

## Abnormal Psychology (PSY404)

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### 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:

- Dissociative Identity Disorder (Previously known as Multiple Personality Disorder)
- Dissociative Amnesia
- Depersonalization/ Derealization Disorder
- Other Specified Dissociative Disorder
- 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:

- 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.
- Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 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.

- 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:**

- 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.

- 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).
- 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).
- 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.

## **Lesson 24**

### **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:

- **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).
- **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:**

- Dissociative disorders have been classified in DSM 5 as trauma related disorders, so traumatic events play a very important role.
- Trauma can differ from e.g. physical and sexual abuse
- Avoidance of emotions experienced during a traumatic event tend to play a major role in development of dissociative disorders.
- As discussed earlier, adverse childhood experiences can also lead to development of these disorders, as they seek shelter as being someone else.

#### **Personal Factors:**

- 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.
- People with immature defenses also tend to develop of these disorders as their coping styles are not very mature.

- 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.

**Lesson 25**

**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:

- Pica
- Rumination Disorder
- Avoidant/Restrictive Food Intake Disorder
- Anorexia Nervosa
- Bulimia Nervosa
- Binge-eating Disorder
- Other Specified Feeding and Eating Disorder
- 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:**

- Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
- The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.
- The eating behavior is not part of a culturally supported or socially normative practice.

- 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.

- Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re-chewed, re-swallowed, or spit out.
- The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux, pyloric stenosis).
- The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.
- 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.

- 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:

- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.
- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
- 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.
- 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/m<sup>2</sup>
- Moderate: BMI 16-16.99 kg/m<sup>2</sup>
- Severe: BMI 15-15.99 kg/m<sup>2</sup>
- Extreme: BMI < 15 kg/m<sup>2</sup>
- 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:

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - 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.
  - 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).

- 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.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- 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:

- 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.
- 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:

- Eating much more rapidly than normal.
- Eating until feeling uncomfortably full.
- Eating large amounts of food when not feeling physically hungry.
- Eating alone because of feeling embarrassed by how much one is eating.
- 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:

- **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.
- **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.
- **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.
- **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.
- **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.

## **Lesson 27**

### **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:

- Insomnia Disorder

- Hyper-somnolence Disorder (formally called hypersomnia)
- Narcolepsy
- Breathing-related Sleep Disorders
  - Obstructive Sleep Apnea Hypopnea
  - Central Sleep Apnea
  - Sleep-Related Hypoventilation
- Circadian Rhythm Sleep-wake Disorders
- Parasomnias
  - Non-Rapid Eye Movement (NREM) Sleep Arousal Disorders
  - Nightmare Disorder
  - Rapid Eye Movement (REM) Sleep Behavior Disorder
  - Restless Legs Syndrome
- 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 predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms:
  - Difficulty initiating sleep. (In children, this may manifest as difficulty initiating sleep without caregiver intervention.)
  - 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.)
  - Early-morning awakening with inability to return to sleep.

- The sleep disturbance causes clinically significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
- The sleep difficulty occurs at least 3 nights per week.
- The sleep difficulty is present for at least 3 months.
- The sleep difficulty occurs despite adequate opportunity for sleep.
- 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).
- The insomnia is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- 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:**

- Self-reported excessive sleepiness (hyper-somnolence) despite a main sleep period lasting at least 7 hours, with at least one of the following symptoms:
  - Recurrent periods of sleep or lapses into sleep within the same day.

- 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.

- The hyper-somnolence occurs at least three times per week, for at least 3 months.
- The hyper-somnolence is accompanied by significant distress or impairment in cognitive, social, occupational, or other important areas of functioning.
- 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).
- The hyper-somnolence is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- 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:

- Cause significant distress or impairment in all important areas of functioning.
- Not better explained by / do not occur exclusively during the course of another sleep-wake disorder
- Not attributable to the physiological effects of a substance.
- 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:**

- 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.
- The presence of at least one of the following:
  - Episodes of cataplexy, defined as either (a) or (b), occurring at least a few times per month:
    - 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.
  - 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.
  - 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:

- Obstructive sleep apnea hypopnea
- Central sleep apnea
- 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:**

- Either (1) or (2):
- Evidence by polysomnography of at least five obstructive apneas or hypopneas per hour of sleep and either of the following sleep symptoms:
  - Nocturnal breathing disturbances: snoring, snorting/gasping, or breathing pauses during sleep.
  - 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.
- 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:**

- Evidence by polysomnography of five or more central apneas per hour of sleep.
- 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:**

- Polysomnography demonstrates episodes of decreased respiration associated with elevated CO<sub>2</sub> levels. (Note: In the absence of objective measurement of CO<sub>2</sub>, persistent low levels of hemoglobin oxygen saturation unassociated with apneic/hypopneic events may indicate hypoventilation.)
- 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 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.
- The sleep disruption leads to excessive sleepiness or insomnia, or both.

