Abnormal Psychology (PSY404)

Table of Content

Lesson 01

Introduction to Abnormal Psychology

Topic: 1-3

Topic 01: Abnormal Psychology: An Introduction

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

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

"The Four Ds":

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

Deviance

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

Distress

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

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

Dysfunction

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

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

Danger

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

DSM-5 Definition of Abnormal behavior:

DSM stands for Diagnostic and statistical manual for psychological disorders.

It defines abnormal behavior as:

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

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

Topic 02: Different Criteria of Abnormality

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

Statistical Criteria

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

Personal Distress

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

Dysfunction

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

Violation of Social Norms

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

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

Behaviors that violate social norms are considered abnormal or disordered.

Topic 03: Causes of Abnormality

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

Biological Causes/Factors:

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

Psychological Causes/Factors:

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

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

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

- **Negative Irrational Cognitions**

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

Sociocultural Factors:

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

Lesson 02

Historical Perspective on Abnormal Behavior

Topic: 4-8

Topic 4: Ancient Views and Treatments

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

Expelling the Evil Spirits:

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

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

Exorcism

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

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

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

Greek and Roman Views and Treatments:

500 B.C. to 500 A.D.

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

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

Europe in the Middle Ages: Demonology I:

500– 1350 A.D.

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

Europe in the Middle Ages: Demonology II:

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

Topic 5: Islamic Perspective-Golden Period

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

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

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

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

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

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

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

Topic 6: The Renaissance and the Rise of Asylums

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

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

Topic 7: Reform and Moral Treatment

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

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

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

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

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

The Early Twentieth Century: Dual Perspectives:

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

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

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

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

Topic 8: Current Trends

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

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

Following are few current trends for treatment of mental disorders:

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

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

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

Outpatient Treatment:

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

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

Private Psychotherapy:

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

A Growing Emphasis on Preventing Disorders

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

Promoting Mental Health

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

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

Lesson 03

Diagnosis

Topic: 9-14

Topic 9: Diagnosis: Definition

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

Definition

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

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

The diagnosis of the disorder is based on:

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

The Diagnosis Process:

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

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

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

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

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

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

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

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

Topic 10: Assessment

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

Clinical assessment tools fall into three categories:

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

Clinical Interview

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

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

Limitations of Clinical Interview:

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

Topic 11: Mental Status Examination

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

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

General Appearance

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

- Hygiene
- Odor
- Facial expressions

Psychomotor Behavior

- Gait
- Handshake
- Abnormal movements
- Rate of movements

Speech

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

Mood and Affect

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

Cognition

- Cognition attention and concentration
- Memory
- Abstraction

- Insight into illness
- Orientation
- Judgement

Thought Pattern

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

Topic 12: Formal Assessment

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

Characteristics of a Psychological Test

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

Procedure:

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

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

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

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

Categories of Tests:

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

Intelligence Testing

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

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

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

Personality Testing

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

Self-Report Tests

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

- Big Five Inventory

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

Projective Tests

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

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

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

Topic 13: Neuropsychological Assessment

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

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

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

Specific Disorder Related Tests

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

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

Behavioral Observation

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

Clinical Observation

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

Assessment Reports

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

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

Topic 14: What is New in DSM-5?

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

What is the difference between DSM and ICD?

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

What is new in DSM-5?

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

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

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

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

Mental Retardation has been changed to Intellectual Disability.

The communication disorders, which are newly named from DSM-IV phonological disorder and stuttering, respectively, include: Language disorder (which combines the previous

expressive and mixed receptive-expressive language disorders), Speech sound disorder (previously phonological disorder), Childhood-onset fluency disorder (previously stuttering) Also included is social (pragmatic) communication disorder, a new condition involving persistent difficulties in the social uses of verbal and nonverbal communication.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What is ICD-10?

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

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

Lesson 04

Treatment

Topic: 15-16

Topic 15: Treatment

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

Planning a Treatment

All forms of therapy have three essential features:

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

Treatment Team

Treatment team includes the followings:

