PSYCHOPATHOLOGY
DPSY536

Edited by:
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LOVELY PROFESSIONAL UNIVERSITY

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DPSY536 PSYCHOPATHOLOGY

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Introduction to Psychopathology

CONTENTS

Objectives

After completion of this chapter, the students will be able to:

- understand the meaning of Psychopathology
- familiar with the different approaches of Psychopathology
- know about the Diagnosing System

Introduction

Throughout history, human civilizations have held quite different views of the problems that we consider now to be mental disorders. The search for explanations of the causes of abnormal behavior dates to ancient times, as do conflicting opinions about the etiology of mental disorders. There have also been a number of approaches to treat these mental disorders or psychopathologies. Ancient beliefs attributed abnormal behavior to the disfavor of a supernatural power or the mischief of demons. A second stream of beliefs started attributing mental disorders to some physiological dysfunctions and biochemical imbalances in the body. This was only late nineteenth or early twentieth century when psychological explanations of nature, etiology and treatment of mental disorders began to be conceptualized and getting importance.

If anyone wants to know about psychological and psychiatric symptoms – it is in the domain of Psychopathology. Clinical psychopathology deals with the clinical aspects of the Psychiatrists for making diagnosis and providing better mental health.

Karl Jaspers is known as the Father of Psychopathology. He stressed on Psychosis and different types of delusions and hallucinations.

This discipline can be understood as an in-depth study of problems related to mental health. Just like pathology is the study of the nature of disease (including causes, development, and outcomes), psychopathology is the study of the same concepts within the realm of mental health (or illness)

Psychopathology is all about exploring problems related to mental health: how to understand them, how to classify them, and how to fix them. Because of this, the topic of psychopathology extends from research to treatment and covers every step in between. The better we can understand why a mental disorder develops, the easier it will be to find effective treatments.

If we want to know about the nature of the diseases including aetiology, development and consequences, we will go for Pathology, psychopathology deals with the same concept with mental disorders. So, psychopathology covers the exploration of problems in relation to mental health, to know them, to identify them and to locate them. So the subject-matter of psychopathology has a wide spectrum from research to treatment and maintain every ways in between. As long as we can make out the reason of the development of mental disorder, we can easily find effective treatment.

There are two broad divisions to elaborate the nature of psychiatric illness. First one is philosophical- where questions are asked about the existence of mental illness. It also tries to explain the meaning of it and the symptoms we identify as disorders are really signifies the disease, social scenario which changes in different cultures and different times to give meaning of human behavior.

The second method is clinical. Different causes, symptoms etc. are discussed here. It tries to make difference between general psychological phenomena and symptoms of disorders in population. It is being discussed by the most clinicians. In this regard, Diagnostic and Statistical Manual (DSM) and International Classification of Diseases (ICD) have been developed.

1.1 Theoretical Background of Psychopathology

As a whole, if we consider psychopathological origin, we have to know four different approaches.

1. The Biological Approach-

It assumes that the mental disorders of the person are caused by biological determinants. Psychological disorders can be caused by alleviating the root cause of the illness. This approach has been caused by three things.

A Genetic Inheritance-

Malfunctioned anatomical or chemical characteristics are passed down from the parents to the patient. In this connection, Psychologists will investigate identical twins to show the symptoms are passing or not. In case of Schizophrenia, if one twin has it then the other is very prone to have it- this shows the genetic connection of it.

B. Biochemistry or Neuroanatomy-

Various neurotransmitters cause mental disorders- in the form of chemical imbalance of different hormones, like Serotonin- it is determined mostly by genes. Anxiety Disorder Patients show high level of serotonin whereas the opposite will see in case of depression. So biochemistry or neuroanatomy has a detrimental effect on mental disorders.

C. Viral Infections-

According to Torrey (2001), it may be seen that viral infection in the mother's womb gives rise to mental disorders of the new born child. The child may develop schizophrenia and associated symptoms.

2. The Behavioral Approach-

According to this view, mental disorders are the product of social learning or conditioning. The behavior is not differing between abnormal and normal, only how we learn and condition it, accordingly we express it into the environment. Abnormal behaviors also have influenced by environment- like media can affect the psychological condition of us- like from TV show- anxiety, phobia or aggression can be generated.

3. The Psychodynamic Approach-

This theory tells those mental disorders stem from mental conflicts probably individual is not aware of it. Freud postulated that mental disorders are rooted from the unresolved conflicts in childhood. He mentioned that our mind has three structures.

a. Id-

It is based on pleasure principle and it is the reservoir of energy. It is irrational and wants to gratify the desires.

b. Ego-

It is governed by reality principle and it is the executive of our mind. It always controls the self.

c. Super-ego-

It is related to the moral aspects of our mind; the right and wrong judgement are given it to the ego. Super-ego is the advisor of ego.

d. Ego-defenses-

It is the method of ego to repress the irrational idistic impulses for effective dealing with the environment.

When Ego fails to repress the impulse, there will be conflict with other parts of personality and anxiety occurs. Freud said that children do not have maturity in emotional state, anxiety develops as well as due to trauma in childhood also brings back depression when it will be reexperienced.

4. The Cognitive Approach-

In this theory, it is believed that our thinking plays an important role in psychological well-being. How we perceive, reason and judge the outer world, that finalize our behavior. If this thinking is disturbed, then psychological disorders will take place. Four distinguished aspects of our cognition are: -

A. Cognitive Structures-

When a stimulus comes, how we receive information is important here.