- 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:**

- 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.

- No or little (e.g., only a single visual scene) dream imagery is recalled.
- Amnesia for the episodes is present.
- The episodes cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- 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**

- 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.
- On awakening from the dysphoric dreams, the individual rapidly becomes oriented and alert.
- The sleep disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The nightmare symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication).
- 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:**

- Repeated episodes of arousal during sleep associated with vocalization and/or complex motor behaviors.
- 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.
- Upon awakening from these episodes, the individual is completely awake, alert, and not confused or disoriented.
- Either of the following:
- REM sleep without atonia on polysomnographic recording.
- A history suggestive of REM sleep behavior disorder and an established synucleinopathy diagnosis (e.g., Parkinson’s disease, multiple system atrophy).
- 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).

- 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:**

- 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:
  - The urge to move the legs begins or worsens during periods of rest or inactivity.
  - The urge to move the legs is partially or totally relieved by movement.
  - 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.
- The symptoms in Criterion A occur at least three times per week and have persisted for at least 3 months.
- The symptoms in Criterion A are accompanied by significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
- 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).
- 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:

- These disorders cause significant distress or impairment in all important areas of functioning.
- Symptoms of these disorders are not attributable to the physiological effects of a substance.
- 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 prominent and severe disturbance in sleep.
- There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
  - The symptoms in Criterion A developed during or soon after substance intoxication or after withdrawal from or exposure to a medication.
  - The involved substance/medication is capable of producing the symptoms in Criterion A.
- 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 is 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.

## Lesson 29

### 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 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**

- Often loses temper.
- Is often touchy or easily annoyed.
- Is often angry and resentful.

**Argumentative/Defiant Behavior**

- Often argues with authority figures or, for children and adolescents, with adults.
- Often actively defies or refuses to comply with requests from authority figures or with rules.

- Often deliberately annoys others.
- Often blames others for his or her mistakes or misbehavior.

#### **Vindictiveness**

- 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;

- 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.
- 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 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**

- Often bullies, threatens, or intimidates others.
- Often initiates physical fights.
- Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
- Has been physically cruel to people.
- Has been physically cruel to animals.
- Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
- Has forced someone into sexual activity.

### **Destruction of Property**

- Has deliberately engaged in fire setting with the intention of causing serious damage.
- 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**

- Has broken into someone else's house, building, or car.
- Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
- Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).

#### **Serious Violations of Rules**

- Often stays out at night despite parental prohibitions, beginning before age 13 years.

- 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.
- 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:**

- Deliberate and purposeful fire setting on more than one occasion.

- Tension or affective arousal before the act.
- Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences).
- Pleasure, gratification, or relief when setting fires or when witnessing or participating in their aftermath.
- 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).
- 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:**

- Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.
- Increasing sense of tension immediately before committing the theft.
- Pleasure, gratification, or relief at the time of committing the theft.

- The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination.
- The stealing is not better explained by conduct disorder, a manic episode, or antisocial personality disorder.

## Lesson 31

### 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.

## **Lesson 32**

### **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**

- 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:
  - Cognition (i.e., ways of perceiving and interpreting self, other people, and events).
  - Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).
  - Interpersonal functioning.
  - Impulse control.

**Topic 181: Common Diagnostic criteria of Personality Disorder**

**(In continuation to the previous topic 180)**

- The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
- The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.
- 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 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:
  - Suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her.
  - Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
  - Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
  - Reads hidden demeaning or threatening meanings into benign remarks or events.
  - Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).
  - Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.
  - Have recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.
- 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 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:
  - Neither desires nor enjoys close relationships, including being part of a family.
  - Almost always chooses solitary activities.
  - Has little, if any, interest in having sexual experiences with another person.
  - Takes pleasure in few, if any, activities.
  - Lacks close friends or confidants other than first-degree relatives.
  - Appears indifferent to the praise or criticism of others.