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

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

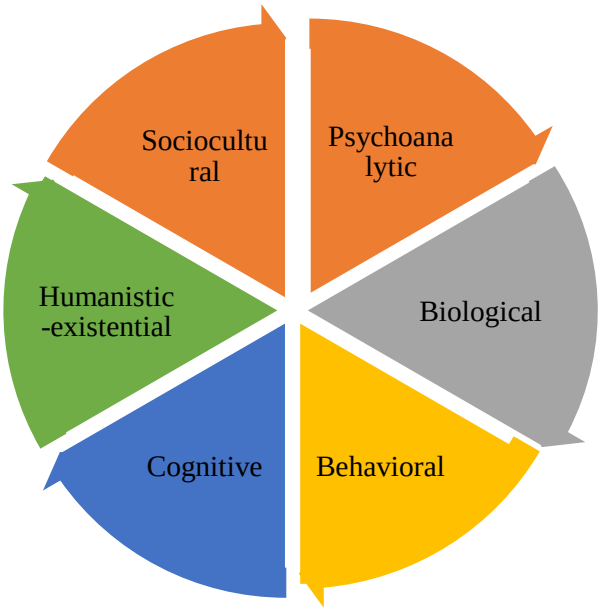
Topic 16: Modality of Treatment

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

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

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

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



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

Lesson 05

Theoretical Perspectives I

Topic: 17-21

Topic 17: Introducing Perspectives

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

Models' Influence

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

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

Topic 18: Biological Perspective

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

Brain Anatomy and Abnormal Behavior

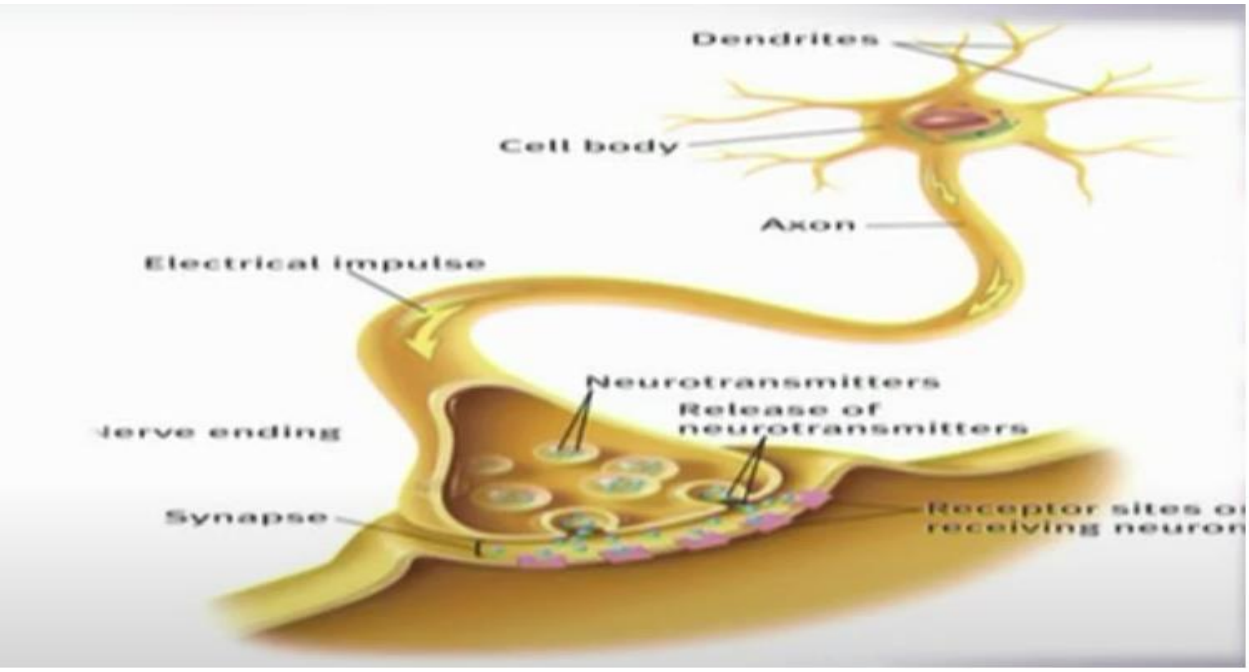
Brain is composed of 100 billion nerve cells called neurons and thousands of billions of support cells called glia/glial cells. Within the brain large groups of neurons form distinct regions, or brain structures. Clinical researchers have sometimes discovered connections between particular psychological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

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

Topic 19: Brain Chemistry and Abnormal Behavior

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

Structure of a Neuron:



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

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

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

Topic 20: Neurotransmitters

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

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

Endocrine Glands

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

Genetic Factors

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

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

Topic 21: Viral Infections

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

Treatment:

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

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

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

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

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

Lesson 06

Theoretical Perspectives II

Topic: 22-25

Psychodynamic & Behavioristic Perspective

Topic 21: Psychodynamic Perspective

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

Freud's Three Levels of Mind:

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

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

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

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

Structure of Personality:

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

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

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

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

Development of Personality:

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

Psychosexual Stages of Development:

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

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

Topic 23: Defense Mechanisms

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

Following are few mechanisms:

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

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

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

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

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

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

Normal/Abnormal Functioning:

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

Topic 24: Therapeutic Techniques of Psychoanalytic Therapy

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

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

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

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

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

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

Post Freudians:

