neuroleptic sensitivity.

D. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

Vascular Neurocognitive Disorders:

Another possible cause of neurocognitive disorder is cardiovascular disease affecting the supply of blood to the brain. This condition, called vascular neurocognitive disorder, is highly prevalent and researchers link it to a variety of cardiovascular risk factors.

Diagnostic Criteria:

- A. The criteria are met for major or mild neurocognitive disorder.
- B. The clinical features are consistent with a vascular etiology, as suggested by either of the following:
 - 1. Onset of the cognitive deficits is temporally related to one or more cerebrovascular events.
 - 2. Evidence for decline is prominent in complex attention (including processing speed) and frontal-executive function.
- C. There is evidence of the presence of cerebrovascular disease from history, physical examination, and/or neuroimaging considered sufficient to account for the neurocognitive deficits.
- D. The symptoms are not better explained by another brain disease or systemic disorder.

Probable vascular neurocognitive disorder is diagnosed if one of the following is present, otherwise possible vascular neurocognitive disorder should be diagnosed:

- 1. Clinical criteria are supported by neuroimaging evidence of significant parenchymal injury attributed to cerebrovascular disease (neuroimaging-supported).
- 2. The neurocognitive syndrome is temporally related to one or more documented cerebrovascular events.
- 3. Both clinical and genetic (e.g., cerebral autosomal dominant arterio-pathy with subcortical infarcts and leukoencephalopathy) evidence of cerebrovascular disease is present.

Possible vascular neurocognitive disorder is diagnosed if the clinical criteria are met but neuroimaging is not available and the temporal relationship of the neurocognitive syndrome with one or more cerebrovascular events is not established.

Neurocognitive Disorders II

Topic 212-217

Topic 212: Neurocognitive Disorders Due to Traumatic Brain Injury

Trauma to the head that results in an alteration or loss of consciousness, or post-traumatic amnesia, is called traumatic brain injury (TBI). The diagnostic criteria for neurocognitive disorder due to traumatic brain injury require evidence of impact to the head along with loss of consciousness, amnesia following the trauma, disorientation and confusion, and neurological abnormalities such as seizures. The symptoms must occur immediately after the trauma or after recovering consciousness, and past the acute post injury period.

Diagnostic Criteria:

- A. The criteria are met for major or mild neurocognitive disorder.
- B. There is evidence of a traumatic brain injury—that is, an impact to the head or other mechanisms of rapid movement or displacement of the brain within the skull, with one or more of the following:
 - 1. Loss of consciousness.
 - 2. Posttraumatic amnesia.
 - 3. Disorientation and confusion.
 - 4. Neurological signs (e.g., neuroimaging demonstrating injury; a new onset of seizures; a marked worsening of a preexisting seizure disorder; visual field cuts; anosmia; hemiparesis).
- C. The neurocognitive disorder presents immediately after the occurrence of the traumatic brain injury or immediately after recovery of consciousness and persists past the acute post-injury period.

Substance/Medication-Induced Neurocognitive Disorder:

Diagnostic Criteria:

- A. The criteria are met for major or mild neurocognitive disorder.
- B. The neurocognitive impairments do not occur exclusively during the course of a delirium and persist beyond the usual duration of intoxication and acute withdrawal.
- C. The involved substance or medication and duration and extent of use are capable of producing the neurocognitive impairment.

- D. The temporal course of the neurocognitive deficits is consistent with the timing of substance or medication use and abstinence (e.g., the deficits remain stable or improve after a period of abstinence).

Topic 213: Neurocognitive Disorders Due to HIV Infection

HIV (human immunodeficiency virus) is a virus that damages the immune system. The immune system helps the body fight off infections.

Diagnostic Criteria:

- A. The criteria are met for major or mild neurocognitive disorder.
- B. There is documented infection with human immunodeficiency virus (HIV).
- C. The neurocognitive disorder is not better explained by non-HIV conditions, including secondary brain diseases such as progressive multifocal leukoencephalopathy or cryptococcal meningitis.
- D. The neurocognitive disorder is not attributable to another medical condition and is not better explained by a mental disorder.

Neurocognitive Disorders Due to Parkinson's Disease:

Parkinson's disease, the slowly progressive neurological disorder marked by tremors, rigidity, and unsteadiness, can result in neurocognitive disorder due to Parkinson's disease, particularly in older people or those whose cases are advanced.

Diagnostic Criteria:

- A. The criteria are met for major or mild neurocognitive disorder.
- B. The disturbance occurs in the setting of established Parkinson's disease.
- C. There is insidious onset and gradual progression of impairment.
- D. The neurocognitive disorder is not attributable to another medical condition and is not better explained by another mental disorder.

Neurocognitive disorder due to Huntington Disease:

Huntington's Disease is A hereditary condition causing neuro-cognitive disorder that involves a widespread deterioration of the subcortical brain structures and parts of the frontal cortex that control motor movements.

Diagnostic Criteria:

- A. The criteria are met for major or mild neurocognitive disorder.

- B. There is insidious onset and gradual progression.
- C. There is clinically established Huntington's disease, or risk for Huntington's disease based on family history or genetic testing.
- D. The neurocognitive disorder is not attributable to another medical condition and is not better explained by another mental disorder.

Neurocognitive disorder due to another medical condition:

Diagnostic Criteria:

- A. The criteria are met for major or mild neurocognitive disorder.
- B. There is evidence from the history, physical examination, or laboratory findings that the neurocognitive disorder is the pathophysiological consequence of another medical condition.
- C. The cognitive deficits are not better explained by another mental disorder or another specific neurocognitive disorder (e.g., Alzheimer's disease, HIV infection).

Topic 214: Etiology of Delirium

Possible causes of delirium include the following:

- Certain medications or drug toxicity
- Alcohol or drug intoxication or withdrawal
- A medical condition, such as a stroke, heart attack, worsening lung or liver disease, or an injury from a fall
- Metabolic imbalances, such as low sodium or calcium
- Severe, chronic or terminal illness
- Fever and acute infection, particularly in children
- Urinary tract infection, pneumonia or flu, especially in older adults
- Exposure to a toxin, such as carbon monoxide, cyanide or other poisons
- Surgery/medical procedures that include anesthesia

Topic 215: Etiology of Neurocognitive Disorders

Alzheimer's Disease: The exact cause is not known, but the person will have amyloid plaques and tangles in their brain.

Lewy Body Dementia: Lewy bodies are clumps of protein that develop in people with Lewy body dementia, Alzheimer's, and Parkinson's disease.

Fronto-temporal NCD: The cause is not entirely understood. However, the symptoms may occur because the frontal and temporal lobes of the brain shrink over time. Several gene mutations have been linked to types of fronto-temporal dementia.

Topic 216: Etiology

Vascular Neurocognitive Disorder:

- Stroke (infarction) that block a brain artery usually cause a range of symptoms that may include vascular dementia.
- But some strokes don't cause any noticeable symptoms. These silent strokes still increase dementia risk.
- Conditions that narrow or inflict long-term damage on brain blood vessels can lead to vascular dementia.
- Wear and tear associated with aging, high blood pressure, abnormal aging of blood vessels (atherosclerosis), diabetes, and brain hemorrhage.

Neurocognitive Disorder due Traumatic Brain Injury

- Falls are the most common cause, and falling poses an especially serious risk for older adults.
- Motor vehicle crashes are another common cause.

