# ABNORMAL PSYCHOLOGY

PmLE | Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

## MANIFESTATIONS OF BEHAVIOR (5)

**PSYCHOPATHOLOGY –** the field concerned with the nature, development, and treatment of psychological disorders

**ABNORMAL PSYCHOLOGY –** a branch of psychology that studies unusual patterns of behaviors, emotions, and thought, which may or may not indicate an underlying condition

**PSYCHOLOGICAL DISORDERS –** psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected

- **Dysfunction –** breakdown in cognitive, emotional, or behavioral functioning
- **Distress –** the individual is extremely upset and cannot function properly
- **Deviance** (Atypical or Not Culturally Expected) – deviates from the average or the norm of the culture
- **Dangerousness –** creates potential harm to self and others
- **Disability –** impairment (limitations) in some important area of life
- **Duration –** how long the mental state has been persisting

**NORMAL BEHAVIOR –** one behavior that is like other people in society

- Normality is **social conformity**
- Normality is **personal comfort**
- Normality is a **process**

**Indicators for Determining Abnormal Behavior**

- ➔ Subjective Distress
- ➔ Maladaptiveness
- ➔ Statistical Deviancy
- ➔ Violation of the Standards of Society
- ➔ Personal/Social Discomfort
- ➔ Irrationality and Unpredictability
- ➔ Dangerousness

## A Describing Abnormal Behavior

- **Presenting Problem –** chief complaint
- **Clinical Description –** represents the unique combination of behaviors, thoughts, and feelings that make up a specific disorder
- **Diagnosis –** process of determining whether the particular problem afflicting the individual meets all criteria for a psychological disorder
- **Prevalence –** how many people experience the disorder (# of active cases)
- **Incidence –** how many cases occur during a given period (# of new cases)
- **Cause –** how the disorder will progress
  - **Chronic –** lifetime
  - **Episodic –** likely to recover
  - **Time-limited –** one time, will improve without treatment
- **Onset –** how the disorder develops
  - **Acute –** sudden
  - **Insidious –** gradual
- **Prognosis –** anticipated course of a disorder
  - **Good –** high chance of possibility to recover
  - **Guarded –** low chance of recovery
- **Sign –** manifestation of disease that the physician receives
- **Symptoms –** subjective representation of the complaints of the patient
- **Syndrome –** a group of symptoms that occur together more often by chance
- **Etiology –** study of the origins of why the disorder begins
- **Epidemiology –** study of the distribution of disease, or health-related behaviors in a given population
- **Ego Syntonic –** actions align with the client's personal goals, values, and beliefs
- **Ego Dystonic –** actions that are inconsistent with the client's ego

**Multiaxial System (DSM-IV to DSM-5)**

- ➔ **Axis I:** Mental Health and Substance Use Disorder (Clinical Disorder)
- ➔ **Axis II:** Personality Disorders and Mental Retardation
- ➔ **Axis III:** General Medical Conditions
- ➔ **Axis IV:** Psychosocial and Environmental Problems
- ➔ **Axis V:** Assessment of Overall Functioning (Global Assessment of Functioning)

## PSYCHOLOGICAL DISORDERS AND SPECIFIC SYMPTOMS BASED ON DSM-5 (50)

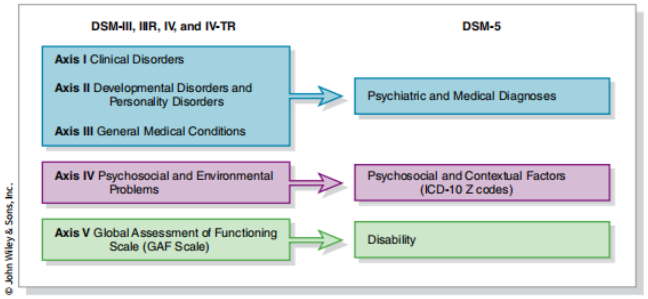
**DIAGNOSTIC STATISTICAL MANUAL OF MENTAL DISORDERS 5TH EDITION**

- In 1952, the **American Psychiatric Association** published its first **Diagnostic and Statistical**

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**Manual (DSM)**

- DSM-5 was released in **2013**
- The DSM-5 **provides information about each disorder**
- The DSM-5 provides **specific diagnostic criteria—symptoms for a given diagnosis**




**Mental Disorder (DSM-5)**

- ➔ Is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning
- ➔ Usually associated with significant distress or disability in social, occupational, or other important activities
- ➔ An expectable or culturally approved response to a common stressor or loss, such as death of a loved one, is not a mental disorder
- ➔ Socially deviant behavior and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual

## A | Differentiating Anxiety Disorders, Trauma-and-Stressor-Related Disorders, and OCD-Related Disorders

**Anxiety Disorders** – excessive and persistent fear, worry, or anxiety that is disproportionate to the actual situation, which significantly impairs daily functioning

- **Fear –** is the emotional response to real or perceived imminent threat, more associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviors
- **Anxiety –** is the anticipation of a future threat, more often associated with muscle tension and vigilance in preparation for future danger, and cautious or avoidant behavior
- **Panic Attack –** is featured prominently within the anxiety disorders as a particular type of fear response

**ANXIETY DISORDERS (5)**

**Separation Anxiety Disorder –** is a mental disorder characterized by an excessive fear or anxiety concerning separation from a home or attachment figure(s). The anxiety exceeds what is expected at the individual's developmental level.

- ➔ Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least 3 of the following:
  - ◆ Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
  - ◆ Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
  - ◆ 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.
  - ◆ Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
  - ◆ Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
  - ◆ Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
  - ◆ Repeated nightmares involving the theme of separation.
  - ◆ Repeated complaints of physical symptoms (e.g. - headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.
- ➔ The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents and typically 6 months or more in

adults.

- ➔ The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.
- ➔ The disturbance is not better explained by another mental disorder, such as:
  - ◆ Refusing to leave home because of excessive resistance to change (autism spectrum disorder)
  - ◆ Delusions or hallucinations concerning separation (psychotic disorders)
  - ◆ Refusal to go outside without a trusted companion (agoraphobia)
  - ◆ Worries about ill health or other harm befalling significant others (generalized anxiety disorder)
  - ◆ Concerns about having an illness (illness anxiety disorder)

**Selective Mutism –** is a mental disorder where individuals (most commonly children) do not initiate speech or reciprocally respond when spoken to by others.

- ➔ The child consistently fails to speak in specific social situations where there is an expectation for speaking (e.g., at school), even though they speak in other situations (e.g., at home).
- ➔ The disturbance interferes with educational or occupational achievement or with social communication.
- ➔ The disturbance lasts for at least 1 month. (Note: This is not limited to the first month of school, as many children are shy when starting a new year).
- ➔ The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- ➔ The disturbance is not better explained by a communication disorder (like stuttering) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

**Specific Phobia –** is defined as a marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation.

- ➔ About a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
- ➔ The phobic object or situation almost always provokes immediate fear or anxiety.
- ➔ The phobic object or situation is actively avoided or endured with intense fear or anxiety.
- ➔ The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
- ➔ The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- ➔ The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ➔ The disturbance is not better explained by the symptoms of another mental disorder (e.g., Agoraphobia, OCD, or PTSD).

| Type | Example |
|---|---|
| Animal | Spiders (Arachnophobia), Dogs (Cynophobia), Snakes. |
| Natural Environment | Heights (Acrophobia), Storms, Water. |
| Blood-Injection-Injury | Needles, medical procedures, or seeing blood. |
| Situational | Airplanes, elevators, enclosed places (Claustrophobia). |
| Others | Choking, vomiting, loud sounds, costumed characters. |

**Social Anxiety Disorder –** (also known as social phobia) is an anxiety disorder characterized by a significant amount of fear in one or more social situations, causing significant distress and impaired ability to function in some aspects of daily life. These fears can be triggered by perceived or actual scrutiny, or negative evaluation from others.

- ➔ 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).
  - ◆ Performing in front of others (e.g., giving a speech).
- ➔ The individual fears that they 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).

- ➔ The social situations almost always provoke fear or anxiety.
- ➔ The social situations are avoided or endured with intense fear or anxiety.
- ➔ The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
- ➔ The fear, anxiety, or avoidance is persistent, typically lasting for **6 months or more**.
- ➔ The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Panic Disorder –** is defined by the presence of recurrent, unexpected panic attacks followed by a persistent concern about having more attacks or a significant change in behavior to avoid them.

- ➔ The individual experiences recurrent, unexpected panic attacks (attacks that seem to occur "out of the blue" without an obvious trigger).
  - ◆ Sweating
  - ◆ Trembling or shaking
  - ◆ Unsteady, dizziness, light-headed, or faint
  - ◆ Derealization (feelings of unreality) or depersonalization (being detached from one self)
  - ◆ Excessive/accelerated heart rate, palpitations, or pounding heart
  - ◆ Nausea or abdominal distress
  - ◆ Tingling, numbness, parathesesias
  - ◆ Shortness of breath
  - ◆ Fear of losing control or "going crazy"
  - ◆ Fear of dying
  - ◆ Choking feelings
  - ◆ Chest pain or discomfort
  - ◆ Chills or heat sensations
- ➔ At least one of the attacks has been followed by **1 month (or more)** of one or both of the following:
  - ◆ **Persistent concern or worry** about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").
  - ◆ **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).
- ➔ The disturbance is not attributable to the physiological effects of a substance (e.g., caffeine, drugs of abuse, or medication).
- ➔ The disturbance is not better explained by another mental disorder (e.g., Social Anxiety Disorder, Phobias, or OCD) or a medical condition (e.g., hyperthyroidism or cardiac arrhythmias).

**Agoraphobia –** is an anxiety disorder where an individual has intense fears about at least two different types of situations, with the fear being that escape may be difficult or help may be unavailable if panic-like symptoms occur.

- ➔ Marked fear or anxiety about **at least 2** of the following 5 situations:
  - ◆ **Public transportation** (e.g. - automobiles, buses, trains, ships, planes)
  - ◆ **Open spaces** (e.g. - parking lots, malls, marketplaces, bridges)
  - ◆ **Enclosed places** (e.g. - rooms, shops, theatres, cinemas)
  - ◆ **Crowds or standing in line**
  - ◆ **Being outside of home alone**
- ➔ 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 or fear of incontinence in the elderly).
- ➔ The agoraphobic situations almost always provoke fear or anxiety.
- ➔ The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.
- ➔ The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.
- ➔ The fear, anxiety, or avoidance is persistent, typically lasting for **6 months or more**.
- ➔ The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ➔ If another medical condition (e.g. - inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.
- ➔ The fear, anxiety, or avoidance is not better

explained by the symptoms of another mental disorder:

- The symptoms are not confined to a specific phobia, situational type
- Do not involve only social situations (social anxiety disorder)
- Do not relate exclusively to obsessions (obsessive-compulsive disorder)
- Do not relate to defects or flaws in physical appearance (body dysmorphic disorder)
- Do not relate to reminders of traumatic events (post-traumatic stress disorder)
- Do not relate to fear of separation (separation anxiety disorder).

**Generalized Anxiety Disorders –** is characterized by excessive anxiety and worry about multiple events or activities (e.g. - school or work difficulties, relationships, finances) on a majority of days over at least half a year.

- ➔ 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).
- ➔ The individual finds it difficult to control the worry. It feels "runaway" or uncontrollable.
- ➔ 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):
  - **Restlessness** or feeling keyed up or on edge.
  - Being **easily fatigued**.
  - **Difficulty concentrating** or mind going blank.
  - **Irritability**.
  - **Muscle tension** (the most characteristic physical sign of GAD).
  - **Sleep disturbance** (difficulty falling or staying asleep, or restless, unsatisfying sleep).

  **Note:** Only **one** item is required for children.
- ➔ The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ➔ The disturbance is not attributable to the physiological effects of a substance (e.g., caffeine, thyroid medication) or another medical condition (e.g., hyperthyroidism).
- ➔ The disturbance is not better explained by another mental disorder (e.g., anxiety about having a panic attack, being scrutinized in social situations, or being away from attachment figures).

**Trauma-and-Stressor-Related Disorders –** development of psychological problems following exposure to a traumatic or stressful event

- Exposure to actual or threatened death, serious injury, sexual violence, or other severely stressful events

## TRAUMA-AND-STRESSOR-RELATED DISORDERS (4)

**Reactive Attachment Disorder –** cis a disorder of infancy and early childhood, characterized by a pattern of significant disturbance and developmentally inappropriate attachment behaviors.

- ➔ A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by **both** of the following:
  - The child rarely or minimally seeks comfort when distressed.
  - The child rarely or minimally responds to comfort when distressed.
- ➔ A persistent social and emotional disturbance characterized by **at least two** of the following:
  - Minimal social and emotional responsiveness to others.
  - Limited positive affect (rarely smiles or shows joy).
  - Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.
- ➔ The child has experienced a pattern of extremes of insufficient care (pathogenic care) as evidenced by **at least one** of the following:
  - **Social neglect or deprivation:** Lack of having basic emotional needs for comfort and stimulation met by caregivers.
  - **Repeated changes of primary caregivers:** (e.g., frequent changes in foster care) that limit opportunities to form stable attachments.
  - **Rearing in unusual settings:** (e.g., institutions with high child-to-caregiver ratios) that severely limit opportunities to form selective attachments.
- ➔ The care in Criterion C is presumed to be responsible for the disturbed behavior in

Criterion A.
- ➔ Criteria are not met for Autism Spectrum Disorder.
- ➔ The disturbance is evident before **age 5 years**.
- ➔ The child has a developmental age of **at least 9 months**.

**Disinhibited Social Engagement Disorder –** characterized by a pattern of overly familiar and disinhibited behavior towards unfamiliar adults

- ➔ A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits **at least two** of the following:
  - ◆ **Reduced or absent reticence** in approaching and interacting with unfamiliar adults.
  - ◆ **Overly familiar verbal or physical behavior** (that is not consistent with culturally sanctioned and age-appropriate social boundaries).
  - ◆ **Diminished or absent checking back** with adult caregivers after venturing away, even in unfamiliar settings.
  - ◆ **Willingness to go off with an unfamiliar adult** with minimal or no hesitation.
- ➔ The behaviors in Criterion A are not limited to impulsivity (such as in ADHD) but include socially disinhibited behavior.
- ➔ The child has experienced a pattern of extremes of insufficient care (**pathogenic care**), evidenced by at least one of the following:
  - ◆ **Social neglect or deprivation** (lack of basic emotional needs being met).
  - ◆ **Repeated changes of primary caregivers** (e.g., frequent foster home moves).
  - ◆ **Rearing in unusual settings** that limit selective attachments (e.g., large-scale orphanages).
- ➔ The child must have a developmental age of **at least 9 months**.
- ➔ The neglect in Criterion C is presumed to be the cause of the behaviors in Criterion A.

**Posttraumatic Stress Disorder –** exposure to actual or threatened death, serious injury, or sexual violence

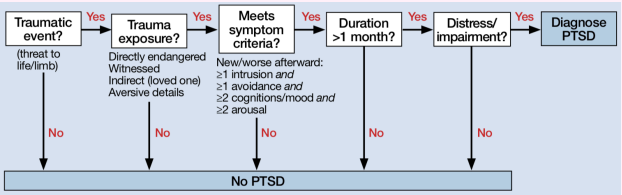
- ➔ **Exposure** to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
  - ◆ **Direct experience** of the event.
  - ◆ **Witnessing**, in person, the event occurring to others.
  - ◆ **Learning** that the event occurred to a close family member or friend (must be violent or accidental).
  - ◆ **Experiencing repeated/extreme exposure** to aversive details (e.g., first responders). *Note: This does not include media exposure unless it is work-related.*
- ➔ Presence of at least 1 of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
  - ◆ Recurrent, involuntary, and intrusive distressing memories.
  - ◆ Distressing dreams (nightmares).
  - ◆ **Dissociative reactions (Flashbacks)** where the person feels the event is recurring.
  - ◆ Intense psychological distress or physiological reactions (racing heart, sweating) when exposed to triggers.
- ➔ Avoidance. Persistent avoidance of stimuli associated with the event:
  - ◆ Avoidance of internal reminders (distressing memories, thoughts, or feelings).
  - ◆ Avoidance of external reminders (people, places, conversations, or objects).
- ➔ Negative Alterations in Cognition and Mood. The "emotional numbing" and cognitive shift:
  - ◆ Inability to remember key aspects of the trauma (dissociative amnesia).
  - ◆ Persistent, exaggerated negative beliefs about oneself or the world ("The world is completely dangerous").
  - ◆ Distorted blame of self or others for causing the trauma.
  - ◆ Persistent negative emotional state (fear, horror, anger, guilt).
  - ◆ Markedly diminished interest in activities.
  - ◆ Feelings of detachment or estrangement from others.
  - ◆ Persistent inability to experience positive emotions.
- ➔ Alterations in Arousal and Reactivity. The "fight or flight" system is stuck on high:
  - ◆ Irritability and angry outbursts.
  - ◆ Reckless or self-destructive behavior.
  - ◆ **Hypervigilance** (constantly scanning for threats).

- ◆ Exaggerated startle response (jumpiness).
- ◆ Problems with concentration.
- ◆ Sleep disturbance.

➔ Symptoms must last for **more than 1 month**.

➔ The disturbance causes clinically significant distress or impairment (social, occupational).

➔ Not due to medication, substance use, or another medical condition.




**Acute Stress Disorder** –acute stress reaction, psychological shock) is a mental disorder that arises in response to experiencing or witnessing a traumatic event that induces a strong emotional response within the individual.

➔ Exposure to actual or threatened death, serious injury, or sexual violence (the same "trauma" definition used for PTSD).

➔ Unlike PTSD, which requires a specific number of symptoms from *each* cluster, ASD requires a total of **9 or more** symptoms from any of the following five categories:

- ◆ Intrusion Symptoms
  - Recurrent, involuntary, and intrusive distressing memories.
  - Recurrent distressing dreams.
  - Dissociative reactions (Flashbacks).
  - Intense psychological or physiological distress in response to cues.
- ◆ Negative Mood
  - Persistent inability to experience positive emotions (happiness, satisfaction, or loving feelings).
- ◆ Dissociative Symptoms
  - 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).
  - Inability to remember an important aspect of the traumatic event (Dissociative Amnesia).
- ◆ Avoidance Symptoms
  - Efforts to avoid distressing memories, thoughts, or feelings about the event.
  - Efforts to avoid external reminders (people, places, conversations, objects).
- ◆ Arousal Symptoms
  - Sleep disturbance.
  - Irritable behavior and angry outbursts.
  - Hypervigilance.
  - Problems with concentration.
  - Exaggerated startle response.

➔ The duration of the disturbance is **3 days to 1 month** after trauma exposure. *If symptoms persist beyond 30 days, the diagnosis is changed to PTSD.*

➔ The disturbance causes clinically significant distress or impairment.

➔ Not due to a substance, medical condition, or brief psychotic disorder.

**Adjustment Disorder** – emotional and behavioral symptoms develop in response to a specific stressor, such as a life change or stressful event

➔ The development of emotional or behavioral symptoms in response to an identifiable stressor occurring **within 3 months** of the onset of the stressor.

➔ These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:

- ◆ **Marked distress** that is out of proportion to the severity or intensity of the stressor (taking into account the cultural context).
- ◆ **Significant impairment** in social, occupational, or other important areas of functioning.

➔ The stress-related disturbance does not meet the criteria for another mental disorder (e.g., Major Depressive Disorder) and is not an exacerbation of a pre-existing mental disorder.

➔ The symptoms do not represent normal bereavement.

➔ Once the stressor (or its consequences) has terminated, the symptoms **do not persist for more than an additional 6 months**.

**Prolonged Grief Disorder (DSM 5-TR) –** describes a state where the grieving process remains "stuck" in a way that is severe, persistent, and disabling, lasting much longer than social or cultural norms would expect.

- ➔ The death of a person close to the bereaved occurred at least **12 months ago** (for adults) or at least **6 months ago** (for children and adolescents).
- ➔ Since the death, there is a persistent and pervasive grief response characterized by **one or both** of the following:
  - ◆ **Intense yearning/longing** for the deceased person.
  - ◆ **Preoccupation** with thoughts or memories of the deceased person (in children, this may focus on the circumstances of the death).
- ➔ The individual must experience at least **three** of the following symptoms to a clinically significant degree, present most days for at least the last month:
  - ◆ **Identity disruption:** Feeling as though part of oneself has died.
  - ◆ **Marked sense of disbelief** about the death.
  - ◆ **Avoidance** of reminders that the person is dead.
  - ◆ **Intense emotional pain:** (e.g., anger, bitterness, sorrow) related to the death.
  - ◆ **Difficulty moving on:** Difficulty engaging with friends, pursuing interests, or planning for the future.
  - ◆ **Emotional numbness:** (Absence or marked reduction of emotional experience).
  - ◆ **Feeling that life is meaningless** as a result of death.
  - ◆ **Intense loneliness:** Feeling alone or detached from others.

**OCD-Related Disorders –** Characterized by persistent, intrusive thoughts (obsessions) and/or repetitive behaviors or mental acts (compulsions) that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly

- **Obsessions –** recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, causing marked anxiety or distress
- **Compulsions –** repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly
- Obsessions are typically the primary trigger for compulsions
- **Accommodation –** involvement of family and friends in compulsive rituals

## OCD-RELATED DISORDERS (4)

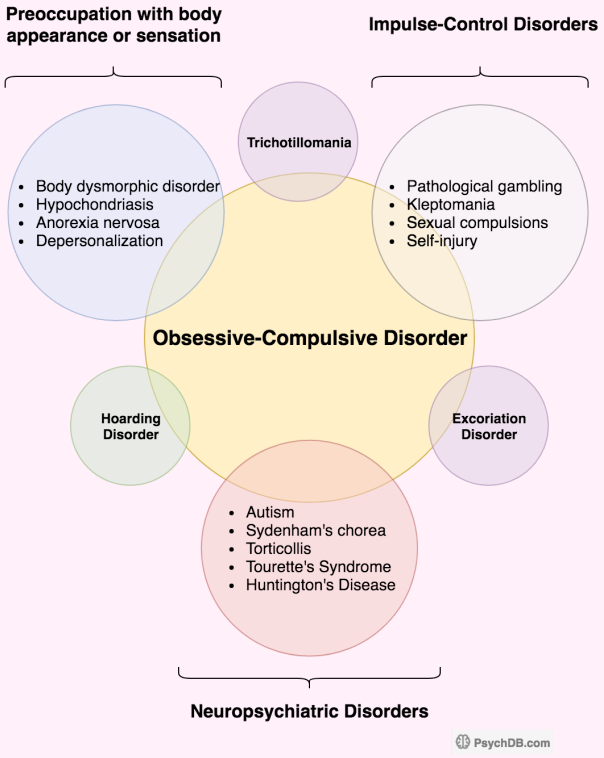
**Obsessive-Compulsive Disorder –** s defined by the presence of obsessions, compulsions, or both. These symptoms must be time-consuming and cause significant distress or impairment.

- ➔ Presence of obsessions, compulsions, or both:
  *Obsessions are defined by (1) and (2):*
  - ◆ **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
  - ◆ **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):*
  - ◆ **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
  - ◆ **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
- ➔ 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.
- ➔ 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.
- ➔ The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical

condition.

➔ The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries in GAD, or skin picking in Excoriation Disorder).




**Body Dysmorphic Disorder** – preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others

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

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

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

➔ 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 (like Anorexia Nervosa).

***Muscle Dysmorphia*** – *is a form of BDD that occurs almost exclusively in males, and individuals are preoccupied with the idea that their body is too small or not lean enough or muscular enough. Ironically, individuals actually have a normal-appearing body, or may already even be muscular. Most will also exercise or lift weights excessive, sometimes to the point of causing physical injury.*

**Hoarding Disorder** –is an obsessive-compulsive and related disorder characterized by persistent difficulty discarding or parting with possessions (regardless of their actual value) due to a strong perceived need to save the items. There is also associated distress associated with discarding these items.

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

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

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

➔ 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).

➔ The hoarding is not attributable to another medical condition (e.g., brain injury)

➔ And is not better explained by the symptoms of another mental disorder (e.g., obsessions in OCD, decreased energy in Major Depressive Disorder).

**Trichotillomania (Hair-Pulling Disorder)** – is an obsessive-compulsive and related disorder characterized by a long term, irresistible urge to pull out one's hair. The hair pulling occurs to the degree that significant hair loss occurs.

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

➔ Repeated attempts to decrease or stop hair pulling.

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

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

dermatological condition like alopecia areata).
- ➔ 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).

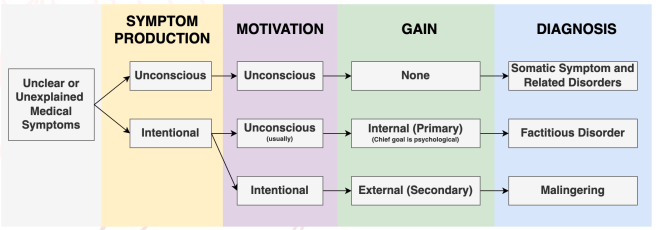
**Excoriation (Skin-Picking) Disorder –** is an obsessive-compulsive and related disorder characterized by the repeated urge to pick at one's own skin, often to the extent that significant skin damage is caused.
- ➔ Recurrent skin picking resulting in skin lesions.
- ➔ Repeated attempts to decrease or stop skin picking.
- ➔ The skin picking causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (e.g., avoiding social events or the gym to hide lesions).
- ➔ The picking is not attributable to the physiological effects of a substance (e.g., cocaine or amphetamines, which can cause sensations of "bugs crawling" on the skin) or another medical condition (e.g., scabies or dermatological issues).
- ➔ The picking is not better explained by symptoms of another mental disorder (e.g., delusions in a psychotic disorder or attempts to improve a perceived appearance flaw in Body Dysmorphic Disorder).