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

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

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

Topic 25: Behavioral Perspective

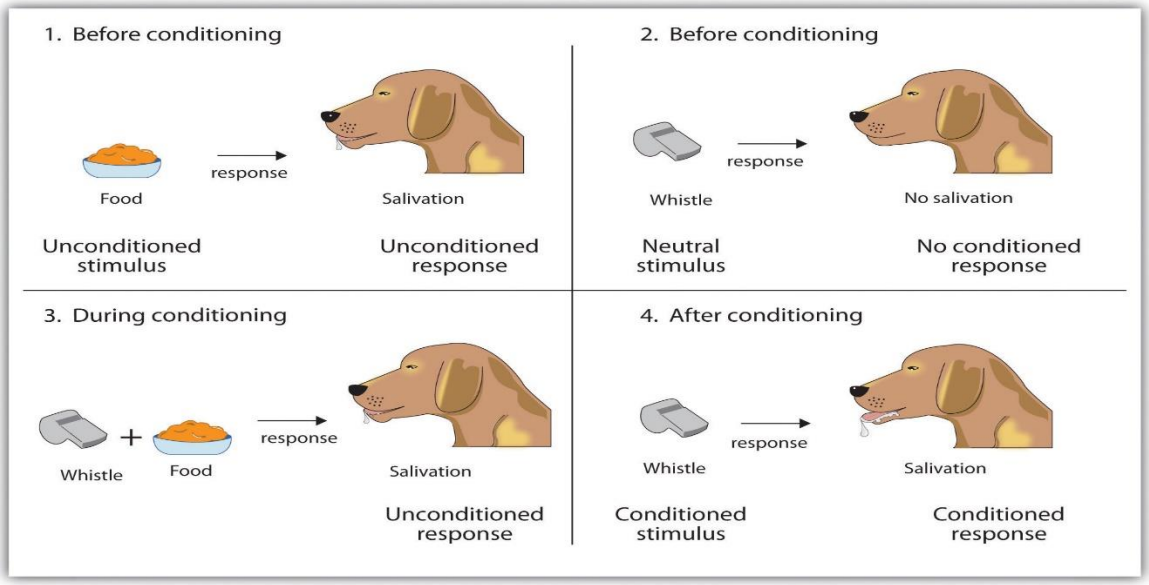
Basic Concepts

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

Conditioning:

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

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



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

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

Following are the principles of operant conditioning:

1. **Immediacy:** The reward of a behavior must be closed in time and space. For example, it should be immediate and not be delayed after a certain behavior has been shown.

2. **Consistency:** Consistency refers that a certain type of behavior must be reinforced/punished every time. If there is not consistency in reinforcement/punishment, the behavior will not be shaped.

3. **Reinforcement:** If the consequences of a behavior are satisfying, they are called reinforcers, and they serve to increase the likelihood of the person repeating the behavior in the future, it could be either positive or negative. A consequence is reinforcing when it

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

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

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

Lesson 07

Theoretical Perspectives III

Topic: 26-29

Cognitive, Humanistic & Sociocultural Perspectives

Topic 26: Cognitive Perspective

Basic Concepts

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

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

Beck's Cognitive Therapy

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

Albert Ellis' Rational Emotive Behavior Therapy

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

Topic 27: Humanistic Perspective

Basic Concepts

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

Roger's Humanistic Theory

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

Client Centered Therapy

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

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

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

- Genuineness (sincere communication)

Topic 28: Sociocultural Perspective

Basic Concepts

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

Family Social Treatments

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

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

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

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

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

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

Topic 29: Other Perspectives

Biopsychosocial Model

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

Diathesis Stress Theory

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

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

Summing Up:

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

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

Lesson 08

Neurodevelopmental Disorders I

Topic: 30-35

Topic 30: Introduction

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

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

Topic 31: Intellectual Disability

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

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

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

- Communication

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

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

Topic 32: Intellectual Disability Diagnostic Criteria

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

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

Topic 33: Intellectual Disability Specifiers/Diagnostic Criteria

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

- Mild
- Moderate
- Severe
- Profound

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

Global Developmental Delay

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

Topic 34: Autism Spectrum Disorder

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

Diagnostic Criteria:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history

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

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

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

Topic 35: Autism Spectrum Disorder

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

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

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

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life). D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

D. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Specify Current Severity:

Following parameters needs to be seen in this section:

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

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

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

Lesson 09

Neurodevelopmental Disorders II

Topic: 36-41

Topic 36: Specific Learning Disorder

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

Diagnostic Criteria for Specific Learning Disorders:

A. Difficulties learning and using academic skills, as indicated by the presence of at least one of the following symptoms that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:

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

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

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

Topic 37: Specific Learning Disabilities

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

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

Reading Disability: With impairments in reading:

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

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

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

Writing Disability: With impairment in the written expression:

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

Mathematical Disability: With impairments in mathematics

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

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

We also need to specify current severity on the followings:

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

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

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

Topic 38: Communication Disorders

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

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

Language Disorder

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

Diagnostic Criteria:

Following is the diagnostic criteria of language disorders:

A. Persistent difficulties in the acquisition and use of language across modalities (i.e., spoken, written, sign language, or other) due to deficits in comprehension or production that include the following:

1. Reduced vocabulary (word knowledge and use).
2. Limited sentence structure (ability to put words and word endings together to form sentences based on the rules of grammar and morphology).
3. Impairments in discourse (ability to use vocabulary and connect sentences to explain or describe a topic or series of events or have a conversation).