B. Cognitive Content-

Persons assume certain situations either positively or negatively.

C. Cognitive Process-

When individual goes through information processing system, how it has been processed- either rational or irrational way.

D. Cognitive Products-

When the individual concludes the processed information in a specific way, then it is a typical product.

1.2 Classification of Disorders

Professionals engaged in research and treatment of psychopathology must use systems to arrive at conclusions regarding the best course of action for treatment. These systems are used to classify what are considered mental health disorders. Currently, the most widely used systems for classifying mental illness in the United States are the following.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is created by the American Psychiatric Association (APA) as an assessment system for mental illness. The DSM-5 published in 2013 is the current edition and includes identifiable criteria that mental health professionals use to arrive at a specific diagnosis.

The criteria and list of disorders sometimes change as new research emerges. Some examples of disorders listed in the DSM-5 include major depressive disorder, bipolar disorder, schizophrenia, paranoid personality disorder, and social anxiety disorder.

Second, the DSM-5 is a categorical system. Thus, individual disorders are regarded as discrete units—"you either have it, or you don't." DSM-5 states about this: "(…) scientific evidence places

many, if not most, disorders on a spectrum with closely related disorders that have shared symptoms, shared genetic and environmental risk factors (…)." And "(…) we have come to recognize that the boundaries between disorders are more porous than originally perceived" (American Psychiatric Association, 2013, p. 6). This leads to a fundamental problem. Because the overwhelming majority of psychiatric disorders examined thus far using taximetrics methods appear to be dimensional in nature (Haslam, 2003; Widiger and Samuel, 2005), consequently all of their categorizations become artificial and debatable. Even though DSM-5 took a modest step toward a more dimensional approach, its core remains categorical.

To illustrate, consider the borderline personality disorder (BPD). This classification consists of nine diagnostic criteria of which a minimum of five need to be present for the diagnosis of BPD. A simple numerical combination algorithm leads to a staggering number of 256 distinct presentations of BPD (Albion et al., 2013). Due to this chameleon-like nature, the disorder's diagnostic validity becomes questionable. Strikingly, this number is relatively small when compared to other conditions, e.g., there are 636,120 ways to have posttraumatic stress disorder (Galatzer-Levy and Bryant, 2013).

DSM-5 does propose an alternative model for personality disorders based on personality functioning and traits (American Psychiatric Association, 2013, p. 761), as a possible answer to the problem that most patients fit with multiple co-morbid personality disorders or to the category of personality disorder not otherwise specified. In November 2012, the chair committee of APA decided to move this alternative model to section III of DSM-5 and to sustain the categorical system in section II.

International Classification of Diseases (ICD)

The ICD is a system similar to the DSM. Now in its eleventh version, the ICD was developed over a century ago and was taken over by the World Health Organization (WHO) when it was founded in 1948. So, how does the ICD-11 differ from the DSM-5?

First, the ICD-11 is produced by a global agency (the World Health Organization), while the DSM-5 is produced by a national professional association (the American Psychiatric Association). The ICD-11 is approved by the World Health Assembly composed of health ministers from 193 WHO member countries.

Second, the goal of the ICD-11 is to reduce the burden of disease globally. It includes medical as well as mental health diagnoses. Third, the ICD-11 is freely available on the Internet. In contrast, the DSM must be purchased, and the American Psychiatric Association derives revenue from sales of the book and related products.

Still, the DSM-5 is the standard for classification among American mental health professionals and is generally used for treatment planning and insurance purposes.

1.3 Approaches to Psychopathology

Philosophical Approach-

To discuss the nature of psychiatric disorders, Kendler (2016) mentioned three approaches namely- realism, constructivism and pragmatism.

Realism denotes those psychological disorders occur just as physiological disorders like broken bone or acute pancreatitis. Many of them believe that mental disorders like Generalized anxiety disorder, Depression or Schizophrenia persist as disease can be identified in their genetic and physiological pathways. It is related to biological background of disorders.

In the domain of Constructivism, it is believed that psychiatric disorders originate from the social and political reasons not by the biological force. They give instances of Post-Traumatic Stress Disorder (PTSD), Multiple Personality Disorder- these have developed through environmental influences.

Pragmatism emphasizes on the role of the individual and its utility in the society, if it is being fulfilled, then there is no use of classifying the person in the domain of psychiatric disorder. In this context, Jablensky (2016) put stress on 'comparative validity' where the criteria should be justified rationally and should be in line with current specific knowledge.

Clinical Approach-

In this category, symptoms, their frequencies and duration have been emphasized in the definition of every disorder and this has been used in DSM and to some extent in ICD. All these have been made significant clinically.

The objectives of the diagnosis are to: -

1. Differentiate between normal and abnormal states.

- In non-psychotic states
- In psychotic states

2. Differentiate between psychiatric disorder from another.

1.2 Diagnostic Systems: -

In this domain of research and treatment of psychopathology, people are trying to arrive at conclusions regarding the most fitted course of action for treatment. These systems are made to categorize mental health disorders. These are: -

Diagnostic and Statistical Manual of Mental Disorders (DSM)-

It has been framed by American Psychiatric Association for diagnosing mental illness. The recent edition is DSM-V, was published in 2013 that incorporates different categories, by which mental health professionals can make a specific diagnosis.

International Classification of Diseases (ICD)-

It is similar to DSM, which has been framed by World Health Organization (WHO), now in recent, eleventh version has been developed in 2019.