**Other Specified OCD-Related Disorders**
- ➔ **BD-like Disorder w/ Actual Flaws –** the preoccupation is with a physical defect or flaw that is actually observable by others
- ➔ **BD-like Disorder w/o Repetitive Behaviors –** meets all the criteria for BDD except that the individual has not performed repetitive behaviors or mental acts in response to the appearance concerns
- ➔ **Body-Focused Repetitive Behavior Disorder –** involves repetitive behaviors (other than hair pulling or skin picking) such as nail biting, lip biting, cheek chewing
- ➔ **Obsessional Jealousy –** a non-delusional preoccupation with a partner's perceived infidelity
- ➔ **Olfactory Reference Syndrome –** persistent preoccupation with the belief that one emits a foul or offensive body odor, even when this is not noticed by others

## B Explaining Somatic Symptom and Related Disorders, Eating and Sleeping Disorders, Substance-Related and Addictive Disorders, Disruptive, Impulse-Control, and Conduct Disorders

**Somatic Symptom Disorder and Related Disorders –** individuals experiencing physical symptoms that are distressing and significantly disrupt their daily lives
- These symptoms are not fully explained by a medical condition
- The focus is on the individual's thoughts, feelings, and behaviors related to their physical symptoms

**COMPARISON OF SOMATIC DISORDERS, FACTITIOUS DISORDER, AND MALINGERING**




### SOMATIC SYMPTOMS AND RELATED DISORDERS (4)

**Somatic Symptom Disorder –** is a mental disorder characterized by multiple, current, somatic symptoms that are distressing or result in significant disruption of daily life.
- ➔ One or more somatic symptoms (such as pain, fatigue, or shortness of breath) that are distressing or result in significant disruption of daily life.
- ➔ This is the core of the diagnosis. The individual must show excessive concern related to the somatic symptoms or associated health concerns, as manifested by **at least one** of the following:
  - ◆ **Disproportionate and persistent thoughts** about the seriousness of one's symptoms.
  - ◆ **Persistently high level of anxiety** about health or symptoms.
  - ◆ **Excessive time and energy** devoted to these symptoms or health concerns (e.g., spending hours researching symptoms or frequent doctor visits).
- ➔ Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically **more than 6 months**).

**Illness Anxiety Disorder (Hypochondriasis) –** is a mental

disorder characterized by a preoccupation with having or acquiring a serious, undiagnosed medical illness. Somatic symptoms are either not present or mild in intensity. Illness anxiety can be thought of as a generalized anxiety disorder that focuses exclusively on health concerns.

- ➔ Preoccupation with having or acquiring a serious illness.
- ➔ Somatic (physical) symptoms are **not present** or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing one (e.g., strong family history), the preoccupation is clearly excessive or disproportionate.
- ➔ There is a high level of anxiety about health, and the individual is easily alarmed about personal health status (e.g., hearing about someone else getting sick triggers a panic).
- ➔ The individual performs excessive health-related behaviors (e.g., repeatedly checking their body for signs of illness, obsessive "googling" of symptoms) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
- ➔ The illness preoccupation has been present for **at least 6 months**, though the specific illness feared may change during that time.
- ➔ The preoccupation is not better explained by another mental disorder, such as Somatic Symptom Disorder, Panic Disorder, Generalized Anxiety Disorder, or Body Dysmorphic Disorder.

**Conversion Disorder (Functional Neurological Symptom Disorder) –** is a mental disorder characterized by neurologic symptoms (either motor or sensory) that is incompatible with any known neurologic disease.

- ➔ One or more symptoms of altered voluntary motor or sensory function.
- ➔ Clinical findings provide evidence of **incompatibility** between the symptom and recognized neurological or medical conditions.
- ➔ The symptom or deficit is not better explained by another medical or mental disorder.
- ➔ The symptom causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Psychological Factors Affecting Other Medical Conditions –** is a mental disorder that is diagnosed when clinically significant psychological or behavioral factors adversely affects an individual's medical condition and increases their risk for suffering, death, or disability.

- ➔ A medical symptom or condition (other than a mental disorder) is present.
- ➔ Psychological or behavioral factors adversely affect the medical condition in **one** of the following ways:
  - ◆ **Influence on the course:** The factors have influenced the course of the medical condition, as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
  - ◆ **Interference with treatment:** The factors interfere with the treatment of the medical condition (e.g., poor adherence to medication).
  - ◆ **Additional health risks:** The factors constitute additional well-defined health risks for the individual.
  - ◆ **Influence on underlying pathophysiology:** The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.
- ➔ The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., Panic Disorder, Major Depressive Disorder, or PTSD).

**Factitious Disorder –** involves the falsification of physical or psychological signs or symptoms with no obvious reward.

- ➔ The essential feature is that the individual presents themselves (or another person) as ill or injured even in the absence of obvious external rewards (like financial gain or avoiding legal trouble).
- ➔ Factitious disorder is different from hypochondriasis (an obsolete DSM-IV diagnosis) and somatic symptom disorder (now the DSM-5 diagnosis) in that patients are aware that they are exaggerating, whereas sufferers of hypochondriasis actually believe they have a disease.

**Factitious Disorder Imposed on Self**

*This was historically known as* ***Munchausen Syndrome.***

- ➔ Falsification (i.e. - deliberately feigning) of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.

- ➔ The individual presents himself or herself to others as ill, impaired, or injured.
- ➔ The deceptive behavior is evident even in the absence of obvious external rewards.
- ➔ The behavior is not better explained by another mental disorder, such as Delusional Disorder or another psychotic disorder.

**Factitious Disorder Imposed on Another**

*This was historically known as* ***Munchausen Syndrome by proxy.***

- ➔ Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
- ➔ The individual presents another individual (the victim) to others as ill, impaired, or injured.
- ➔ The deceptive behavior is evident even in the absence of obvious external rewards.
- ➔ The behavior is not better explained by another mental disorder.

  ***Note:*** *The diagnosis is given to the* ***perpetrator****, not the victim. The victim may receive a separate diagnosis of abuse.*

**Eating Disorders –** characterized by persistent disturbances of eating or eating-related behavior that result in the altered consumption or absorption of food and that significantly impair physical health or psychosocial functioning

## EATING DISORDERS (1)

**Pica Disorder –** is an eating disorder characterized by the eating of one or more non-nutritive, non-food substances on a persistent basis over a period of at least one month that is severe enough to warrant clinical attention.

- ➔ Persistent eating of nonnutritive, nonfood substances over a period of **at least 1 month**.
- ➔ The eating of nonnutritive, nonfood substances is inappropriate to the **developmental level** of the individual.
- ➔ The eating behavior is not part of a culturally supported or socially normative practice.
- ➔ If the eating behavior occurs in the context of another mental disorder (e.g., Intellectual Disability, Autism Spectrum Disorder, or Schizophrenia) or medical condition (e.g., pregnancy), it is sufficiently severe to warrant independent clinical attention.

**Rumination Disorder –** characterized by repeated regurgitation of food that is re-chewed, re-swallowed, or spit out

- ➔ Repeated regurgitation of food over a period of **at least 1 month**. Regurgitated food may be re-chewed, re-swallowed, or spit out.
- ➔ The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastroesophageal reflux disease (**GERD**), pyloric stenosis).
- ➔ The behavior does not occur exclusively during the course of Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, or Avoidant/Restrictive Food Intake Disorder (**ARFID**).
- ➔ If the symptoms occur in the context of another mental disorder (e.g., Intellectual Disability or a Neurodevelopmental Disorder), they are sufficiently severe to warrant independent clinical attention.

**Avoidant/Restrictive Food Intake Disorder (ARFID) –** involves restricted food intake due to a lack of interest in eating, sensory issues with food, or fear of negative consequences from eating

- ➔ An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with **one (or more)** of the following:
  - ◆ Significant weight loss (or failure to achieve expected weight gain in children).
  - ◆ Significant nutritional deficiency (e.g., scurvy, anemia).
  - ◆ Dependence on enteral feeding (tube feeding) or oral nutritional supplements.
  - ◆ Marked interference with psychosocial functioning (e.g., inability to eat with others).
- ➔ The behavior is **not** better explained by lack of available food or by an associated culturally sanctioned practice.
- ➔ The eating disturbance does **not** occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa, and there is **no evidence** of a disturbance in the way in which one's body weight or shape is experienced.
- ➔ The eating disturbance is not attributable to a concurrent medical condition or better explained by another mental disorder.

**Anorexia Nervosa –** characterized by restricted food intake, intense fear of gaining weight, and a distorted perception of body weight and shape

- ➔ Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.
  - ◆ **Significantly low weight** is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- ➔ Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
  - ◆ This can include excessive exercise, weighing oneself multiple times a day, or obsessive calorie counting.
- ➔ Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.
  - ◆ This is often referred to as "body dysmorphia," where the individual looks in the mirror and sees themselves as "large" despite being medically underweight.
- ➔ **Restricting Type:** During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging. Weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
- ➔ **Binge-Eating/Purging Type:** During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
- ➔ Severity Rating (BMI-based)
  - ◆ Mild. BMI≥ 17.5
  - ◆ Moderate. BMI 16 - 16.99
  - ◆ Severe. BMI 15 - 15.99
  - ◆ Extreme. BMI > 15

**Bulimia Nervosa –** characterized by recurrent episodes of binge eating, compensatory behaviors to prevent weight gain, and self-evaluation that is significantly influenced by body shape and weight.

- ➔ An episode of binge eating is characterized by **both** of the following:
  - ◆ Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period under similar circumstances.
  - ◆ A sense of **lack of control** over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- ➔ Recurrent inappropriate behaviors to prevent weight gain, such as:
  - Self-induced vomiting (the most common).
  - Misuse of laxatives, diuretics, or other medications.
  - Fasting.
  - Excessive exercise.
- ➔ The binge eating and inappropriate compensatory behaviors both occur, on average, at least **once a week for 3 months**.
- ➔ Self-evaluation is unduly influenced by body shape and weight.
- ➔ The disturbance does not occur exclusively during episodes of Anorexia Nervosa. (If the patient is significantly underweight, the diagnosis is Anorexia, Binge-Purge type).
- ➔ Severity
  - ◆ Mild: An average of 1 to 3 episodes of inappropriate compensatory behaviours per week.
  - ◆ Moderate: An average of 4 to 7 episodes of inappropriate compensatory behaviours per week.
  - ◆ Severe: An average of 8 to 13 episodes of inappropriate compensatory behaviours per week.
  - ◆ Extreme: An average of 14 or more episodes of inappropriate compensatory behaviours per week.

**Binge Eating Disorder –**characterized by recurrent episodes of binge eating, compensatory behaviors to prevent weight gain, and self-evaluation that is significantly influenced by body shape and weight.

- ➔ An episode of binge eating is characterized by **both**:
  - ◆ Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period under similar circumstances.
  - ◆ A sense of **lack of control** over eating during the episode (feeling that one cannot stop or control what/how much

is being eaten).

- ➔ The binge-eating episodes are associated with **three (or more)** of the following:
  - ◆ Eating much more rapidly than normal.
  - ◆ Eating until feeling uncomfortably full.
  - ◆ Eating large amounts of food when not feeling physically hungry.
  - ◆ Eating alone because of feeling embarrassed by how much one is eating.
  - ◆ Feeling disgusted with oneself, depressed, or very guilty afterward.
- ➔ Marked distress regarding binge eating is present.
- ➔ Binge eating occurs, on average, at least **once a week for 3 months**.
- ➔ The binge eating is not associated with the recurrent use of inappropriate compensatory behaviors (as in Bulimia Nervosa) and does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa.
- ➔ Severity
  - ◆ Mild: 1 to 3 binge-eating episodes per week.
  - ◆ Moderate: 4 to 7 binge-eating episodes per week.
  - ◆ Severe: 8 to 13 binge-eating episodes per week.
  - ◆ Extreme: 14 or more binge-eating episodes per week.

**Other Specified Feeding or Eating Disorders**

- ➔ **Atypical Anorexia Nervosa –** all of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.
- ➔ **Bulimia Nervosa (of low frequency and/or limited duration) –** all of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.
- ➔ **Binge-Eating Disorder (of low frequency and/or limited duration) –** all of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.
- ➔ **Purging Disorder –** recurrent purging behavior to influence weight or shape (e.g. - self induced vomiting: misuse of laxatives, diuretics, or other medications) in the absence of binge eating.
- ➔ **Night Eating Syndrome –** recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal.
  - ◆ There is awareness and recall of the eating.
  - ◆ The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms.
  - ◆ The night eating causes significant distress and/or impairment in functioning.
  - ◆ The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

**Elimination Disorders (1) –** involve the inappropriate elimination of urine or feces. While these behaviors are common in very young children, they are diagnosed as disorders when they occur beyond the age when a child is developmentally expected to have achieved continence.

- **Enuresis –** it involves the repeated voiding of urine into bed or clothes, whether that behavior is involuntary or intentional. It is only diagnosed when it is developmentally inappropriate (usually after age 5).
  - ○ Repeated voiding of urine into bed or clothes, whether involuntary or intentional.
  - ○ The behavior is clinically significant as manifested by either:
    - ■ A frequency of at least **twice a week** for at least **3 consecutive months**.
    - ■ The presence of clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
  - ○ **Criterion C: Age** Chronological age is at least **5 years** (or equivalent developmental level).
  - ○ The behavior is not attributable to the physiological effects of a substance (e.g., a diuretic, an antipsychotic medication) or another medical condition (e.g., diabetes, spina bifida, a seizure disorder).
  - ○ **Nocturnal Only –** occurs only during nighttime sleep. This is the most common


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subtype and is often referred to as "monosymptomatic enuresis." It is frequently linked to a family history of bedwetting or a delay in the body's ability to signal the brain during deep sleep.
    - **Diurnal Only –** occurs during waking hours. This is often characterized by "voiding postponement," where the child ignores the urge to go until it is too late. It is sometimes associated with social anxiety or reluctance to use public/school restrooms.
    - Nocturnal and Diurnal
- **Encopresis –** is the repeated passage of feces into inappropriate places (such as clothing or the floor)
    - Repeated passage of feces into inappropriate places (e.g., clothing, floor), whether involuntary or intentional.
    - At least **one such event each month** for at least **3 months**.
    - Chronological age is at least **4 years** (or equivalent developmental level).
    - The behavior is not attributable to the physiological effects of a substance (e.g., laxatives) or another medical condition, except through a mechanism involving constipation
    - **With Constipation and Overflow Incontinence –** this is the most common form. The child becomes chronically constipated, leading to **impaction** (a hard mass of stool in the colon).
    - **Without Constipation and Overflow Incontinence –** feces are of normal consistency, and there is no evidence of constipation.

**Sleeping Disorders –** involves dissatisfaction regarding the quality, timing, and amount of sleep, resulting in daytime distress and impairment

- **Dyssomnias –** characterized by disturbances in the amount, quality, or timing of sleep
- **Parasomnias –** involve abnormal behaviors, experiences, or physiological events that occur in association with sleep, specific sleep stages, or the transitions between sleep and wakefulness
- **Breathing-Related Sleep Disorders –** characterized by abnormal breathing patterns during sleep that lead to disrupted sleep and other health problems
- **REM Sleep –** during which the majority of typical story-like dreams occur (20% - 25% of total sleep)

**NREM Sleep Stages**

- ➔ **Stage 1 (N1): Light Sleep –** transition from wakefulness to sleep, and occupies about 5% of time spent asleep in healthy adults
- ➔ **Stage 2 (N2): Deeper Sleep –** characterized by specific electroencephalographic waveforms (sleep spindles and K-complexes), occupied about 50% of the time spent sleeping
- ➔ **Stage 3 (N3): Deep Sleep –** slow wave sleep; deepest level of sleep

## SLEEPING DISORDERS (1)

**Insomnia Disorder –** is the dissatisfaction with sleep quantity or quality, with complaints of difficulty initiating or maintaining sleep.

- ➔ A predominant complaint of dissatisfaction with sleep quantity or quality, associated with **one (or more)** of the following symptoms:
    - ◆ **Difficulty initiating sleep.** (In children, this may manifest as difficulty initiating sleep without caregiver intervention). *In children, this may manifest as difficulty initiating sleep without caregiver intervention*
    - ◆ **Difficulty maintaining sleep**, characterized by frequent awakenings or problems returning to sleep after awakenings. *In children, this may manifest as difficulty initiating sleep without caregiver intervention*
    - ◆ **Early-morning awakening** with inability to return to sleep.
- ➔ The sleep disturbance causes **clinically significant distress** or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
- ➔ The sleep difficulty occurs at least **3 nights per week**.
- ➔ The sleep difficulty is present for at least **3 months**.
- ➔ The sleep difficulty occurs despite **adequate opportunity** for sleep. (This distinguishes insomnia from sleep deprivation due to external factors like a newborn or a loud environment).
- ➔ Not better explained by and does not occur exclusively during the course of another sleep-wake disorder (e.g., Narcolepsy, Breathing-Related Sleep Disorder).
- ➔ Not attributable to the physiological effects of a

substance (e.g., drug of abuse, medication).

- ➔ Coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia.
- ➔ **Sleep-Onset Insomnia (Initial Insomnia) –** difficulty initiating sleep at bedtime
  - ◆ Defined by a subjective sleep latency greater than 20-30 minutes
- ➔ **Sleep Maintenance Insomnia (Middle Insomnia) –** frequent or prolonged awakening throughout the night
  - ◆ Defined by subjective time awake after sleep onset greater than 20-30 minutes
- ➔ **Late Insomnia –** early-morning awakening with inability to return to sleep
- ➔ **Early-Morning Awakening –** awakening at least 30 minutes before the scheduled time and before total sleep time reaches 6.5 hours.
- ➔ **Non-Restorative Sleep –** poor sleep quality that does not leave the individual rested upon awakening despite adequate duration.
  - ◆ This is a common sleep complaint usually occurring in association with difficulty initiating or maintaining sleep, or less frequently in isolation.

**Hypersomnolence Disorder –** is a broad diagnosis and includes symptoms of excessive quantity of sleep, deteriorated quality of wakefulness, and sleep inertia.

- ➔ Self-reported excessive sleepiness (hypersomnolence) despite a main sleep period lasting at least 7 hours, with at least **one** of the following:
  - ◆ **Recurrent periods of sleep** or lapses into sleep within the same day.
  - ◆ **A prolonged main sleep episode** of more than 9 hours per day that is non-restorative (does not feel refreshing).
  - ◆ **Difficulty being fully awake** after abrupt awakening (often called "sleep drunkenness" or sleep inertia).
- ➔ The hypersomnolence occurs at least **3 times per week**.
- ➔ The symptoms have been present for at least **3 months**.
- ➔ Sleepiness causes **clinically significant distress** or impairment in social, occupational, or other important areas of functioning.
- ➔ Not better explained by another sleep disorder (e.g., Narcolepsy, Breathing-Related Sleep Disorder, or Circadian Rhythm Sleep-Wake Disorder).
- ➔ Not attributable to the physiological effects of a substance (e.g., drug of abuse or medication).
- ➔ Coexisting mental or medical disorders do not adequately explain the complaint.

**Narcolepsy –** is a sleep disorder characterized by sleepiness with recurrent daytime naps or lapses into sleep.

- ➔ The individual must experience recurrent periods of an irrepressible need to sleep, lapsing into sleep, or napping occurring within the same day. These must occur at least **3 times per week over the past 3 months**.
- ➔ At least **one** of the following three markers must be present:
  - ◆ Episodes of cataplexy, defined as either (A) or (B), occurring at least a few times per month:
    - (A) In individuals with long-standing disease, brief (seconds to minutes) episodes of sudden bilateral loss of muscle tone with maintained consciousness that are precipitated by laughter or joking, OR
    - (B) In children or in individuals within 6 months of onset, spontaneous grimaces or jaw-opening episodes with tongue thrusting or a global hypotonia, without any obvious emotional triggers.
  - ◆ Hypocretin deficiency, as measured using cerebrospinal fluid (CSF) hypocretin-1 immunoreactivity values (less than or equal to one-third of values obtained in healthy subjects tested using the same assay, or less than or equal to 110 pg/mL). Low CSF levels of hypocretin-1 must not be observed in the context of acute brain injury, inflammation, or infection.
  - ◆ Nocturnal sleep polysomnography showing rapid eye movement (REM) sleep latency less than or equal to 15 minutes, or a multiple sleep latency test (MSLT) showing a mean sleep latency less than or equal to 8 minutes and two or more sleep-onset REM periods (SOREMPs).

- **Narcolepsy Tetrad**
  - **Excessive Daytime Sleepiness (EDS):** Often described as a "sleep attack" that can happen while talking, eating, or driving.
  - **Cataplexy:** The muscle weakness mentioned above.
  - **Sleep Paralysis:** The temporary inability to move or speak while falling asleep or waking up.
  - **Hypnagogic/Hypnopompic Hallucinations:** Vivid, often scary, dream-like experiences that occur when transitioning between sleep and wake.
- **Narcolepsy without cataplexy but with hypocretin deficiency:** Criterion B requirements of low CSF hypocretin-1 levels and positive polysomnography/multiple sleep latency test are met, but no cataplexy is present (Criterion B1 not met).
- **Narcolepsy with cataplexy but without hypocretin deficiency:** In this rare subtype (less than 5% of narcolepsy cases), Criterion B requirements of cataplexy and positive polysomnography/multiple sleep latency test are met, but CSF hypocretin-1 levels are normal (Criterion B2 not met).
- **Autosomal dominant cerebellar ataxia, deafness, and narcolepsy:** This subtype is caused by exon 21 DNA (cytosine-5)-methyltransferase-1 mutations and is characterized by late-onset (age 30-40 years) narcolepsy (with low or intermediate CSF hypocretin-1 levels), deafness, cerebellar ataxia, and eventually dementia.
- **Autosomal dominant narcolepsy, obesity, and type 2 diabetes:** Narcolepsy, obesity, and type 2 diabetes and low CSF hypocretin-1 levels have been described in rare cases and are associated with a mutation in the myelin oligodendrocyte glycoprotein gene.
- **Narcolepsy secondary to another medical condition:** This sub type is for narcolepsy that develops secondary to medical conditions that cause infectious (e.g., Whipple's disease, sarcoidosis), traumatic, or tumoral destruction of hypocretin neurons.

**Obstructive Sleep Apnea –** is a sleeping disorder characterized by multiple episodes of cessation of breathing, lasting at least 10 seconds with desaturations and arousals.

- OSAH also involves episodes of upper (pharyngeal) airway obstruction (apneas and hypopneas) during sleep.
- **Apnea –** is the complete obstruction of airflow,
- **Hypopnea –** is a reduction in airflow. It is the most common breathing-related sleep disorder.
- Evidence by polysomnography of at least 5 obstructive apneas or hypopneas per 1 hour of sleep and either of the following sleep symptoms:
  - (A) Nocturnal breathing disturbances: snoring, snorting/gasping, or breathing pauses during sleep. AND/OR
  - (B) Daytime sleepiness, fatigue, or unrefreshing sleep despite sufficient opportunities to sleep that is not better explained by another mental disorder (including a sleep disorder) and is not attributable to another medical condition.
- Evidence by polysomnography of 15 or more obstructive apneas and/or hypopneas per hour of sleep regardless of accompanying symptoms

**Central Sleep Apnea –** evidence of polysomnography of 5 or more central apneas per hour of sleep

- **Cheyne-Stokes Breathing –** an abnormal pattern of breathing characterized by progressive, deeper, and sometimes faster breathing, followed by a gradual decrease, results in a temporary stop in breathing called an apnea
- Evidence by polysomnography of 5 or more central apneas for each 1 hour of sleep.
- The disorder is not better explained by another current sleep disorder.
- **Idiopathic Central Sleep Apnea –** characterized by repeated pauses in breathing and airflow without evidence of airway obstruction. The cause is unknown, but it usually involves an oversensitivity to carbon dioxide levels
- **Cheyne-Stokes Breathing –** a specific pattern of periodic breathing where the volume of breath increases and then decreases in a "crescendo-decrescendo" fashion, followed by an apnea.
  - Commonly associated with: Heart failure, stroke, or renal failure.
- **Central Sleep Apnea Comorbid with Opioid Use –** caused by the effects of opioids (e.g., methadone, oxycodone, morphine) on the

brain's respiratory rhythm generator. The drugs suppress the drive to breathe, especially during sleep.

**Sleep-Related Hypoventilation –** is a sleep disorder related to progressive respiratory impairment.

- ➔ When this disorder occurs comorbidly with other disorders (e.g., COPD, neuromuscular disorders, obesity), disease severity reflects the severity of the underlying condition, and the disorder progresses as the condition worsens.
- ➔ Evidence of **episodes of decreased respiration** during sleep associated with elevated $PaCO_2$ (partial pressure of arterial carbon dioxide) levels. This is typically measured in one of two ways:
    1. **Direct measurement:** $PaCO_2$ is elevated to > 45 mmHg during sleep.
    2. **Proxy measurement:** A persistent increase in $CO_2$ during sleep that is not attributable to an apnea or hypopnea.

  *Note: In the absence of objective measurement of CO2 , persistent low levels of hemoglobin oxygen saturation unassociated with apneic/hypopneic events may indicate hypoventilation.*
- ➔ The disturbance is not better explained by another current sleep disorder (such as Obstructive Sleep Apnea).

**Circadian Rhythm Sleep-Wake Disorders –** are sleep disorders that involve a change in the timing of when an individual sleeps and is awake.