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

Topic 39: Speech Sound Disorders

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

Diagnostic Criteria:

Following is the diagnostic criteria of speech sound disorders:

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

Topic 40: Childhood-Onset Fluency Disorder (Stuttering)

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

Diagnostic Criteria:

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

A. Disturbances in the normal fluency and time patterning of speech that are inappropriate for the individual's age and language skills, persist over time, and are characterized by frequent and marked occurrences of one (or more) of the following:
   1. Sound and syllable repetitions.
   2. Sound prolongations of consonants as well as vowels.
   3. Broken words (e.g., pauses within a word).
   4. Audible or silent blocking (filled or unfilled pauses in speech).
   5. Circumlocutions (word substitutions to avoid problematic words).
   6. Words produced with an excess of physical tension.
   7. Monosyllabic whole-word repetitions (e.g., "I-I-I-I see him").

B. The disturbance causes anxiety about speaking or limitations in effective communication, social participation, or academic or occupational performance, individually or in any combination.

C. The onset of symptoms is in the early developmental period. (Note: Later-onset cases are diagnosed as 307.0 [F98.5] adult-onset fluency disorder.)

D. The disturbance is not attributable to a speech-motor or sensory deficit, dysfluency associated with neurological insult (e.g., stroke, tumor, trauma), or another medical condition and is not better explained by another mental disorder.

Topic 41: **Social Communication Disorder**

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

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

Diagnostic Criteria:

Following is the diagnostic criteria of social communication disorder:

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

Lesson 10

Neurodevelopmental Disorders III

Topic: 42-45

Topic 42: Attention Deficit Hyperactivity Disorder (ADHD)

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

There are two features of ADHD:

1. Inattention and Disorganization Entail:

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

2. Hyperactivity-Impulsivity Entails:

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

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

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

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

Diagnostic Criteria:

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

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

Topic 43: Attention Deficit Hyperactivity Disorder (ADHD)

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

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

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

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

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

Topic 44: Attention Deficit Hyperactivity Disorder (ADHD)

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

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

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

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

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

Topic 45: Attention Deficit Hyperactivity Disorder (ADHD)

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

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

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

We need to specify if:

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

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

Severity:

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

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

Lesson 11

Neurodevelopmental Disorders IV

Topic: 46-50

Topic 46: Motor Disorder

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

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

Developmental Coordination Disorder

Diagnostic Criteria:

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

Topic 47: Stereotypic Movement Disorder

Diagnostic Criteria:

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

Topic 48: Stereotypic Movement Disorder

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

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

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

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

Mild: Symptoms are easily suppressed by sensory stimulus or distraction

Moderate: Symptoms require explicit protective measures and behavioral modification

Severe: Continuous monitoring and protective measures are required

Topic 49: Tic Disorders

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

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

Tourette's Disorder

Diagnostic Criteria:

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

A. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently.

B. The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset.

C. Onset is before age 18 years.

D. The disturbance is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington's disease, post viral encephalitis).

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

Diagnostic Criteria:

This disorder is diagnosed when:

A. Single or multiple motor or vocal tics have been present during the illness, but not both motor and vocal.

B. The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset.

C. Onset is before age 18 years.

D. The disturbance is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington's disease, post-viral encephalitis).

E. Criteria have never been met for Tourette's disorder.

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

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

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

Lesson 12

Schizophrenia spectrum & other Psychotic Disorders I

Topic 51-56

Topic 51

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

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

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

Following disorders fall in this category:

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

9. Catatonic Disorder Due to another Medical Conditions

Schizophrenia

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

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

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

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

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

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

Diagnostic Criteria

A. Two (or more) of the following, each present for a significant portion of time during a 1 - month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
   1. Delusions: A delusion is a strange false belief firmly held despite evidence to the contrary There are many types of schizophrenia. It is one of the major features of schizophrenia.
   2. Hallucinations: Hallucinations refer to experiencing of sights, sounds, or other perceptions in the absence of external stimuli.
   3. Disorganized speech: It refers to a disorganized pattern of speech which includes rapid shift of topics, irrelevant and incoherent conversation, neologisms i.e. made up words etc. or phrases.
   4. Grossly disorganized or catatonic behavior: Catatonic behavior is remaining in one posture for long hours.
   5. Negative symptoms: deficits in behavior

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs of the disturbance persist for at least 6 months (Duration). This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

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

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

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

Specify if:

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

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

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

Specify current severity:

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

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

Topic 53: Schizophrenoform Disorder

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

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

    1. Delusions.

    2. Hallucinations.

    3. Disorganized speech (e.g., frequent derailment or incoherence).

    4. Grossly disorganized or catatonic behavior.

    5. Negative symptoms (i.e., diminished emotional expression or avolition).

B. An episode of the disorder lasts at least 1 month but less than 6 months. When the diagnosis must be made without waiting for recovery, it should be qualified as “provisional.”
C. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred

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

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

Specify if:

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

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

Specify current severity:

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

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

specifier.