- Shows emotional coldness, detachment, or flattened affectivity.
- 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 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:
  - Ideas of reference (excluding delusions of reference).
  - 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).
  - Unusual perceptual experiences, including bodily illusions.
  - Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped).
  - Suspiciousness or paranoid ideation.
  - Inappropriate or constricted affect.
  - Behavior or appearance that is odd, eccentric, or peculiar.
  - Lack of close friends or confidants other than first-degree relatives.
  - Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self.
- 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 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:
  - Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
  - Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
  - Impulsivity or failure to plan ahead.
  - Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
  - Reckless disregard for safety of self or others.
  - Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
  - Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
- The individual is at least age 18 years.
- There is evidence of conduct disorder with onset before age 15 years.

- 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:

- Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance: markedly and persistently unstable self-image or sense of self.
- 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.)
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

- 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).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- 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:

- Is uncomfortable in situations in which he or she is not the center of attention.
- Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior.
- Displays rapidly shifting and shallow expression of emotions.
- Consistently uses physical appearance to draw attention to self.
- Has a style of speech that is excessively impressionistic and lacking in detail.
- Shows self-dramatization, theatricality, and exaggerated expression of emotion.
- Is suggestible (i.e., easily influenced by others or circumstances).
- 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:

- Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
- Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
- 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).
- Requires excessive admiration.
- Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations).
- Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends).
- Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
- Is often envious of others or believes that others are envious of him or her.
- 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:

- Avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.

- Is unwilling to get involved with people unless certain of being liked.
- Shows restraint within intimate relationships because of the fear of being shamed or ridiculed. '
- Is preoccupied with being criticized or rejected in social situations.
- Is inhibited in new interpersonal situations because of feelings of inadequacy.
- Views self as socially inept, personally unappealing, or inferior to others.
- 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:

- Has difficulty making everyday decisions without an excessive amount of advice and reassurance from others.
- Needs others to assume responsibility for most major areas of his or her life.
- Has difficulty expressing disagreement with others because of fear of loss of support or approval. (Note: Do not include realistic fears of retribution.)
- 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).
- Goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant.
- Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
- Urgently seeks another relationship as a source of care and support when a close relationship ends.
- 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:

- Is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
- 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).
- Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity).
- Is over conscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification).
- Is unable to discard worn-out or worthless objects even when they have no sentimental value.
- Is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things.
- Adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes.
- Shows rigidity and stubbornness

**Lesson 34**

**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 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.

- There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- The disturbance is not better explained by another mental disorder (including another mental disorder due to another medical condition).
- 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 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 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:

- Paraphilic Disorders
- 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:**

- Voyeuristic Disorder
- Exhibitionistic Disorder
- Frotteuristic Disorder
- Sexual Masochism
- Sexual Sadism Disorder
- Pedophilic Disorder
- Fetishistic Disorder
- Transvestic Disorder

**Common Diagnostic Criteria for the above mentioned disorders:**

- 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.
- The individual has acted on these sexual urges with a non-consenting person,
- 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:**

- 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.
- 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:**

- 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.
- 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:**

- 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.
- 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:**

- 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.
- 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:**

- 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).
- The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
- 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:**

- 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.
- The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 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:**

- Over a period of at least 6 months, recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviors.
- 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.

## Lesson 36

### 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 marked incongruence between one's experienced / expressed gender and assigned gender, of at least 6 months' duration.
- Causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

### **Gender Dysphoria in Children Diagnostic Criteria:**

- 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):
  - 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).
  - 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.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.

- A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- 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.
- A strong dislike of one's sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- 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**

- 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:
  - 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).
  - 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).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - 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).
- 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).

## Lesson 37

### 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:**

- A disturbance in attention (i.e., reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment).
- 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.
- An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception).
- 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.
- 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**

- 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:
  - Concern of the individual, a knowledgeable informant, or clinician that there has been decline in cognitive function
  - 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.