- ➔ The human body has a master circadian clock in a control centre of the brain known as the suprachiasmatic nucleus (SCN).
- ➔ Occurs when there is a misalignment between an individual's internal biological clock (the circadian rhythm) and the sleep-wake schedule required by their environment or social/professional obligations.
- ➔ A persistent or recurrent pattern of sleep disruption that is primarily due to an alteration of the circadian system or to a misalignment between the endogenous circadian rhythm and the sleep-wake schedule required by an individual's physical environment or social or professional schedule.
- ➔ The sleep disruption leads to excessive sleepiness, insomnia, or both.
- ➔ The sleep disturbance causes clinically significant distress or impairment in social, occupational, and other important areas of functioning.
- ➔ The disturbance is not better explained by another sleep disorder, a mental disorder, the effects of a substance, or a separate medical condition.
- ➔ **Advanced Sleep Phase Type –** a history of sleep-wake times that are several hours earlier than conventional or desired times.
- ➔ **Irregular Sleep-Wake Type –** a history of symptoms of insomnia at night and excessive sleepiness (napping) during the day.
- ➔ **Non-24-Hour Sleep-Wake Type –** a history of symptoms of insomnia or excessive sleepiness related to a pattern of sleep and wake times that "drift" later and later each day.
- ➔ **Shift Work Type –** excessive sleepiness at work (usually during the night) and insomnia at home (usually during the day) due to a work schedule that overlaps with the conventional sleep period.
- ➔ **Unspecified Type**

**NREM Sleep Arousal Disorders –**are a category of parasomnias that involve incomplete awakening from sleep.

- ➔ These usually occur during **Stage N3 (deep slow-wave sleep)**, which is why they most frequently happen during the first third of the night.
- ➔ includes sleepwalking and sleep terrors (night terrors).
- ➔ Both of these conditions consist of repeated occurrences of incomplete arousals, usually beginning during the first third of the major sleep episode, that typically are brief, lasting 1-10 minutes, but may be protracted, lasting up to 1 hour.
- ➔ The maximum duration of an event is unknown.
- ➔ The eyes are typically open during these events.
- ➔ Recurrent episodes of incomplete awakening from sleep, usually occurring during the first third of the major sleep episode, accompanied by either **Sleepwalking** or **Sleep Terrors**:
    - ◆ **Sleepwalking Type:** Repeated episodes of rising from bed and walking about. While sleepwalking, the individual has a blank, staring face; is relatively unresponsive to the efforts of others to communicate with him or her; and can be awakened only with great difficulty.
    - ◆ **Sleep Terror Type:** Recurrent episodes of abrupt terror arousals from sleep,

usually beginning with a panicky scream. There is intense fear and signs of autonomic arousal, such as tachycardia (rapid heart rate), rapid breathing, and sweating during each episode.

- ➔ No or very little (e.g., only a single visual scene) dream imagery is recalled.
- ➔ Amnesia for the episodes is present. The individual typically has no memory of the event the following morning, even if they appeared to be "awake" during it.
- ➔ The episodes cause **clinically significant distress** or impairment in social, occupational, or other important areas of functioning (e.g., injury to self/others, embarrassment, or sleep avoidance).
- ➔ The disturbance is not attributable to the physiological effects of a **substance** (e.g., a drug of abuse or medication like Ambien).
- ➔ Coexisting mental and medical disorders do not explain the episodes.

**Rapid Eye Movement (REM) Sleep Behavior Disorder –** is a sleep disorder characterized by repeated episodes of arousal, often associated with vocalizations and/or complex motor behaviours arising during REM sleep.

- ➔ Repeated episodes of arousal during sleep associated with vocalization and/or complex motor behaviors.
- ➔ These behaviors arise during **REM sleep** and therefore usually occur more than 90 minutes after sleep onset, are more frequent during the later portions of the sleep period, and uncommonly occur during daytime naps.
- ➔ Upon awakening from these episodes, the individual is **completely awake, alert, and not confused or disoriented**.
- ➔ At least **one** of the following must be true:
  - ◆ **Sleep study (Polysomnography) evidence:** Documentation of REM sleep without atonia (muscle paralysis).
  - ◆ **Clinical History:** A history suggestive of REM sleep behavior disorder and an established diagnosis of a synucleinopathy (e.g., Parkinson's disease, multiple system atrophy).
- ➔ The behaviors cause **clinically significant distress** or impairment in social, occupational, or other important areas of functioning (which may include injury to self or the bed partner).
- ➔ The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- ➔ Coexisting mental and medical disorders do not explain the episodes.

**Nightmare Disorder –** is a sleep disorder characterized by typically lengthy, elaborate, story-like sequences of dream imagery that seem real and that incite anxiety, fear, or other dysphoric emotions.

- ➔ epeated occurrences of extended, extremely dysphoric, and well-remembered dreams that usually involve efforts to avoid threats to **survival, security, or physical integrity**.
- ➔ On awakening from the dysphoric dreams, the individual rapidly becomes **oriented and alert**.
- ➔ The sleep disturbance causes **clinically significant distress** or impairment in social, occupational, or other important areas of functioning. This may manifest as:
  - ◆ Anxiety or persistent fear after waking.
  - ◆ Daytime fatigue or sleepiness.
  - ◆ Resistance to going to sleep (sleep avoidance).
- ➔ The nightmare symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication like beta-blockers or antidepressants).
- ➔ The occurrence of nightmares cannot be adequately explained by coexisting mental and medical disorders (e.g., PTSD, though nightmares are a symptom of PTSD, a separate diagnosis of Nightmare Disorder is only made if the nightmares are severe enough to warrant independent clinical attention).

**Restless Legs Syndrome –** also known as Willis-Ekbom Disorder (WED) is a motor-sensory neurological sleep disorder characterized by uncomfortable sensations in the lower extremities that are accompanied by an almost irresistible urge to move the legs or arms.

- ➔ An urge to move the legs, usually accompanied by or occurring in response to uncomfortable and unpleasant sensations in the legs. This is characterized by **all** of the following:
  - ◆ **Rest/Inactivity:** The urge to move the legs begins or worsens during periods of rest or inactivity.
  - ◆ **Relief by Movement:** The urge to move the legs is partially or totally relieved by movement, such as walking or stretching, at least as long as the

activity continues.
    - **Evening/Night Worsening:** The urge to move the legs is worse in the evening or at night than during the day, or occurs only in the evening or at night.
- ➔ The symptoms occur at least **3 times per week**.
- ➔ The symptoms have been present for at least **3 months**.
- ➔ The symptoms are accompanied by significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.
- ➔ The symptoms are not attributable to another mental disorder or medical condition (e.g., leg edema, arthritis, or muscle cramps).
- ➔ The symptoms are not attributable to the physiological effects of a drug of abuse or medication (e.g., akathisia from antipsychotics).

**Substance-Related and Addictive Disorders –** encompass a range of problems associated with the use of psychoactive substances and addictive behaviors, most notably gambling disorder

- ➔ Characterized by a pattern of compulsive engagement in substance use or gambling despite significant harmful consequences
- ➔ The individual experiences a loss of control over their use or behavior, and this often leads to distress and impairment in various aspects of their life, including health, relationships, work, and social functioning
- ➔ **Substance –** chemical compounds that are ingested to alter mood or behavior
- ➔ **Psychoactive Substances –** alter mood, behavior, or both
- ➔ **Substance Use –** ingestion of psychoactive substances in moderate amounts that does not significantly interfere with social, educational, or occupational functioning
- ➔ **Substance Intoxication –** physiological reaction to ingested substances
- ➔ **Depressant –** use generally causes mood elevation, anxiety, sedation, behavioral, disinhibition, and respiratory depression during intoxication.
    - Withdrawal symptoms generally speaking cause anxiety, tremor, seizures, insomnia
- ➔ **Stimulant –** use generally causes mood elevation, decreased appetite or anorexia, psychomotor agitation, insomnia, cardiac arrhythmias, tachycardia, and anxiety.
    - Withdrawal symptoms typically include a "post-use crash" that includes symptoms such as depression, fatigue/lethargy, increased appetite, insomnia, and vivid nightmares.
- ➔ **Hallucinogens –** are substances that can cause mind and body separation ("dissociative") effects and visual and/or auditory hallucinations.
    - Of note, hallucinogens such as PCP and LSD do not cause withdrawal symptoms, and hence do not have a DSM-5 diagnosis for withdrawal.
    - Other hallucinogens however, like MDMA (which is officially designated as a hallucinogen in the DSM-5, but in fact has strong stimulant properties) and cannabis, can trigger withdrawal symptoms.
- ➔ Finally, gambling disorder is the only non-substance DSM-5 addictive disorder.

**10 Separate Classes of Drugs**

- ➔ **Alcohol**. The most commonly used substance
    - Alcohol withdrawal is one of the few that can be medically **life-threatening** (e.g., Delirium Tremens).
- ➔ **Caffeine** (Note: No "Use Disorder" for caffeine, only Intoxication/Withdrawal)
- ➔ **Cannabis**. Includes marijuana and synthetic cannabinoids.
- ➔ **Hallucinogens** (PCP, LSD, etc.)
    - **Phencyclidine (PCP):** Often associated with aggression and "nystagmus" (involuntary eye movement).
    - **Other Hallucinogens:** Such as LSD, MDMA (Ecstasy), and Psilocybin.
- ➔ **Inhalants**. Volatile hydrocarbons (e.g., glue, gasoline, paint thinners).
- ➔ **Opioids**. Includes prescription analgesics (oxycodone, morphine) and illegal drugs like heroin or fentanyl.
    - Characterized by rapid development of **tolerance** and a severe "flu-like" withdrawal syndrome.
- ➔ **Sedatives, Hypnotics, or Anxiolytics** (Anti-anxiety meds/Sleeping pills). Includes benzodiazepines (Valium, Xanax) and barbiturates.
    - Like alcohol, sudden withdrawal from high doses of these substances can be **life-threatening** due to seizures.
- ➔ **Stimulants** (Cocaine, Amphetamines). Includes amphetamines, cocaine, and prescription stimulants (used for ADHD).

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- Often leads to a "crash" during withdrawal, characterized by intense fatigue and depression.

➔ **Tobacco**. Specifically focuses on the effects of nicotine.

➔ **Other (or unknown) substances.** A "catch-all" category for substances that do not fit into the other nine classes (e.g., anabolic steroids, betel nut, or synthetic "designer" drugs).

## SUBSTANCE-RELATED AND ADDICTIVE DISORDERS (2)

**Substance Use Disorder –** characterized by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance or engaging in the behavior despite significant substance- or behavior-related problems

➔ Impaired Control
➔ Social Impairment
➔ Risky Use
➔ Pharmacological Criteria (Tolerance and Withdrawal)

**Substance-Induced Disorders –** include substance intoxication, substance withdrawal, and substance-induced mental disorders (e.g., substance-induced psychotic disorder, substance-induced depressive disorder)

➔ Typically, temporary conditions that develop during or soon after substance use or withdrawal

**Gambling Disorder –** persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by a cluster of symptoms such as:

➔ Persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress, as indicated by the individual exhibiting at least 4 of the following in a 12-month period:
- Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
- Is restless or irritable when attempting to cut down or stop gambling.
- Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
- Is often preoccupied with gambling (e.g. - having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).
- Often gambles when feeling distressed (e.g. - helpless, guilty, anxious, depressed).
- After losing money gambling, often returns another day to get even ("chasing" one's losses).
- Lies to conceal the extent of involvement with gambling.
- Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
- Relies on others to provide money to relieve desperate financial situations caused by gambling.

➔ The gambling behavior is not better explained by a manic episode.

**Disruptive, Impulse-Control, and Conduct Disorders –** involves problems with self-control of emotions and behaviors that violate the rights of others and/or bring the individual into significant conflict with societal norms or authority figures

➔ Often emerge in childhood or adolescence and can have significant consequences for social relationships, academic or occupational functioning, and legal involvement

## DISRUPTIVE, IMPULSE-CONTROL DISORDERS AND CONDUCT DISORDER (3)

**Oppositional Defiant Disorder (ODD) –** is characterized by a frequent and persistent pattern of anger, irritability, arguing, defiance, or vindictiveness.

➔ A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting **at least 6 months**, evidenced by at least **four symptoms** from any of the following categories:
- Angry/Irritable Mood
  - Often loses temper.
  - Is often touchy or easily annoyed.
  - Is often angry and resentful.
- Argumentative/Defiant Behavior
  - Often argues with authority figures or (for children and adolescents) with adults.

- Often actively defies or refuses to comply with requests from authority figures or with rules.
- Often deliberately annoys others.
- Often blames others for his or her mistakes or misbehavior.

◆ Vindictiveness

- Has been spiteful or vindictive at least twice within the past 6 months.

➔ The disturbance in behavior is associated with distress in the individual or others in their immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

➔ The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria for **Disruptive Mood Dysregulation Disorder (DMDD)** are not met.

**Intermittent Explosive Disorder (iED) –** is characterized by repeated, impulsive, and unplanned outbursts of verbal or physical aggression

➔ Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by **either** of the following:

◆ **High Frequency / Low Intensity:** Verbal aggression (e.g., temper tantrums, tirades, verbal arguments) or physical aggression toward property, animals, or other individuals, occurring **twice weekly**, on average, for a period of **3 months**.

◆ **Low Frequency / High Intensity:** Three behavioral outbursts involving **damage or destruction of property** and/or physical assault involving **physical injury** against animals or other individuals occurring within a **12-month period**.

➔ The magnitude of aggressiveness expressed during the recurrent outbursts is **grossly out of proportion** to the provocation or to any precipitating psychosocial stressors.

➔ The recurrent aggressive outbursts are **not premeditated** (i.e., they are impulsive and/or anger-based) and are **not committed to achieve some tangible objective** (e.g., money, power, intimidation).

➔ The outbursts cause either marked distress in the individual, impairment in occupational or interpersonal functioning, or are associated with negative financial or legal consequences.

➔ The individual is at least **6 years of age** (or equivalent developmental level).

➔ The outbursts are not better explained by another mental disorder (e.g., Depressive Disorder, ADHD, Bipolar Disorder) and are not attributable to another medical condition or substance use. *Note: This diagnosis can be made in addition to the diagnosis of attention-deficit/hyper-activity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder when recurrent impulsive aggressive outbursts are in excess of those usually seen in these disorders and warrant independent clinical attention.*

**Conduct Disorder –** characterized by a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated.

➔ At least **3 of the following 15 criteria** must be present in the **past 12 months**, with at least one criterion present in the **last 6 months**. These are divided into four main pillars:

◆ Aggression to People and Animals

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

◆ Destruction of Property

- Has deliberately engaged in fire setting with the intention of causing serious damage.
- Has deliberately destroyed others' property (other than by fire setting).

- ◆ Deceitfulness or Theft
  - Has broken into someone else's house, building, or car.
  - Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
  - Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).
- ◆ Serious Violations of Rules
  - Often stays out at night despite parental prohibitions, beginning before age 13 years.
  - Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
  - Is often truant from school, beginning before age 13 years.

➔ The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

➔ If the individual is age 18 years or older, criteria are not met for **Antisocial Personality Disorder**.

**Pyromania** – is characterized by a pathological fascination with fire and a recurring failure to resist the impulse to set them.

An individual must fulfill **all** of the following criteria:

➔ Deliberate and purposeful **fire setting** on more than one occasion.

➔ Tension or affective arousal immediately **before** the act of setting a fire.

➔ Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., equipment, uses, or the aftermath of fires).

➔ Pleasure, gratification, or relief when setting fires or when witnessing or participating in their aftermath.

➔ The fire setting is **not** done for any of the following "proactive" reasons:

- ◆ Monetary gain (e.g., insurance fraud).
- ◆ To further a sociopolitical ideology.
- ◆ To conceal criminal activity.
- ◆ To express anger or vengeance.
- ◆ To improve one's living circumstances.
- ◆ In response to a delusion or hallucination (which would suggest a Psychotic Disorder).
- ◆ As a result of impaired judgment (e.g., in major neurocognitive disorder or substance intoxication).

➔ The fire setting is not better explained by **Conduct Disorder**, a **Manic Episode**, or **Antisocial Personality Disorder**.

➔

**Kleptomania** – is an impulse-control disorder characterized by the repeated failure to resist urges to steal.

An individual must meet **all** of the following:

➔ Recurrent failure to resist impulses to steal objects that are **not needed** for personal use or for their monetary value.

➔ An increasing sense of **tension** or affective arousal immediately **before** committing the theft.

➔ Pleasure, gratification, or **relief** at the time of committing the theft.

➔ The stealing is **not** committed to express anger or vengeance and is not in response to a delusion or a hallucination.

➔ The stealing is not better explained by **Conduct Disorder**, a **Manic Episode**, or **Antisocial Personality Disorder**.

## C | Evaluating Dissociative Disorders, Sexual Dysfunctions, Paraphilic Disorders, and Gender Dysphoria

**Dissociative Disorders** – characterized by a disruption in and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior

- **Detachment** – feeling disconnected from one's body, thoughts, feelings, or sense of self
- **Amnesia** – difficulty remembering personal information, often related to traumatic events
- **Identity Confusion** – feeling uncertain about one's identity, sense of self, or place in the world
- **Identity Alteration** – experiencing distinct shifts in sense of self, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning, as if experiencing different "selves"
- **Derealization** – feeling that the external world is unreal, dreamlike, or distorted
- **Depersonalization** – feeling detached from one's

own body, thoughts, feelings, or actions, as if one is an outside observer

## DISSOCIATIVE DISORDERS (3)

**Dissociative Identity Disorder (DID) –** is defined by the presence of two or more distinct personality states. It is often a creative, albeit painful, survival mechanism used by the brain to cope with overwhelming, inescapable childhood trauma (usually occurring before age 6 to 9).

- ➔ A disruption of identity characterized by **two or more distinct personality states**, which may be described in some cultures as an experience of possession. The disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in:
  - ◆ Affect (mood)
  - ◆ Behavior
  - ◆ Consciousness
  - ◆ Memory and perception
  - ◆ Cognition and/or sensory-motor functioning

  **Note:** These signs and symptoms may be observed by others or reported by the individual.
- ➔ Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are **inconsistent with ordinary forgetting**.
- ➔ The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ➔ The disturbance is not a normal part of a broadly accepted cultural or religious practice.
  - **In children:** The symptoms are not better explained by imaginary playmates or other fantasy play.
- ➔ The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).
- ➔ Formerly known as Multiple Personality Disorder
- ➔ The most severe and chronic of the dissociative disorders.
- ➔ DID remains a controversial diagnosis despite its inclusion in the DSM-5. It is highly comorbid with other psychiatric disorders including psychotic disorders, personality disorders, substance use disorders, and posttraumatic stress disorder (PTSD).
- ➔ **Alters –** or "parts" in DID are not entirely separate people living in one body, but rather a fragmented identity.
  - ◆ **The Host:** The part that "holds" the most time and manages daily life (work, school, chores). Ironically, the host is often unaware of the other alters or the trauma.
  - ◆ **The Protectors:** Parts that emerge to defend the system. They may be aggressive or hyper-vigilant to ensure the body's safety.
  - ◆ **The Persecutors:** Alters that mirror the abuser. They may self-harm or "punish" the system to keep it in line and prevent it from "telling" the secrets of the trauma.
  - ◆ **Littlealters (Littles):** Child-like parts that hold the memories of the abuse. They often represent the age at which the trauma occurred.

**Dissociative Amnesia –** is a disorder characterized by an inability to recall important autobiographical information that is successfully stored in memory and ordinarily would be readily remembered.

- ➔ An inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting.
- ➔ The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ➔ The disturbance is not attributable to the physiological effects of a substance (e.g., alcohol, drugs, or medication) or a neurological or other medical condition (e.g., partial complex seizures, transient global amnesia, or sequelae of a closed head injury).
- ➔ The disturbance is not better explained by Dissociative Identity Disorder (DID), Post-Traumatic Stress Disorder (PTSD), Acute Stress Disorder, Somatic Symptom Disorder, or Major Neurocognitive Disorder.
- ➔ **Localized Amnesia –** loss of memory for a specific period of time, often immediately following a traumatic event.
- ➔ **Selective Amnesia –** loss of memory for some, but not all, events during a specific period.
- ➔ **Generalized Amnesia –** loss of memory for one's entire life history.
- ➔ **Continuous Amnesia –** loss of memory for

events from a specific time up to the present.

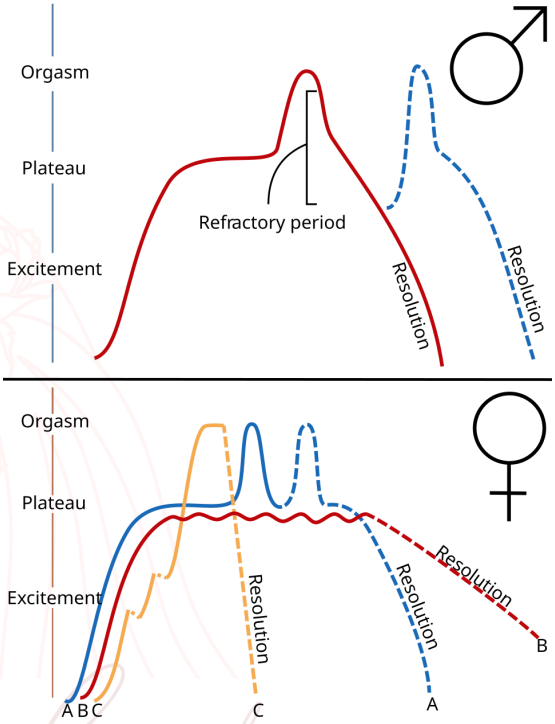
- ➔ **Systematized Amnesia –** loss of memory for a specific category of information (e.g., memories related to an abusive family member)
- ➔ **Dissociative Fugue –** memory loss resolves around a specific incident, an unexpected trip; the individuals just take off and later find themselves in a new place, unable to remember why and how they got there

**Depersonalization/Derealization Disorder –** are persistent or recurrent episodes of depersonalization, derealization, or both.

- ➔ The individual experiences one or both of the following:
  - ◆ **Depersonalization:** Feelings of unreality, detachment, or being an outside observer of one's own thoughts, feelings, sensations, body, or actions. *Examples*: Feeling like a robot, being in a dream, or experiencing "head-in-a-fog" sensations.
  - ◆ **Derealization:** Feelings of unreality or detachment from the surroundings. *Examples*: People or objects are experienced as visually distorted, "flat," lifeless, or "behind a pane of glass."
- ➔ During the episodes, **reality testing remains intact**.
- ➔ The symptoms cause clinically significant distress or impairment (social, occupational).
- ➔ The disturbance is not attributable to the physiological effects of a substance (e.g., hallucinogens, ketamine, or marijuana) or a medical condition (e.g., temporal lobe epilepsy).
- ➔ The disturbance is not better explained by another mental disorder, such as Schizophrenia, Panic Disorder, Major Depressive Disorder, Acute Stress Disorder, or PTSD.

**Sexual Dysfunctions –** involve a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure

- ➔ **Lifelong –** present since the individual became sexually active
- ➔ **Acquired –** developed after a period of relatively normal sexual functioning
- ➔ **Generalized –** occurs in all or most sexual situations
- ➔ **Situational –** occurs only in specific situations




**5 Stages of the Sexual Response Cycle**

1. **Desire (Libido) –** initial phase characterized by sexual thoughts, fantasies, or the urge to have sex
2. **Excitement (Arousal) –** involves the body's initial responses to sexual stimulation, whether physical or mental
3. **Plateau –** represents the heightening of arousal, where the physical changes from the excitement phase become more intense and stabilize
4. **Orgasm –** the peak or climax of sexual excitement, characterized by a sudden release of accumulated sexual tension
5. **Resolution –** the body gradually returns to its pre-aroused state

**SEXUAL DYSFUNCTIONS (2)**

**Delayed Ejaculation –** marked delay in or infrequency/absence of ejaculation.

- ➔ At least 6 months and must be experience in almost or all occasions

**Erectile Disorder –** characterized by marked difficulty in obtaining an erection during sexual activity, marked difficulty in maintaining an erection until the completion of sexual activity, and/or a marked decrease in erectile rigidity

➔ At least 6 months and must be experience in almost or all occasions

**Female Orgasmic Disorder –** characterized by persistent or recurrent delay in, infrequency of, or absence of orgasm, or markedly reduced intensity of orgasmic sensations

➔ At least 6 months and must be experience in almost or all occasions

**Female Sexual Interest/Arousal Disorder –** characterized by a persistent or recurrent lack of sexual interest and/or lack of subjective sexual arousal or genital or nongenital sensations

➔ At least 6 months and must be experience in almost or all occasions

**Genito-Pelvic Pain/Penetration Disorder –** characterized by persistent or recurrent difficulties with one or more of the following

➔ Vaginal penetration during intercourse;
➔ Marked vulvovaginal or pelvic pain during intercourse or other attempts at penetration;
➔ Marked fear or anxiety in anticipation of, during, or as a result of genito-pelvic pain;
➔ And marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration
➔ At least 6 months and must be experience in almost or all occasions

**Male Hypoactive Sexual Disorder –** characterized by persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity

➔ At least 6 months and must be experience in almost or all occasions

**Premature (Early) Ejaculation –** characterized by a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately one minute following vaginal penetration and before the individual wishes it to occur

➔ At least 6 months and must be experience in almost or all occasions

**Paraphilic Disorders –** distinguish between unconventional sexual interests and those that cause actual harm or distress

- involve intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners.
- Paraphilic disorders specifically cause either distress/impairment or results in risk to self or others.
- Two common classification schemes based in DSM-5
    - **Anomalous Activity Preferences**
        - **Courtship Disorders –** which resemble distorted components of human courtship behavior
        - **Algolagnic Disorders –** which involve pain and suffering
    - **Anomalous Target Preferences –** include one directed to other humans and two directed elsewhere
- **Voyeuristic Disorder –** sexual arousal from observing an unsuspecting person who is naked, disrobing, or engaging in sexual activity.
- **Exhibitionistic Disorder –** sexual arousal from the exposure of one's genitals to an unsuspecting person.
- **Frotteuristic Disorder –** sexual arousal from touching or rubbing against a non-consenting person.
- **Sexual Masochism Disorder –** sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer.
- **Sexual Sadism Disorder –** sexual arousal from the physical or psychological suffering of another person
- **Pedophilic Disorder –** sexual arousal from sexual activity with prepubescent children. The individual must be at least 16 years old and at least five years older than the child
- **Fetishistic Disorder –** sexual arousal from nonliving objects or non-genital body parts
- **Transvestic Disorder –** sexual arousal from cross-dressing, with significant distress or impairment
- **Other Specified Paraphilic Disorder**
    - *Zoophilia* (sexual attraction to animals)
    - *Necrophilia* (sexual attraction to corpses)
    - *Telephone Scatologia* (sexual arousal from making obscene phone calls)
    - *Urophilia* (sexual arousal involving urine)
    - *Coprophilia* (sexual arousal involving feces)
    - *Klismaphilia* (sexual arousal involving enemas)

**Gender Dysphoria –** is characterized by a marked incongruence between an individual's experienced or expressed gender and the gender they were assigned at birth.