Topic 54: Schizoaffective Disorder

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

Diagnostic Criteria

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

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

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

Specify whether:

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

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

Specify if:

With catatonia

Specify if:

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

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

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

Specify current severity:

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

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

Topic 55: Delusional Disorder

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

Diagnostic Criteria

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

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

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

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

Specify whether:

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

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

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

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

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

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

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

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

Specify if:

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

Topic 56: Delusional Disorder

Specifier:

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

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

Specify current severity:

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

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

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

Lesson 13

Schizophrenia & other Psychotic Disorders II

Topic 57-62

Topic 57: Brief Psychotic Disorder

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

Diagnostic Criteria

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

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

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

Specify if:

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

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

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

Specify if: With catatonia

Specify current severity:

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

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

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

Topic 58: Substance /Medicine Induced Psychotic Disorder

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

Diagnostic Criteria

Substance /Medicine Induced Psychotic Disorder will be diagnosed if

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

    1. Delusions.

2. Hallucinations.

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

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

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

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

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

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

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

Specifiers:

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

- With onset during intoxication
- With onset during withdrawal

Severity:

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

Topic 59: Psychotic Disorders Due to another Medical Condition

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

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

Specifiers:

It is important to specify whether predominant symptoms are:

- With delusions
- With hallucinations

Severity:

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

Topic 60: Catatonia Associated with another Mental Disorder

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

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

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

Followings must be kept in mind:

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

Unspecified Catatonia:

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

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

Topic 61: Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

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

Etiology of Schizophrenia and other psychotic Disorder:

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

Genetic Factors

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

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

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

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

Familial High-Risk Studies

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

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

Topic 62: Etiology of Schizophrenia and other psychotic Disorder

Psychological Factors

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

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

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

Developmental Factors

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

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

Lesson 14

Depressive Disorders

Topic 63-69

Topic 63

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

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

Disruptive Mood Dysregulation Disorder

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

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

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

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

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

Topic 64: Major Depressive Disorder

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

Following is the diagnostic criteria of MDD:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

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

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note**: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

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

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

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

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

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

Specifiers:

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

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

- Mild
- Moderate

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

Topic 65: Persistent Depressive Disorders (Dysthemia)

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

Diagnostic Criteria:

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

    1. Poor appetite or overeating.

    2. Insomnia or hypersomnia.

    3. Low energy or fatigue.

    4. Low self-esteem.

    5. Poor concentration or difficulty making decisions.

    6. Feelings of hopelessness.

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.
D. Criteria for a major depressive disorder may be continuously present for 2 years.

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

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

Severity:

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

- Mild
- Moderate
- Severe

Topic 66: Substance/Medication-Induced Depressive Disorders

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

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

A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.
B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

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

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

C. The disturbance is not better explained by a depressive disorder that is not substance/medication-induced. Such evidence of an independent depressive disorder could include the following:
   The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced depressive disorder (e.g., a history of recurrent non substance/medication-related episodes).

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

Specifiers:

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

- intoxication
- withdrawal

Topic 67: Depressive Disorder Due to Another Medical Condition

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

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

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

Specifiers:

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

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

Other Specified Depressive Disorders

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

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

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

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

Topic 68: Etiology of Depressive Disorders

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

Neurobiological Factors:

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

Social Factors:

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

Topic 69: Etiology of Depressive Disorders

Psychological Factors

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

Cognitive Biases:

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

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

Negative Triad:

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

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

Rumination

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

Lesson 15

Bipolar and Related Disorders

Topic 70-76

Topic 70: Bipolar Disorders

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

Bipolar disorder is a category that includes three different conditions:

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

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

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

- Manic Episode
- Hypomanic Episode
- Depressive Episode

Manic Episode

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

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

Distinctive Features

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

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

Topic 71: Diagnostic Criteria of Manic Episode

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

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a sig-nificant degree and represent a noticeable change from usual behavior:
    1. Inflated self-esteem or grandiosity.
    2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
    3. More talkative than usual or pressure to keep talking.
    4. Flight of ideas or subjective experience that thoughts are racing.
    5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
    6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e. purposeless non-goal-directed activity).

7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

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

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

Topic 72: Hypomanic Episode

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

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

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

Diagnostic Criteria

A. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
   1. Inflated self-esteem or grandiosity.
   2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

B. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
C. The disturbance in mood and the change in functioning are observable by others.
D. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
E. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).