Early Distinctions; -

Categorization of mental disorders was based on the differentiation between organic and functional disorders. Organic disorders stem from disease of brain which is related to neurobiological processes. Previously abnormal brain functioning was restricted to delirium and dementia only. Later on, it includes more criteria apart from that.

Organic Disorders: -

It is divided into three categories- acute, sub-acute and chronic.

In acute disorders, alteration of consciousness is most common- which can give four subtypes- delirium, sub-acute delirium, organic stupor and the twilight state. In delirium, we can see dream like changes in consciousness, for that patient is unable to differentiate between mental images and perceptions, which may give rise to hallucinations and illusions. In stupor state, the patient reacts diffusely or not at all to the stimulation. In sub-acute delirium, we can see low awareness level and lack of coherence of psychic activity, so the patient is confused. Hallucination, delusion and illusion occur at this stage. In twilight ate, mind is governed by a group of ideas, attitudes and images and the patient may show complex actions.

Functional Disorders: -

It may be regarded as those disorders referring symptoms which do not originate directly from brain, though it is believed that finer connection with brain is there in cellular level.

These disorders have been divided into two broad categories – neurosis and psychosis for many years. Neurotic persons have insight into his problems, only a part of his/her personality is

involved in this disorder, contact to reality is intact. In psychotic case, insight is lacking and the whole personality is affected due to illness and the patient shows hallucinations and delusions. DSM-V has kept the term 'neurosis' intact whereas ICD-10 has been reduced to 'neurotic, stress-related and somatoform disorders.'

Differentiating between one Psychological Disorder to Another-

It has been observed that Psychologists and Psychiatrists focus on distinguishing mental disorders from one another. Emil Kraeplin (1918) differentiated Schizophrenia from bipolar disorder. It is very difficult to differentiate between anxiety and depression because 85-90% cases, these two disorders coexist. For that ICD-10 mentioned, "mixed anxiety and depressive disorders" (MADD) which can include co-morbidity, consanguinity and cooccurrence.

Importance of Psychopathology

- Psychopathology helps in diagnosing in psychiatry where many conditions or syndrome underpinned by abnormal subjective experience of the patients.
- Psychopathology functions as a bridge between the human and clinical sciences, it provides basic tools to make sense of mental sufferings.
- Psychopathology attempts to separate the normal experiences from the abnormal in context of illness.
- Psychopathology bridges the gap between understanding of illness and caring attempting to establish a methodological as well as ethical framework for this.
- Psychopathology attempts to bridge understanding and explanation in research and clinical study.

Signs of Psychopathology

Signs of psychopathology vary depending on the nature of the condition. Some of the signs that a person might be experiencing some form of psychopathology include:

- Changes in eating habits
- Changes in mood
- Excessive worry, anxiety, or fear
- Feelings of distress
- Inability to concentrate
- Irritability or anger
- Low energy or feelings of fatigue
- Sleep disruptions
- Thoughts of self-harm or suicide
- Trouble coping with daily life
- Withdrawal from activities and friends

Types of Psychopathologies

Psychopathology is the study of abnormal cognitions, behavior and experiences which differs according to social norms and rests upon a number of constructs that are deemed to be the social norm at any particular era. It can be broadly separated into descriptive and explanatory.

Descriptive psychopathology

It involves categorizing, defining and understanding symptoms as reported by people and observed through their behavior which are then assessed according to a social norm.

Explanatory psychopathology

It looks to find explanations for certain kinds of symptoms according to theoretical models such as psychodynamics, cognitive behavioral therapy or through understanding how they have been constructed by drawing upon Constructivist Grounded Theory (Charmaz, 2016) or Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2013). A practitioner in a clinical or academic field is referred to as a psychopathologist.

Biological psychopathology

It is the study of the biological etiology of abnormal cognitions, behavior and experiences.

Child psychopathology

It is a specialization applied to children and adolescents.

Animal psychopathology

It is a specialization applied to non-human animals. This concept is linked to the philosophical ideas first outlined by Galton (1869) and is linked to the appliance of eugenical ideations around what constitutes the human.

Identifying Psychopathology

How do psychologists and psychiatrists decide what extends beyond normal behavior to enter the territory of "psychopathology?" Psychiatric disorders can be conceptualized as referring to problems in four areas: deviance, distress, dysfunction, and danger.

For example, if you were experiencing symptoms of depression and went to see a psychiatrist, you would be assessed according to a list of symptoms (most likely those in the DSM-5):

Deviance:

This term refers to thoughts, emotions, or behaviors that deviate from what is common or at odds with what is deemed acceptable in the society. In the case of depression, you might report thoughts of guilt or worthlessness that are not common among other people.

Distress:

This symptom refers to negative feelings either felt within a person or that result in discomfort in others around that person. In the case of depression, you might report extreme feelings of distress over sadness or guilt.

Dysfunction:

With this symptom, professionals are looking for the inability to achieve daily functions like going to work. In the case of depression, you might report that you can't get out of bed in the morning or that daily tasks take you much longer than they should.

Danger:

This term refers to behavior that might put you or someone else at some type of detrimental risk. In the case of depression, this could include reporting that you are having thoughts of suicide or harming yourself.

In this way, you can see that the distinction between normal versus psychopathological behavior comes down to how issues are affecting you or the people around you.

Who Works in Psychopathology?

Just as the scope of psychopathology is broad-ranging from research to treatment, so too is the list of types of professionals who tend to be involved in the field. At the research level, you will find research psychologists, psychiatrists, neuroscientists, and others trying to make sense of the different manifestations of mental disorders seen in clinical practice.