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least **6 months' duration**, as manifested by at least **two** of the following:
    - **Incongruence with Sex Characteristics:** A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - **Desire to be Rid of Characteristics:** A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of anticipated secondary sex characteristics).
    - **Desire for Other Sex Characteristics:** A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - **Desire to be the Other Gender:** A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - **Desire to be Treated as Other Gender:** A strong desire to be treated as the other gender (or some alternative gender).
    - **Conviction of Feelings:** A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender).
- The condition must be associated with **clinically significant distress** or impairment in social, occupational, or other important areas of functioning.

**Gender Dysphoria Diagnostic Criteria for Children**

➔ The criteria for children are more stringent, requiring at least **six** symptoms for at least **6 months**. Crucially, **Criterion 1 must be met**:

- ◆ **A strong desire to be of the other gender** or an insistence that one is the other gender (or some alternative gender).
- ◆ **Clothing Preference:** In boys, a strong preference for cross-dressing or simulating female attire; in girls, a strong preference for wearing only typical masculine clothing and strong resistance to wearing typical feminine clothing.
- ◆ **Role Play:** A strong preference for cross-gender roles in make-believe play or fantasy play.
- ◆ **Activity Preference:** A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
- ◆ **Playmate Preference:** A strong preference for playmates of the other gender.
- ◆ **Rejection of Assigned Stereotypes:** In boys, a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; in girls, a strong rejection of typically feminine toys, games, and activities.
- ◆ **Anatomy Dislike:** A strong dislike of one's sexual anatomy.
- ◆ **Desire for Matching Anatomy:** A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

## D | Illustrating Mood Disorders, Personality Disorders, and Schizophrenia and Other Psychotic Disorders

**Mood Disorders (3) –** characterized by a significant disturbance in a person's predominant mood

- This disturbance involves either excessively low mood (depression) or excessively elevated mood (mania or hypomania)

**2 Main Categories of Mood Disorders**

1. **Depressive Disorders –** characterized by the presence of sadness, emptiness, or irritability, often accompanied by a loss of interest or pleasure in activities
2. **Bipolar Related Disorders –** characterized by significant shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks

**Mood Disorders Specifiers**

1. **Psychotic Features –** psychotic symptoms (hallucinations and delusions)


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- ➔ **Mood-congruent –** directly related to the depression
- ➔ **Mood-incongruent –** does not seem consistent with the depressed mood

2. **Anxious Distress (mild to severe) –** presence and severity of accompanying anxiety; makes suicidal thoughts and completed suicide more likely
3. **Mixed Features –** have several (at least 3) symptoms of MANIA
4. **Melancholic Features specifier –** applies only if the full criteria for MDE have been met; includes some of the more severe somatic (physical) symptoms: early-morning awakenings, weight loss, loss of libido, excessive guilt
5. **Catatonic Features –** can be applied to MDE, whether they occur in a personality disorder or not, even with a manic episode (rare)
   - ➔ **Catalepsy –** absence of movement (stuporous state) which muscles are waxy and semirigid
6. **Atypical Features –** applies to both depressive episodes, whether in the context of PDD or not; individuals consistently oversleep and overeat during depression = gain weight; they can react with interest or pleasure to some things; a greater percentage of women and an earlier age onset
7. **Peripartum Onset –** can apply to both MDE and Manic Episode; higher incidence of depression is found postpartum; mothers had serious thoughts of harming themselves, difficulty understanding why she is depressed; extreme stress can be brought on by physical exhaustion
   - ➔ **Baby Blues –** normal responses to the stresses of childbirth, and disappear quickly
8. **Seasonal Pattern –** temporal specifier applies to recurrent MDD; begins in the late fall and ends with the beginning of spring; must have occurred for at least 2 years with no evidence of nonseasonal MDE

## Depressive Disorders

**Disruptive Mood Dysregulation Disorder –** referring to the presentation of children with persistent irritability and frequent episodes of extreme behavioral dyscontrol, is added to the depressive disorders for children up to 12 years of age

- ➔ 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
- ➔ The temper outbursts are inconsistent with developmental devel
- ➔ The temper outbursts occur, on average, three or more times per week
- ➔ 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)
- ➔ 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
- ➔ 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
- ➔ The diagnosis should not be made for the first time before age 6 years or after age 18 years
- ➔ By history or observation, the age at onset of Criteria A–E is before 10 years
- ➔ 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.
- ➔ 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])
- ➔ The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition

**Major Depressive Disorder –** is characterized by discrete episodes of at least 2 weeks' duration (although most episodes last considerably longer) involving clear-cut changes in affect, cognition, and neurovegetative functions and interepisode remissions.

- ➔ 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.
  - ◆ Depressed mood most of the day, nearly every day, as indicated by either

subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, it can be an irritable mood.)
- ◆ 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)
- ◆ 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.)
- ◆ Insomnia or hypersomnia nearly every day.
- ◆ Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down)
- ◆ Fatigue or loss of energy nearly every day
- ◆ Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- ◆ Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- ◆ 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

➔ The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

➔ The episode is not attributable to the physiological effects of a substance or another medical condition

➔ The occurrence of 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

➔ There has never been a manic episode or a hypomanic episode

**Persistent Depressive Disorder (PDD) (Dysthymia) –** more chronic form of depression, can be diagnosed when the mood disturbance continues for at least 2 years in adults or 1 year in children

➔ 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

➔ Presence, while depressed, of two (or more) of the following:
- ◆ Poor appetite or overeating
- ◆ Insomnia or hypersomnia
- ◆ Low energy or fatigue
- ◆ Low self-esteem
- ◆ Poor concentration or difficulty making decisions
- ◆ Feelings of hopeless

➔ 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

➔ Criteria for a major depressive disorder may be continuously present for 2 year

➔ There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder

➔ 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.

➔ 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)

➔ The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

**Premenstrual Dysphoric Disorder (PMDD) –** almost 20 years of additional of research on this condition has confirmed a specific and treatment-responsive form of depressive disorder that begins sometime following ovulation and remits within a few days of menses and has a marked impact on functioning

➔ In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to *improve* within a few days after the onset of menses, and become *minimal* or absent in the week

postmended

- ➔ One (or more) of the following symptoms must be present:
  - ◆ Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection)
  - ◆ Marked irritability or anger or increased interpersonal conflicts
  - ◆ Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts
  - ◆ Marked anxiety, tension, and/or feelings of being keyed up or on edge
- ➔ One (or more) of the following symptoms must be additionally be present, to reach a total of *five* symptoms when combined with symptoms from Criterion B above
  - ◆ Decreased interest in usual activities (e.g., work, school, friends, hobbies)
  - ◆ Subjective difficulty in concentration
  - ◆ Lethargy, easy fatigability, or marked lack of energy
  - ◆ Marked change in appetite; overeating; or specific food cravings
  - ◆ Hypersomnia or insomnia
  - ◆ A sense of being overwhelmed or out of control
  - ◆ Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of "bloating," or weight gain
- ➔ The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home
- ➔ The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders
- ➔ Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (Note: The diagnosis may be made provisionally prior to this confirmation.)
- ➔ The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism)

## Bipolar Disorders

**Bipolar I Disorder –**is a mental disorder characterized by episodes of highly elevated mood, known as mania.

- ➔ Individuals may also present with decreased sleep, grandiosity, talkativeness, racing thoughts, and indiscretion or risk-taking behaviours. In some presentations, one's mood can shift very quickly between mania, anger, irritability, and/or depression, indicating a "mixed features" presentation of bipolar disorder.
- ➔ Criteria have been met for **at least one manic episode** (Criteria A-D under "Manic Episode)
  - ◆ During the period of mood disturbance and increased energy and activity, at least 3 of the following symptoms have persisted (4 symptoms if the mood is only irritable), represent a noticeable change from usual behaviour, and have been present to a significant degree:
    - Distractibility (i.e. - attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
    - Indiscretion, characterized by excessive involvement in activities that have a high potential for painful consequences (e.g. - unrestrained buying sprees, sexual behaviours, or foolish business investments).
    - Grandiosity or inflated self-esteem.
    - Flight of ideas or subjective experience that thoughts are racing.
    - Activity (goal-directed) increasing (e.g. - either socially, at work or school, or sexually) or psychomotor agitation.
    - Sleep decreased (e.g. - feels rested after only 3 hours of sleep).
    - Talkative (more than usual or pressure to keep talking)
- ➔ The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or

other specified or unspecified schizophrenia spectrum and other psychotic disorder

**Bipolar II Disorder –** is a mental disorder characterized by a clinical course of recurring mood episodes consisting of at least major depressive episode and at least one hypomanic episode

- ➔ The depressive episode must last at least 2 weeks, and the hypomanic episode must last at least 4 days.
- ➔ Criteria have been met for at least one hypomanic episode (Criteria A–F under "Hypomanic Episode") and at least one major depressive episode (Criteria A–C under "Major Depressive Episode)
- ➔ There has never been a manic episode
- ➔ The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder
- ➔ The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

**Cyclothymic Disorder –** is a mood disorder characterized by chronic, fluctuating mood disturbances that consist of numerous hypomanic symptoms (not a hypomanic episode) and depressive symptoms (not a depressive episode), that are chronologically distinct from each other. It is best conceptualized as a "mild" form of bipolar II disorder.

- ➔ 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
- ➔ 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
- ➔ Criteria for a major depressive, manic, or hypomanic episode have never been met
- ➔ 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
- ➔ 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
- ➔ The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

**Personality Disorders –** are enduring patterns of behaviours and inner experiences that deviate significantly from the expectations of an individual's culture. These patterns begin in adolescence or early adulthood, are pervasive and inflexible, usually remain stable over time.

- A core feature of personality disorders is that they also must lead to distress or impairment.
- Prevalence estimates for any personality disorder is 9.1% with Cluster A personality disorder at 5.7%, Cluster B at 1.5%, and Cluster C at 6%. The prevalence for any personality disorder ranges from 9%-15%
- The prognosis of a personality disorder depends on the specific personality disorder. For example, antisocial and borderline personality disorder tends to improve or self-extinguish with age. Other personality disorders, like obsessive-compulsive personality disorder and schizotypal personality disorder are less likely to remit over time.
- Personality disorders are highly comorbid with other personality disorders, and then high overlap between the different clusters.
- Personality traits are an enduring, repetitive pattern of perceiving, relating to, and thinking about the environment and oneself. Personality traits are not disorders
- The dimensional model of personality disorders is a new proposed model and approach to personality disorders. In contrast to the current model, this approach proposes that personality disorders are maladaptive variants of personality traits that merge subtlety with normal behaviour and other personality traits. The integration, clinical utility, and relationship of the dimensional approach with the current personality disorder diagnostic categories remain under research.


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## PERSONALITY DISORDERS (5)

**Paranoid PD –** consists of a pervasive distrust or suspiciousness of others to the point that their motives are interpreted as malevolent.

- ➔ It is characterized by a pattern of distrust and suspiciousness of others.
- ➔ Individuals with this disorder tend to negatively interpret the actions, words, and intentions of others.
- ➔ They suspect that others intend to harm or deceive them, though there may be little supporting evidence for such concerns.
- ➔ Individuals can also hold grudges for long periods of time and are reluctant to confide in others.

**Schizoid PD –** characterized by a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings that begins by early adulthood.

- ➔ These individuals often appear to be socially isolated or "loners," and do not desire intimacy.

**Schizotypal PD –** characterized by pervasive patterns of "strange" or "odd" behavior, appearance, or thinking.

- ➔ These peculiarities are not so severe that they can be diagnosed as schizophrenia, and there is no history of actual psychotic episodes. Individuals will often have ideas of reference, but not to a delusional quality.
- ➔ Symptoms may be first apparent in childhood, when the individual has peculiar thoughts, unusual language, and/or bizarre fantasies.

**Antisocial PD –**characterized by a history of continuous and chronic behaviour where there is disregard for and violation of the rights of others.

- ➔ Individuals repeatedly engage in unlawful activities (e.g. - drug use, assault, or theft), endanger the well-being of others, and frequently lie.
- ➔ They tend to be aggressive and impulsive and may find it difficult to maintain employment for long.
- ➔ Contrary to the name, having antisocial personality does not mean the individual does not have friends; on the contrary, they may have a superficial charm and be very deceptive.
- ➔ **Underarousal Hypothesis –** psychopaths have abnormally low levels of cortical arousal
- ➔ **Fearlessness Hypothesis –** psychopaths possess a higher threshold for experiencing fear than most other individuals

**Borderline PD –** characterized by emotional dysregulation, a pattern of unstable interpersonal relationships and high impulsivity/recklessness.

- ➔ Patients can oscillate quickly between devaluing and idealizing relationships (commonly known as "splitting").
- ➔ Other features include difficulty controlling anger, recurrent suicidal or self-harm behaviours, identity disturbance, and chronic feelings of emptiness.

**Histrionic PD –** characterized by individuals who are flamboyant, seek attention, and demonstrate excessive emotionality.

- ➔ Emotions are shallow and shift rapidly.
- ➔ Typically, they are attractive and seductive and, like narcissistic persons, overly concerned with their appearance.
- ➔ Individuals often use their physical appearance to draw the attention of others and may behave in a sexually provocative manner.
- ➔ They tend to exaggerate and dramatize their emotions, which otherwise lack depth.

**Narcissistic PD –** where individuals have a grandiose sense of their own self-importance but are also extremely sensitive to criticism.

- ➔ There may be little ability to empathize with others, and individuals are more concerned about appearance than substance.
- ➔ It is characterized by arrogance, grandiosity, a need for admiration, and a tendency to exploit others.
- ➔ Individuals with this condition often have a sense of excessive entitlement and may demand special treatment.

**Avoidant PD –**where individuals are timid and shy, and because they are so uncomfortable and afraid of rejection or criticism, they avoid social contact.

- ➔ However, they do wish to have friends, unlike individuals with schizoid personality.
- ➔ In addition, they are self-critical and have low self-esteem.
- ➔ If affected individuals are given strong guarantees of uncritical acceptance, however, they will make friends and participate in social gatherings.

**Dependent PD –** characterized by clingy and submissive behavior.

- ➔ Individuals are passive and allow others to direct their lives because they are unable to do so themselves.
- ➔ Other people such as spouses or parents make all the major life decisions, including where to live and what type of employment to obtain.
- ➔ These patients fear separation and tend to be indecisive and unable to take the initiative.
- ➔ They are often preoccupied with the thought of being left to fend for themselves, and want others to assume responsibility for all major decision making.
- ➔ They have difficulty expressing disagreement because they fear abandonment.

**Obsessive-Compulsive PD –** where individuals may be perfectionistic, inflexible, and unable to express warm, tender feelings.

- ➔ There can be preoccupation with trivial details and rules, and difficulty adapting to changes in routine.
- ➔ Obsessive-compulsive disorder (OCD) is a separate disorder that involves irresistible obsessions and compulsions and is not the same as OCPD.

**Schizophrenia and Other Psychotic Disorders –** are a group of severe mental illnesses characterized by a disconnection from reality, referred to as **psychosis**

- **John Haslam –** superintendent of a British Hospital who outlined a description of the symptoms of Schizophrenia in his book *"Observations on Madness and Melancholy"*
- **Philippe Pinel –** French physician who described cases of schizophrenia
- **Benefit Morel –** *"demence precoce"* (early or premature loss of mind
- **Emil Kraepelin –** unified the distinct categories of schizophrenia under the name *"dementia praecox"*
  - **Catatonia –** altering immobility and excited agitation
  - **Hebephrenia –** silly and immature emotionality
  - **Paranoia –** delusions of grandeur or persecution
- **Eugene Bleuler –** introduced the term "schizophrenia" (splitting of the mind)
- **Schizophrenogenic Mother –** used for a time to describe a mother whose cold, dominant, and rejecting nature was thought to cause schizophrenia in her children
- **Double bind Communication –** sed to portray a communication style that produced conflicting messages, which caused schizophrenia to develop

**Key Features of Psychotic Symptoms**

- ➔ **Delusions –** false beliefs that are firmly held despite contradictory evidence
  - ◆ **Persecutory –** one is being harmed or plotted against
  - ◆ **Referential –** common cues or events have special meaning directed at oneself
  - ◆ **Grandiose –** one has exceptional abilities, wealth, or fame
  - ◆ **Erotomanic –** believes falsely that another person is in love with him/her
  - ◆ **Nihilistic –** a major catastrophe will occur
  - ◆ **Somatic –** focus on preoccupations regarding health and organ function
  - ◆ **Thought Withdrawal –** thoughts have been removed by an outside force
  - ◆ **Thought Insertion –** thoughts have been put into one's mind
  - ◆ **Delusions of Control –** believing one's thoughts, feelings, or actions are being controlled by someone else
  - ◆ **Capgras Syndrome –** a person believes someone he/she know has been replaced by a double
  - ◆ **Cotard's Syndrome –** a person believes he/she is dead
  - ◆ **de Clérambault's Syndrome –** characterized by the delusional idea, usually in a young woman, that a man whom she considers to be of higher social and/or professional standing is in love with her
  - ◆ **Fregoli Syndrome –** a person holds a delusional belief that different people are in fact a single person who changes his/her appearance or is in disguise
- ➔ **Hallucinations –** sensory experiences that occur without an actual external stimulus
  - ◆ **Hypnagogic –** falling asleep
  - ◆ **Hypnopompic –** awakening from sleep
  - ◆ **Auditory –** false perception of sound, usually voices, other noises, music; most common
  - ◆ **Visual –** both formed images and unformed images

- **Olfactory –** smell; rare
- **Gustatory –** taste
- **Tactile (Haptic) –** touch or surface sensation
- **Somatic –** things occurring in or to the body

➔ **Disorganized Thinking (Speech) – an** individual may switch from one topic to another (derailment or loose associations) or answers to questions may be related or completely unrelated (tangentiality)

- **Circumstantiality –** excessive and irrelevant detail in descriptions, with the person eventually making his/her point
- **Concrete Thinking –** unable to abstract and speaks in concrete, literal terms
- **Clang Association –** are groups of words chosen because of the catchy way they sound, not because of what they mean
- **Loose Association –** a loose connection between thoughts that are often unrelated
- **Neologism –** creating a new words that have no meaning
- **Word Salad –** a combination of words that have no meaning

➔ **Grossly Disorganized or Abnormal Motor Behavior –** unusual, unpredictable, or inappropriate for the situation

- Can range from childlike silliness to agitation, or even **catatonia –** a state of marked motor abnormalities, including immobility or excessive, purposeless movement

➔ **Negative Symptoms –** usually indicate the absence or insufficiency of normal behavior

- **Diminished Emotional Expression (Flat Affect) –** reduced expression of emotions in the face, tone of voice, or body language
- **Avolition –** lack of motivation or directedness; difficulty initiating and persisting in goal-directed activities
- **Alogia –** reduced speech output
- **Anhedonia –** inability to experience pleasure
- **Asociality –** lack of interest in social interactions

## SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS (5)

### Delusional Disorder

- ➔ Characterized by the presence of one or more delusions with a duration of 1 month or longer
- ➔ These delusions are fixed, false beliefs that are firmly held despite clear evidence to the contrary
- ➔ Tend not to have Negative Symptoms
- ➔ Functioning is better than what is observed in schizophrenia
- ➔ Absence of the active phase of schizophrenia (*Attenuated Psychosis Syndrome*)
- ➔ **Shared Psychotic Disorder (Folie a Deux) –** a condition in which an individual develops delusions simply as a result of a close relationship with a delusional individual
- ➔ Types of Delusional Disorder: Erotomanic, Grandiose, Jealous, Persecutory, Somatic, Mixed, Unspecified, With bizarre content

### Brief Psychotic Disorder

- ➔ Characterized by the sudden onset of at least one psychotic symptom (delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior)
- ➔ The disturbance lasts for at least one day but less than one month
- ➔ Full Return to Premorbid Functioning

### Schizophreniform Disorder

- ➔ Similar to schizophrenia, but the total duration of the illness (including the prodromal, active, and residual phases)
- ➔ At least 1 month but less than 6 months
- ➔ If the symptoms persist beyond 6 months, the diagnosis is typically changed to Schizophrenia or Schizoaffective Disorder, depending on the full symptom picture

### Schizophrenia

- ➔ Requires at least two of the characteristic symptoms (delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, negative symptoms)
- ➔ Continuous signs of the disturbance persist for at least 6 months

### Schizoaffective Disorder

- ➔ A combination of psychotic symptoms of schizophrenia and a major mood episode (major depressive or manic episode)

- ➔ The mood episode and psychotic symptoms must occur for a significant portion of the illness
- ➔ Delusions or hallucinations for at least 2 weeks without mood symptoms
- ➔ Symptoms that meet criteria for a major mood episode (depressive or manic) must be present for the majority of the total duration of the active and residual portions of the illness
- ➔ Types: Bipolar or Depressive

**Phases of Schizophrenia**

1. **Prodromal Phase –** the *early phase* of schizophrenia, where subtle changes begin to appear, but full-blown psychotic symptoms are not yet present or are very mild and intermittent
    - It can last for weeks, months, or even years before the active phase
2. **Active Phase (or Acute Phase) –** the *most prominent and severe psychotic symptoms* become evident
    - This is typically when schizophrenia is first diagnosed, as the symptoms are noticeable and significantly disrupt the individual's life and those around them
3. **Residual Phase (or Recovery Phase) –** a reduction in positive symptoms, but negative symptoms and cognitive deficits may persist, sometimes becoming the most challenging aspects of the illness

**Catatonia Specifiers**

1. **Stupor** (no psychomotor activity; not actively relating to the environment)
2. **Catalepsy** (passive induction of a posture held against gravity)
3. **Waxy flexibility** (slight, even resistance to positioning by examiner)
4. **Mutism** (no or very little verbal response, exclude if aphasia)
5. **Negativism** (opposition or no response to instructions or external stimuli)
6. **Posturing** (spontaneous & active maintenance of posture against gravity)
7. **Mannerism** (odd, circumstantial caricature of normal actions)
8. **Stereotypy** (repetitive, abnormally frequent, non-goal-directed movements)
9. **Agitation**, not influenced by external stimuli
10. **Grimacing**
11. **Ecolalia** (mimicking another's speech)
12. **Echopraxia** (mimicking another's movement)

**E** | **Identify the different Neurodevelopmental and Neurocognitive Disorders based on DSM-5**

**Neurodevelopmental Disorders** – a group of conditions with onset in the developmental period

- They are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning

**NEURODEVELOPMENTAL DISORDERS (3)**

**Intellectual Developmental Disorder (Intellectual Disability) –** is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in 3 domains: (1) conceptual, (2) social, and (3) practical domains. Intellectual disability is a heterogeneous condition with many different etiologies.

- ➔ Characterized by deficits in general mental abilities (e.g., reasoning, problem-solving, planning, abstract thinking, judgment, academic learning, learning from experience)
- ➔ Also involves deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. These deficits limit functioning in one or more activities of daily life (e.g., communication, social participation, independent living)
- ➔ Onset is during the developmental period
- ➔ Severity is specified based on adaptive functioning in conceptual, social, and practical domains (mild, moderate, severe, profound)
    - ◆ Mild: 50 - 55 & 70
    - ◆ Moderate: 35 - 40 & 50 - 55
    - ◆ Severe: 20 - 25 & 35 - 40
    - ◆ Profound: below 20 - 25

**Global Developmental Delay –** is a diagnosis for individuals under the age of 5 years when the clinical severity level cannot be reliably assessed during early childhood. The diagnosis is given when an individual fails to meet expected developmental milestones in several areas of intellectual functioning, and applies to individuals who are unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized testing. This category requires reassessment after a period of

time.

- ➔ GDD is a **temporary diagnosis**. It is reserved for children who are too young to undergo the standardized formal testing required for a diagnosis of Intellectual Disability.

**Language Disorder –** is a disorder characterized by difficulties in the acquisition and use of language, due to deficits in the production or comprehension of vocabulary, discourse, and sentence structure. These deficits will be apparent in spoken communication, written communication, or sign language.

- ➔ Limited speech in all situations
- ➔ Expressive language is significantly below receptive language
  - ◆ Reduced vocabulary
  - ◆ Limited sentence structure
  - ◆ Impairments in disclosure

**Speech Sound Disorder –** (also known as Phonological Disorder) is a disorder where speech sound production is not consistent with what is expected based on the child's developmental stage and age.

- ➔ Additionally, the speech production deficits must not be due to a physical, structural, neurological, or hearing impairment.
- ➔ Children with the disorder may not have knowledge of phonological speech sounds, or be unable to coordinate movements (i.e. - articulation) for speech.

**Childhood-Onset Fluency Disorder (Stuttering) –** (more commonly known as Stuttering) is a communication disorder characterized by a disturbance in the normal fluency and time patterning of speech that is inappropriate for an individual's age.