- Evidence of a causative Alzheimer's disease genetic mutation from family history or genetic testing.
- All three of the following are present:
  - Clear evidence of decline in memory and learning and at least one other cognitive domain (based on detailed history or serial neuropsychological testing).
  - Steadily progressive, gradual decline in cognition, without extended plateaus.
  - 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:

- Clear evidence of decline in memory and learning.
- Steadily progressive, gradual decline in cognition, without extended plateaus.
- 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:

- Behavioral disinhibition.
- Apathy or inertia.
- Loss of sympathy or empathy.
- Perseverative, stereotyped or compulsive/ritualistic behavior.
- Hyperorality and dietary changes.
- Prominent decline in social cognition and/or executive abilities.

2. Language variant:

- 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:

- Fluctuating cognition with pronounced variations in attention and alertness.
- Recurrent visual hallucinations that is well formed and detailed.
- Spontaneous features of parkinsonism, with onset subsequent to the development of cognitive decline.

#### 2. Suggestive diagnostic features;

- Meets criteria for rapid eye movement sleep behavior disorder.
- 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:

- Onset of the cognitive deficits is temporally related to one or more cerebrovascular events.
- 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.

- 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:

- Clinical criteria are supported by neuroimaging evidence of significant parenchymal injury attributed to cerebrovascular disease (neuroimaging-supported).
- The neurocognitive syndrome is temporally related to one or more documented cerebrovascular events.
- 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:
- Loss of consciousness.
  - Posttraumatic amnesia.
  - Disorientation and confusion.
  - 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:**

- The criteria are met for major or mild neurocognitive disorder.
- The neurocognitive impairments do not occur exclusively during the course of a delirium and persist beyond the usual duration of intoxication and acute withdrawal.
- The involved substance or medication and duration and extent of use are capable of producing the neurocognitive impairment.
- 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:**

- The criteria are met for major or mild neurocognitive disorder.
- There is documented infection with human immunodeficiency virus (HIV).
- The neurocognitive disorder is not better explained by non-HIV conditions, including secondary brain diseases such as progressive multifocal leukoencephalopathy or cryptococcal meningitis.
- 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:**

- The criteria are met for major or mild neurocognitive disorder.
- There is insidious onset and gradual progression.
- There is clinically established Huntington's disease, or risk for Huntington's disease based on family history or genetic testing.
- 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:**

- The criteria are met for major or mild neurocognitive disorder.
- There is evidence from the history, physical examination, or laboratory findings that the neurocognitive disorder is the pathophysiological consequence of another medical condition.
- 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.

## **Lesson 39**

### **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 call 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.

- **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.
- **Morphine** is a highly addictive substance derived from opium, is particularly effective in relieving pain.
- **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:

- Substance Use Disorders
- Substance Induced Disorders

### **Substance Use Disorders**

#### **General Features:**

- 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.
- 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.
- 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.
- Substance use was previously split into abuse or dependence
- It involves impaired control, social impairment, risky use and pharmacological criteria.
- The individual may take the substance in larger amounts or over a longer period than was originally intended.
- 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:**

- The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects.
- In some instances of more severe substance use disorders, virtually all of the individual's daily
- 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.
- Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home
- he individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- 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.
- Individual use substance in situations in which it is physically hazardous.
- 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.
- An individual may develop tolerance.
- Withdrawal is another significant feature of substance abuse disorder.

#### **Lesson 40**

### **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 include physiological & cognitive components. Withdrawal causes significant distress in social, occupational or other important areas of functioning. If 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:

- The disorder developed during or within 1 month of a substance intoxication or withdrawal or taking a medication; and
- 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:

- The disorder preceded the onset of severe intoxication or withdrawal or exposure to the medication; or
- 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:

- Certain substance is often taken in larger amounts or over a longer period than was intended.
- Persistent desire or unsuccessful efforts to cut down or control --use.
- A great deal of time is spent in activities necessary to obtain, use, or recover from its effects.
- Craving, or a strong desire or urge to use the substance
- Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by use
- Important social, occupational, or recreational activities are given up or reduced.
- Recurrent use in situations in which it is physically hazardous.
- 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.
- Tolerance
- 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.

**Lesson 41**

**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:

- Alcohol is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.

- A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
- Craving, or a strong desire or urge to use alcohol.
- Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- Recurrent alcohol use in situations in which it is physically hazardous.
- 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.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of alcohol.