At the clinical level, you will find many types of professionals attempting to apply the diagnostic systems that are in place to provide effective treatments to individuals living with psychopathology. These can include the following and more:

- Clinical psychologists
- Counselors
- Criminologists
- Marriage and family therapists
- Nurse practitioners
- Psychiatric nurses
- Psychiatrists
- Social workers
- Sociologists

Summary: -

It has been believed that genetic and neurobiological researches would dominate the range of psychiatric disorders over time. In recent years, validation of psychiatric disorders has been predominant. It has been observed that on the basis of behaviors or symptoms always do not give the proper direction of psychiatric disorders, validations of characteristics are found according to the difference of human conditions.

It is important to notice that this is a major area of psychology, with links to wider clinical practices such as psychiatry, psychiatric nursing, social work, and the medical sciences in general.

However, the contribution of psychopathology to our understanding of individual differences cannot be neglected. Differential psychology attempts to explain differences

between individuals, and such differences can often be explained in terms of mental illness or psychological disorders. Although this may suggest an overlap between personality and psychopathology, there is a distinction between the two. Whereas personality refers to individual differences in general or normal behavior, psychopathology focuses exclusively on abnormality. In the past decade there has been increased interest in the relationship between personality and psychopathology as conceptualized in terms of a continuum between normality and abnormality.

Keywords

Psychopathology, psychosis, neurosis, pragmatism, functional disorder, id, ego, super-ego, ego-defenses, cognitive content, Diagnostic and Statistical Manual, International Classification of Diseases, deviance, distress, dysfunction, danger.

Self-Assessment

1. Kraepelin differentiated Schizophrenia and Bipolar Disorder (T/F).
2. Currently fifth version of DSM is available (T/F).
3. Presently ICD-10 is available (T/F).
4. DSM published in 2019 (T/F).
5. Kendler mentioned three approaches (T/F).
6. ------- is known as the Father of Psychopathology.

a. Sigmund Freud
b. Emil Kraepelin
c. Karl Jaspers
d. None of them

7. Which is not mentioned in Kendler's approaches?

a. Realism
b. Constructivism
c. Autism
d. None of them

8. ------ is governed by Reality Principle.

a. Id
b. Ego
c. Super-ego
d. None of them

9. ------ is governed by Pleasure Principle.

a. Id
b. Ego
c. Super-ego
d. None of them

10. Which is not matched with our cognition?

a. Cognitive patch
b. Cognitive structure
c. Cognitive process
d. None of them

11. DSM is created by --------

a. World Health Organization
b. American Psychiatric Association
c. British Psychoanalytical Society
d. None of them

12. WHO was founded in-------

a. 1924
b. 1948
c. 1952
d. None of them

13. Among Psychiatric Disorders, anxiety and depression present in ------ cases.

a. 60-70%
b. 70-80%
c. 85-90%
d. None of them

14. ------- is the advisor of ego.
a. Id
b. Ego
c. Super-ego
d. None of them
15. The full form of MADD is --------
a. Mixed anxiety and depressive disorder
b. Mania, anxiety and depressive disorder
c. Mood, anxiety and depressive disorder
d. None of them

Scoring Key

1T, 2T, 3F, 4F, 5T, 6C, 7C, 8B, 9A, 10A, 11B, 12B, 13C, 14C, 15A

Review Questions

1. Give an introduction to Psychopathology.
2. Briefly discussthe Philosophical approaches to Psychopathology?
3. Briefly discuss the diagnostic systems of Psychopathology.
4. What are the ways of identifying Psychopathology?
5. Who works in Psychopathology?
6. Write a note on International Classification of Diseases (ICD).
7. Briefly discuss the Clinical Approaches to Psychopathology.
8. What is the importance of Psychopathology?
9. Describe different types of Psychopathologies.
10. Elucidate the Biological approach to Psychopathology.

Further/Suggested Readings

1. Fish's Clinical Psychopathology: Signs and Symptoms by Patricia Casey and Brenden Kelly. 3rd ed. RCPsych Publication.2007.
2. Clinical Psychopathology: A very short Introduction by Susan Llewelyn and Katie Aafjes-van Doom. 1st ed. Oxford University Press,2017.

Unit 2: Psychological Distress

Contents

Objectives

1. To understand the concept of stress
2. To identify the different levels of stress and distress
3. To know the characteristics of distress

2.1 Introduction psychological distress and its Epidemiology

Mental distress (or psychological distress) is a term used, by some mental health practitioners and users of mental health services, to describe a range of symptoms and experiences of a person's internal life that are commonly held to be troubling, confusing or out of the ordinary. Mental distress can potentially lead to a change of behavior, affect a person's emotions in a negative way, and affect their relationships with the people around them.

Certain traumatic life experiences such as: bereavement, stress, lack of sleep, use of drugs or alcohol, assault, abuse or accidents can induce mental distress. This may be something which resolves without further medical intervention, though people who endure such symptoms longer term are more likely to be diagnosed with mental illness. This definition is not without controversy as some mental health practitioners would use the terms mental distress and mental illness interchangeably.

Some users of mental health services prefer the term mental distress in describing their experience as they feel it better captures that sense of the unique and personal nature of their experience, while also making it easier to relate to, since everyone experiences distress at different times. The term also fits better with the social model of disability.