- ➔ The disorder is characterized by frequent repetitions or prolongations of sounds or syllables. Other speech deficits include:
  - ◆ (1) single words that are broken up (e.g. - pauses within a word),
  - ◆ (2) audible or silent blocks (i.e. - filled or unfilled pauses in speech),
  - ◆ (3) circumlocutions (i.e. - word substitutions to avoid problematic words),
  - ◆ (4) words produced with excess physical tension, and
  - ◆ (5) monosyllabic whole-word repetitions (e.g., 'He-he-he-he is here").

**Social (Pragmatic) Communication Disorder –**is characterized by a primary difficulty with pragmatics, or the social use of language and communication, as manifested by deficits in understanding and following social rules of verbal and nonverbal communication in naturalistic contexts, changing language according to the needs of the listener or situation, and following rules for conversations and storytelling.

**Autism Spectrum Disorder–** is characterized by persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviors used for social interaction, and skills in developing, maintaining, and understanding relationship

- ➔ ASD encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder.
- ➔ Core diagnostic features are evident in the developmental period, but intervention, compensation, and current supports may mask difficulties in at least some contexts. Manifestations of the disorder also vary greatly depending on the severity of the autistic condition, developmental level, and chronological age; hence, the term spectrum
- ➔ Severity is specified based on the level of support required for social communication and restricted, repetitive behaviors
- ➔ Severity
  - ◆ Level 1 – requiring support
  - ◆ Level 2 – substantial support
  - ◆ Level 3 – very substantial support
- ➔ **Rett Disorder –** a genetic condition that affects mostly females and is characterized by hand wringing and poor coordination

**Attention-Deficit/Hyperactivity Disorder (ADHD) –** is a neurodevelopmental disorder defined by impairing levels of inattention, dis organization, and/or hyperactivity-impulsivity.

- ➔ **Inattention –** manifests behaviorally in ADHD as wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of compensation
- ➔ **Hyperactivity –** refers to excessive motor activity (such as a child running about) when it is not appropriate, or excessive fidgeting, tapping, or talkativeness

- In adults, hyperactivity may manifest as extreme restlessness or wearing others out with their activity

➔ **Impulsivity –** refers to hasty actions that occur in the moment without forethought and that have high potential for harm to the individual (e.g., darting into the street without looking)

➔ **Combined Presentation (ADHD-C):** if both A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for 6 months

➔ **Predominantly Inattentive Presentation (ADHD-PI):** if Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months

➔ **Predominantly Hyperactive/Impulsive Presentation (ADHD-HI):** if Criterion A2 (hyperactivity-impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months

**Specific Learning Disorder–** is diagnosed when there are specific deficits in an individual's ability to perceive or process information efficiently and accurately.

➔ This neurodevelopmental disorder first manifests during the years of formal schooling and is characterized by persistent and impairing difficulties with learning foundational academic skills in reading, writing, and/or math.

➔ With impairment in reading (Dyslexia)

➔ With impairment in written expression (Dysgraphia)

➔ With impairment in mathematics (Dyscalcula)

**Developmental Coordination Disorder –** is characterized by deficits in the acquisition and execution of coordinated motor skills and is manifested by clumsiness and slowness or inaccuracy of performance of motor skills that cause interference with activities of daily living.

**Stereotypic Movement Disorder –** is diagnosed when an individual has repetitive, seemingly driven, and apparently purposeless motor behaviors, such as hand flapping, body rocking, head banging, self biting, or hitting.

➔ **With self-injurious behavior:** If the behavior results in bodily injury (e.g., head banging that causes bruising or retinal detachment).

➔ **Without self-injurious behavior:** If the movements are harmless (e.g., rhythmic hand flapping).

➔ **Associated with a known medical/genetic condition:** (e.g., Lesch-Nyhan syndrome, Rett syndrome, or Intellectual Disability).

**Tic Disorders –** are sudden, rapid, recurrent, non-rhythmic motor movements or vocalizations.

➔ Individuals with tics experience a feeling of a mounting inner tension or urge (known as a premonitory urge), which is transiently relieved by tic expression.

➔ Tics will wax and wane with time, and can be worsened with stress, fatigue, or excitement.

➔ Although tics can include almost any muscle group or vocalization, certain tic symptoms, such as eye blinking or throat clearing, are more common.

➔ Tics are generally experienced as "involuntary" but are usually temporarily suppressible.

➔ **Tourette's Disorder –** multiple motor tics and at least one vocal tic, persisting for more than 1 year

➔ **Persistent (Chronic) Motor or Vocal Tic Disorder –** single or multiple motor or vocal tics, but not both, persisting for more than 1 year

➔ **Provisional Tic Disorder –** single or multiple motor and/or vocal tics, present for less than 1 year

**Neurocognitive Disorders –** characterized by a decline from a previously attained level of cognitive functioning

- They typically involve cognitive deficits that are *acquired* (not developmental) and are often due to underlying brain pathology, disease, injury, or substance use
- The impact is primarily on cognitive domains such as memory, attention, language, and problem-solving

## NEUROCOGNITIVE DISORDERS (2)

**Delirium –** is a serious neuropsychiatric syndrome characterized by an acute confusional state with global impairments in attention and cognition.

➔ Delirium is often associated with a disturbance in the sleep-wake cycle, including daytime sleepiness, nighttime agitation, insomnia, excessive sleepiness, or wakefulness throughout the night.

➔ In some cases, complete reversal of the night-day sleep-wake cycle can occur.

➔ A disturbance in attention (i.e. - reduced ability to direct, focus, sustain, and shift attention) and awareness (reduced orientation to the environment).

➔ The disturbance develops over a short period of

time (usually hours to a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day.

- ➔ An additional disturbance in cognition (e.g. - memory deficit, disorientation, language, visuospatial ability, or perception).
- ➔ The disturbances in Criteria A and C are not better explained by another preexisting, established, or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal, such as coma.
- ➔ There is evidence from the history, physical examination, or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal (i.e. - due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple etiologies.
- ➔ **The "Clouding" of Consciousness:** Unlike dementia (Major NCD), where a person is usually alert but forgetful, a person with delirium is often "out of it." They may struggle to follow a simple conversation or stay awake.
- ➔ **Sundowning:** Symptoms often worsen in the evening or at night when environmental cues (light, noise) are reduced.
- ➔ **Perceptual Disturbances:** It is common for patients to experience illusions (misinterpreting a real object, like seeing a coat rack as a person) or hallucinations.

**Major Neurocognitive Disorder –** and mild neurocognitive disorder) exists on a spectrum of cognitive and functional impairment.

- ➔ The term major neurocognitive disorder corresponds to the condition referred to what was previously referred to in the DSM-IV as dementia.
- ➔ The core feature of neurocognitive disorders is an acquired cognitive decline in one or more cognitive domains based on
  - ◆ (A) both a concern about cognition on the part of the individual, a knowledgeable informant, or the clinician, and
  - ◆ (B) performance on an objective assessment that falls below the expected level or observed decline over time.
- ➔ Formerly *Dementia*
- ➔ Characterized by significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition).
- ➔ The cognitive deficits are sufficient to interfere with independence in everyday activities (e.g., managing medications, paying bills, maintaining hygiene).
- ➔ Not exclusively occurring during the course of a delirium.
- ➔ The cognitive deficits are not better explained by another mental disorder

**Mild Neurocognitive Disorder –** also known as Mild Cognitive Impairment, or MCI) is a condition in which individuals demonstrate cognitive impairment with minimal impairment of instrumental activities of daily living (IADLs).

- ➔ Although it can be the first cognitive sign of Alzheimer's Disease (AD), it can also be secondary to other disease processes (e.g. - neurologic, other neurodegenerative disorders, systemic, infectious, or psychiatric disorders).
- ➔ When there is interference with independence in everyday activities, a major neurocognitive disorder needs to be considered instead.
- ➔ Characterized by modest cognitive decline from a previous level of performance in one or more cognitive domains
- ➔ The cognitive deficits do not interfere with independence in everyday activities (though more effort, compensatory strategies, or accommodation may be required)
- ➔ Not exclusively occurring during the course of a delirium
- ➔ The cognitive deficits are not better explained by another mental disorder

**Neurocognitive Disorders Etiologies**

**Neurodegenerative Diseases** – these involve the progressive loss of neurons in the brain

- ➔ **Alzheimer's Disease –** characterized by the accumulation of amyloid plaques and neurofibrillary tangles in the brain, leading to gradual memory loss, cognitive decline, and behavioral changes. Genetic factors may also play a significant role in some cases
- ➔ **Frontotemporal Lobar Degeneration (FTLD) –** a group of disorders primarily affecting the frontal

and temporal lobes of the brain. This results in prominent changes in personality, behavior, and/or language, with varying underlying proteinopathies (e.g., tau, TDP-43)

- ◆ **Pick's Disease –** a rare neurological condition that produces symptoms similar to Alzheimer's, usually occurring relatively early in life

- ➔ **Lewy Body Disease –** distinguished by the presence of Lewy bodies (abnormal protein deposits) in the brain. This leads to fluctuating cognition, visual hallucinations, Parkinsonian motor features, and REM sleep behavior disorder
- ➔ **Parkinson's Disease –** primarily a motor disorder due to the loss of dopamine-producing neurons, but can also lead to cognitive impairment and eventually dementia in some individuals. Lewy bodies are also implicated
- ➔ **Huntington's Disease –** an inherited genetic disorder that causes the degeneration of nerve cells in the brain. It manifests with a triad of motor abnormalities (chorea), cognitive decline, and psychiatric symptoms
- ➔ **Prion Disease –** a rare and rapidly progressive neurodegenerative disorder caused by infectious prions (abnormal proteins)
  - ◆ **Creutzfeldt-Jakob Disease –** symptoms include spasms of the body caused by a slow-acting virus that may live in the body for years before the disease develops

**Vascular Disease** – results from problems with the blood supply to the brain

- ➔ **Vascular Neurocognitive Disorder –** caused by cerebrovascular events such as strokes (infarcts) or small vessel disease, leading to brain damage and cognitive impairment. The pattern of cognitive deficits can be variable depending on the location and extent of the vascular injury

**Traumatic Brain Injury (TBI)** – cognitive impairment resulting from a blow or jolt to the head that disrupts normal brain function. The severity pattern of cognitive deficits depends on the nature and extent of the injury. Repeated TBIs can lead to chronic traumatic encephalopathy (CTE)

**Substance/Medication Use** – cognitive decline that persists beyond the acute intoxication or withdrawal phase of substance use. Various substances can cause neurocognitive impairment. Certain medications can also have lasting cognitive effects

**HIV Infection** – the human immunodeficiency virus can directly and indirectly affect the brain, leading to HIV-associated neurocognitive disorder (HAND). The severity can range from mild to severe dementia

**Prion Disease** – (also listed under neurodegenerative, but also specified separately due to its unique infectious etiology. Caused by abnormal prion proteins leading to rapidly progressive neurodegeneration

**Another Medical Condition** – this is a broad category encompassing NCDs resulting from various systemic or neurological conditions not listed specifically

- ➔ Multiple Sclerosis
- ➔ Brain Tumors
- ➔ Infections of the brain or meninges

### Other Specified & Unspecified Disorder

**Other Specified Disorder**

- ➔ Used when the clinician chooses to specify the reason why the presentation does not meet the full criteria for a specific disorder
- ➔ It means the clinician has enough information to indicate why a more precise diagnosis isn't being made
- ➔ The clinician provides a brief explanation for why the criteria for a specific disorder are not met, but the symptoms cause clinically significant distress or impairment
- ➔ Example: Other Specified Depressive Disorder, with insufficient symptoms

**Unspecified Disorder**

- ➔ Used when the clinician chooses not to specify the reason why the criteria for a specific disorder are not met
- ➔ There is insufficient information to make a more specific diagnosis
- ➔ The clinician determines that a mental disorder is present, but the individual's symptoms are complex, atypical, or do not conform clearly to any specific psychiatric diagnosis, and the clinician isn't yet ready or able to specify the reason
- ➔ No specific reason is provided for not meeting the full criteria
- ➔ Example: Unspecified Depressive Disorder

# ABNORMAL PSYCHOLOGY

PmLE | Main References: Barlow & Durand 8th ed.; Kring et al., 14th ed.; DSM-5/5-TR

## THEORETICAL APPROACHES IN EXPLAINING THE ETIOLOGY OF PSYCHOLOGICAL DISORDER (20)

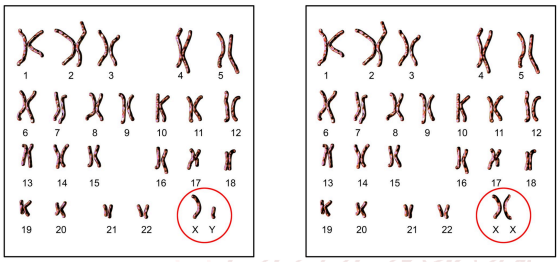
**ONE-DIMENSIONAL –** looking for a single cause
**MULTIDIMENSIONAL** – looking for a systemic cause

### A Genetic Contributions (4)

**Genetic Paradigm –** almost all behavior is heritable to some degree (i.e., it involves genes)

- People have **23 pairs of chromosomes**; **46 total**
  - **22 Autosomes; 1 Sex Chromosome**
  - **XX (Females); XY (Males)**

Male | Female



- The carriers of the **genetic information (DNA)** are passed from parents to the child
- People have **between 20,000 and 25,000 genes**; the absolute number is hard to fully estimate
- **Gene Expression –** switch other genes on and off, the flexibility of genes and how they turn on or off has closed the door on beliefs about the inevitability of the effects of genes, good or bad
- **Polygenic –** meaning several genes, perhaps operating at different times during development, turning themselves on and off as they interact with a person's environment, is the essence of genetic vulnerability
- **Heritability –** refers to the extent to which variability in a particular behavior (or disorder) in a population can be accounted for by genetic factors

**2 Environmental Factors**

1. **Shared Environment –** includes those things that members of a family have in common, such as family income level, child-rearing practices, and parents' marital status and quality
2. **Nonshared Environment –** unique environment factors are those things believed to be distinct among members of a family, such as relationships with friends or specific events unique to a person

- **Genotype –** the total genetic makeup of an individual, consisting of inherited genes, which cannot be observed outwardly
- **Phenotype –** the totality of observable behavioral characteristics
- **Endophenotypes –** genetic mechanisms that ultimately contribute to the underlying problems causing the symptoms and difficulties experienced by people with psychological disorders
- **Alleles –** different forms of the same genes, which are commonly found at the same location, or locus, of a chromosome pair
- **Genetic Polymorphism –** refers to a difference in DNA sequence on a gene that has occurred in a population
- **Single Nucleotide Polymorphism (SNPs) –** refers to differences between people in a single nucleotide (A, T, G, or C) in the sequence of a particular gene
- **Copy Number Variations (CNVs) –** can be present in a single gene or multiple genes.
  - The name refers to an abnormal copy of one or more sections of DNA within the gene(s)
- **Basic Genetic Epidemiology –** statistical analysis of family, twin, and adoption studies; whether the disorder can be inherited and how much is attributable to genetics
  - **Family Studies –** examine behavioral patterns or emotional traits in the context of the family
  - **Proband –** family member with the trait singled out for the study (possibly having a genetic disorder and who may receive genetic counseling or testing)
  - **Adoption Studies –** identify adoptees who have a particular behavioral pattern of psychological disorder and attempt to locate first-degree relatives who were raised in different family settings
  - **Twin Studies –** usually conducted on identical twins because they share genetic makeup
- **Advanced Genetic Epidemiology –** studies the factors that influence the disorder
- **Gene Finding –** what gene influences the behavior
- **Molecular Genetics –** biological processes genes affect to produce symptoms of the disorder
- **Epigenetics –** "above or outside the gene" and refers to the chemical "marks," such as DNA methyl tags or histones, that are attached to and protect the DNA in each gene

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## B | Biological and Neurological Bases (4)

**Neuroscience Paradigm** – psychological disorders are linked to aberrant processes in the brain

**Neurotransmitters** – are the body's chemical messengers, acting as a crucial communication system for the nervous system

- ➔ **The Synaptic Transmission Process**
  - When an electrical signal (action potential) reaches the end of a neuron (the terminal button), it triggers the release of neurotransmitters stored in tiny sacs called vesicles.
  - **Synaptic Cleft –** these chemicals do not simply touch the next cell; they are expelled into the synapse—the microscopic gap between the sending (presynaptic) neuron and the receiving (postsynaptic) cell.
  - The neurotransmitters drift across the synapse and attach to specific, matching receptors on the neighboring cell (which could be a neuron, a muscle fiber, or a gland). Just like a key fitting into a specific lock, a neurotransmitter will only bind to its corresponding receptor, ensuring that messages are sent to the correct neural pathways.
  - Once the message is delivered, the neurotransmitters must be cleared from the synapse to prevent constant overstimulation. This happens either through *reuptake* (being absorbed back into the sending neuron) or *enzymatic degradation* (being broken down by enzymes). Many psychotropic medications (like SSRIs for depression) work by altering this exact cleanup process.
- ➔ **Three Categories of Neurotransmitters**
  - **Excitatory –** these neurotransmitters encourage a receiving cell to fire an action potential (an electrical signal), thereby passing the message along
  - **Inhibitory –** these neurotransmitters reduce the likelihood that a receiving cell will fire, effectively acting as a "break" on the nervous system
  - **Modulatory –** these neurotransmitters can influence a larger group of neurons at once and over a longer period, "fine-tuning" or adjusting how cells communicate

### The Neural Infrastructure: How the Brain Communicates

- **Neurons –** these are the foundational building blocks of the nervous system. The brain and body contain billions of these specialized cells, which are designed to receive, process, and transmit electrical and chemical signals.
- **Synapse –** is the small gap between the terminal endings of the sending axon and the cell membrane of the receiving neuron
- **Reuptake –** is a process where some of what remains in the synapse is broken down by the enzymes, and some is taken back into the presynaptic cell

### Neuropharmacology: How Drugs Alter Neural Activity

- **Agonist –** substances *increase* or enhance the activity of a specific neurotransmitter. They either mimic the natural neurotransmitter, binding to the receptor and causing the same excitatory or inhibitory response, or they stimulate the release of more of the natural chemical. (*Excitatory*)
- **Antagonist –** substances *decrease* or block a neurotransmitter's activity. An antagonist acts like a broken key stuck in a lock—it binds to the receptor but does not activate it, effectively blocking the natural neurotransmitters from attaching and delivering their message. (*Inhibitory*)
- **Inverse Agonists –** are highly specialized substances that not only bind to the receptor but produce the *exact opposite* physical effect of the natural neurotransmitter that normally binds there.

### The Primary Neurotransmitters and Their Core Functions

- **Neurotransmitters –** are chemicals that allow neurons to send signals across the synapse to other neurons
  - **Glutamate (Excitatory): The Memory Molecule –** as the brain's most abundant excitatory neurotransmitter, glutamate is the primary driver of neural activation. It is essential for synaptic plasticity—the brain's ability to adapt and grow—making it central to learning, memory formation, and cognitive speed.
  - **GABA (Gamma-Aminobutyric Acid) (Inhibitory): The Calming Chemical –** is the brain's main inhibitory neurotransmitter. It acts as the nervous

system's brake pedal, slowing down excessive neural firing. It induces physical and mental relaxation, promotes sleep, and is the primary defense against anxiety and overstimulation.

- **Serotonin (Inhibitory/Modulatory): The Mood Regulator –** plays a massive role in maintaining emotional balance and well-being. Beyond stabilizing mood, it regulates sleep cycles (circadian rhythms), appetite, and digestion.
- **Dopamine: The Reward and Motivation Chemical –** is central to the brain's reward pathway. It is released during pleasurable situations, driving motivation, desire, and reinforcement learning. It is also crucial for coordinating smooth, voluntary motor movements.
- **Epinephrine (Adrenaline): The Fight-or-Flight Hormonal Transmitter –** produced in high stress situations, epinephrine floods the body to prepare it for immediate physical action. It increases heart rate, dilates airways, and surges energy to muscles, initiating the acute survival response.
- **Norepinephrine (Noradrenaline): The Concentration Chemical –** closely related to epinephrine but more focused in the brain, norepinephrine governs alertness, focus, and arousal. It enhances vigilance and shifts the brain's attention to rapidly respond to environmental stimuli.
- **Endorphins: The Natural Painkillers –** (endogenous morphines) are the body's natural opioids. Released during exercise, excitement, or physical pain, they bind to opiate receptors to block pain signals and produce a profound sense of euphoria and well-being.
- **Acetylcholine (Excitatory): The Learning and Movement Messenger –** acts in both the central and peripheral nervous systems. In the brain, it is vital for attention, learning, and the transition of experiences into long-term memory. In the body, it is the primary neurotransmitter responsible for triggering voluntary muscle contractions.

| Neurotransmitters | High | Low |
|---|---|---|
| Dopamine | Schizophrenia | Parkinson's Disease |
| Acetylcholine | Severe muscle spasms | Alzheimer's Disease (Dementia) |
| Norepinephrine | Mania | Depression |
| GABA | Extreme Relaxation/ Sedation | Anxiety, OCD |
| Serotonin | Mania | Depression, Anxiety, Eating Disorders |
| Epinephrine | Chronic Stress | Sleeping Disorders, Fatigue |
| Glutamate | Psychosis, Neuron Death | Associated with Huntington's Disease |
| Endorphin | Euphoria/ Insensitivity to pain | Eating Disorders |

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## Structure and Function of the Human Brain: The Anatomy of Behavior

- **The Cerebrum and The Cortex: Higher-Order Processing –** the topmost layer of the brain is responsible for complex thought, perception, and voluntary movement.
  - **Gray Matter (The Cerebral Cortex) –** this is the heavily folded, thin outer covering of the brain composed of dense clusters of neuron cell bodies.
    - It provides humans with their distinct cognitive qualities—the ability to plan, reason, create, and possess self-awareness.
  - **Left Hemisphere –** primarily responsible for verbal processing, language production, logic, and sequential cognitive processes.
  - **Right Hemisphere –** dominates in perceiving the world spatially, creating and processing visual images, recognizing

faces, and interpreting nonverbal emotional cues.

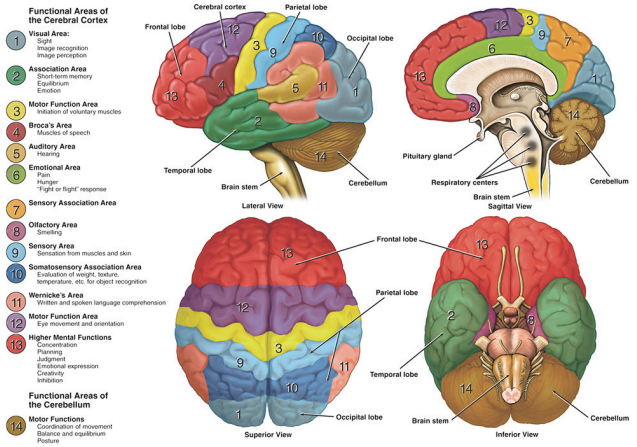
- **Four Lobes**
  - **Frontal Lobe –** responsible for reasoning, motor control, emotion, and language.
  - **Parietal Lobe –** processes sensory information from the body (touch, temperature, pain).
  - **Occipital Lobe –** the primary visual processing center.
  - **Temporal Lobe –** essential for hearing, memory, emotion, and some aspects of language.
- **Prefrontal Cortex –** located at the very front of the frontal lobe, this is the brain's executive control center.
  - It governs higher cognitive functions (decision-making, impulse control) and is crucial for regulating the amygdala.
  - Dysfunction here is implicated in ADHD, schizophrenia, and impulse-control disorders.
- **White Matter –** situated beneath the gray matter, this is composed of large tracts of myelinated (sheathed) nerve fibers.
  - The myelin acts as insulation, allowing electrical signals to travel rapidly, connecting cell bodies in the cortex with the spinal cord and other brain regions.

- **Subcortical Structures and The Limbic System: Emotion and Memory –** located deep within the brain, beneath the cortex, these older structures govern emotion, basic drives, and memory formation.
  - **Limbic System –** a ring of interconnected structures located around the center of the brain, heavily involved in emotion and survival behaviors.
    - **Amygdala –** the brain's "threat detector." It is crucial for assigning emotional significance to stimuli (especially fear and anger) and is highly overactive in anxiety and trauma-related disorders.
    - **Hippocampus –** the memory center. It consolidates short-term experiences into long-term memories and helps regulate the stress response. (Often found to be shrunken in chronic depression and PTSD).
    - **Anterior Cingulate –** acts as a bridge between the emotional limbic system and the cognitive prefrontal cortex, helping regulate autonomic functions, empathy, and decision-making.
  - **Thalamus –** the brain's sensory relay station. It receives sensory information (except smell) and routes it to the appropriate areas of the cortex for processing.
  - **Hypothalamus –** the master regulator of homeostasis. It controls vital biological drives including metabolism, temperature, perspiration, blood pressure, sleep-wake cycles, and appetite.
  - **Basal Ganglia –** located at the base of the forebrain, this group of structures regulates voluntary movement and habitual behaviors.
    - Degeneration here is directly related to Parkinson's Disease, and dysfunction is implicated in OCD and Tourette's.
- **Brain Stem and Hindbrain: Autonomic Survival –** this is the most ancient, evolutionary primitive part of the brain, connecting the brain to the spinal cord. It operates unconsciously to keep the body alive.
  - **Medulla & Pons –** regulate critical, life-sustaining autonomic activities such as heart rate, breathing, and blood pressure.
  - **Cerebellum –** the "little brain" at the back of the skull. It coordinates smooth motor movements and balance. Abnormalities in the cerebellum have been increasingly associated with motor and cognitive deficits in Autism Spectrum Disorder.
- **Brain Development and Connectivity**
  - **Ventricles and Cerebrospinal Fluid (CSF) –** ventricles are interconnected cavities deep within the brain filled with CSF. This fluid circulates through the brain and spinal cord, providing a protective cushion, clearing waste, and delivering nutrients. (Enlarged ventricles are a structural abnormality consistently found in schizophrenia).
  - **Synaptic Pruning –** a crucial developmental process (peaking during

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adolescence) where the brain eliminates unused or inefficient synaptic connections to streamline neural networks and improve processing efficiency.