11. Withdrawal, as manifested by either of the following:

- The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal, pp. 499-500).
- 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:

- Slurred speech.
- Incoordination.
- Unsteady gait.
- Nystagmus.
- Impairment in attention or memory.
- 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:

- Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm).
- Increased hand tremor.
- Insomnia.
- Nausea or vomiting.
- Transient visual, tactile, or auditory hallucinations or illusions.
- Psychomotor agitation.
- Anxiety.
- 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:

- Restlessness.
- Nervousness.
- Excitement.
- Insomnia.
- Flushed face.
- Diuresis.
- Gastrointestinal disturbance.
- Muscle twitching.
- Rambling flow of thought and speech.
- Tachycardia or cardiac arrhythmia.
- Periods of inexhaustibility.

- 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:

- Headache.
- Marked fatigue or drowsiness.
- Dysphoric mood, depressed mood, or irritability.
- Difficulty concentrating.
- 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:

- Cannabis is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control cannabis use.
- A great deal of time is spent in activities necessary to obtain cannabis, use cannabis, or recover from its effects.
- Craving, or a strong desire or urge to use cannabis.
- Recurrent cannabis use resulting in a failure to fulfill major role obligations at work, school, or home.

- Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis.
- Important social, occupational, or recreational activities are given up or reduced because of cannabis use.
- Recurrent cannabis use in situations in which it is physically hazardous.
- 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.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of cannabis to achieve intoxication or desired effect.
  - Markedly diminished effect with continued use of the same amount of cannabis.

11. Withdrawal, as manifested by either of the following:

- The characteristic withdrawal syndrome for cannabis
- 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:

- Conjunctival injection.
- Increased appetite.
- Dry mouth.
- 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:

- Irritability, anger, or aggression.
- Nervousness or anxiety.
- Sleep difficulty (e.g., insomnia, disturbing dreams).
- Decreased appetite or weight loss.
- Restlessness.

- Depressed mood.
- 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.

- Vertical or horizontal nystagmus.
- Hypertension or tachycardia.
- Numbness or diminished responsiveness to pain.
- Ataxia.
- Dysarthria.
- Muscle rigidity.
- Seizures or coma.

- 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:

- Pupillary dilation.
- Tachycardia.
- Sweating.
- Palpitations.
- Blurring of vision.
- Tremors.
- 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:

- Dizziness.
- Nystagmus.
- Incoordination.
- Slurred speech.
- Unsteady gait.
- Lethargy.

- Depressed reflexes.
- Psychomotor retardation.
- Tremor.
- Generalized muscle weakness.
- Blurred vision or diplopia (simultaneous perception of two images of a single object).
- Stupor or coma.
- 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:

- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire or urge to use opioids.
- Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.

- Recurrent opioid use in situations in which it is physically hazardous.
- 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.
- 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:

- Drowsiness or coma.
- Slurred speech.
- 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:

- Sedatives, hypnotics, or anxiolytics are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control sedative, hypnotic, or anxiolytic use.
- 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.
- Craving, or a strong desire or urge to use the sedative, hypnotic, or anxiolytic.
- 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).
- 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).

- Important social, occupational, or recreational activities are given up or reduced because of sedative, hypnotic, or anxiolytic use.
- 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).
- 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.
- 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:

- The stimulant is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control stimulant use.
- A great deal of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects.
- Craving, or a strong desire or urge to use the stimulant.
- Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant.
- Important social, occupational, or recreational activities are given up or reduced because of stimulant use.

- Recurrent stimulant use in situations in which it is physically hazardous.
- 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.
- 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.

- 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:

- Tobacco is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control tobacco use.
- A great deal of time is spent in activities necessary to obtain or use tobacco.
- Craving, or a strong desire or urge to use tobacco.
- Recurrent tobacco use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., interference with work).
- 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).
- Important social, occupational, or recreational activities are given up or reduced because of tobacco use.
- Recurrent tobacco use in situations in which it is physically hazardous (e.g., smoking in bed).

- 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.
- 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.
    - 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:
  - Irritability, frustration, or anger.
  - Anxiety.
  - Difficulty concentrating.
  - Increased appetite.
  - Restlessness.

- Depressed mood.
- 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.

## **Lesson 44**

### **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:

- Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
- Is restless or irritable when attempting to cut down or stop gambling.
- Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
- 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).
- Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
- After losing money gambling, often returns another day to get even (“chasing” one’s losses).
- Lies to conceal the extent of involvement with gambling.
- Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
- 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.

**Lesson 45**

## **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

- **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