Neurocognitive Disorder due HIV Infection

- Caused by the HIV infection affecting the subcortical regions of the brain.
- Risk factors for HIV infection include unprotected sex and injection, drug use.

Topic 217: Etiology of Neurocognitive Disorders

Parkinson's Disease: Older age and the duration of Parkinson's disease are two risk factors for developing major or mild neurocognitive disorders.

Huntington's Disease: Major and mild neurocognitive disorder due to Huntington's disease occurs as part of the progression of the disease. Huntington's disease is hereditary, and so genetics are a strong risk factor.

Medication or Substance-Induced NCD: A wide variety of psychoactive substances can cause mild NCD due to substance/medication use, including Alcohol, Inhalants, Cocaine, Methamphetamine and Opioids.

Due to Another Medical Condition: There are literally hundreds of conditions that can lead to cognitive problems.

Some of these may be reversible and others may not be fully reversible. Some of the most common are:

- Disruption of Hormones
- Problems with insulin
- Hyperthyroidism
- Nutritional problems
- People who do not receive sufficient amounts of certain vitamins or minerals may develop cognitive problems.

Substance Related and Addictive Disorders I

Topic 218-223

Topic 218: Introduction

Human beings enjoy a remarkable variety of foods and drinks. Every substance on earth probably has been tried by someone, somewhere, at some time. We also have discovered substances that have interesting effects—both medical and pleasurable—on our brains and the rest of our bodies. We may swallow an aspirin to quiet a headache, an antibiotic to fight an infection, or a tranquilizer to calm us down. We may drink coffee to get going in the morning or wine to relax with friends. We may smoke cigarettes to soothe our nerves. However, many of the substances we consume can harm us or disrupt our behavior or mood. The misuse of such substances has become one of society’s biggest problems. It has been estimated that the cost of substance misuse is over \$600 billion each year in the US alone.

Not only are numerous substances available in our society, new ones are introduced almost every day. Some are harvested from nature, others derived from natural substances, and still others produced in the laboratory. Some, such as antianxiety drugs, require a physician’s prescription for legal use. Others, such as alcohol and nicotine, are legally available to adults. Still others, such as heroin, are illegal under all circumstances.

Topic 219: Introduction

Substance is interchangeably known as Drug also. drug is defined as any substance other than food that affects our bodies or minds. It need not be a medicine or be illegal. The term “substance” is now frequently used in place of “drug,” in part because many people fail to see that such substances as alcohol, tobacco, and caffeine are drugs, too. When a person ingests a substance—whether it be alcohol, cocaine, marijuana, or some form of medication—trillions of powerful molecules surge through the bloodstream and into the brain. Once there, the molecules set off a series of biochemical events that disturb the normal operation of the brain and body. Not surprisingly, then, substance misuse may lead to various kinds of abnormal functioning.

Topic 220: Substance intoxication

A cluster of temporary undesirable behavioral or psychological changes that develop during or shortly after the ingestion of a substance is called substance intoxication. For example, an excessive amount of alcohol may lead to alcohol intoxication, a temporary state of poor judgment, mood changes, irritability, slurred speech, and poor coordination. Similarly, drugs such as LSD may produce hallucinogen intoxication, sometimes called hallucinosis, which consists largely of perceptual distortions and hallucinations.

In many cases, people with substance abuse also become physically dependent on the substance, developing a *tolerance* for it and experiencing *withdrawal* reactions. *Tolerance* is the brain and body need for ever larger doses of a drug to produce earlier effects. When people develop tolerance, they need increasing doses of the substance to produce the desired state. *Withdrawal* reactions consist of unpleasant and sometimes dangerous symptoms—cramps, anxiety attacks, sweating, nausea—that occur when the person suddenly stops taking or cuts back on the substance.

Following are the types of different substances which people use:

Sedatives: Sedative are the medicines which slower the central nervous system and brain, hence body becomes slow. These include hypnotics and anxiolytics.

Stimulants: Stimulants are opposite to the sedatives and accelerate the functioning of Central nervous system,

Tobacco: It is the most widely used substance and is highly addictive.

Caffeine: Caffeine is a natural stimulant most commonly found in tea, coffee and cacao plants and works by stimulating central nervous system, keeping one alert.

Alcohol: Alcohol is another depressant and sedative, is most commonly used in different countries, not permissible in Pakistan though.

Cannabis: Cannabis, also known as marijuana among other names, is a psychoactive drug from the Cannabis plant used primarily for medical or recreational purposes

Hallucinogens: Hallucinogens are a class of drugs that cause profound distortions in a person's perceptions of reality, otherwise known as hallucinations.

Inhalants: Inhalants are various products easily bought and found for example spray paints, markers, glues, and cleaning fluids. They contain dangerous substances that have psychoactive properties when inhaled.

Opioids: Opioids, comes from poppy plants, are substances e.g. heroine that act on opioid receptors to produce morphine-like effects. Medically they are primarily used for pain relief, including anesthesia

Other (or unknown) Substances. There are many other substances which people use.

Topic 221:

Following are the types of substances commonly being used:

Benzodiazepines

Benzodiazepines are the most common group of antianxiety drugs, which includes Valium and Xanax. They are generally safer and less likely to lead to intoxication, tolerance effects, and withdrawal reactions.

Opioid

Opioids include opium, which is taken from the sap of the opium poppy; drugs derived from opium, such as heroin, morphine, and codeine; and similar synthetic (laboratory-blended) drugs.

1. **Opium** is a highly addictive substance made from the poppy plant. Opium itself has been in use for thousands of years. In the past it was used widely in the treatment of medical disorders because of its ability to reduce both physical and emotional pain.
2. **Morphine** is a highly addictive substance derived from opium, is particularly effective in relieving pain.
3. **Heroin** morphine was converted into yet another new pain reliever, heroin. For several years, heroin was viewed as a wonder drug and was used as a cough medicine and for

other medical purposes. Eventually, however, physicians learned that heroin is even more addictive than the other opioids.

Endorphins:

Endorphins are neurotransmitters that help relieve pain and reduce emotional tension and elevating mood. These are sometimes referred to as the body's own opioids.

Gambling:

Though it is not a substance, gambling is also included in addictive disorders as it is highly addictive. Gambling behavior activates reward systems similar to those activated by drugs. It produces some behavioral symptoms comparable to the substance use disorders.

Topic 222:

Broadly, the substance-related disorders are divided into two groups:

1. Substance Use Disorders
2. Substance Induced Disorders

Substance Use Disorders

General Features:

1. The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.
2. An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders.
3. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects may benefit from long-term approaches to treatment.
4. Substance use was previously split into abuse or dependence

5. It involves impaired control, social impairment, risky use and pharmacological criteria.
6. The individual may take the substance in larger amounts or over a longer period than was originally intended.
7. The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use

Topic 223: Substance Use Disorders

General Features:

1. The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects.
2. In some instances of more severe substance use disorders, virtually all of the individual's daily
3. activities revolve around the substance. Craving is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used. Craving has also been shown to involve classical conditioning and is associated with activation of specific reward structures in the brain.
4. Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home
5. he individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
6. Important social, occupational, or recreational activities may be given up or reduced because of substance use. The individual may withdraw from family activities and hobbies in order to use the substance.
7. Individual use substance in situations in which it is physically hazardous.
8. The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
9. An individual may develop tolerance.
10. Withdrawal is another significant feature of substance abuse disorder.