- **Brain Networks –** rather than working in isolation, the brain operates via distributed networks—clusters of brain regions that consistently activate together when performing specific tasks (e.g., the Default Mode Network, which activates during rest and daydreaming).




## Peripheral and Endocrine Systems: Mind-Body Connection

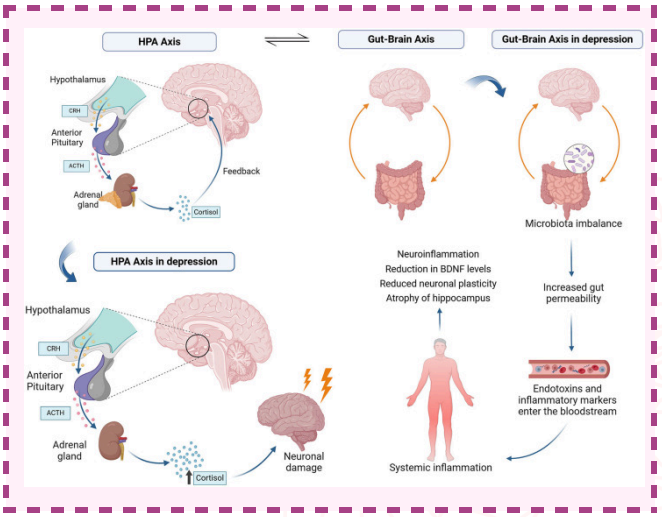
- **Somatic Nervous System –** controls voluntary movements of skeletal muscles.
- **Autonomic Nervous System –** operates involuntarily, innervating internal organs, the heart, smooth muscles, and endocrine glands.
  - **Sympathetic Nervous System –** triggers the "fight or flight" response, accelerating heart rate, dilating pupils, and halting digestion during perceived danger.
  - **Parasympathetic Nervous System –** triggers the "rest and digest" response, helping the body calm down and return to a baseline state of homeostasis after a threat has passed.

**Endocrine System –** a network of glands that produce and release hormones directly into the bloodstream, heavily influencing mood, metabolism, and stress responses.

| Gland | Primary Functions and Hormones |
|---|---|
| **Pituitary** | The "Master Gland"controls all other endocrine glands.<br><br>Regulates growth; intimately tied to the brain's hypothalamus. |
| **Pineal** | Secretes Melatonin.<br><br>Regulates circadian rhythms and sleep-wake cycles. |
| **Thyroid** | Controls metabolism and growth.<br><br>Overactive (hyperthyroidism) mimics anxiety; underactive (hypothyroidism) mimics depression. |
| **Parathyroid** | Controls calcium levels in the blood.<br><br>Calcium imbalances can cause neurological symptoms like confusion or lethargy. |
| **Adrenal** | Secretes stress hormones (Cortisol, Epinephrine).<br><br>Drives the physiological stress response; chronic activation leads to burnout and immune suppression. |
| **Pancreas** | Secretes Insulin.<br><br>Regulates blood sugar levels. |
| **Ovaries/ Testes** | Secretes Estrogen, Progesterone/ Testosterone.<br><br>Drives sexual development, libido, and can significantly influence mood and aggression. |

**HPA Axis –** is central to the body's response to stress figures prominently in many of the disorders

- ➔ When people are faced with a threat, the hypothalamus releases *corticotropin-releasing factor (CRF)*, which then communicates with the ***pituitary gland***.
- ➔ The pituitary then releases *adrenocorticotropic hormone*, which travels via the blood to the adrenal glands. The outer layers of the adrenal glands are referred to as the ***adrenal cortex;*** this area promotes the release of the hormone cortisol
- ➔ **Cortisol –** often referred to as the "stress hormone"




**Temperament –** refers to the innate, biologically based traits that dictate a child's natural disposition, emotional reactivity, and characteristic ways of self-regulation.

- Unlike personality, which is shaped over time through lived experiences and environmental interactions, temperament is hardwired and observable from infancy.
- **Reactivity –** this describes the baseline excitability of a child's nervous system. It includes how easily, intensely, and for how long a child responds to sensory, emotional, or environmental stimuli (e.g., a loud noise, a new caregiver, or physical discomfort).
- **Self-Regulation –** this refers to the behavioral and neural processes a child uses to modulate their reactivity. It encompasses a child's ability to soothe themselves, shift their attention away from distressing stimuli, and exhibit "effortful control" over their impulses.

**Permissive Hypothesis –** provides a specific neurobiological framework for understanding how neurotransmitter interactions trigger mood disorders, particularly Major Depressive Disorder and Bipolar Disorder.

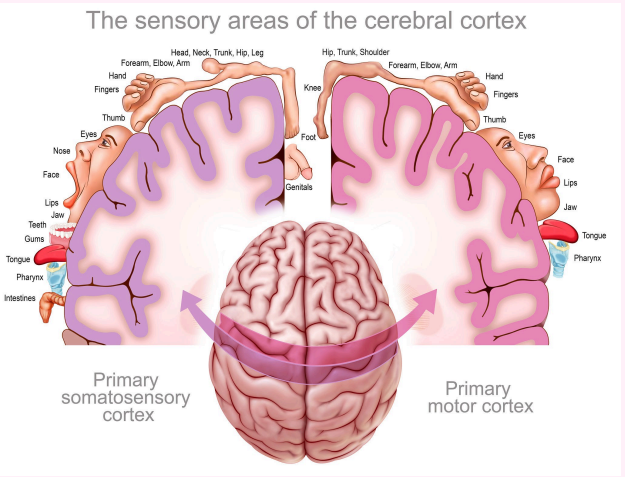
- Rather than attributing mood irregularities to the malfunction of just one chemical, this theory posits that serotonin acts as the brain's primary regulatory system—essentially serving as the "manager" that keeps other neurotransmitters in check.
- When serotonin levels fall below a critical threshold, this regulatory oversight is lost. The low serotonin permits other critical neurotransmitters—namely norepinephrine and dopamine—to range more widely, fluctuate erratically, and become severely dysregulated.
- The erratic behavior of these other neurotransmitters determines the specific symptoms of the mood episode. For example, if serotonin is low and norepinephrine subsequently plummets, the individual will experience profound depression. However, if serotonin is low and norepinephrine wildly spikes, the individual will experience a manic episode.

| Structure | Core Functions |
|---|---|
| **Frontal Lobe** | Learning, abstracting, reasoning, inhibiting impulses.<br><br>Executive Dysfunction: Central to ADHD (poor impulse control), personality changes, and the inability to plan or foresee consequences. |
| **Parietal Lobe** | Somesthetic (tactile) and motor discriminations.<br><br>Spatial Deficits: Damage can lead to apraxia (inability to perform purposeful movements) or spatial neglect (ignoring one side of space). |
| **Temporal Lobe** | Discrimination of sounds, verbal, and speech behavior.<br><br>Language & Psychosis: Lesions here cause Wernicke's aphasia (inability to comprehend language). Hyperactivity is linked to auditory hallucinations in schizophrenia. |
| **Occipital Lobe** | Visual discrimination and visual memory.<br><br>Visual Processing: Damage can cause visual agnosia (inability to recognize familiar objects or faces) or visual hallucinations. |
| **Corpus Callosum** | Communication bridge between the left and right hemispheres.<br><br>Integration: Severing this tract (corpus callosotomy) is a rare treatment for severe epilepsy, resulting in "split-brain" syndrome where the two hemispheres cannot share information. |
| **Limbic System** | Attention, emotion, and the |

| | |
|---|---|
| | fight-or-flight response.<br><br>Emotional Dysregulation: The core neural circuitry implicated in trauma (PTSD), severe anxiety, and mood disorders. |
| **Hypothalamus** | Regulation of metabolism, temperature, and basic drives (hunger, thirst, sex).<br><br>Biological Drives: Heavily implicated in eating disorders, sleep-wake cycle disruptions, and driving the physiological stress response via the HPA axis. |
| **Thalamus** | Major relay station for sensory messages from the body; processes pain sensation.<br><br>Sensory Gating: Deficits in how the thalamus filters sensory input are thought to contribute to the overwhelming sensory overload experienced in schizophrenia and autism. |
| **Reticular Formation** | Arousal reaction and information screening (the brain's volume dial for wakefulness).<br><br>Arousal Disorders: Dysregulation here can result in sleep-wake disorders (like narcolepsy) or the chronic under-arousal/ hyperarousal seen in ADHD. |
| **Medulla** | Autonomic control of breathing, blood pressure, and vital functions.<br><br>Survival Mechanisms: This is the structure suppressed during fatal central nervous system depressant overdoses (e.g., opioids). It also drives the acute physiological symptoms of panic attacks. |
| **Cerebellum** | Fine motor coordination, posture, and balance.<br><br>Motor Deficits: Beyond basic balance, cerebellar abnormalities are increasingly recognized as contributing to the motor and cognitive deficits in Autism Spectrum Disorder. |

**Motor and Sensory Strips –** a cortex contains highly specialized bands of tissue that map directly to specific body parts—a mapping known as the "homunculus."

- ➔ **Sensory Strip (Somatosensory Cortex)** – located at the front of the parietal lobe, it integrates tactile sensory information (touch, temperature, pain) from various parts of the body.
  - ◆ Anomalies here can contribute to somatic symptom disorders, phantom limb pain, or sensory conversion symptoms (e.g., psychogenic numbness).
- ➔ **Motor Strip (Motor Cortex) –** located at the rear of the frontal lobe, it regulates voluntary movement.
  - ◆ Dysfunction in these pathways is seen in tic disorders (like Tourette's), movement initiation issues in Parkinson's disease, or psychogenic paralysis in Conversion Disorder.




**Monoamine Hypothesis of Depression –** is a theory that suggests a **deficiency** in certain monoamine neurotransmitters in the brain is the underlying cause of depression

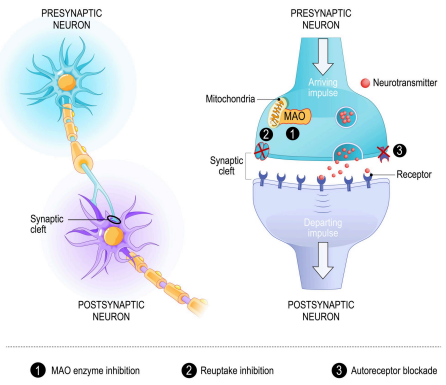
- **The Big Three Monoamines**
  - **Serotonin (5-HT): The Mood Stabilizer.** Intense sadness, anxiety, irritability, sleep disturbances, and altered appetite.

(Because serotonin acts as a "manager" per the Permissive Hypothesis, its deficit allows the other two monoamines to become dysregulated).

- **Norepinephrine (NE): The Energy Chemical.** Profound fatigue, psychomotor retardation (sluggish physical movement and thought processes), and lack of concentration.
- **Dopamine (DA): The Reward Messenger.** Anhedonia (the inability to feel pleasure), lack of motivation, and feelings of worthlessness.

- Monoamine Hypothesis does not necessarily argue that the brain is producing too little of these chemicals, but rather that there is an insufficient concentration of them remaining in the synaptic cleft (the space between the sending and receiving neurons) long enough to properly deliver their messages.

Mechanism of action of antidepressants




- When a presynaptic neuron releases serotonin into the cleft, it naturally "vacuums" the leftover serotonin back up to be recycled—a process called reuptake.
  - Selective Serotonin Reuptake Inhibitors (SSRIs): Drugs like Fluoxetine (Prozac) or Sertraline (Zoloft) physically block the reuptake pumps on the sending neuron.
  - Because the serotonin cannot be sucked back up, it accumulates and stays in the synaptic cleft for much longer. This forces the serotonin to continuously bind to the postsynaptic receptors, effectively turning up the "volume" of the serotonin signal and alleviating depressive symptoms.

## C | Learning (4)

**Classical Conditioning** – it explains how an organism learns to connect a biologically potent, naturally occurring event with a neutral, previously meaningless event.

- Classical Conditioning deals strictly with involuntary, autonomic, or reflexive responses—such as salivating, heart rate spikes, or a fear response (like in phobias or PTSD).
- Over time, the neutral stimulus alone becomes a conditioned stimulus, capable of triggering a learned, or "conditioned," response
- **Unconditioned Stimulus (US) –** a stimulus that naturally and automatically triggers a response (e.g., food)
- **Unconditioned Response (UR) –** the natural, automatic response to the unconditioned stimulus (e.g., salivation)
- **Neutral Stimulus –** a stimulus that, before conditioning, does not trigger a specific response (e.g., a bell)
- **Conditioned Stimulus (CS) –** the neutral stimulus that, after being paired with the unconditioned stimulus, triggers a conditioned response (e.g., the bell)
- **Conditioned Response (CR) –** the learned response to the conditioned stimulus (e.g., salivation)
- **Acquisition –** the initial stage of learning where the Neutral Stimulus (NS) and the Unconditioned Stimulus (US) are repeatedly paired
- **Extinction –** the gradual weakening of the conditioned response when the CS is no longer paired with the US
- **Generalization –** the tendency for a conditioned response to occur in response to stimuli that are similar to the conditioned stimulus
- **Discrimination –** the learned ability to distinguish between the Conditioned Stimulus and other, similar stimuli.
- **Extinction –** gradual weakening and eventual disappearance of the Conditioned Response
- **Spontaneous Recovery –** a phenomenon where, after a period of extinction and rest, presenting the Conditioned Stimulus suddenly triggers a weak version of the Conditioned Response again

**John B. Watson**

➔ "Give me a dozen healthy infants, well-formed, and my own specified world to bring them up in and I'll guarantee to take any one at random and train him to become any type of specialist I might select—doctor, lawyer, artist, merchant-chief and, yes, even beggar-man and

thief…"
- ➔ Founder of behaviorism
- ➔ Little Albert Experiment

**Operant Conditioning** – consequences of "operating" on the environment; reinforcements and punishments

- **Reinforcement –** increasing the likelihood that the behavior will be repeated
- **Punishment –** decreasing the likelihood of repetition, reinforcement is most effective when it immediately follows a behavior
- **Extinguished –** behavior returns to its original level when a response is no longer reinforced

**Mowrer's Two-Factor Theory of Avoidance Learning –** explains how fear-based avoidance behaviors are learned and maintained through a combination of classical conditioning and operant conditioning

- **Stage 1: Acquisition (Classical Conditioning)**
  - A neutral stimulus (like a specific sound or place) is paired with an unconditioned stimulus that naturally elicits a fear response (such as a painful shock)
  - Through this pairing, the neutral stimulus becomes a conditioned stimulus that, on its own, evokes fear (a conditioned response)
- **Stage 2: Maintenance (Operant Conditioning)**
  - Once the fear is conditioned, the individual learns to avoid the conditioned stimulus
  - Avoiding the stimulus provides relief from the fear and anxiety. This reduction of fear acts as a form of **negative reinforcement**
  - Because avoidance leads to the removal of an unpleasant feeling (fear), the behavior becomes more likely to occur in the future, thus maintaining the phobia or other avoidance behaviors

**Association in Psychopathology**

- ➔ Phobias: avoidance of the feared stimulus (e.g., a spider, an elevator, heights) provides immediate, though temporary, relief from anxiety
  - ◆ This relief reinforces the avoidance behavior, preventing the person from ever learning that the stimulus is not actually dangerous
  - ◆ The phobia, therefore, becomes a self-perpetuating cycle of fear and avoidance
- ➔ Obsessive-Compulsive Disorder (OCD): an obsession (e.g., "my hands are dirty" 😱) causes intense anxiety. The person then performs a compulsion (e.g., washing their hands 🧼) to reduce that anxiety
  - ◆ The relief provided by the handwashing negatively reinforces the compulsive behavior, making them more likely to repeat it whenever they feel anxious

**Social Learning –** learning occurs through observation, imitation, and modeling, emphasizing that people learn by observing others and their consequences, rather than solely through direct experience

- Hitting Doll Experiment
- **Self-efficacy –** confidence in one's ability
- **Observational Learning –** people learn appropriate social behavior chiefly by observing and imitating models, that is, by watching other people
- **Social Cognitive Theory –** cognitive processes are at work as people observe models, learn chunks of behavior, and mentally put the chunks together into complex new behavior patterns

**Learned Helplessness –** how individuals (and animals) can develop a perceived lack of control over their circumstances after repeated exposure to uncontrollable, adverse events

- Perceived Lack of Control
- Passivity and Reduced Motivation
- Emotional Symptoms

**3 Dimensions of Reformulated Learned Helplessness Model**

- ➔ **Internal –** internal failings
- ➔ **Stable –** "always be my fault"
- ➔ **Global –** extend across a variety of issues

- **Learned Optimism –** if people faced with considerable stress and difficulty in their lives, nevertheless, display an optimistic, upbeat attitude, they are likely to function better psychologically and physically
- **Positive Psychology**

**Prepared Learning –** we have become highly prepared for learning about certain types of objects or situations over the course of evolution because this knowledge contributes to the survival of the species

**Hopelessness Theory –** a negative expectation that highly desired outcomes will not occur, or that highly aversive outcomes will occur, and that one has no control over these


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outcomes

| Primary Gain | Secondary Gain |
|---|---|
| Refers to the relief from psychological conflict or anxiety that a person experiences by developing physical or psychological symptoms (*unconscious*)<br><br>The symptoms act as a defense mechanism, allowing the individual to avoid dealing with internal conflicts or painful emotions. | Are the external advantages or benefits a person receives as a result of their symptoms, often unconsciously<br><br>These benefits reinforce the continuation of the symptoms, as they provide some form of gratification or relief from other issues (*unconscious or conscious*) |

## D | Cognitive Theories with Psychoanalytic (2)

**Introjection –** direct all their feelings for the loved one, including sadness and anger, toward themselves

- **Introjected Loss –** actual death of a person

**Attributional Style –** ways in which people explain the cause of events within their lives

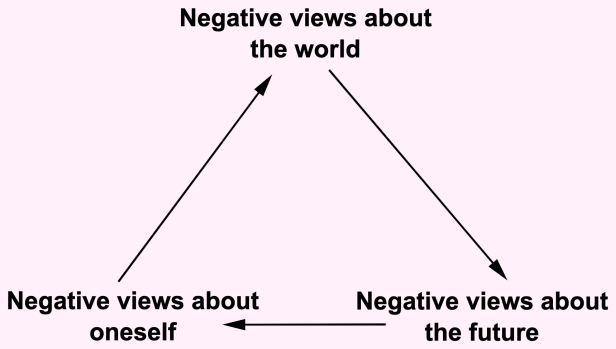
- **Internal vs. External –** Is the cause due to something about me (internal) or something outside of me (external)?
- **Stable vs. Unstable –** Is the cause permanent (stable) or temporary (unstable)?
- **Global vs. Specific –** Does the cause affect all areas of my life (global) or just this specific situation (specific)?

**Cognitive Theory of Depression –** depression is primarily caused and maintained by maladaptive or irrational ways of thinking

- Aaron Beck

**Beck's Cognitive Triad**

- ➔ **Negative view of the self –** tend to see themselves as flawed, inadequate, worthless, or unlovable
- ➔ **Negative view of the world/experiences –** perceive their experiences and the world around them as negative, depriving, or overwhelming
  - ◆ "No one cares about me"
- ➔ **Negative view of the future –** hold pessimistic and hopeless outlooks about the future, believing that their current difficulties will continue indefinitely and that things will never improve
  - ◆ "Things will never get better"




- **Negative Schema –** an enduring negative cognitive system about some aspects of life
- **Self-Blame Schema –** people feel personally responsible for every bad happening
- **False Consensus Effect/Bias –** people tend to overestimate the extent to which their opinions, beliefs, preferences, values, and habits are typical of others

**Cognitive Distortions (Thinking Errors)**

- ➔ **Dichotomous Thinking –** viewing situations in extreme terms, with no middle ground
  - ◆ "If I'm not perfect, I'm a total failure"
- ➔ **Overgeneralization –** drawing a sweeping conclusion based on a single negative event
  - ◆ "I failed this one test, so I'm going to fail all my exams and never succeed in life"
- ➔ **Selective Abstraction –** receiving many compliments but dwelling only on one minor criticism
- ➔ **Arbitrary Inference –** an individual concludes without sufficient or relevant evidence
- ➔ **Magnification (Catastrophizing) and Minimization –** exaggerating the importance of negative events while downplaying positive ones
  - ◆ "This minor setback is a disaster!"
- ➔ **Emotional Reasoning –** believing that what you feel must be true
  - ◆ "I feel like a failure, therefore I am a failure"
- ➔ **Labeling/Mislabeling –** attaching a global, negative label to oneself or others based on a single event or behavior


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- "I made a mistake, so I'm a complete idiot"

➔ **Personalization –** taking disproportionate blame for negative events, even when there are other contributing factors
- "It's my fault that the party wasn't fun"

➔ **"Should" Statements –** holding rigid rules about how oneself and others "should" or "must" behave, leading to guilt, anger, or frustration when these rules are violated
- "I should always be happy and productive"

**General Adaptation Syndrome Theory –** is a widely recognized model that describes the body's universal and predictable physiological response to stress

- Hans Selye
- **Alarm Reaction Stage –** the initial shock phase, where the body mobilizes its resources to deal with the threat
- **Resistance Stage –** tries to adapt to the persistent stressor and return to a state of equilibrium (homeostasis), but it remains on high alert
- **Exhaustion Stage –** the body's ability to cope with stress becomes overwhelmed

**Stress-Appraisal/Cognitive Appraisal Theory –** stress is a two-way process; it involves the production of stressors and the response of an individual subjected to these stressors

- **Primary Appraisal:** "Is this a threat or a challenge?"
- **Secondary Appraisal:** "What can I do about it?"
  - Positive: I can do it if I do my best
  - Negative: I cannot do it

**Memory Disorders**

➔ **Anosognosia –** no memories of his own illness
➔ **Confabulation –** filling in memory gaps with imaginary experiences
➔ **Disorientation –** cannot identify or recognize time, places, and persons
➔ **Deja Vu –** unfamiliar perceived as familiar
➔ **Jamais Vu –** familiar perceived as unfamiliar
➔ **Hypermnesia –** increased memory
➔ **Paramnesia –** false perverted memory
➔ **Amnesia –** loss of memory

**Type of Amnesia**

- **Biogenic –** caused by brain damage or disease
  - **Retrograde Amnesia –** remote memory loss
  - **Anterograde Amnesia –** recent memory loss
- **Organic Amnesia (Neurological Amnesia) –** caused by physical damage or dysfunction to the brain
- **Dissociative Amnesia (Psychogenic Amnesia) –** involves an inability to recall important personal information, often related to a traumatic or stressful event
  - **Localized Amnesia –** cannot recall events within a specific, usually short, period (e.g., the hours immediately after a traumatic event)
  - **Selective Amnesia –** can recall some, but not all, events during a specific period
  - **Generalized Amnesia –** a rare and severe form where the individual forgets their entire life history, including their identity, name, and personal relationships
  - **Continuous Amnesia –** cannot recall events from a specific point in time up to the present
  - **Systematized Amnesia –** an individual loses memory for a specific category of information (e.g., all memories related to a particular person or a specific type of event, like childhood abuse)

**Memory** – the process by which we encode, store, and retrieve information

- **Declarative –** factual information
- **Procedural –** skills and habits
- **Semantic –** general knowledge
- **Episodic –** events

**Three-System Approach to Memory** – information must travel if it is to be remembered

- **Sensory –** initial storage of information, perceived by the senses
- **STM –** holds info for 15 to 20 seconds
- **LTM –** stores on a relatively permanent basis

**Chunks** – meaningful grouping of stimuli that can be stored as a unit in STM

**Rehearsal** – repetition of information that has entered the STM

- **Repetitive –** stays in STM
- **Elaborative –** transfers to LTM

**Tip-of-the-Tongue Phenomenon** – inability to recall information that one realizes one knows

**Retrieval Cue –** allows us to recall more easily

- **Recall –** memory task with specific information is


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retrieved

- **Recognition –** the individual is presented with a stimulus and asked whether they have been exposed to it in the past or to identify it from the list of alternatives

**Level of Processing Theory –** the degree to which new materials are mentally analyzed

- **Implicit Memory –** can be recalled automatically without thinking
- **Explicit Memory –** requires conscious retrieval of information

**Constructive Processes –** memories are influenced by the meaning we give to them

- **Autobiographical –** episodes from our own lives
- **Flashbulb Memories –** specific or surprising events that are so vivid in memory it as if they represented a snapshot of the event

**Forgetting –** permits us to form general impressions and recollections

- **Failure of Encoding –** failure to pay attention and place information in memory
- **Decay –** loss of information due to nonuse
- **Cue-Dependent Forgetting –** insufficient retrieval cues
- **Proactive Interference –** you forget the new information
- **Retroactive Interference** – you forget the old information

**Lewinsohn's Behavioral Theory –** depression is caused by a combination of stressors in a person's environment and a lack of personal skills

## E Diathesis-Stress Model (3)

**Diathesis-Stress Model –** individuals inherit tendencies to express certain traits or behaviors, which may then be activated under conditions of stress




- Eric Kandel
- **Diathesis –** a person's underlying predisposition or vulnerability to developing a particular disorder
- **Stress –** are environmental factors or life events that can trigger the onset or exacerbation of a disorder in someone with a diathesis
- Individuals with a strong diathesis may develop a disorder with relatively low levels of stress
- Individuals with a weaker diathesis may require more significant or prolonged stress to trigger a disorder

**4 Factors in Developing a Disorder**

- ➔ **Predisposing Factor –** cause of a disorder
  - ◆ Underlying vulnerabilities or long-term influences that increase a person's risk of developing a particular mental health condition
  - ◆ "Why me?"
- ➔ **Precipitating Factor –** factors that allow the disorder to develop
  - ◆ The immediate triggers or specific events that lead to the onset or exacerbation of a mental health condition
  - ◆ "Why now?"
- ➔ **Protective Factor –** reduces the severity of the problems
  - ◆ Strengths, resources, and supportive elements that buffer against the development or worsening of a mental health condition, or that promote recovery
  - ◆ "What can I rely on?"
- ➔ **Perpetuating Factor –** maintain the problem once established
  - ◆ Ongoing influences that maintain or worsen the mental health condition once it has developed, preventing recovery
  - ◆ "Why does it continue?"