2.2 Stress

Stress is a normal reaction the body has when changes occur, resulting in physical, emotional and intellectual responses. Stress management training can help you deal with changes in a healthier way.Stress is a normal human reaction that happens to everyone. In fact, the human body is designed to experience stress and react to it. When you experience changes or challenges (stressors), your body produces physical and mental responses. That's stress.Stress responses help your body adjust to new situations. Stress can be positive, keeping us alert, motivated and ready to avoid danger. For example, if you have an important test coming up, a stress response might help your body work harder and stay awake longer. But stress becomes a problem when stressors continue without relief or periods of relaxation.What happens to the body during stress? The body's autonomic nervous system controls your heart rate, breathing, vision changes and more. Its built-in stress response, the "fight-or-flight response," helps the body face stressful situations.When a person has long-term (chronic) stress, continued activation of the stress response causes wear and tear on the body. Physical, emotional and behavioral symptoms develop.

Physical symptoms of stress include:

- Aches and pains.

- Chest pain or a feeling like your heart is racing.
- Exhaustion or trouble sleeping.
- Headaches, dizziness or shaking.
- High blood pressure.
- Muscle tension or jaw clenching.
- Stomach or digestive problems.
- Trouble having sex.
- Weak immune system.
- Stress can lead to emotional and mental symptoms like:

- Anxiety or irritability.
- Depression.
- Panic attacks.
- Sadness.
- Often, people with chronic stress try to manage it with unhealthy behaviors, including:

- Drinking alcohol too much or too often.
- Gambling.
- Overeating or developing an eating disorder.
- Participating compulsively in sex, shopping or internet browsing.
- Smoking.

- Using drugs.

2.3 stressors

- Effective stress management starts with identifying your sources of stress and developing strategies to manage them. One way to do this is to make a list of the situations, concerns or challenges that trigger your stress response. Take a moment to write down some of the top issues you're facing right now. Recognize whether your stress is driven by a person, an event or a situation. You'll notice that some of your stressors are events that happen to you while others seem to originate from within. External exasperations External stressors are events and situations that happen to you. Some examples of external stressors include: Major life changes. These changes can be positive, such as a new marriage, a planned pregnancy, a promotion or a new house. Or they can be negative, such as the death of a loved one, an illness or a divorce. Environment. The input from the world around you can be a source of stress. Consider how you react to sudden noises, such as a barking dog, or how you react to a bright sunlit room or a dark room. Or think about if you feel more stressed in crowds or in traffic during rush hour. Unpredictable events. Out of the blue, uninvited houseguests arrive. Or you discover your rent has gone up or that your pay has been cut. Workplace. Common stressors at work include an impossible workload, endless emails, urgent deadlines and a demanding boss. Or some people may feel extra stress with their work schedules and demands if they work from home. Or they may feel stress from having too many videoconference meetings. Social. Meeting new people can be stressful. Just think about going on a blind date, and you probably start to sweat. Relationships with family often spawn stress as well. Consider your last fight with your partner or child.

Traumatic events. Some people may experience very stressful events such as war, accidents, natural disasters or assaults.

Strategies to manage external stressors include lifestyle factors such as eating a healthy diet, being physically active and getting enough sleep — which help boost your resiliency. Other helpful steps include asking for help from others, using humor, learning to be assertive, and practicing problem-solving and time management. Consider how you use your time and energy by focusing on activities that are important to you, paring down the number of activities you're involved in and saying no to new commitments. Find times to unplug, turn off your phone and be unavailable.

Internal irritations

Not all stress stems from things that happen to you. Much of the stress response is self-induced. Those feelings and thoughts that pop into your head and cause you unrest are known as internal stressors. Examples of internal stressors include:

Fears. Common ones include fear of failure, fear of public speaking and fear of flying.

Uncertainty and lack of control. Few people enjoy not knowing or not being able to control what might happen. Think about how you might react when waiting for the results of a medical test.

Beliefs. These might be attitudes, opinions or expectations. You may not even think about how your beliefs shape your experience, but these preset thoughts often set you up for stress. Consider the expectations you put on yourself to create a perfect holiday celebration or advance up the career ladder. The good news is that you have the ability to control your thoughts. The bad news is that your fears, attitudes and expectations have been your companions for a long time and it often takes some effort to change them. Strategies to manage internal stressors include reframing your thoughts and choosing a positive mindset, challenging negative thoughts, using relaxation techniques, and talking with a trusted friend or counselor.

2.4 symptoms of stress include:

Aches and pains.
Chest pain or a feeling like your heart is racing.
Exhaustion or trouble sleeping.
Headaches, dizziness or shaking.
High blood pressure.
Muscle tension or jaw clenching.
Stomach or digestive problems.
Trouble having sex.
Weak immune system.

The kids won't stop screaming, your boss has been hounding you because you turned a report in late, and you owe the IRS thousands of dollars you don't have. You're seriously stressed out.

Stress is actually a normal part of life. At times, it serves a useful purpose. Stress can motivate you to get that promotion at work, or run the last mile of a marathon. But if you don't get a handle on your stress and it becomes long-term, it can seriously interfere with your job, family life, and health. More than half of Americans say they fight with friends and loved ones because of stress, and more than 70% say they experience real physical and emotional symptoms from it.

Causes of Stress

Everyone has different stress triggers. Work stress tops the list, according to surveys. Forty percent of U.S. workers admit to experiencing office stress, and one-quarter say work is the biggest source of stress in their lives.