Substance Related and Addictive Disorders II

Topic 224-228

Topic 224: Substance Induced Disorders

These are characterized by the clinically significant problematic behavioral or psychological changes associated with intoxication (e.g., belligerence, mood lability, impaired judgment) which are attributable to the physiological effects of the substance on the central nervous system and develop during or shortly after use of the substance. Following can be induced because of a specific substance:

- Intoxication
- Withdrawal
- Psychotic Disorder
- Bipolar Disorder
- Depressive Disorder
- Anxiety Disorder
- Sleep Disorder
- Delirium
- Neurocognitive
- Sexual Dysfunction

Intoxication:

Intoxication is a reversible substance-specific syndrome due to recent ingestion of a substance. Behavioral/psychological changes occur due to effects on CNS after ingestion e.g. disturbances of perception. The problem is not due to another medical condition or mental disorder. Moreover, it does not apply to tobacco.

Topic 225: Substance Induced Disorders

Intoxication:

Clinical picture of intoxication depends on a number of following factors:

- Type of substance
- Dose
- Route of Administration
- Duration/chronicity
- Individual degree of tolerance
- Time since last dose
- Person's expectations of substance effect
- Contextual variables

Withdrawal:

Withdrawal is a substance specific syndrome, problematic behavioral changes due to stopping or reducing prolonged use. It includes physiological & cognitive components. Withdrawal causes significant distress in social, occupational or other important areas of functioning. It will not be considered withdrawal if the symptoms are due to another medical condition or mental disorder.

Topic 226: Substance-Induced Mental Disorder

The substance/medication-induced mental disorders are potentially severe, usually temporary, but sometimes persisting central nervous system (CNS) syndromes that develop in the context of the effects of substances of abuse, medications, or several toxins. They are distinguished from the substance use disorders, in which a cluster of cognitive, behavioral, and physiological symptoms contributes to the continued use of a substance despite significant substance-related problems. The substance/medication-induced mental disorders may be induced by different classes of substances that produce substance use disorders, or by a great variety of other medications used in medical treatment.

It is important to recognize these common features to aid in the detection of these disorders. These features are described as follows:

A. The disorder represents a clinically significant symptomatic presentation of a relevant mental disorder.

B. There is evidence from the history, physical examination, or laboratory findings of both of the following:

1. The disorder developed during or within 1 month of a substance intoxication or withdrawal or taking a medication; and
2. The involved substance/medication is capable of producing the mental disorder.

C. The disorder is not better explained by an independent mental disorder (i.e., one that is not substance- or medication-induced). Such evidence of an independent mental disorder could include the following:

1. The disorder preceded the onset of severe intoxication or withdrawal or exposure to the medication; or
2. The full mental disorder persisted for a substantial period of time (e.g., at least 1 month) after the cessation of acute withdrawal or severe intoxication or taking the medication. This criterion does not apply to substance-induced neurocognitive disorders or hallucinogen persisting perception disorder, which persist beyond the cessation of acute intoxication or withdrawal.

D. The disorder does not occur exclusively during the course of a delirium.

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

Neuro-adaptation:

If refers to underlying CNS changes that occur following repeated use such that person develops tolerance and/or withdrawal symptoms.

Tolerance:

Tolerance refers to need to use an increased amount of a substance in order to achieve the desired effect or markedly diminished effect with continued use of the same amount of the substance.

Topic 227: DSM 5 Diagnostic Criteria for Substance-Related and Addictive Disorders

There are some common criteria for the disorders which is listed below:

- Alcohol Use Disorder
- Cannabis Use Disorder
- Phencyclidine (angel dust) Use Disorder
- Other Hallucinogen Use Disorder
- Inhalant Use Disorder
- Opioid Use Disorder
- Sedative, Hypnotic, or Anxiolytic Use Disorder

Similar Diagnostic Criteria:

A. A problematic pattern of use leading to clinically significant impairment or distress, by at least 2 of the following occurring within a 12-month period:

1. Certain substance is often taken in larger amounts or over a longer period than was intended.
2. Persistent desire or unsuccessful efforts to cut down or control --use.
3. A great deal of time is spent in activities necessary to obtain, use, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance
5. Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by use
7. Important social, occupational, or recreational activities are given up or reduced.
8. Recurrent use in situations in which it is physically hazardous.
9. Use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by use of drug/substance.
10. Tolerance
11. Withdrawal

Topic 228: Similar Criteria

For Intoxication of Alcohol, Cannabis, Phencyclidine, Hallucinogen, Inhalant, Opioids, Sedatives, Hypnotic, or Anxiolytic and Stimulants

B. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Withdrawal of Alcohol, Opioid Sedative, Hypnotic, or Anxiolytic, Stimulant and Tobacco:

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

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Substance Related and Addictive Disorders III

Topic 229-234

Topic 229: Alcohol-Related Disorders

Alcohol use is associated with several categories of disorders. WHO regards alcohol use as one of the top 10 risk factors for morbidity and mortality. To understand how alcohol affects an individual's behavior, it is important to understand that, from a physiological standpoint, alcohol is a nervous system depressant. The way that it affects the individual depends, however, on how much the drinker ingests. In small amounts, alcohol has sedating effects, and the drinker therefore feels more relaxed. In larger and larger amounts, drinkers may begin to feel more outgoing, self-confident, and uninhibited. Beyond that point, the depressant effects become apparent, leading users to experience sleepiness, lack of physical coordination, dysphoria, and irritability. In larger and larger amounts, alcohol can be fatal, leading the individual's vital functions to shut down.

Following disorder fall under this category:

- Alcohol Use Disorder
- Alcohol Intoxication
- Alcohol Withdrawal
- Other Alcohol-induced Disorders
- Unspecified Alcohol-Related Disorder

Alcohol Use Disorder:

Alcohol use disorder, or alcoholism, is an addiction to alcohol. According to DSM 5 following the diagnostic criteria of this disorder:

Diagnostic Criteria:

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal, pp. 499-500).
 - b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Alcohol Intoxication

Alcohol intoxication is the negative behavior and physical effects due to the recent drinking of alcohol.

Diagnostic Criteria:

A. Recent ingestion of alcohol.

B. Clinically significant problematic behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood lability, impaired judgment) that developed during, or shortly after, alcohol ingestion.

C. One (or more) of the following signs or symptoms developing during, or shortly after, alcohol use:

1. Slurred speech.
2. Incoordination.
3. Unsteady gait.
4. Nystagmus.
5. Impairment in attention or memory.
6. Stupor or coma.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Topic 230: Alcohol Withdrawal

If an individual drinks heavily for a long time, he might have problems when he stops or cuts back on how much alcohol he drinks. This is called alcohol withdrawal.

Diagnostic Criteria:

A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.

B. Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use described in Criterion A:

1. Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm).
2. Increased hand tremor.
3. Insomnia.
4. Nausea or vomiting.
5. Transient visual, tactile, or auditory hallucinations or illusions.
6. Psychomotor agitation.
7. Anxiety.

8. Generalized tonic-clonic seizures.

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

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Topic 231: Caffeine-Related Disorders

Caffeine is a stimulant found in coffee, tea, chocolate, energy drinks, diet pills, and headache remedies. By activating the sympathetic nervous system through increasing the production of adrenaline, caffeine increases an individual's perceived level of energy and alertness. Caffeine also increases blood pressure and may lead to increases in the body's production of cortisol, the stress hormone.