## F Gene-Environment Interaction (2)

**Gene-Environment Interaction –** the *effect* of the environment depends on the genotype

- e.g., stress affects people with gene A more than people with gene B

**Gene-Environment Correlation Model –** genotypes *influence* their exposure to certain environments

- It proposes that nature and nurture are not independent forces but rather are constantly intertwined, with our genes often shaping the very

environments we experience

- **Reciprocal Gene-Environment Model –** claims that people with a genetic predisposition to a disorder may also have a genetic tendency to create environmental factors that promote the disorder

**3 Kinds of Gene-Environment Correlation Model**

- ➔ **Passive Gene-Environment Correlation –** Parents provide both genes and an environment correlated with those genes
  - ◆ E.g., musically inclined parents provide musical genes and a home with musical instruments
- ➔ **Evocative Gene-Environment Correlation (or Reactive) –** a child's genetically influenced traits evoke certain responses from others
  - ◆ E.g., a cheerful child evokes more positive attention
- ➔ **Active Gene-Environment Correlation (or Niche-Picking) –** individuals actively select environments that are compatible with their genetic predispositions
  - ◆ E.g., an extroverted person seeks out social gatherings

## G Role of Culture, Social Interactions, and Interpersonal in the Development of Psychological Disorder (1)

- Culture defines what is considered "normal" or "abnormal" behavior
- Behaviors that might be deemed pathological in one culture could be accepted or even celebrated in another
- In some cultures, mental health issues are seen as weaknesses, moral failings, or even spiritual problems, leading to reluctance to seek professional help and increased shame
- Strong, positive social connections (friends, family, community) act as a powerful protective factor against psychological disorders
- Lack of social interaction, loneliness, and social isolation are major risk factors for various mental health conditions, including depression, anxiety, and even physical health problems
- Exposure to substance abuse, risky behaviors, or negative peer groups can increase the likelihood of developing certain disorders
- Early relationships with primary caregivers (attachment) are crucial. Secure attachments foster a sense of safety, trust, and healthy emotional regulation, while insecure attachments can contribute to difficulties in future relationships, anxiety, and other disorders
- Chronic conflict, abuse, neglect, or lack of support within family, romantic, or close friendships can be significant stressors and perpetuating factors for psychological disorders
- Experiences like the death of a loved one, divorce, or betrayal can precipitate psychological distress and disorders like depression or PTSD
- The quality of the therapeutic relationship itself (e.g., in psychotherapy) is a significant factor in successful treatment and recovery, demonstrating the healing power of positive interpersonal connections

**Suicide –** self-inflicted death in which the person acts intentionally, directly, and consciously

- ➔ **Death Seekers –** clearly intend to end their lives at the time they attempt suicide
- ➔ **Death Initiators –** clearly intend to end their lives, but they act out of a belief that the process is already underway and that they are simply hastening the process
- ➔ **Death Ignorers –** do not believe that their self-inflicted death will mean the end of their existence
- ➔ **Death Darers –** experience mixed feelings, or ambivalence about their intent to die, even at the moment of their attempt, and they show this ambivalence in the act itself
- ➔ **Subintentional Death –** a death in which the victim plays an indirect, hidden, partial, or unconscious role
- ➔ **Suicidal Ideation –** thinking seriously about suicide
- ➔ **Suicidal Plans –** formulation of a specific method for killing oneself
- ➔ **Suicidal Attempts –** the person survives attempts

**Emile Durkheim's Suicide Types**

1. **Egoistic Suicide: Too Little Social Integration –** happens when a person feels extremely isolated and detached from their community, family, or social groups
2. **Altruistic Suicide: Too Much Social Integration –** occurs when a person is too integrated into a group, and their individual life is seen as less important than the group's goals or honor
3. **Anomic Suicide: Too Little Social Regulation –** happens when society's rules, norms, or

expectations suddenly break down or become unclear

4. **Fatalistic Suicide: Too Much Social Regulation –** a person's life is excessively controlled, oppressive, and without any hope or freedom

## THERAPEUTIC INTERVENTIONS OF PSYCHOLOGICAL DISORDERS (10)

### DEFINITION OF TERMS

- **Idiographic Data –** specific details and background information
- **Nomothetic –** broad information, nature, and treatment
- **Treatment –** a.k.a therapy, a procedure designed to change abnormal behavior to a more normal behavior

### A Different Psychological Interventions (3)

#### Psychodynamic Interventions

- **Free Association –** the client is encouraged to say whatever comes to mind without censorship, regardless of how trivial or illogical it may seem
- **Transference –** unconscious redirection of feelings and attitudes from a significant person in the client's past (e.g., a parent) onto the therapist
- **Resistance –** conscious or unconscious opposition by the client to the therapeutic process or to exploring certain thoughts or feelings
- **Dream Interpretation –** where the therapist helps the client explore the symbolic meanings of their dreams
    - **Manifest –** consciously remembered dream
    - **Latent –** meaning
- **Catharsis –** process of releasing, and thereby providing relief from, strong or repressed emotions
- **Working Through –** confronting, clarifying, and integrating insights into one's understanding of self and relationships, leading to lasting change
- **Short-term Psychodynamic Therapies –** a more focused and time-limited approach to psychodynamic therapy, often targeting specific problems or relational patterns rather than a complete overhaul of the personality
- **Relational Psychoanalytic Therapy –** focuses on how past and present relationships shape the individual's sense of self and interactions
- **Hypnotherapy –** use of hypnosis to induce a state of heightened suggestibility and relaxation, allowing access to the subconscious mind to address psychological or physical issues
- **Play Therapy –** primarily used with children, where play is utilized as a natural medium for expression and communication

#### Humanistic

- **Client-Centered Therapy –** therapist provides a non-directive, empathic, and genuinely accepting environment to facilitate the client's self-exploration and actualization
- **Support Group –** a gathering of individuals who share a common experience or concern, providing mutual support, understanding, and encouragement
- **Home-Based Self-Help Programs –** programs or materials (e.g., workbooks, online resources) that individuals can use independently at home to address specific psychological concerns or promote well-being
- **Social Skills Therapy –** helps individuals develop and improve their interpersonal communication, assertiveness, and other social competencies to navigate social situations more effectively
- **Family Therapy –** works with families as a system to address communication patterns, relational dynamics, and conflicts that affect individual members and the family as a whole
    - **Maudsley Model –** a specific, intensive family therapy approach primarily used for adolescents with anorexia nervosa
- **Psychological Debriefing –** structured intervention, typically offered soon after a traumatic event, designed to reduce the risk of post-traumatic stress disorder (PTSD) by allowing individuals to recount their experiences and normalize their reactions
    - Note: Its effectiveness is debated and sometimes considered potentially harmful if not done carefully
- **Interpersonal Psychotherapy –** time-limited therapy that focuses on improving interpersonal relationships and social functioning to alleviate psychological symptoms (particularly depression)
- **Motivational Interviewing –** a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence
- **Milieu Therapy –** a therapeutic approach that involves structuring the entire environment (e.g., a hospital ward, residential facility) to be therapeutic
- **Parent Management Training –** a behavioral intervention that teaches parents specific skills and

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strategies to manage their children's challenging behaviors and improve family relationships
- **Gestalt Therapy –** holistic, experiential therapy that emphasizes present moment awareness ("here and now"), personal responsibility, and the integration of fragmented aspects of the self
- **Interpersonal Social Rhythm Therapy –** specific therapy for bipolar disorder that combines interpersonal psychotherapy with a focus on regulating daily routines and social rhythms (e.g., sleep, wake, meal times) to stabilize mood

**Cognitive**
- **Cognitive Behavioral Therapy –** focuses on identifying and changing distorted thinking patterns and problematic behaviors
  - **Rational-Emotive Behavioral Therapy –** a highly directive form of CBT that challenges irrational beliefs and helps individuals develop more rational and self-helping thoughts, feelings, and behaviors
  - **Mindfulness-Based CBT –** teaches individuals to observe their thoughts and feelings without judgment, fostering a sense of detachment from negative cognitive patterns
  - **Cognitive Remediation –** a set of interventions designed to improve cognitive functions such as attention, memory, executive functioning, and problem-solving, often used in conditions like schizophrenia or traumatic brain injury
  - **Panic Control Treatment –** specific CBT protocol for panic disorder that involves psychoeducation, interoceptive exposure (exposure to physical sensations of panic), and cognitive restructuring
  - **Enhanced CBT (CBT-E) –** a transdiagnostic form of CBT developed for eating disorders, addressing the core psychopathology of eating disorders and relevant maintaining mechanisms
  - **Hallucination Reinterpretation and Acceptance –** a cognitive therapy approach for psychosis that helps individuals reframe their understanding of hallucinations, reducing distress and encouraging acceptance rather than fighting or fearing them
  - **Dialectical Behavior Therapy –** a comprehensive CBT-based treatment developed for Borderline Personality Disorder, emphasizing distress tolerance, emotion regulation, interpersonal effectiveness, and mindfulness skills
- **Neutralizing –** often seen in OCD, where an individual performs a mental or behavioral act to "undo" or cancel out the perceived negative consequences of an intrusive thought or obsession
- **Exposure and Response (Ritual) Prevention –** where individuals are gradually exposed to anxiety-provoking stimuli or situations while being prevented from engaging in their typical compulsive rituals or avoidance behaviors
- **Beck's Cognitive Therapy –** focusing on identifying and challenging "automatic thoughts" and underlying dysfunctional core beliefs that contribute to emotional problems
- **Aversion Therapy –** pairs an undesirable behavior with an unpleasant stimulus to reduce the frequency of that behavior
- **Relapse-Prevention Therapy –** teaches individuals to identify high-risk situations, develop coping strategies, and manage cravings or urges to prevent a return to problematic behaviors
- **Cognitive Processing Therapy –** helps individuals process traumatic memories and challenge distorted beliefs related to the trauma, such as self-blame or safety concerns
- **Mentalization –** helps individuals improve their ability to reflect on their own and others' internal experiences
- **Affectual Awareness –** it involves helping clients become more attuned to their emotional states and the underlying meaning of those emotions
- **Positive Family Interaction Therapy –** focuses on enhancing positive communication, warmth, and supportive interactions within families, aiming to build family strengths and improve overall well-being

**Biological**
- **Sedative-Hypnotic Drugs –** a class of drugs that depress the central nervous system, leading to calming (sedative) or sleep-inducing (hypnotic) effects
  - **Benzodiazepines –** common type of sedative-hypnotic drug that enhances the effect of the neurotransmitter GABA, leading to reduced anxiety and muscle relaxation
  - **Barbiturates –** an older class of sedative-hypnotic drugs that are highly addictive and have a narrow therapeutic window, now largely replaced by

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benzodiazepines due to safety concerns

- **Antidepressants –** primarily work by affecting neurotransmitters like serotonin, norepinephrine, and dopamine in the brain
- **Antipsychotics –** primarily work by blocking dopamine receptors
- **Vagus Nerve Stimulation –** involves implanting a device that sends electrical impulses to the vagus nerve in the neck
- **Electroconvulsive Therapy –** involving the induction of a controlled seizure by passing small electrical currents through the brain
- **Transcranial Magnetic Stimulation –** a non-invasive brain stimulation technique that uses magnetic fields to stimulate nerve cells in the brain
- **Mood Stabilizers –** a class of medications primarily used to treat bipolar disorder by helping to regulate mood swings (both manic and depressive episodes)
    - **Lithium –** reduces the frequency and severity of manic and depressive episodes
- **Detoxification –** the process of safely withdrawing from a substance of abuse under medical supervision
    - **Disulfiram –** produces an unpleasant reaction (nausea, vomiting, flushing) when alcohol is consumed, deterring individuals from drinking
- **Antagonist Drug –** blocks or reverses the effects of another drug or a natural substance in the body by binding to and blocking receptor sites
- **Antianxiety –** used to reduce anxiety
- **SSRIs –** a common class of antidepressant medications that work by increasing the amount of serotonin in the brain by blocking its reabsorption

**Behavioral**

- **Exposure Treatment –** it involves systematically exposing individuals to feared objects, situations, or memories in a safe and controlled environment to help them habituate to the anxiety and learn that the feared stimulus is not dangerous
    - **Virtual Therapy/Virtual Reality Treatment –** use of virtual reality technology to create immersive and interactive environments for therapeutic purposes
    - **Prolonged Exposure –** involves imaginal exposure (repeatedly recounting the traumatic memory) and in vivo exposure (confronting situations, people, or objects that trigger fear related to the trauma)
    - **Eye Movement Desensitization and Reprocessing –** involves recalling distressing memories while simultaneously engaging in bilateral stimulation (e.g., eye movements, tapping), which is thought to help process and integrate the traumatic memory
    - **Participant Modeling –** a therapist models the desired behavior for the client, and then guides the client through performing the behavior themselves
    - **Interoceptive Exposure –** involves intentionally inducing physical sensations that are similar to those experienced during a panic attack (e.g., dizziness, shortness of breath) to help the individual habituate to these sensations and learn that they are not dangerous
- **Systematic Desensitization –** involves teaching relaxation techniques and then gradually exposing the individual to increasingly anxiety-provoking situations (either real or imagined) while maintaining a relaxed state, eventually leading to desensitization
- **Following (Implosive Therapy) –** involves prolonged and intense exposure to a feared object, situation, or memory without the opportunity to escape or avoid it
- **Token Economy Programs –** individuals earn "tokens" (e.g., points, chips) for engaging in desired behaviors, which can then be exchanged for tangible rewards or privileges
- **Contingency Management –** uses systematic reinforcement (rewards) or punishment to increase desirable behaviors and decrease undesirable ones

## B | Illustrate the Application of Psychological Interventions for Treatment (5)

| Disorder | Treatment |
|---|---|
| IDD | Augmentative Communication Strategies<br>Behavioral Therapy<br>Cognitive Therapy<br>Psychodynamic Therapy<br>Family Education<br>Social Intervention |
| Language Disorder | May be self-correcting and may not (be) require special intervention |


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# ABNORMAL PSYCHOLOGY

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| | |
|---|---|
| **Childhood-Onset Fluency Disorder (Stuttering)** | Regulated-breathing method<br>Altered auditory feedback<br>Psychosocial Therapy |
| **Social (Pragmatic) Communication Disorder** | Individualized social skills training |
| **Autism Spectrum Disorder** | No completely effective treatment exists<br>Major tranquilisers and SSRIs<br>Behavioral approaches<br>Naturalistic teaching strategies<br>Incidental teaching<br>Pivotal response training<br>Milieu teaching<br>Behavior therapy combined with pharmacologic treatment<br>CBT<br>UCLA/Lovaas-based Model<br>Early Start Denver Model<br>Parent Training Approaches<br>Social Skills Approaches<br>Treatment and education of autistic and communication-related handicapped children<br>Broad-based approaches<br>Computer-based approaches and virtual reality<br>Neurofeedback<br>Management of insomnia |
| **ADHD** | Methylphenidate (Ritalin, Adderall)<br>Other non-stimulant medications: Atomoxetine (Strattera), Guanfacine (Tenex), and Clonidine<br>Improving academic performance<br>Decreasing disruptive behavior<br>Social skills training<br>Reinforcement programs<br>Parent education programs<br>CBT |
| **Specific Learning Disorder** | Methylphenidate (Ritalin, Adderall)<br>Restricted to individuals who may also have comorbid ADHD<br>Specific skills instructions<br>Strategy instruction<br>Direct instruction<br>Remedial treatment |
| **Motor Disorders** | Self-monitoring<br>Relaxation training<br>Habit reversal<br>Sensory integration programs<br>Modified physical education |
| **Delirium** | Antipsychotic medications |
| **Separation Anxiety Disorder** | CBT<br>Exposure Therapy<br>Relaxation Techniques |
| **Selective Mutism** | Behavior Therapy |
| **Specific Phobia** | Behavior Therapy<br>Insight-Oriented Therapy<br>Virtual Therapy<br>Exposure Therapy<br>Systematic Desensitization<br>In-Vivo (real life) Exposure<br>Other Therapeutic Modalities<br>Hypnosis |
| **Social Anxiety Disorder** | Paxil (SSRI) or Zoloft (SSRI)<br>Effexor (SSRI)<br>D-cycloserine (DCS) + CBT treatments = enhanced effect of treatment<br>Cognitive therapy program<br>Interpersonal Psychotherapy (IPT)<br>Family-based treatment<br>Cognitive retraining, desensitization, rehearsal during sessions, and a range of homework assignments<br>Role-playing<br>Social skills training |
| **Panic Disorder** | Gradual exposure exercises, combined with anxiety-reducing coping mechanisms such as relaxation or breathing retraining<br>Panic Control Therapy<br>CBT |
| **Agoraphobia** | Supportive Psychotherapy<br>Insight-Oriented Psychotherapy<br>Behavior Therapy<br>CBT<br>Virtual Therapy |
| **GAD** | Anxiolytics (sedatives, minor tranquilizers) |

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|---|---|
| | Benzodiazepines<br>Antidepressants (SSRIs)<br>Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)<br>Behavior, Cognitive & Psychodynamic Therapies<br>Using images<br>Relaxing deeply to combat tension |
| **RAD** | Behavior Management Training (BMT)<br>Attachment Therapy<br>Holding Therapy<br>Holding Therapy<br>Play Therapy |
| **DSED** | Talk Therapy<br>Play Therapy<br>Art Therapy<br>Behavioral Management Training<br>Parent-Child Interaction Therapy<br>CBT |
| **PTSD**<br>**Acute Stress Disorder** | SSRIs: Prozac, Paxil<br>Hospitalization<br>Cognitive Processing Therapy<br>Prolonged Exposure Therapy<br>Stress Management<br>Eye Movement Desensitization and Reprocessing<br>Group Therapy<br>Family Therapy<br>Catharsis<br>Imaginal Exposure |
| **Adjustment Disorder** | Group Therapy<br>Individual Psychotherapy<br>Short-term treatments |
| **OCD** | Deep Brain Stimulation<br>Clomipramine (a.k.a Anafranil)<br>Antidepressant<br>SSRIs<br>Behavior therapy<br>Exposure and Ritual Prevention<br>Cognitive Treatments<br>Neurosurgery |
| **BDD** | Clomipramine (a.k.a Anafranil)<br>Fluvoxamine<br>CBT<br>Dermatology (skin) treatment |
| | Plastic surgery |
| **Hoarding Disorder** | Exposure and Ritual Prevention<br>CBT<br>Motivational interviewing<br>Teaching people to assign different values to objects<br>Reducing anxiety about throwing away items (with less value) |
| **Trichotillomania**<br>**Excoriation** | SSRIs<br>Habit Reversal Training<br>Behavior Therapy<br>Hypnotherapy |
| **SSD**<br>**IAD** | Antidepressant (SSRI)<br>Patients with this disorder usually resist psychiatric treatment<br>Schedule a physical examination<br>Group Psychotherapy<br>CBT<br>Reassurance and education<br>Reducing the frequency of help-seeking behaviors<br>Individual Insight-Oriented Psychotherapy, Behavior Therapy, Cognitive Therapy, and Hypnosis |
| **Psychological Factor Affecting Medical Condition** | Stress Management and Relaxation Therapy<br>CBT<br>Aware, educate, teach<br>Stress Management Training |
| **Conversion Disorder** | Insight-oriented therapy and Psychoanalysis<br>Behavior Therapy<br>Hypnosis, anxiolytics, and behavioral relaxation exercises |
| **Factitious Disorder** | No specific treatment has been effective<br>Treatment is best focused on management rather than on cure<br>Legal intervention |
| **Pica** | Nutrition Counseling |
| **Rumination Disorder** | Behavior Modification<br>Habit Reversal Training<br>Diaphragmatic Breathing Exercises |

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| **ARFID** | CBT-AR (CBT for avoidant/restrictive disorder)<br>Family-Based Therapy<br>Occupational Therapy |
| **Anorexia Nervosa** | Nutritional Rehabilitation<br>Tube & Intravenous Feedings<br>Motivational Interviewing<br>Restore the patient's weight<br>CBT<br>Cognitive-Behavioral Therapy-Enhanced<br>Family-based Treatment |
| **Bulimia Nervosa** | Fluoxetine (Prozac)<br>Antidepressants<br>Nutritional Rehabilitation<br>Short-term cognitive-behavioral treatments<br>Cognitive-Behavioral Therapy-Enhanced<br>Exposure and Response Prevention<br>Interpersonal Psychotherapy |
| **Binge-Eating Disorder** | Antidepressants<br>CBT<br>For Obesity: Bariatric Surgery |
| **Enuresis** | Desmopressin<br>Tricyclic Antidepressants<br>Urine Alarm (Bell and Pad)<br>Dry Bed Training<br>Fluid Management<br>Scheduled Voiding<br>Bladder Training Exercises<br>Positive Reinforcement<br>Hypnotherapy<br>Counseling/Therapy<br>Parent Education and Support |
| **Encopresis** | Disimpaction<br>Maintenance Therapy<br>Dietary Changes<br>Scheduled Toilet Sitting<br>Positive Reinforcement<br>Bowel Retraining<br>Education and Demystification<br>Symptom Diary<br>Biofeedback<br>CBT<br>Parent Education and Support |

| | |
|---|---|
| **Insomnia Disorder** | Benzodiazepine<br>Triazolam (Halcion)<br>Zaleplon (Sonata)<br>Zolpidem (Ambien)<br>Flurazepam (Dalmane)<br>Cognitive Therapy<br>Guided Imagery Relaxation<br>Graduated Extinction<br>Paradoxical Intention<br>Progressive Relaxation |
| **Hypersomnolence Disorder** | Amphetamine<br>Methylphenidate<br>Modafinil<br>Antidepressants<br>Monoamine Oxidase Inhibitors (MAOIs) |
| **Narcolepsy** | Stimulants<br>Amphetamines<br>Antidepressants (SNRIs, SSRIs)<br>Sodium Oxybate<br>Histamine-affecting Drugs |
| **Breathing-Related Sleep Disorders** | Polysomnography<br>Home sleep apnea testing<br>Positive Airway Pressure (PAP)<br>Non-Invasive Ventilation (NIV) |
| **Circadian Rhythm Sleep-Wake Disorder** | Phase delays (moving bedtime later)<br>Phototherapy<br>Stimulus Control<br>Progressive relaxation or sleep hygiene<br>CBT<br>Sleep restriction |
| **Parasomnias** | Benzodiazepines<br>Tricyclic<br>Prazosin<br>Melatonin<br>Clonazepam (Klonopin)<br>Schedule Awakening<br>Hypnosis<br>Relaxation Therapy<br>CBT<br>Imagery Rehearsal Therapy (IRT) |
| **SUDs** | First step: help someone through the withdrawal process<br>Ultimate goal: abstinence |

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| | Sedative drug (benzodiazepines)<br>Clonidine<br>Nicotine Replacement Therapy<br>Agonist Substitution<br>Aversive Treatment<br>Psychosocial Treatments |
| **ODD**<br>**IED**<br>**CD** | Family Intervention<br>CBT<br>Individual psychotherapy |
| **Pyromania**<br>**Kleptomania** | Family Therapy<br>CBT<br>Antidepressants: Naltrexone<br>Systematic desensitization,<br>Aversive Conditioning |
| **Dissociative Disorders** | Benzodiazepines<br>Psychoanalytic Therapy<br>Cognitive Therapy<br>Hypnosis<br>Movement Therapy<br>Occupational Therapy<br>Electroconvulsive Therapy<br>Group Therapy |
| **Delayed Ejaculation** | Include techniques to reduce performance anxiety and increase stimulation |
| **Erectile Disorder** | Sildenafil (Viagra)<br>Tease Technique |
| **Female Orgasmic Disorder** | Directed Masturbation Training |
| **Female Sexual Interest/Arousal Disorder** | Estrogen Therapy<br>Androgen Therapy<br>Flibanserin (Addyi)<br>Bremelanotide (Vyleesi)<br>Mindfulness-Based Cognitive Therapy (MBCT) |
| **Genito-Pelvic Pain/Penetration Disorder** | Practice tightening and relaxing vaginal muscles<br>Gradual behavioral exposure treatment<br>Botox |
| **Male Hypoactive Sexual Desire** | Sildenafil (Viagra)<br>Levitra |
| **Disorder** | Cialis<br>Injection of vasodilating drugs<br>Surgery<br>Vacuum Device Therapy<br>Basic education<br>Senate focus<br>Nondemand pleasuring |
| **Premature (Early) Ejaculation** | SSRIs<br>Squeeze Technique<br>Stop, Start, or Pause Procedure |
| **Paraphilic Disorders** | Cyproterone acetate<br>Medroxyprogesterone (Depo-Provera is the injectable form)<br>Covert sensitization<br>Organismic reconditioning<br>Relapse prevention |
| **Gender Dysphoria** | Psychological evaluation and education<br>Administration of gonadal hormones to bring about desired secondary sex characteristics<br>Sex Reassignment Surgery<br>Gynecomastia<br>Hormonal Replacement Therapy<br>Actively affirming and encouraging cross-gender identification |
| **Bipolar I & II Disorder**<br>**Cyclothymic Disorder** | Lithium Carbonate (Lithium)<br>Antipsychotic Medication (Olanzapine)<br>Interpersonal and Social Rhythm Therapy<br>Sleep Deprivation |
| **DMDD** | Stimulants<br>Antidepressants (SSRIs)<br>Atypical antipsychotic medications<br>CBT<br>Dialectical Behavior Therapy for Children<br>Computer Training<br>Parent Training |
| **MDD**<br>**PDD** | Antidepressants<br>Electroconvulsive Therapy<br>Transcranial Magnetic Stimulation<br>Vagal Nerve Stimulation |