Topic 73: Bipolar I Disorder

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

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

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

Severity:

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

- Mild

- Moderate
- Severe

Specify:

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

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

Topic 74: Bipolar II Disorder

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

Diagnostic Criteria:

Following is the diagnostic criteria of Bipolar II disorder:

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

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

Specify:

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

- Hypomanic
- Depressed

It is also needed to be specified it is:

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

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

- In partial remission
- In full remission

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

- Mild
- Moderate
- Severe

Topic 75: Cyclothymic Disorder

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

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

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

Specify:

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

- With anxious distress
- Substance/medication induced

Topic 76: Substance/Medication Induced Bipolar Disorder

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

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

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

Specify:

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

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

It also needs to be specified if:

- With onset during intoxication
- With onset during withdrawal

Lesson 16

Bipolar and Related Disorders II

Topic 77-81

Topic 77: Suicide

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

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

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

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

- Loss

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

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

Topic 78: Etiological Factors of Bipolar and Related disorders

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

Neurobiological and Genetic or Chromosomal Factors:

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

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

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

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

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

Topic 79: Psychological Factors

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

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

Cognitive View

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

Cognitive Triade: (Aaron Beck)

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

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

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

Topic 80: Psychological Factors

Cognitive View

Irrational Thinking (Albert Ellis):

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

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

Learned Helplessness (Seligman)

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

Attribution-Learned helplessness:

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

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

Following is an example of attribution style:

Event: *I failed my test today*

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

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

Topic 81: Environmental Causes

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

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

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

Lesson 17

Anxiety Disorders I

Topic 82-88

Topic 82: General Features 1248/394

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

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

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

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

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

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

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

Types of Anxiety Disorders

Following disorders fall under the category of anxiety disorders:

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

Topic 83: Separation Anxiety Disorder

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

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

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

Diagnostic Criteria:

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

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

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

4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
7. Repeated nightmares involving the theme of separation.
8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.

A. The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in adults.

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

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

Topic 85: Selective Mutism

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

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

Diagnostic Criteria:

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

Topic 86: Specific Phobia

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

Diagnostic Criteria:

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

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

B. The phobic object or situation almost always provokes immediate fear or anxiety.
C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.
D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
E. **Duration:** The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia): objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

Specify if:

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

- Animal (e.g., spiders).

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

Topic 87: Social Anxiety Disorder

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

Diagnostic Criteria:

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

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

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing: will lead to rejection or offend others).
C. The social situations almost always provoke fear or anxiety.

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

While diagnosing we need to specify if it is:

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

Duration: Duration of symptoms must be more than 6 months

Topic 88: Agoraphobia

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

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

Diagnostic Criteria:

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

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

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

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

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

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

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

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

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

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

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

Lesson 18

Anxiety Disorders II

Topic 89-95

Topic 89: Panic Disorder

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

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

Diagnostic Criteria:

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

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

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

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

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

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

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

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

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

Topic 90: Generalized Anxiety Disorder

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

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

Diagnostic Criteria:

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

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

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

Note: Only one item is required in children.

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

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

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

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

Topic 91: Substance/Medication-Induced Anxiety Disorder

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

Diagnostic Criteria:

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

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

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

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

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

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

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

Topic 92: Anxiety Disorder Due to another Medical Condition

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

Diagnostic Criteria:

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

B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.

C. The disturbance is not better explained by another mental disorder.

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

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

Topic 93: Etiology of Anxiety Disorders

Separation Anxiety Disorder:

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

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

Etiology of Selective Mutism:

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

Etiology of Specific Phobia:

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

Topic 94: Etiology of Social Anxiety Disorder

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

Cognitive Perspective:

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

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

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

Topic 95: Etiology of Panic Disorder

Biological Perspective:

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

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

Cognitive Factor:

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

Etiology of Generalized Anxiety Disorder:

Psychodynamic Perspective:

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

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

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

Cognitive Perspective:

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

Lesson 19

Obsessive Compulsive and Related Disorders I

Topic 96-102

Topic 96

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

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

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

DSM IV TR to DSM-5:

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

Topic 97: Obsessive-Compulsive Disorder

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

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

General Features of OCD:

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

Topic 98

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

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

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

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

Topic 99: Diagnostic Criteria of Obsessive Compulsive Disorder

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

A. Presence of obsessions, compulsions, or both:

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

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

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

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

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

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

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

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

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

Specify if:

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

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

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

Specify if:

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

Topic 100: Body Dysmorphic Disorder

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

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

Diagnostic Criteria:

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

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

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

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

Specify:

We need to specify if it is:

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

Specify if:

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

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

Topic 101: Hoarding Disorder

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

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

Diagnostic Criteria:

A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.

B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.

C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).

D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).

Topic 102: Hoarding Disorder

Diagnostic Criteria

(In continuation to the previous topic#101)

E. The hoarding is not attributable to another medical condition (e.g., brain injury, cerebrovascular disease, Prader-Willi syndrome).

F. The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder).

Specify:

We need to specify if it is:

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

It also needs to be specified if the disorder is:

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

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

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

Lesson 20

Obsessive Compulsive and Related Disorders II

Topic 103-108

Topic 103: Trichotillomania (Hair-Pulling Disorder)

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

Diagnostic Criteria:

A. Recurrent pulling out of one's hair, resulting in hair loss.

B. Repeated attempts to decrease or stop hair pulling.

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

D. The hair pulling or hair loss is not attributable to another medical condition (e.g., a dermatological condition).

E. The hair pulling is not better explained by the symptoms of another mental disorder (e.g., attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder).