Following disorders come under this category:

Caffeine Intoxication

Caffeine Withdrawal

Other Caffeine -induced Disorders

Unspecified Caffeine -Related Disorder

Caffeine Intoxication

A caffeine overdose occurs when you take in too much caffeine through drinks, foods, or medications.

Diagnostic Criteria:

A. Recent consumption of caffeine (typically a high dose well in excess of 250 mg).

B. Five (or more) of the following signs or symptoms developing during, or shortly after, caffeine use:

1. Restlessness.
2. Nervousness.
3. Excitement.
4. Insomnia.
5. Flushed face.
6. Diuresis.
7. Gastrointestinal disturbance.
8. Muscle twitching.
9. Rambling flow of thought and speech.
10. Tachycardia or cardiac arrhythmia.
11. Periods of inexhaustibility.
12. Psychomotor agitation.

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

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Topic 232: Caffeine Withdrawal

Diagnostic Criteria:

Following is the diagnostic criteria of caffeine withdrawal according to DSM 5.

A. Prolonged daily use of caffeine.

B. Abrupt cessation of or reduction in caffeine use, followed within 24 hours by three (or more) of the following signs or symptoms:

1. Headache.
2. Marked fatigue or drowsiness.
3. Dysphoric mood, depressed mood, or irritability.

4. Difficulty concentrating.
5. Flu-like symptoms (nausea, vomiting, or muscle pain/stiffness).

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

D. The signs or symptoms are not associated with the physiological effects of another medical condition (e.g., migraine, viral illness) and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Topic 233: Cannabis-Related Disorders

Cannabis, also known as marijuana among other names, is a psychoactive drug from the Cannabis plant used primarily for medical or recreational purposes. It is consumed in many different forms. Following disorder fall under category of cannabis related disorders:

- Cannabis Use Disorder
- Cannabis Intoxication
- Cannabis Withdrawal
- Other Cannabis -induced Disorders
- Unspecified Cannabis -Related Disorder

Cannabis Use Disorder:

Cannabis use disorder is defined as s the continued use of cannabis despite clinically significant impairment.

Diagnostic Criteria:

A. A problematic pattern of cannabis use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Cannabis is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control cannabis use.
3. A great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects.

4. Craving, or a strong desire or urge to use cannabis.
5. Recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
7. Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
8. Recurrent cannabis use in situations in which it is physically hazardous.
9. Cannabis use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by cannabis.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of cannabis to achieve intoxication or desired effect.
 - b. Markedly diminished effect with continued use of the same amount of cannabis.
11. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for cannabis
 - b. Cannabis (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Topic 234: Cannabis Intoxication

When smoked, cannabis produces a mixture of hallucinogenic, depressant, and stimulant effects. Many smokers report sharpened perceptions and fascination with the intensified sounds and sights around them. Time seems to slow down, and distances and sizes seem greater than they actually are. This overall “high” is technically called cannabis intoxication.

Diagnostic Criteria:

According to DSM5, following is the diagnostic criteria of cannabis intoxication:

- A. Recent use of cannabis.

B. Clinically significant problematic behavioral or psychological changes (e.g., impaired motor coordination, euphoria, anxiety, sensation of slowed time, impaired judgment, social withdrawal) that developed during, or shortly after, cannabis use.

C. Two (or more) of the following signs or symptoms developing within 2 hours of cannabis use:

1. Conjunctival injection.
2. Increased appetite.
3. Dry mouth.
4. Tachycardia.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Cannabis Withdrawal:

According to DSM 5, following is the diagnostic criteria of cannabis withdrawal:

Diagnostic Criteria:

A. Cessation of cannabis use that has been heavy and prolonged (i.e., usually daily or almost daily use over a period of at least a few months).

B. Three (or more) of the following signs and symptoms develop within approximately 1 week after Criterion A:

1. Irritability, anger, or aggression.
2. Nervousness or anxiety.
3. Sleep difficulty (e.g., insomnia, disturbing dreams).
4. Decreased appetite or weight loss.
5. Restlessness.
6. Depressed mood.
7. At least one of the following physical symptoms causing significant discomfort: abdominal pain, shakiness/tremors, sweating, fever, chills, or headache.

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

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Substance Related and Addictive Disorders IV

Topic 235-240

Topic 235: Hallucinogen-Related Disorders

Hallucinogens i.e. pharmaceutical drugs, such as LSD, are substances that cause powerful changes primarily in sensory perception. People's perceptions are intensified and they may have illusions and hallucinations. LSD apparently causes such effects by disturbing the release of the neurotransmitter. These drugs cause people to experience profound distortions in their perception of reality. Under the influence of hallucinogens, people see images, hear sounds, and feel sensations that they believe to be real but are not.

Following fall under category of these disorders:

- Phencyclidine Use Disorder
- Other Hallucinogen Use Disorder
- Phencyclidine Intoxication
- Other Hallucinogen Intoxication (other than Phencyclidine)
- Hallucinogen Persisting Perception Disorder
- Other Phencyclidine-induced Disorders
- Other Hallucinogen-induced Disorders
- Unspecified Phencyclidine-Related Disorder
- Unspecified Hallucinogen-Related Disorder

We will look into detail of few of the above mentioned disorders

Phencyclidine Intoxication

According to DSM 5, following is the diagnostic criteria of Phencyclidine Intoxication:

Diagnostic Criteria:

A. Recent use of phencyclidine (or a pharmacologically similar substance).

B. Clinically significant problematic behavioral changes (e.g., belligerence, assaultiveness, impulsiveness, unpredictability, psychomotor agitation, impaired judgment) that developed during, or shortly after, phencyclidine use.

C. Within 1 hour, two (or more) of the following signs or symptoms:

Note: When the drug is smoked, “snorted,” or used intravenously, the onset may be particularly rapid.

1. Vertical or horizontal nystagmus.
2. Hypertension or tachycardia.
3. Numbness or diminished responsiveness to pain.
4. Ataxia.
5. Dysarthria.
6. Muscle rigidity.
7. Seizures or coma.
8. Hyperacusis.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including Intoxication with another substance.

Topic 236: Other Hallucinogen Intoxication

According to DSM 5, following is the diagnostic criteria of Hallucinogen Intoxication:

Diagnostic Criteria:

A. Recent use of a hallucinogen (other than phencyclidine).

B. Clinically significant problematic behavioral or psychological changes (e.g., marked anxiety or depression, ideas of reference, fear of “losing one’s mind,” paranoid ideation, impaired judgment) that developed during, or shortly after, hallucinogen use.

C. Perceptual changes occurring in a state of full wakefulness and alertness (e.g., subjective intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias) that developed during, or shortly after, hallucinogen use.

D. Two (or more) of the following signs developing during, or shortly after, hallucinogen use:

1. Pupillary dilation.
2. Tachycardia.
3. Sweating.
4. Palpitations.
5. Blurring of vision.
6. Tremors.
7. Incoordination.

E. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Topic 237: Hallucinogen Persisting Perception Disorder

Some people who use hallucinogens develop a condition called hallucinogen persisting perception disorder, in which they experience flashbacks or spontaneous hallucinations, delusions, or disturbances in mood similar to the changes that took place while they were intoxicated with the drug.

Diagnostic Criteria:

A. Following cessation of use of a hallucinogen, the re-experiencing of one or more of the perceptual symptoms that were experienced while intoxicated with the hallucinogen (e.g., geometric hallucinations, false perceptions of movement in the peripheral visual fields, flashes of color, intensified colors, trails of images of moving objects, positive afterimages, halos around objects, macropsia and micropsia).