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| | Cognitive Therapy<br>CBT<br>Interpersonal PSychotherapy<br>Behavioral Activation Therapy<br>Psychoanalytically Oriented Therapy<br>Family Therapy<br>Phototherapy<br>Sleep Deprivation |
| **PMDD** | Antidepressants (SSRIs or SNRI)<br>Hormone therapies or medications<br>Aerobic exercise<br>Consumption of complex carbohydrates and frequent meals<br>Relaxation training<br>Light therapy<br>Sleep deprivation<br>CBT |
| **Paranoid PD** | CBT<br>Anxiety-reduction Techniques<br>Antipsychotic Drugs |
| **Schizoid PD** | Social Skills Program<br>Group Therapy<br>CBT |
| **Schizotypal PD** | CBT<br>Speech Lessons<br>Social Skills Training<br>Antipsychotic Drug |
| **Antisocial PD** | Antipsychotic Drugs, CBT |
| **Borderline PD** | Relational Psychoanalytic Therapy<br>DBT<br>Mentalization<br>Antidepressant, Antipsychotic, Antianxiety<br>antipsychotic |
| **Histrionic PD** | CBT<br>Psychodynamic Therapy<br>Group Therapy |
| **Avoidant PD**<br>**Dependent PD** | CBT<br>Psychodynamic Therapy<br>Exposure Treatments<br>Antianxiety<br>Antidepressant<br>Short-term psychotherapy |
| **OCPD** | SSRIs |
| **Schizophrenia and Other Psychotic Disorders** | Antipsychotic Medications<br>Insulin Coma Therapy<br>Psychosurgery<br>Electroconvulsive Therapy<br>Transcranial Magnetic Stimulation<br>Reattach/Complex social skills, Role-playing<br>Virtual assessments and treatments<br>Behavioral Family Therapy<br>Vocational rehabilitation<br>Assertive Community Treatment Program<br>Social Skills Training<br>Case Management<br>CBT<br>Individual Psychotherapy<br>Personal Therapy<br>Dialectical Behavior Therapy<br>Art Therapy<br>Cognitive Training or Remediation |

## C | Evaluate the Efficacy of Psychological Interventions (2)

### Psychodynamic Interventions

- Research over the past few decades has increasingly supported the efficacy of psychodynamic therapies for a range of conditions
- Contrary to earlier beliefs, many studies now suggest that psychodynamic therapy can be as effective as other established treatments, including CBT, for various mental health conditions like depression, anxiety disorders, and some personality disorders (e.g., borderline personality disorder with structured approaches)
- A notable aspect often highlighted is that the benefits of psychodynamic therapy can be long-lasting and continue to develop even after treatment ends, possibly due to its focus on deeper personality changes and self-knowledge, beyond just symptom reduction
- Assessing the full efficacy can be challenging because it aims for broader outcomes like personality change and improved relational patterns, which are harder to quantify than specific symptom reduction
- Short-term psychodynamic therapies have also shown effectiveness for specific issues, offering a more time-limited approach
- Relational psychoanalytic therapy, while newer, also


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emphasizes the therapeutic relationship as a core mechanism of change

### Humanistic Interventions

- Humanistic-experiential psychotherapies, including client-centered therapy and Gestalt therapy, have solid data proving their effectiveness and efficacy
- Meta-analyses show significant improvement in clients and equivalent effectiveness when compared to other therapeutic approaches
- These therapies are often growth-oriented rather than solely problem-oriented, aiming to empower individuals to achieve personal growth, self-actualization, and a greater sense of meaning and purpose
- Approaches like Emotionally Focused Therapy (EFT), which has humanistic roots, have strong evidence for treating relationship issues and couple distress
- While effective for a broad range of difficulties, including relationship issues, self-damaging activities, and coping with chronic medical conditions, some meta-analyses show more controversial data regarding the treatment of depression specifically, compared to other therapies
- The lack of a rigid structure can be a disadvantage for clients seeking quick, specific symptom reduction

### Cognitive Interventions

- Cognitive Behavioral Therapy (CBT) is considered one of the most extensively researched and empirically supported psychological treatments. It is widely recognized as the "gold standard" for many mental health conditions
- CBT and its variations (like REBT, DBT, MBCT, CPT) have demonstrated strong efficacy for a very wide range of disorders, including:
    - Anxiety Disorders: Generalized Anxiety Disorder, Panic Disorder, Social Anxiety Disorder, Specific Phobias, OCD, PTSD (with specific protocols like ERP and CPT)
    - Mood Disorders: Depression (including severe depression), Bipolar Disorder (often in combination with medication)
    - Eating Disorders: CBT-E is particularly effective
    - Substance Use Disorders: Highly effective for relapse prevention and managing cravings
    - Insomnia, Chronic Pain, and other medical conditions
- CBT is highly structured, goal-oriented, and often time-limited, which can make it more accessible and cost-effective. It teaches concrete skills that clients can use independently
- Its focus on identifiable thoughts and behaviors allows for relatively straightforward measurement of outcomes
- Dialectical Behavior Therapy (DBT), a highly specialized form of CBT, has strong evidence for treating Borderline Personality Disorder and other conditions involving severe emotion dysregulation and self-harm

### Biological Interventions

- Biological interventions, primarily psychopharmacology (medications), are highly effective for many severe mental illnesses and are often a first-line or crucial adjunctive treatment
- They work by directly affecting brain chemistry and function
- Medications:
    - Antidepressants: very effective for moderate to severe depression, anxiety disorders, and OCD
    - Antipsychotics: essential for managing positive symptoms (e.g., hallucinations, delusions) in psychotic disorders like schizophrenia and acute manic episodes in bipolar disorder
    - Mood Stabilizers (e.g., Lithium): highly effective in preventing mood swings in bipolar disorder
    - Benzodiazepines/Sedative-Hypnotics: effective for acute anxiety and insomnia, but their use is often limited due to dependence potential and side effects.
- Brain Stimulation Therapies:
    - Electroconvulsive Therapy (ECT): considered one of the most effective treatments for severe, treatment-resistant depression, severe mania, and catatonia, often yielding rapid and significant improvement
    - Transcranial Magnetic Stimulation (TMS): an effective non-invasive option for treatment-resistant depression, with fewer side effects than ECT
    - Vagus Nerve Stimulation (VNS): an option for long-term treatment-resistant depression, though its effects are typically more gradual
- For many severe conditions (e.g., severe depression, bipolar disorder, schizophrenia), the combination of medication and psychotherapy often yields better outcomes than either treatment alone

### Behavioral Interventions

- Behavioral therapies are highly effective, particularly for anxiety disorders, phobias, and obsessive-compulsive disorder. They are firmly rooted in learning theory and directly target maladaptive behaviors
    - Exposure-Based Treatments (Exposure Treatment, Prolonged Exposure, Systematic Desensitization,

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Flooding, Interoceptive Exposure): these are among the most robustly supported interventions for anxiety disorders, phobias (e.g., specific phobias, social anxiety disorder), and PTSD
    - Eye Movement Desensitization and Reprocessing (EMDR): has strong evidence for the treatment of PTSD
    - Token Economy Programs and Contingency Management: highly effective for behavioral management, particularly in structured environments or for substance use disorders, by systematically applying reinforcement principles
- The mechanisms of change in behavioral therapies are often clear and directly observable, focusing on changing specific behaviors through techniques like habituation, counterconditioning, and reinforcement
- A promising and increasingly utilized behavioral intervention, especially for exposure therapy for phobias and PTSD, showing comparable efficacy to in-vivo exposure

**General Considerations for Efficacy**

- The "gold standard" in mental health care emphasizes using treatments supported by the best available research evidence, clinician expertise, and patient values/preferences
- The therapist's competence, empathy, and the quality of the therapeutic alliance (the collaborative relationship between therapist and client) are consistently found to be significant predictors of positive outcomes across various therapeutic modalities
- Client motivation, readiness for change, and the severity and complexity of the presenting issues also influence treatment outcomes
- How closely the therapy is delivered according to its established protocol (treatment fidelity) can impact its efficacy
- Many individuals present with more than one mental health condition (comorbidity), which can complicate treatment and influence outcomes. Some therapies, like CBT and DBT, have transdiagnostic applications, meaning they can address common underlying processes across different disorders

## SOCIO-CULTURAL FACTORS AND ETHICAL PRINCIPLES IN DIAGNOSIS CASES OF ABNORMAL BEHAVIOR (5)

**STIGMA** – refers to the destructive beliefs and attitudes held by a society that are ascribed to groups considered different in some manner, such as people with psychological disorders

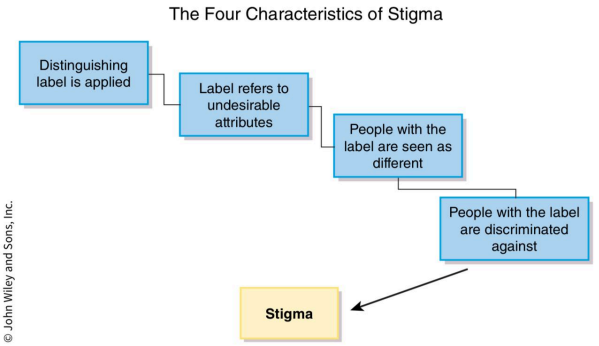



FIGURE 1.1 The four characteristics of stigma.

### A Identifying Socio-Cultural Factors (2)

**Culture-Bound Syndromes** – are patterns of atypical behavior and distressing experiences that are specific to certain cultural groups or localities

- **Locality-Specific** – they are typically found in a particular region, ethnic group, or cultural community
- **Not Always Directly Mappable to Western Diagnoses** – the overall constellation of symptoms, the cultural interpretation, and the traditional healing practices associated with them are distinct
- **Culturally Sanctioned Explanations** – the symptoms and their causes are often explained through cultural beliefs about the body, spirit, social relationships, or supernatural forces
- **Influence on Help-Seeking** – often influences how individuals seek help (e.g., from traditional healers, shamans, or spiritual leaders)

**Examples of Culture-Bound Syndromes (Cultural Concepts of Distress)**

- **Ataque de Nervios** (Latin America/Caribbean) – translated as "attack of nerves," this syndrome is a culturally recognized response to stressful events, particularly those involving family or loss
    - Symptoms can include uncontrollable shouting, crying, trembling, heat in the chest rising to the head, and verbal or physical aggression
- **Koro** (Southeast Asia, China) – an intense, irrational fear that one's genitals are retracting into the body and will disappear, often believed to lead to death
- **Amok** (Malaysia, Indonesia, Philippines) – characterized by a sudden, often unprovoked, violent outburst, usually following a period of brooding or perceived insult, often involving attacking others indiscriminately, followed by

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exhaustion, amnesia, and sometimes death
- **Susto** (Latin America) – meaning "fright" or "soul loss," this illness is attributed to a frightening event that causes the soul to leave the body
    - Symptoms include appetite disturbances, inadequate or excessive sleep, troubled dreams, sadness, lack of motivation, and physical complaints like muscle aches and stomach aches
- **Taijin Kyofusho** (Japan) – intense fear that one's body, its parts, or its functions (e.g., body odor, facial expression, eye contact) are displeasing, embarrassing, or offensive to other people
- **Dhat Syndrome** (India and South Asia) – common anxiety and hypochondriacal concern among men related to the discharge of semen
- **Hikikomori** (Japan) – severe social withdrawal, where individuals isolate themselves from society, often remaining in their homes for months or even years, avoiding social interaction and participation
- **Latah** (Southeast Asia) – a hypersensitivity to sudden fright, often leading to exaggerated startle responses, involuntary actions, echolalia (repeating words), and automatic obedience to commands
- **Khyal Cap** (Cambodia) – panic attacks
- **Maladi Moun (Haiti) –** sent sickness; interpersonal envy and malice cause people to harm their enemies by sending illness
- **Shenjing Shuairuo** – weakness, emotions, excitement, nervous pain, and sleep
- **Dissociative Trance** – counterpart of DID in eastern countries; *sapi*

## B | Ethics (2)

- Mental health professionals must actively strive to understand, respect, and effectively address the diverse cultural backgrounds, beliefs, values, and practices of their patients
- Patients must fully understand the purpose, procedures, potential risks, and benefits of the diagnostic process and proposed treatment
- This information should be presented in a culturally appropriate and understandable manner, considering language proficiency and educational background
    - Informed consent when:
    - ➢ When conducting research, providing assessment, therapy, counseling, or consultation
    - ➢ For legally incapable, they must provide an appropriate explanation, obtain assent, consider the client's preferences and best interests, and obtain permission from a legally authorized person
    - ➢ If court orders, they must inform the nature of the services, whether it is a court order or mandated, as well as its limits of confidentiality before proceeding
    - ➢ Must document written or oral consent, permission, and assent
    - Informed Consent, except: mandated by the law, routine, evaluating decisional capacity
- Maintaining secure records and sharing information only with authorized individuals, while also being mindful of cultural norms around privacy and family involvement
    - Exemptions from disclosure
    - ➢ If the client is disguised or the identity is protected
    - ➢ Has consent
    - ➢ Legally mandated
- Clinicians must be vigilant against diagnostic biases stemming from cultural assumptions, stereotypes, or a lack of understanding of a patient's cultural context
- Non-Maleficence (Do No Harm)
    - The diagnostic process should not cause harm
    - Misdiagnosis can lead to inappropriate or ineffective treatment, stigmatization, and negative life consequences (e.g., impact on employment, social relationships)
- Beneficence (Do Good)
    - The diagnosis should aim to benefit the individual by leading to effective and culturally sensitive interventions that improve their well-being
- Justice
    - Ensuring equitable access to quality mental healthcare and diagnostic services for all individuals, regardless of their cultural background, socioeconomic status, or other social identities. This includes addressing systemic inequalities in healthcare
- Respect for Rights and Dignity
    - Upholding the autonomy and dignity of the individual, respecting their cultural beliefs, values, and choices, even if they

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differ from the clinician's own
    - Challenging stigmatizing beliefs and educating patients and communities about mental health
- Professional Competence and Ongoing Learning
    - Clinicians have an ethical responsibility to continuously update their knowledge and skills, particularly in cultural competence, to provide the best possible care in an increasingly diverse world
- **Telepsychology** – provision of psychological services using telecommunication technologies

## GLOBAL HEALTH CRISIS (COVID-19) AND MENTAL HEALTH LAW (RA 11036) (10)

### GLOBAL HEALTH CRISIS (COVID-19) AND ITS IMPACT ON MENTAL HEALTH IN THE PHILIPPINES

- Fear of Infection and Illness: constant worry about contracting the virus, severe illness, or death for oneself and loved ones
- Lockdowns and Isolation: strict community quarantines, stay-at-home orders, and social distancing measures led to widespread isolation, loneliness, and disruption of social support networks. Studies in the Philippines showed increased feelings of loneliness
- Economic Strain: job losses, reduced income, business closures, and financial uncertainty caused immense stress and anxiety for many Filipino families
- Disruption of Daily Life: closure of schools, shift to remote work/learning, restrictions on movement, and changes in routines contributed to stress, anxiety, and feelings of disarray
- Grief and Loss: the sheer number of deaths from COVID-19 led to widespread grief, often compounded by restrictions on traditional mourning rituals
- Increased Domestic Issues: lockdowns were associated with a spike in cases of domestic violence and child abuse as individuals were confined with their oppressors
- Overwhelmed Healthcare Workers: frontline healthcare workers experienced extreme stress, burnout, and trauma due to long hours, high patient loads, fear of infection, and witnessing severe illness and death
- Prevalence of Symptoms: surveys in the Philippines during the early phase of the pandemic reported high rates of moderate-to-severe anxiety (28.8%), depressive symptoms (16.9%), and stress (13.4%). Younger individuals reported greater levels of stress, anxiety, and depression
- Suicide Rates: the Philippines saw a significant rise in suicide rates during and after the pandemic. Preliminary estimated numbers showed an annual average of 4,085 deaths from 2020-2022, compared to a pre-pandemic average of 2,752 from 2017-2019. Calls to mental health hotlines, especially suicide-related calls, surged dramatically

### THE MENTAL HEALTH ACT (RA 11036): KEY PROVISIONS AND RESPONSE TO THE CRISIS

- Establish a National Mental Health Policy: aimed at enhancing the delivery of integrated mental health services
- Promote and Protect Rights: safeguard the rights of persons utilizing psychiatric, neurologic, and psychosocial health services
- Integrate Mental Health into Primary Care: mandates the provision of basic mental health services in community settings (barangays) and psychiatric, psychosocial, and neurological services in all hospitals
- Strengthen Leadership and Governance: calls for the formulation and implementation of national policies, strategies, and programs
- Protect Rights of Service Users: ensures freedom from discrimination, protection from torture, the right to informed consent, aftercare, and rehabilitation. It explicitly recognizes the rights of persons with mental health conditions under international human rights conventions
- Mental Health in Various Settings: integrates mental health care into educational institutions, workplaces, and communities
- Mental Health Professionals: protects the rights of mental health professionals, ensuring a safe working environment, access to continuing education, and autonomy in practice
- Suicide Prevention: although not solely focused on suicide, the Act mandates comprehensive suicide prevention services, including crisis intervention

#### A RA 11036's Response to COVID-19

**Foundation for Psychosocial Support**

- The law mandates integrating mental health into basic health services and providing psychosocial support during calamities (which COVID-19 certainly was), allowing government agencies like the DSWD to develop technology-based mental

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health and psychosocial support (MHPSS) programs (e.g., DSWD WiSUPPORT) to cater to individuals and families affected by the pandemic

**Telehealth Expansion**

- The pandemic significantly accelerated the use of telepsychology and online consultations, aligning with the spirit of the Act to make mental health services more accessible, especially with physical restrictions

**Increased Awareness and Advocacy**

- The visible mental health toll of the pandemic spurred greater public awareness and advocacy for mental health services, reinforcing the objectives of RA 11036

**National Suicide Prevention Strategy**

- The Act's provisions supported initiatives like the NCMH Crisis Hotline ("Kamusta Ka?, Tara Usap Tayo"), which saw a massive increase in calls during the pandemic, providing immediate psychological first aid

**Legislative Review**

- The surge in mental health concerns prompted Senate inquiries into the implementation of RA 11036 to identify challenges and recommend further legislative interventions, highlighting the Act's importance even if its existing provisions were insufficient to fully address the scale of the pandemic's impact

## B Challenges to RA 11036 Implementation Amplified by the Crisis

**Under-Resourced System**

- Lack of Manpower: the severe shortage of psychiatrists, psychologists, psychiatric nurses, and other mental health professionals (especially outside Metro Manila) became glaringly obvious. RA 11036 aims to strengthen the mental health workforce, but training and deployment could not keep pace with the sudden surge in demand. For instance, reports indicate a dire shortage of child psychiatrists and guidance counselors, areas acutely affected by the pandemic
- Insufficient Funding: mental health continues to receive a disproportionately small share of the national health budget (reportedly 3-5%), making it difficult to fund the comprehensive programs, facilities, and personnel mandated by the Act. Funds were also reallocated to direct the COVID-19 response
- Inadequate Facilities: the Act aims for community-based mental health care and improved facilities, but many areas still lack proper infrastructure, which was critical when access to central hospitals was limited due to lockdowns

**Accessibility and Affordability Barriers**

- Geographic Disparities: the pandemic highlighted how remote and rural areas, already underserved, had even more limited access to mental health professionals and services during lockdowns
- Cost of Services: despite the Act's intent for accessible care, private mental health services remained largely unaffordable for the majority of Filipinos, forcing many to rely on overwhelmed public services or none at all
- Digital Division: while telehealth expanded, the lack of internet access and appropriate devices for many Filipinos, particularly in marginalized communities, created new barriers to care

**Weak Integration into Primary Healthcare**

- RA 11036 mandates integrating mental health into primary care. However, many barangay health centers and general practitioners lacked the training, resources, and confidence to identify and manage mental health conditions effectively, especially with the added pressure of the pandemic
- The breakdown of routine healthcare services during lockdowns further hampered this integration

**Persistent Stigma**

- While RA 11036 aims to combat discrimination and stigma, the intense societal focus on physical health during the pandemic may have inadvertently pushed mental health concerns to the background for some, or made individuals even more reluctant to admit distress for fear of being seen as a "burden"

**Disruption of Implementation Plans**

- The pandemic necessitated a pivot in government priorities and resources. Planned training, policy formulations, and infrastructure developments related to RA 11036 often had to be delayed or put on hold, as resources were diverted to emergency health and economic responses

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**Additional Notes**

- ➔ **Leta Hollingworth –** believed that many mentally defective individuals were actually suffering from emotional and behavioral problems, primarily due to inept treatment by adults and a lack of appropriate intellectual challenge
- ➔ **Monomania –** partial delusion
- ➔ **Neurasthenia –** characterized by persistent and distressing complaints of increased fatigue after mental effort, or persistent and distressing complaints of bodily weakness and exhaustion after minimal effort
- ➔ **Psychasthenia –** anxiety, excessive worrying, and doubting
- ➔ **Phonasthenia –** weakness or hoarseness of voice
- ➔ **Jean Esquirol –** first described a medical disorder quite similar to contemporary OCD and classified it as monomania
- ➔ **Pierre Janet –** proposed that obsessional patients possessed an abnormal personality with features such as anxiety, excessive worrying, and doubting, and described the successful treatment of compulsions and rituals with techniques that are similar to those used in current behavioral therapy

**ADDITIONAL INFORMATION: SCHIZOPHRENIA PATHWAYS**

**SCHIZOPHRENIA –** is a complex and multifaceted disorder, and its neurobiological basis is not fully understood

- However, research has identified several key pathways and neurotransmitter systems that are believed to play a role in its development and symptoms

**Dopamine Hypothesis –** proposes that an imbalance in dopamine activity is a central component of the disorder

- **Mesolimbic Pathway –** an excess of dopamine activity in this pathway, which connects the ventral tegmental area to the limbic system (including the nucleus accumbens and amygdala), is thought to be responsible for the **positive symptoms** of schizophrenia, such as hallucinations, delusions, and disorganized thought
  - This is supported by the fact that many antipsychotic drugs work by blocking dopamine D2 receptors in this pathway
- **Mesocortical Pathway –** a deficit of dopamine activity in this pathway, which projects from the ventral tegmental area to the prefrontal cortex, is believed to be linked to the **negative symptoms** of schizophrenia (e.g., apathy, blunted affect, social withdrawal) and **cognitive symptoms** (e.g., poor attention, memory deficits, executive dysfunction)
- **Nigrostriatal Pathway –** this pathway connects the substantia nigra to the striatum and is involved in motor control. The D2 receptor blockade by antipsychotic medications in this pathway can lead to motor side effects, such as Parkinsonism and tardive dyskinesia
- **Tuberoinfundibular Pathway –** this pathway connects the hypothalamus to the pituitary gland and regulates prolactin release. Antipsychotic-induced D2 receptor blockade here can cause an increase in prolactin levels

**Glutamate Hypothesis –** provides a more comprehensive explanation for the range of schizophrenia symptoms, particularly the negative and cognitive ones

- It suggests that deficient activity at glutamate synapses, specifically those involving NMDA receptors, plays a significant role
- **NMDA Receptor Hypofunction –** drugs like phencyclidine (PCP) and ketamine, which block NMDA receptors, can induce schizophrenia-like positive, negative, and cognitive symptoms in healthy individuals and worsen them in people with schizophrenia
- **Interaction with Dopamine –** the glutamate and dopamine systems are closely interconnected
  - It is thought that hypofunction of NMDA receptors on GABAergic interneurons in the prefrontal cortex leads to a disinhibition of dopamine neurons in the mesolimbic pathway, resulting in the hyperdopaminergic state associated with positive symptoms

**Other Neurotransmitter System**

- **Serotonin –** has been implicated in the disease, and many second-generation antipsychotics work by modulating both dopamine and serotonin receptors
  - The serotonin 5-HT2A receptor is a key target for these medications
  - Serotonin dysfunction may be linked to mood-related symptoms and cognitive deficits in schizophrenia
- **GABA –** plays a crucial role in regulating neural activity
  - Disruption of GABAergic interneurons is thought to lead to problems with neural synchrony and information processing, which may contribute to the cognitive and

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perceptual disturbances seen in schizophrenia

- **Acetylcholine –** abnormalities in the cholinergic system, particularly in nicotinic and muscarinic receptors, have been observed in post-mortem studies and neuroimaging
    - Acetylcholine signaling is important for attention and sensory gating, both of which are impaired in schizophrenia

**Broader Neurological Factors**

- **Neurodevelopmental Abnormalities –** schizophrenia is often considered a neurodevelopmental disorder
    - Genetic and environmental factors can disrupt early brain development, leading to subtle abnormalities in brain structure and circuitry that become clinically apparent in late adolescence or early adulthood
- **Structural and Functional Brain Changes –** neuroimaging studies have consistently shown abnormalities in the brains of people with schizophrenia, including enlarged ventricles and reduced volume in areas such as the prefrontal cortex, hippocampus, and amygdala
- **Inflammation and Immune System –** growing evidence suggests that immune system dysfunction and neuroinflammation may play a role in the development of schizophrenia

**END**

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