Causes of work stress include:

- Being unhappy in your job
- Having a heavy workload or too much responsibility
- Working long hours
- Having poor management, unclear expectations of your work, or no say in the decision-making process
- Working under dangerous conditions
- Being insecure about your chance for advancement or risk of termination
- Having to give speeches in front of colleagues
- Facing discrimination or harassment at work, especially if your company isn't supportive

2.5 Types of stress

Acute stress

Acute stress happens to everyone. It's the body's immediate reaction to a new and challenging situation. It's the kind of stress you might feel when you narrowly escape a car accident. Acute stress can also come out of something that you actually enjoy. It's the somewhat-frightening, yet thrilling feeling you get on a roller coaster or when skiing down a steep mountain slope. These incidents of acute stress don't normally do you any harm. They might even be good for you. Stressful situations give your body and brain practice in developing the best response to future stressful situations. Once the danger passes, your body systems should return to normal Severe acute stress is a different story. This kind of stress, such as when you've faced a life-threatening situation, can lead to post-traumatic stress disorder (PTSD) or other mental health problems.

Episodic acute stress

Episodic acute stress is when you have frequent episodes of acute stress. This might happen if you're often anxious and worried about things you suspect may happen. You might feel that your life is chaotic and you seemingly go from one crisis to the next. Certain professions, such as law enforcement or firefighters, might also lead to frequent high-stress situations. As with severe acute stress, episodic acute stress can affect your physical health and mental well-being.

Chronic stress

When you have high-stress levels for an extended period of time, you have chronic stress. Long-term stress like this can have a negative impact on your health. It may contribute to:

anxiety

cardiovascular disease

depression

high blood pressure

a weakened immune system

Chronic stress can also lead to frequent ailments such as headaches, an upset stomach, and sleep difficulties. Gaining insights into the different types of stress and how to recognize them may help.

2.6 Models of stress

Stress As a Stimulus The theory of stress as a stimulus was introduced in the 1960s, and viewed stress as a significant life event or change that demands response, adjustment, or adaptation. Holmes and Rahe (1967) created the Social Readjustment Rating Scale (SRRS) consisting of 42 life events scored according to the estimated degree of adjustment they would each demand of the person experiencing them (e.g., marriage, divorce, relocation, change or loss of job, loss of loved one). Holmes and Rahe theorized that stress was an independent variable in the health-stress-coping equation — the cause of an experience rather than the experience itself. While some correlations emerged between SRRS scores and illness (Rahe, Mahan, & Arthur, 1970; Johnson & Sarason, 1979), there were problems with the stress as stimulus theory. The stress as stimulus theory assumes: Change is inherently stressful. Life events demand the same levels of adjustment across the population. There is a common threshold of adjustment beyond which illness will result. Rahe and Holmes initially viewed the human subject as a passive recipient of stress, one who played no role in determining the degree, intensity, or valence of the stressor. Later, Rahe introduced the concept of interpretation into his research (Rahe & Arthur, 1978),

suggesting that a change or life event could be interpreted as a positive or negative experience based on cognitive and emotional factors. However, the stress as stimulus model still ignored important variables such as prior learning, environment, support networks, personality, and life experience.

Stress As a Transaction

In attempting to explain stress as more of a dynamic process, Richard Lazarus developed the transactional theory of stress and coping (TTSC) (Lazarus, 1966; Lazarus & Folkman, 1984), which presents stress as a product of a transaction between a person (including multiple systems: cognitive, physiological, affective, psychological, neurological) and his or her complex environment. Stress as a transaction was introduced with the most impact when Dr. Susan Kobasa first used the concept of hardiness (Kobasa, 1979). Hardiness refers to a pattern of personality characteristics that distinguishes people who remain healthy under life stress compared with those who develop health problems. In the late 1970s, the concept of hardiness was further developed by Salvatore Maddi, Kobasa, and their graduate students at the University of Chicago (Kobasa, 1982; Kobasa & Maddi, 1981; Kobasa, Maddi, & Kahn, 1982; Kobasa, Maddi, Puccetti, & Zola, 1985; Maddi & Kobasa, 1984). Hardiness has some notable similarities with other personality constructs in psychology, including locus of control (Rotter, 1966), sense of coherence (Antonovsky, 1987), self-efficacy (Bandura, 1997), and dispositional optimism (Scheier & Carver, 1985), all of which will be discussed in the next section. Researchers introduced multiple variables to the stress-as-transaction model, expanding and categorizing various factors to account for the complex systems involved in experiencing a stressor (Werner, 1993). The nature of stress was described in multiple ways: acute, episodic or intermittent, and chronic. Different types of stressors emerged, such as event, situation, cue, and condition, which then fell into categories based on locus of control, predictability, tone, impact, and duration. Figure 12.7 illustrates theories of stress as a response, stimulus, and transaction.

2.7 coping with stress

Stress management is a wide spectrum of techniques and psychotherapies aimed at controlling a person's level of stress, especially chronic stress, usually for the purpose of and for the motive of improving everyday functioning. Stress produces numerous physical and mental symptoms which vary according to each individual's situational factors. These can include a decline in physical health as well as depression. The process of stress management is named as one of the keys to a happy and successful life in modern society. Life often delivers numerous demands that can be difficult to handle, but stress management provides a number of ways to manage anxiety and maintain overall well-being.

Despite stress often being thought of as a subjective experience, levels of stress are readily measurable; using various physiological tests, similar to those used in polygraphs.

Evaluating the effectiveness of various stress management techniques can be difficult, as limited research currently exists. Consequently, the amount and quality of evidence for the various techniques varies widely. Some are accepted as effective treatments for use in psychotherapy, while others with less evidence favoring them are considered alternative therapies. Many professional organizations exist to promote and provide training in conventional or alternative therapies.