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

C. The symptoms are not attributable to another medical condition (e.g., anatomical lesions and infections of the brain, visual epilepsies) and are not better explained by another mental disorder (e.g., delirium, major neurocognitive disorder, schizophrenia) or hypnopompic hallucinations.

Topic 238: Inhalant Related Disorder

Inhalant-related disorders are a category of disorders that involve the abuse of glue, paint, lighter fluid, or other substances (or inhalants) that generate a "high feeling" when inhaled. Inhalants are a diverse group of substances that cause psychoactive effects by producing chemical vapors. These products are not in and of themselves harmful; in fact, they are all products commonly found in the home and workplace. There are four categories of inhalants: volatile solvents (paint thinners or removers, dry-cleaning fluids, gasoline, glue, and lighter fluid), aerosols (sprays that contain propellants and solvents), gases (butane lighters and propane tanks, ether, and nitrous oxide), and nitrites (a special category of products that individuals use as sexual enhancers) Following disorders fall under this category:

- Inhalant Use Disorder
- Inhalant Intoxication
- Other Inhalant-Induced Disorders
- Unspecified Inhalant-Related Disorder

Inhalant Intoxication:

Diagnostic Criteria:

According to DSM 5, following is the diagnostic criteria of Inhalant Intoxication

- A. Recent intended or unintended short-term, high-dose exposure to inhalant substances, including volatile hydrocarbons such as toluene or gasoline.
- B. Clinically significant problematic behavioral or psychological changes (e.g., belligerence, assaultiveness, apathy, impaired judgment) that developed during, or shortly after, exposure to inhalants.
- C. Two (or more) of the following signs or symptoms developing during, or shortly after, inhalant use or exposure:
1. Dizziness.
 2. Nystagmus.
 3. Incoordination.
 4. Slurred speech.

5. Unsteady gait.
6. Lethargy.
7. Depressed reflexes.
8. Psychomotor retardation.
9. Tremor.
10. Generalized muscle weakness.
11. Blurred vision or diplopia (simultaneous perception of two images of a single object).
12. Stupor or coma.
13. Euphoria (a feeling or state of intense excitement and happiness).

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Topic 239: Opioid Related Disorders

Opioid is mostly widely used in Pakistan. The opiates include opium and its derivatives morphine, heroin, and codeine. An opioid is a substance that relieves pain. Many legally prescribed medications fall within this category, including hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine (e.g., Kadian, Avinza), codeine, and related drugs. Clinicians prescribe hydrocodone products most commonly for a variety of painful conditions, including dental and injury-related pain. Physicians often use morphine before and after surgical procedures to alleviate severe pain. Heroin is a form of opioid. It is a pain-killing drug synthesized from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. Users inject, snort, sniff, or smoke heroin. Once ingested, the body converts heroin to morphine and then it binds to the opioid receptors located in areas throughout the brain and body, particularly those involved in reward and pain perception.

Clinicians prescribe codeine, on the other hand, for mild pain. When people take these medications as prescribed, the medications are effective for managing pain safely. However, because of their potential to produce euphoria as well as physical dependence, these medications are among the most frequently abused prescription drugs.

Following disorders fall under this category:

- Opioid Use Disorder
- Opioid Intoxication
- Opioid Withdrawal
- Other Opioid-induced Disorders
- Unspecified Opioid-Related Disorder

Opioid Use Disorder

According to DSM 5, following is the diagnostic criteria of opioid use disorder:

Diagnostic Criteria:

A. A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of an opioid.

Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

11. Withdrawal, as manifested by either of the following:

a. The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).

b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Opioid Intoxication

According to DSM 5, following is the diagnostic criteria of opioid use disorder:

Diagnostic Criteria:

A. Recent use of an opioid.

B. Clinically significant problematic behavioral or psychological changes (e.g., initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgment) that developed during, or shortly after, opioid use.

C. Pupillary constriction (or pupillary dilation due to anoxia from severe overdose) and one (or more) of the following signs or symptoms developing during, or shortly after, opioid use:

1. Drowsiness or coma.
2. Slurred speech.
3. Impairment in attention or memory.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Specify if:

With perceptual disturbances: This specifier may be noted in the rare instance in which hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium.

Topic 240: Opioid Withdrawal

According to DSM 5, following is the diagnostic criteria of opioid withdrawal:

Diagnostic Criteria:

A. Presence of either of the following;

1. Cessation of (or reduction in) opioid use that has been heavy and prolonged (i.e., several weeks or longer).
2. Administration of an opioid antagonist after a period of opioid use.

B. Three (or more) of the following developing within minutes to several days after Criterion A:

1. Dysphoric mood.
2. Nausea or vomiting.
3. Muscle aches.
4. Lacrimation or rhinorrhea.
5. Pupillary dilation, piloerection, or sweating.
6. Diarrhea.
7. Yawning.
8. Fever.
9. Insomnia.

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

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Substance Related and Addictive Disorders V

Topic 241-245

Topic 241: Sedative, Hypnotic, or Anxiolytic Related Disorders

A *sedative* has a soothing or calming effect (e.g. sleeping pills and tranquilizers) and are available as prescription medicines. A *hypnotic* induces sleep, and an *anxiolytic* is used to treat anxiety symptoms. These central nervous system depressant drugs can be useful for treating anxiety and sleep disorders. Their sedating effects are due to the fact that they increase the levels of the neurotransmitter GABA, which inhibits brain activity and therefore produces a calming effect.

Disorders within this category include use disorder, intoxication, and withdrawal. The detail as per DSM 5 is as follows:

- Sedative, Hypnotic, or Anxiolytic Use Disorder
- Sedative, Hypnotic, or Anxiolytic Intoxication
- Sedative, Hypnotic, or Anxiolytic Withdrawal
- Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders
- Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder

Sedative, Hypnotic, or Anxiolytic Use Disorder

According to DSM 5, following is the diagnostic criteria of Sedative, Hypnotic, or Anxiolytic Use Disorder:

Diagnostic Criteria:

A. A problematic pattern of sedative, hypnotic, or anxiolytic use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Sedatives, hypnotics, or anxiolytics are often taken in larger amounts or over a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control sedative, hypnotic, or anxiolytic use.
3. A great deal of time is spent in activities necessary to obtain the sedative, hypnotic, or anxiolytic; use the sedative, hypnotic, or anxiolytic; or recover from its effects.
4. Craving, or a strong desire or urge to use the sedative, hypnotic, or anxiolytic.
5. Recurrent sedative, hypnotic, or anxiolytic use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences from work or poor work performance related to sedative, hypnotic, or anxiolytic use; sedative-, hypnotic-, or anxiolytic-related absences, suspensions, or expulsions from school; neglect of children or household).
6. Continued sedative, hypnotic, or anxiolytic use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of sedatives, hypnotics, or anxiolytics (e.g., arguments with a spouse about consequences of intoxication; physical fights).
7. Important social, occupational, or recreational activities are given up or reduced because of sedative, hypnotic, or anxiolytic use.
8. Recurrent sedative, hypnotic, or anxiolytic use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by sedative, hypnotic, or anxiolytic use).
9. Sedative, hypnotic, or anxiolytic use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the sedative, hypnotic, or anxiolytic.
10. Tolerance, as defined by either of the following;
 - a. A need for markedly increased amounts of the sedative, hypnotic, or anxiolytic to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of the sedative, hypnotic, or anxiolytic.