Excoriation (Skin-Picking) Disorder:

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

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

Diagnostic Criteria:

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

A. Recurrent skin picking resulting in skin lesions.

B. Repeated attempts to decrease or stop skin picking.

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

D. The skin picking is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., scabies).

E. The skin picking is not better explained by symptoms of another mental disorder (e.g., delusions or tactile hallucinations in a psychotic disorder, attempts to improve a perceived defect or flaw in appearance in body dysmorphic disorder, stereotypies in stereotypic movement disorder, or intention to harm oneself in non-suicidal self-injury).

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

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

Diagnostic Criteria:

A. Obsessions, compulsions, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of the obsessive-compulsive and related disorders predominate in the clinical picture.

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

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

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

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

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

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

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

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

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

Diagnostic Criteria:

A. Obsessions, compulsions, preoccupations with appearance, hoarding, skin picking, hair pulling, other body-focused repetitive behaviors, or other symptoms characteristic of obsessive-compulsive and related disorder predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.

C. The disturbance is not better explained by another mental disorder.

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

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

Specify:

While diagnosing we need to specify if:

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

Topic 106: Other Specified Obsessive-Compulsive and Related Disorder

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

Unspecified Obsessive-Compulsive and Related Disorder

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

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

Topic 107

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

Etiology of Obsessive Compulsive Disorder

Genetic and Physiological Factors

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

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

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

Environmental Factors:

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

Temperamental/Personal Factors:

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

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

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

Behavioral Explanations:

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

Topic 108: Etiology of Body Dysmorphic Disorder

Genetic and Physiological Factors:

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

Environmental Factors:

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

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

Etiology of Hoarding Disorder:

Genetic Factors:

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

Environmental Factors:

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

Temperamental Factor:

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

Cognitive Behavioral Model:

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

Etiology of Trichotillomania and Excoriation Disorder

Genetic and Physiological Factors

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

Lesson 21

Trauma and Stress Related Disorders I

Topic 109-118

Topic 109: Introduction

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

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

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

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

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

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

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

Autonomic Nervous System:

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

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

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

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

Endocrine Glands: Pituitary & Adrenal:

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

General Features of Trauma and Stress Related Disorders

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

4. Dissociative symptoms: De-realization & Depersonalization

Types of Trauma and Stress Related Disorders

Following disorders fall under this category:

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

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

Topic 110: Reactive Attachment Disorder

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

Diagnostic Criteria:

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

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

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

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

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

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

Topic 111: Reactive Attachment Disorder

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

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

F. The disturbance is evident before age 5 years.

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

Specify:

We need to specify if it is:

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

Specify Current Severity:

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

Topic 112: Disinhibited Social Engagement Disorder

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

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

Diagnostic Criteria:

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

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

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

Topic 113: Disinhibited Social Engagement Disorder

(In continuation to the pervious topic 112)

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

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

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

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

Specify:

We need to specify if it is:

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

Specify Current Severity:

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

Topic 114: Posttraumatic Stress Disorder (PTSD)

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

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

Diagnostic Criteria:

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

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

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

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

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

Topic 115: Posttraumatic Stress Disorder (PTSD)

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

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

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

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

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

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

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

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

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
   Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
   Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
   Note: In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Topic 116: Posttraumatic Stress Disorder (PTSD)

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

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

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

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

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

Topic 117: Posttraumatic Stress Disorder (PTSD)

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

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

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

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

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

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

Topic 118: Posttraumatic Stress Disorder (PTSD)

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

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

Specify Whether:

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

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

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

Specify:

While diagnosing we need to specify if it is:

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

Lesson 22

Trauma and Stress Related Disorders II

Topic 119-124

Topic 119: Acute Stress Disorder

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

Diagnostic Criteria:

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

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the event(s) occurred to a close family member or close friend.
   Note: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).
   Note: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

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

Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
   Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

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

Negative Mood

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

Dissociative Symptoms

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

   Avoidance Symptoms
8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
12. Hypervigilance
13. Problems with concentration.

14. Exaggerated startle response.

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

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

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Topic 120: Adjustment Disorder

Adjustment disorder is characterized by excessive and extended feelings of anxiety, depressed mood, or antisocial behavior in response to life stressors. The symptoms of an adjustment disorder are not as severe as those in PTSD or in anxiety disorders, but they do cause individuals considerable stress and may interfere with their job, schoolwork, or social life. In Acute stress disorder and Post traumatic stress disorder, a traumatic event causes the problem, but in adjustment disorder, a significant stressor must be there.

Diagnostic Criteria:

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:

1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
2. Significant impairment in social, occupational, or other important areas of functioning.

C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.

D. The symptoms do not represent normal bereavement.

E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Specify:

We need to specify if it is:

- With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant.
- With anxiety: Nervousness, worry, jitteriness, or separation anxiety is predominant.

Topic 121: Adjustment Disorder

Diagnostic Criteria: (In continuation to the pervious topic 120)

Specify if it is:

- With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant.
- With disturbance of conduct: Disturbance of conduct is predominant.
- With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.
- Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

Topic 122: Etiology of Trauma and Stress Related Disorders

Clearly, extraordinary trauma can cause a stress disorder. The stressful event alone, however, may not be the entire explanation. Anyone who experiences an unusual trauma will be affected by it, but only some people develop a stress disorder. To understand the development of these disorders more fully, researchers have looked at different factors among which few will be discussed here.