There are several models of stress management, each with distinctive explanations of mechanisms for controlling stress. Much more research is necessary to provide a better understanding of which mechanisms actually operate and are effective in practice.

2.8 Summary

You're sitting in traffic, late for an important meeting, watching the minutes tick away. Your hypothalamus, a tiny control tower in your brain, decides to send out the order: Send in the stress hormones! These stress hormones are the same ones that trigger your body's "fight or flight" response. Your heart races, your breath quickens, and your muscles ready for action. This response was designed to protect your body in an emergency by preparing you to react quickly. But when the stress response keeps firing, day after day, it could put your health at serious risk.

2.9 **Keyword:**

Stress, distress, coping, models of stress

2.10 **Self Eveluation**

1. Which of the following statements is true
a) In small quantities, stress is good
b) Too much stress is harmful
c) All stress is bad
d) Only '1' & '2' are right
2. Stress management is about learning
a) How to avoid the pressures of life
b) How to develop skills that would enhance our body's adjustment when we are subjected to the pressures of life
c) Both '1' & '2' are true
d) None of the above
3. Which of the following statements is true about stress management
a) Stress management is learning about the connection between mind and body
b) Stress management helps us control our health in a positive sense
c) Stress management teaches us to avoid all kinds of stress
d) Only '1' & '2' are right
4. Which of the following are the basic sources of stress
a) The Environment
b) Social Stressors
c) Physiological
d) All of the above
5. Examples of environmental stressors are
a) Weather
b) Traffic
c) Financial problems
d) Substandard housing
e) Only '1' , '2' & '4' are right
6. Examples of social stressors are
a) Financial problems
b) Divorce
c) Loss of a loved one
d) Job interviews
e) All of the above
7. Examples of physiological stressors are
a) Menopause
b) Giving birth
c) Sleep disturbances
d) Relationship problems
e) Only '1', '2', & '3' are true
8. The following are the characteristics of Positive Stress
a) It improves performance
b) It feels exciting
c) It motivates
d) All of the above

9. The following are the characteristics of Negative Stress
a) It causes anxiety
b) It feels unpleasant
c) It decreases performance
d) All of the above

10. Which of the following statements is true
a) Positive stress is short-term
b) Negative stress can be short or long-term
c) Negative stress can lead to mental as well as physical problems
d) Negative stress is perceived within our coping abilities
e) All of the above
f) All except '4' is true

11. The following are the examples of negative stressors
a) Unemployment
b) Legal problems
c) Divorce
d) All of the above
12. The following are the examples of positive stressors
a) New job
b) Having a child
c) Buying a home
d) All of the above

13. The following are true about the behavioural symptoms of stress
a) The subject's starts eating more or less
b) The subject starts sleeping more or less
c) The subject isolates himself/herself from others
d) All of the above

14 . Aches, shallow breathing and sweating, frequent colds are
a) Physical symptoms of stress
b) Behavioural symptoms of stress
c) Emotional symptoms of stress
d) Cognitive symptoms of stress

15 . The following are true about the effects of stress
a) Hair loss and baldness
b) Spasmodic pains in the neck and shoulders
c) Hypertension
d) All of the above

Answer
1d, 2b, 3d, 4d, 5e, 6e, 7e, 8d,9d,10d, 11d, 12d,13d, 14a, 15d

8.15 **Review Questions**

1. What is stress?
2. Explain types of stress?
3. What is distress?
4. What causes stress?

8.16 Further Readings

https://openpress.usask.ca/introductiontopsychology/chapter/stress-and-coping/.
https://www.healthline.com/health/stress/effects-on-body

https://en.wikipedia.org/wiki/Stress_management

Anxiety Disorders

CONTENTS

Objectives

After completion of this chapter, the students will be able to;

- Understand different types of anxiety disorders
- Know about the salient features of anxiety disorders
- Familiarize with the diagnosis of these anxiety disorders.

Introduction

Anxiety: - Appreciation of Danger without appropriate cause in the reality. Examples of anxiety disorders include generalized anxiety disorder, social anxiety disorder (social phobia), specific phobias and separation anxiety disorder. You can have more than one anxiety disorder. Sometimes anxiety results from a medical condition that needs treatment. Experiencing occasional anxiety is a normal part of life. However, people with anxiety disorders frequently have intense, excessive and persistent worry and fear about everyday situations. Often, anxiety disorders involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks).

3.1 Generalized Anxiety Disorder (GAD)

These feelings of anxiety and panic interfere with daily activities, are difficult to control, are out of proportion to the actual danger and can last a long time. You may avoid places or situations to prevent these feelings. Symptoms may start during childhood or the teen years and continue into adulthood.

Anxiety is a common phenomenon in normal part of life. When we experience anxiety, it becomes a problem to us, if we can cope it effectively then anxiety situation may be overcome. If anxiety characteristics hamper our everyday life activity and we cannot get rid of that, then it becomes a symptom. When anxiety characteristics are so predominant that it becomes a disorder itself, then it

is called anxiety disorder where repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes. People have excessive, intense, persistent worry and fear about every situation.

Types of Anxiety Disorders (DSM-V)

1. Generalized Anxiety Disorders
2. Panic Disorders
3. Agora Phobia
4. Specific Phobias
5. Social Anxiety disorders

Several types of anxiety disorders exist:

Agoraphobia is a type of anxiety disorder in which you fear and often avoid places or situations that might cause you to panic and make you feel trapped, helpless or embarrassed.