Note: This criterion is not considered to be met for individuals taking sedatives, hypnotics, or anxiolytics under medical supervision.

11. Withdrawal, as manifested by either of the following:

- a. The characteristic withdrawal syndrome for sedatives, hypnotics, or anxiolytics (refer to Criteria A and B of the criteria set for sedative, hypnotic, or anxiolytic withdrawal).
- b. Sedatives, hypnotics, or anxiolytics (or a closely related substance, such as alcohol) are taken to relieve or avoid withdrawal symptoms.

Note: This criterion is not considered to be met for individuals taking sedatives, hypnotics, or anxiolytics under medical supervision.

Sedative, Hypnotic, or Anxiolytic Intoxication:

According to DSM 5, following is the diagnostic criteria of Sedative, Hypnotic, or Anxiolytic Intoxication:

Diagnostic Criteria:

- A. Recent use of a sedative, hypnotic, or anxiolytic.
- B. Clinically significant maladaptive behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood liability, impaired judgment) that developed during, or shortly after, sedative, hypnotic, or anxiolytic use.
- C. One (or more) of the following signs or symptoms developing during, or shortly after, sedative, hypnotic, or anxiolytic use:
 1. Slurred speech.
 2. Incoordination.
 3. Unsteady gait.
 4. Nystagmus.
 5. Impairment in cognition (e.g., attention, memory).

6. Stupor or coma.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Topic 242: Sedative, Hypnotic, or Anxiolytic Withdrawal

According to DSM 5, following is the diagnostic criteria of Sedative, Hypnotic, or Anxiolytic withdrawal:

Diagnostic Criteria:

A. Cessation of (or reduction in) sedative, hypnotic, or anxiolytic use that has been prolonged.

B. Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) sedative, hypnotic, or anxiolytic use described in Criterion A:

1. Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm).

2. Hand tremor.

3. Insomnia.

4. Nausea or vomiting.

5. Transient visual, tactile, or auditory hallucinations or illusions.

6. Psychomotor agitation.

7. Anxiety.

8. Grand mal seizures.

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

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Specify if:

With perceptual disturbances: This specifier may be noted when hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium.

Topic 243: Stimulant Related Disorders

The category of drugs called stimulants includes substances that have an activating effect on the nervous system. These differ in their chemical structure, their specific physical and psychological effects, and their potential danger to the user. Stimulants are associated with disorders involving use, intoxication, and withdrawal. Detail is as follows:

- Stimulant Use Disorder
- Stimulant Intoxication
- Stimulant Withdrawal
- Other Stimulant-Induced Disorders
- Unspecified Stimulant-Related Disorder

Stimulant Use Disorder:

According to DSM 5, following is the diagnostic criteria of stimulant use disorder:

Diagnostic Criteria:

A. A pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The stimulant is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control stimulant use.
3. A great deal of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects.

4. Craving, or a strong desire or urge to use the stimulant.
5. Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant.
7. Important social, occupational, or recreational activities are given up or reduced because of stimulant use.
8. Recurrent stimulant use in situations in which it is physically hazardous.
9. Stimulant use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the stimulant.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of the stimulant to achieve intoxication or desired effect.
 - b. A markedly diminished effect with continued use of the same amount of the stimulant.

Note: This criterion is not considered to be met for those taking stimulant medications solely under appropriate medical supervision, such as medications for attention-deficit/hyperactivity disorder or narcolepsy.

11. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for the stimulant (refer to Criteria A and B of the criteria set for stimulant withdrawal).
 - b. The stimulant (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Note; This criterion is not considered to be met for those taking stimulant medications solely under appropriate medical supervision, such as medications for attention-deficit hyperactivity disorder or narcolepsy

Specify Current Severity:

Mild: Presence of 2-3 symptoms.

Amphetamine-type substance

Cocaine

Other or unspecified stimulant

Moderate: Presence of 4-5 symptoms.

Amphetamine-type substance

Cocaine

Other or unspecified stimulant

Severe: Presence of 6 or more symptoms.

Amphetamine-type substance

Cocaine

Other or unspecified stimulant

Stimulant Intoxication:

According to DSM 5, following is the diagnostic criteria of stimulant intoxication:

Diagnostic Criteria:

A. Recent use of an amphetamine-type substance, cocaine, or other stimulant.

B. Clinically significant problematic behavioral or psychological changes (e.g., euphoria or affective blunting: changes in sociability: hypervigilance: interpersonal sensitivity: anxiety, tension, or anger; stereotyped behaviors: impaired judgment) that developed during, or shortly after, use of a stimulant.

C. Two (or more) of the following signs or symptoms, developing during, or shortly after, stimulant use:

1. Tachycardia (accelerated heart beat) or bradycardia (abnormally slow heart action).
 2. Pupillary dilation.
 3. Elevated or lowered blood pressure.
 4. Perspiration or chills.
 5. Nausea or vomiting.
 6. Evidence of weight loss.
 7. Psychomotor agitation or retardation.
 8. Muscular weakness, respiratory depression, chest pain, or cardiac arrhythmias (slow heart beat).
 9. Confusion, seizures, dyskinesias (impairment of voluntary muscles), dystonias twitching or irregular movement of muscles), or coma.
- D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

Specify the specific intoxicant (i.e., amphetamine-type substance, cocaine, or other stimulant).

Specify if:

With perceptual disturbances: This specifier may be noted when hallucinations with intact reality testing or auditory, visual, or tactile illusions occur in the absence of a delirium.

Topic 244: Stimulant Withdrawal

According to DSM 5, following is the diagnostic criteria of stimulant withdrawal:

Diagnostic Criteria:

A. Cessation of (or reduction in) prolonged amphetamine-type substance, cocaine, or other stimulant use.

B. Dysphoric mood and two (or more) of the following physiological changes, developing within a few hours to several days after Criterion A:

1. Fatigue.

2. Vivid, unpleasant dreams.

3. Insomnia or hypersomnia.

4. Increased appetite.

5. Psychomotor retardation or agitation.

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

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Specify the specific substance that causes the withdrawal syndrome (i.e., amphetamine-type substance, cocaine, or other stimulant).

Topic 245:Tobacco-Related Disorders

The health risks of tobacco are well known; these risks are primarily associated with smoking cigarettes, which contain tar, carbon monoxide, and other additives. Nicotine is the psychoactive substance found in cigarettes. Readily absorbed into the bloodstream, nicotine is also present in chewing tobacco, pipe tobacco, and cigars. When nicotine enters the bloodstream, it stimulates the release of adrenaline (norepinephrine), which activates the autonomic nervous system and increases blood pressure, heart rate, and respiration. Like other psychoactive substances, nicotine increases the level of dopamine, affecting the brain's reward and pleasure centers.

Following disorders fall under this category:

- Tobacco Use Disorder
- Tobacco Withdrawal
- Other Tobacco-Induced Disorders
- Unspecified Tobacco-Related Disorder

Tobacco Use Disorder

According to DSM 5, following is the diagnostic criteria of Tobacco use disorder:

Diagnostic Criteria:

A. A problematic pattern of tobacco use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Tobacco is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control tobacco use.
3. A great deal of time is spent in activities necessary to obtain or use tobacco.
4. Craving, or a strong desire or urge to use tobacco.
5. Recurrent tobacco use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., interference with work).
6. Continued tobacco use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of tobacco (e.g., arguments with others about tobacco use).
7. Important social, occupational, or recreational activities are given up or reduced because of tobacco use.
8. Recurrent tobacco use in situations in which it is physically hazardous (e.g., smoking in bed).
9. Tobacco use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by tobacco.
10. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of tobacco to achieve the desired effect.

b. A markedly diminished effect with continued use of the same amount of tobacco.