1. Pre-trauma factors

2. Peri-trauma factors
3. Post trauma factors

Pre-Trauma Factors:

A Pre-trauma factor is defined as a vulnerability factor can be defined as an enduring, endogenous trait inherent in the individual that serves to increase the likelihood of developing a particular disorder

Temperamental Factors:

Childhood emotional problems/disturbance by the age 6 years e.g., externalizing or anxiety problems can make a child vulnerable to cope with the life stressors.

Prior mental disorders e.g., panic disorder, depressive disorder increases the probability for a disorder to be developed in an individual.

Moreover, Research suggests that people with certain personalities, attitudes, and coping styles are particularly likely to develop posttraumatic stress disorder

Environmental Factors:

Researchers have found that certain childhood experiences increase a person's risk for later PTSD. People whose childhoods were marked by poverty appear more likely to develop the disorder in the face of later trauma. So do people whose childhoods included an assault, abuse, or a catastrophe; multiple traumas; parental separation or divorce; or living with family members suffering from psychological disorders. Childhood adversities e.g. economic adversities play an important role in this regard.

Genetic and Physiological Factors:

Investigators have linked posttraumatic stress disorder to several biological factors. Female gender is more prone and vulnerable to develop stress related disorders. Moreover, age is also important in this regard that if adult females experience a trauma at a younger age, they are more likely to develop the disorder. Moreover, there are certain genotypes may either be protective or increase risk of PTSD after exposure to a trauma.

Topic 123: Peri-Traumatic Factors

Peri-traumatic factors refer to those factors which play a role during a traumatic event is taking place.

Environmental Factors:

The severity of the trauma influences whether or not a person will develop PTSD. The greater the magnitude of trauma, the greater is the likelihood of PTSD development. Perceived life death and personal injury are also likely to cause stress ultimately developing PTSD. Interpersonal violence particularly trauma perpetrated by a caregiver can also lead to development of this disorder. Along with that, being a perpetrator could also cause stress.

Temperamental Factors:

These factors include negative appraisals, inappropriate coping strategies, and development of acute stress disorder. Appraisal is of two kinds i.e. primary appraisal and secondary appraisal. Primary appraisal is an assessment of how significant an event is for a person, including whether it is a threat or opportunity. Secondary appraisal then considers one's ability to cope or take advantage of the situation. If a person negatively appraises a situation, then likelihood of developing Post traumatic disorder increases. Along with that, coping strategies are also very important. Coping strategies are the specific efforts, both behavioral and psychological, that people use to control, tolerate, reduce, or minimize stressful events. There are two types of coping strategies i.e. emotion focused coping and problem focused coping. Emotion-focused coping is a type of stress management strategy that attempts to reduce negative emotional responses that occur due to exposure to stressors. Problem-focused coping is that kind of coping aimed at resolving the stressful situation or event or altering the source of the stress. Maladaptive patterns of emotional focused strategies also cause stress and lead to development of such disorders.

Topic 124: Post Trauma Factors

These refer to the factors which play a role after a specific trauma.

Environmental Factors:

When individual experiences a trauma, and copes well, when they experience a subsequent exposure to trauma it leads to development of PTSD. Moreover, subsequent adverse life events, such financial or other trauma-related losses also very important in this regard.

Social support including family stability, children, a network of friends all are a protective factor that moderates outcome after trauma. Those who do not find this support after a trauma, are at higher risk of developing PTSD.

Neurobiological Factors

As with other anxiety disorders, PTSD appears to be related to greater activation of the amygdala and diminished activation of the medial prefrontal cortex, regions that are integrally involved in learning and extinguishing fears. Although these two regions seem involved in many of the anxiety disorders, PTSD appears uniquely related to the function of the hippocampus.

The hippocampus is known for its role in memory, particularly for memories related to emotions. Brain-imaging studies show that among people with PTSD, the hippocampus has a smaller volume than among people who do not have PTSD.

Personal Factors:

Personal factors also play a major in development of PTSD. Selective attention causes people to fell a prey to stress who only focus on the negative aspects of a situation. Neuroticism is another major factor in this regard. For example, a classic study conducted after the monster 1989 storm, Hurricane Hugo, revealed that children who had been highly anxious before the storm were more likely than other children to develop severe stress reactions. Negative effectivity is another important factor. It has been seen that people who generally view life's negative events as beyond their control tend to develop more severe stress symptoms after traumatic events than people who feel that they have more control over their lives. Similarly, people who generally find it difficult to derive anything positive from unpleasant situations adjust more poorly after traumatic events than other people. People with avoidance coping are more likely to develop PTSD. People with low level of intelligence, who are not effectively able to solve their problems are also at a risk of developing trauma and stress related disorders subsequent to a trauma.