11. Withdrawal, as manifested by either of the following:

a. The characteristic withdrawal syndrome for tobacco (refer to Criteria A and B of the criteria set for tobacco withdrawal).

b. Tobacco (or a closely related substance, such as nicotine) is taken to relieve or avoid withdrawal symptoms.

Tobacco Withdrawal

According to DSM 5, following is the diagnostic criteria of Tobacco withdrawal:

Diagnostic Criteria:

A. Daily use of tobacco for at least several weeks.

B. Abrupt cessation of tobacco use, or reduction in the amount of tobacco used, followed within 24 hours by four (or more) of the following signs or symptoms:

1. Irritability, frustration, or anger.
2. Anxiety.
3. Difficulty concentrating.
4. Increased appetite.
5. Restlessness.
6. Depressed mood.
7. Insomnia.

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

D. The signs or symptoms are not attributed to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Substance Related and Addictive Disorders VI

Topic 246-251

Topic 246: Non-Substance-Related Disorders

Gambling Disorder:

People who have gambling disorder are unable to resist recurrent urges to gamble despite knowing that the gambling will bring about negative consequences to themselves or others. The diagnosis of gambling disorder in DSM-IV-TR included gambling disorder as an impulse-control disorder. In DSM-5, it is included with substance use disorders as it is now conceptualized as showing many of the same behaviors, such as cravings, increasing needs to engage in the behavior, and negative social consequences. The unique features of gambling disorder include behaviors seen when people engage in chasing a bad bet, lying about how much they have lost, seeking financial bailouts, and committing crimes to support their gambling.

Diagnostic Criteria:

A. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).

6. After losing money gambling, often returns another day to get even (“chasing” one’s losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

Gambling Disorder:

Diagnostic Criteria (In continuation to the previous topic 246):

B. The gambling behavior is not better explained by a manic episode.

Specify if it is:

Episodic: Meeting diagnostic criteria at more than one-time point, with symptoms subsiding between periods of gambling disorder for at least several months.

Persistent: Experiencing continuous symptoms, to meet diagnostic criteria for multiple years.

Specify if it is:

In early remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met for at least 3 months but for less than 12 months.

In sustained remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met during a period of 12 months or longer.

Specify Current Severity:

Mild: 4-5 criteria met.

Moderate: 6-7 criteria met.

Severe: 8-9 criteria met.

Topic 248: Ethological factors of Substance Related and Addictive Disorders

There is no single factor instead there are multiple interacting factors which influence using addictive behavior. Not all who become dependent experience it same way or motivated by the same factors

Becoming physiologically dependent on a substance is a developmental process for some people. That is, for some people, they begin with a positive attitude toward a substance, then begin to experiment with using it, then begin using it regularly, then use it heavily, and finally become dependent on it. It appears that the factors that contribute to substance use disorders may depend on the point in the process that is being considered.

Following different factors may be more or less important at different stages i.e. earlier stage, sustaining stage and rehabilitation stage:

- Drug availability
- Peer pressure
- Personality
- Biology

Environment Factors:

Among environmental factors, the family is of utmost importance. Family's beliefs, attitudes e.g. acceptability plays a major role in initiation and sustaining these addictive behaviors. For example, developing a positive attitude toward smoking and beginning to experiment with tobacco are strongly related to smoking by other family members.

Exposure to a peer group that encourages drug use is also a major influencer. For example, becoming a regular smoker is more strongly related to smoking by peers and being able to acquire cigarettes readily. Both of these factors seem to play a role in initial drug use.

Topic 249: Etiological Factors

Biological:

Much research has addressed the possibility that there is a genetic contribution to drug and alcohol use disorders. Once started using a drug, the development into addiction may be influenced by inherited (genetic) traits. They may delay or speed up the disease progression.

Neurological Factors:

Researchers have found that changes in structure and neurochemistry transform voluntary drug-using into compulsive behavior. There are many neurotransmitters i.e. neurochemicals within the brain, play a significant role in this regard. Following neurotransmitters play a significant role in addictive behaviors:

- Opioid
- Catecholamines
- GABA
- Serotonin
- Dopamine

Too little endogenous opioid activity (i.e. low endorphins) or too much endogenous opioid antagonist activity increases the risk of dependence. Brain's normal endogenous receptors are in place. But despite that, if there is long-term drug use, it necessitates adjustment, so our brain needs exogenous (external) substance to maintain homeostasis and to carry on the normal functioning.

Topic 250: Risk Factors for Substance Related and Addictive Disorders

There are certain factors because of which an individual is vulnerable to develop certain disorders. In terms of Substance Related and Addictive Disorders, it has been found that people of any age, any sex or any socioeconomic status can become addicted to certain drugs. But, it has been found more prevalent in lower socioeconomic status. There are some factors which can affect the likelihood and speed of developing an addiction:

Self-Medication: People who use self-medication are more vulnerable to develop addiction. Most people use opioids to reduce pain and despair. Similarly, amphetamine is used to reduce depression.

Family history of addiction, lack of family involvement, difficult family situations lack of a bond with family and lack of parental supervision may increase the risk of addiction.

Psychiatric disorders: Different psychiatric disorders such as depression and ADHD increase likelihood of becoming addict. Using drugs can become a way of coping with painful feelings, such as anxiety, depression.

Peer pressure: A strong factor in starting use and misuse drugs, particularly for youngsters as they want to identify with the group members. Sometimes they get persuaded and end up in addiction.

Topic 251: Risk Factors for Substance Related and Addictive Disorders

Early usage: Using drugs at an early age can cause changes in the developing brain and increase the likelihood of progressing to drug addiction.

Taking a highly addictive drug: Some drugs are highly addictive. People may start taking these drugs for the sake of experimentation but cannot let go off. These medicines including stimulants, Cocaine or Opioid painkillers, may result in faster development of addiction than other drugs. Moreover, Smoking or injecting drugs can increase the potential for addiction.

Taking less addictive drugs: Taking drugs considered to be less addicting- so-called "light drugs", can start one on a pathway of drug use and addiction.

Substance Related and Addictive Disorders VI

Topic 252-256

Topic 252: Etiology of Substance Related and Addictive Disorders

Sociocultural Perspective:

A number of sociocultural theorists propose that people are most likely to develop substance use disorders when they live under *stressful socioeconomic conditions*. Studies have found that regions with higher unemployment levels have higher rates of alcohol or opioid use disorder. People in regions with *higher unemployment levels* have higher alcoholism rates and are more prone to develop these disorders. Similarly, people in *lower socioeconomic* classes have rates of substance use disorder that are higher than those of the other classes. *Unemployment in youth* is also a major cause and this population is the most vulnerable to develop these disorders. Sociocultural theorists hold that people confronted regularly by other kinds of *stress* also have a heightened risk of developing substance use disorders. Theorists propose that people are more likely to develop substance use disorders if they are part of a *family or social environment* in which substance use is valued or at least accepted.

Psychodynamic Perspective:

Psychodynamic theorists believe that people with substance use disorders have powerful dependency needs that can be traced to their early years. They suggest that when parents fail to satisfy a young child's need for nurturance, the child is likely to grow up depending excessively on others for help and comfort, trying to find the nurturance that was lacking during the early years. If this search for outside support includes experimentation with a drug, the person may well develop a dependent relationship with the substance. Some psychodynamic theorists also believe that certain people respond to their early deprivations by developing a substance abuse personality that leaves them particularly prone to drug abuse. Such individuals have disturbed ego function (inability to deal with reality) and then they use drugs as a defense mechanism (coping).

Topic 253: Etiology of Substance Related and Addictive Disorder

Cognitive Behavioristic Perspective:

According to cognitive-behavioral theorists, operant conditioning may play a key role in substance use disorders. They argue that the temporary reduction of tension or raising of spirits produced by a drug has a rewarding effect, thus increasing the likelihood that the user will seek this reaction again. Similarly, the rewarding effects may eventually lead users to try higher dosages or more powerful methods of ingestion. According to it, behavior maintained by its consequences as it terminates aversive state (pain, anxiety) and creates a euphoric state.

Beyond these conditioning explanations, cognitive-behavioral theorists further argue that such rewards eventually produce an expectancy that substances will be rewarding, and this expectation helps motivate people to increase drug use at times of tension. In support of these views, studies have found that many people do drink more alcohol or seek heroin when they feel tense. In a manner of speaking, the cognitive-behavioral theorists are arguing that many people take drugs to “medicate” themselves when they feel tense. If so, one would expect higher rates of substance use disorders among people who suffer from anxiety, depression, and other such problems.

Numbers of cognitive-behavioral theorists have proposed that classical conditioning may also play a role in these disorders. Classical conditioning occurs when two stimuli that appear close together in time become connected in a person’s mind, so that eventually, the person responds similarly to each stimulus. Cues or objects present in the environment at the time a person takes a drug may act as classically conditioned stimuli and come to produce some of the same pleasure brought on by the drugs themselves. Just the sight of a hypodermic needle, drug buddy, or regular supplier, for example, has been known to comfort people who are addicted to heroin or amphetamines and to relieve their withdrawal symptoms. In a similar manner, cues or objects that are present during withdrawal distress may produce withdrawal-like symptoms.

Topic 254: Etiology of Substance Related and Addictive Disorders

Biological Perspective:

Over the past few decades, researchers have become clear that biological factors play a major role in drug misuse

1. Genetic Predisposition:

For years, breeding experiments have been conducted to see whether certain animals are genetically predisposed to become addicted to drugs. Two types of studies are conducted in this regard:

Twin Studies: Research with human twins has suggested that people may inherit a predisposition to misuse substances. Numerous studies have found an alcoholism concordance rate of around 54 percent in identical twins; that is, if one identical twin displays alcoholism, the other twin also does in 54 percent of the cases. In contrast, in these same studies, fraternal twins have a concordance rate of only 28 percent. As you have read, however, such findings do not rule out other interpretations. For one thing, the parenting received by two identical twins may be more similar than that received by two fraternal twins.

Adoptee Studies: A clearer indication that genetics may play a role in substance use disorders comes from studies of alcoholism rates in people adopted shortly after birth. These studies have compared adoptees whose biological parents abuse alcohol with adoptees whose biological parents do not. By adulthood, the individuals whose biological parents abuse alcohol typically show higher rates of alcoholism than those with nonalcoholic biological parents.

Genetic linkage strategies and molecular biology techniques provide more direct evidence in support of a genetic explanation. One line of investigation has found an abnormal form of the so-called dopamine-2 (D2) receptor gene in a majority of research participants with substance use disorders but in less than 20 percent of participants who do not have such disorders.

Topic 255: Etiology of Substance Related and Addictive Disorders

Biological Perspective (In continuation to the previous topic 254):

Neurotransmitters (NT):

Over the past few decades, some researchers have pieced together a neurotransmitter-focused explanation of drug tolerance and withdrawal symptoms. These theorists contend that when a

particular drug is ingested, it increases the activity of certain neurotransmitters whose normal purpose is to calm, reduce pain, lift mood, or increase alertness. When a person keeps on taking the drug, the brain apparently makes an adjustment and reduces its own production of the neurotransmitters. Because the drug is increasing neurotransmitter activity or efficiency, the brain's release of the neurotransmitter is less necessary.

As drug intake increases, the body's production of the neurotransmitters continues to decrease, leaving the person in need of progressively more of the drug to achieve its effects. In this way, drug takers build tolerance for a drug, becoming more and more reliant on it rather than on their own biological processes to feel comfortable, happy, or alert. If they suddenly stop taking the drug, their natural supply of neurotransmitters will be low for a time, producing the symptoms of withdrawal. Withdrawal continues until the brain resumes its normal production of the neurotransmitters.

Topic 256: Biological Perspective

Neurotransmitters (NT): (In continuation to the previous topic 255):

Association between Drugs & NTs reduction in brain:

To some extent, the abused substance dictates which neurotransmitters will be affected.

- Repeated and excessive use of alcohol or benzodiazepines may lower the brain's production of the neurotransmitter GABA,
- Regular use of opioids may reduce the brain's production of endorphins,
- Regular use of cocaine or amphetamines may lower the brain's production of dopamine.
- In addition, researchers have identified a neurotransmitter called anandamide that operates much like THC; excessive use of marijuana may reduce the production of anandamide.

The Brain's Reward Circuit:

The neurotransmitter-focused explanation of substance abuse helps explain why people who regularly take substances have tolerance and withdrawal reactions. But why are drugs so rewarding, and why do certain people turn to them in the first place? Brain imaging studies

conducted in recent years answer these questions by pointing to the operation of a particular brain circuit—the circuit within which the neurotransmitters under discussion do their work. A brain circuit is a network of brain structures that work together, triggering each other into action to produce a distinct behavioral, cognitive, or emotional reaction. The circuit that has been tied to substance misuse is the reward circuit, also called the reward center and the pleasure pathway. Apparently, whenever a person ingests a substance (from foods to drugs), the substance eventually activates the brain's reward circuit.

This reward circuit features the brain structure called the ventral tegmental area (in the midbrain), a structure known as the nucleus accumbens, and the prefrontal cortex. In addition, the circuit includes the striatum, hippocampus, and several other important structures. The key neurotransmitter in this circuit is dopamine. When dopamine is activated throughout this circuit, a person feels pleasure. Music may activate dopamine in the reward circuit. So may a hug or a word of praise. And so do drugs. Although other neurotransmitters also play roles in the reward circuit, dopamine is the primary one.

Certain drugs directly stimulate the structures in the reward circuit. Remember that cocaine and amphetamines directly increase dopamine activity. Other drugs seem to stimulate it in roundabout ways. The biochemical reactions triggered by alcohol, opioids, and marijuana set in motion a series of chemical events that eventually lead to increased dopamine activity in the reward circuit and, in turn, excessive communications (that is, heightened interconnectivity) between the structures in the reward circuit.

A number of theorists further believe that as substances repeatedly stimulate this reward circuit, the circuit develops a hypersensitivity to the substances. Neurons in the circuit fire more readily when stimulated by the substances, contributing to future desires for them. This theory, called the *incentive-sensitization theory* of addiction, has received considerable support in both animal and human studies. Still other theorists suspect that people who chronically use drugs may suffer from a *reward deficiency syndrome*: their reward circuit is not readily activated by the usual events in their lives, so they turn to drugs to stimulate