Anxiety disorder due to a medical condition includes symptoms of intense anxiety or panic that are directly caused by a physical health problem.

Generalized anxiety disorder includes persistent and excessive anxiety and worry about activities or events — even ordinary, routine issues. The worry is out of proportion to the actual circumstance, is difficult to control and affects how you feel physically. It often occurs along with other anxiety disorders or depression.

Panic disorder involves repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks). You may have feelings of impending doom, shortness of breath, chest pain, or a rapid, fluttering or pounding heart (heart palpitations). These panic attacks may lead to worrying about them happening again or avoiding situations in which they've occurred.

Selective mutism is a consistent failure of children to speak in certain situations, such as school, even when they can speak in other situations, such as at home with close family members. This can interfere with school, work and social functioning.

Separation anxiety disorder is a childhood disorder characterized by anxiety that's excessive for the child's developmental level and related to separation from parents or others who have parental roles.

Social anxiety disorder (social phobia) involves high levels of anxiety, fear and avoidance of social situations due to feelings of embarrassment, self-consciousness and concern about being judged or viewed negatively by others.

Specific phobias are characterized by major anxiety when you're exposed to a specific object or situation and a desire to avoid it. Phobias provoke panic attacks in some people.

Substance-induced anxiety disorder is characterized by symptoms of intense anxiety or panic that are a direct result of misusing drugs, taking medications, being exposed to a toxic substance or withdrawal from drugs.

Other specified anxiety disorder and unspecified anxiety disorder are terms for anxiety or phobias that don't meet the exact criteria for any other anxiety disorders but are significant enough to be distressing and disruptive.

Epidemiology of Anxiety Disorders

It is the most common category of Psychiatric Disorders. It has been reported that one out of four persons meets the criteria of any type of anxiety disorders. Women (30.50%) are more prone to have anxiety disorders than men (17.70%). The occurrence of this disorders has been found to be more prevalent in higher socio-economic status

Generalized Anxiety Disorders are also known as Anxiety Neurosis. In this disorder, people have uncontrollable worry about common aspects of life situations.

Symptoms of Generalized Anxiety Disorders (Tyror,1984): -

1. Feeling of nervousness, restlessness
2. Fear of impending doom (feeling of falling from a high place)
3. Palpitation
4. Perspiration (excessive sweating)
5. Tremors in hands and feet
6. Feeling of weakness or tiredness
7. Inability to concentrate
8. Sleep disturbance (broken sleep, lack of initiation in sleep)
9. Gestation Aura (Butterfly sensation in the stomach)
10. Shortness of breath
11. Frequent Micturition (frequently goes to pass urine, very little or no urine is coming out)
12. Numbness in different parts of the body

Medical Causes: -

Anxiety may occur with some chronic diseases. Sometimes, anxiety symptoms are the first indicators of a medical illness. Such as-

1. Heart disease
2. Diabetes
3. Thyroid Problems- particularly hyperthyroidism
4. Respiratory disorders like chronic obstructive pulmonary disease (COPD) and asthma.
5. Drug misuse or withdrawal
6. Withdrawal from alcohol, anxiolytic drugs or other medications
7. Chronic pain or irritable bowel syndrome
8. Rare tumors which produce certain hormonal discharge
9. Sometimes anxiety may be a side effect of drugs prescribed by the doctors.

Risk Factors in Anxiety: - Certain issues can increase the risk of building anxiety among us.

1. Trauma- Children who are abused or witnessed traumatic events are more susceptible to develop anxiety disorders. This is true for adults also.

2. Stress due to Illness- Prolonged suffering from a disease and excessive worry about that can develop anxiety among us.

3. Stress situation- Situation can give stress. High expectations about the outcome, uncertainty, death in a family, stress in work place recurrent financial problems can give rise to anxiety.

4. Other Mental Health Disorders- If people have other psychological disorders like depression may develop anxiety disorders.

5. Drug or Alcohol Use- Drug or alcohol addicts when they are using more, want to withdraw from those often may have anxiety disorder.

Etiology: -

Psychoanalytic Point of View

Anxiety is one of the core constructs in Psychoanalytic theory. Freud identified three types of anxiety: real anxiety, neurotic anxiety and moral anxiety. Real anxiety arises when one is confronted by danger or threats in the external world; neurotic anxiety arises when one's id impulses threaten to break through his/her ego controls and result in behavior that will call for punishment; and moral anxiety arises when one does something or even thinks of doing something that transgresses the moral code and arouses feelings of guilt.

Unconscious material libidinal-repression-psychic energy attached to it-break through unconscious material-unconscious materials into disturbed and disorganized form- display of Anxiety. So, according to Freud, anxiety is a failed repression.

Learning Theory-

According to the Learning theorists, anxiety is learned from environment, it is not the unconscious material that causes anxiety. Individual feels helpless when he/she is anticipating something but it is not achievable due to some reasons. Suppose, child is expecting mother to feed him, but the mother is not coming. In this situation the child is feeling helpless and for that he is crying. Learning theorists are telling that this helplessness is learned from getting unexpected outcome. Seligman told this as Learned helplessness.

Genetic loading-

This theory gives importance to the genetic inheritance of anxiety from parents. They believe that anxiety can be transmitted from generation to generation through genes structures.MZ (Mono Zygotic) twins have found more anxiety than DZ (Di Zygotic) twins (Brown,1982). Eysenck found neuroticism is inherited. But these studies have severe criticisms.

Biochemical Factors-

Excessive lactic acid production among anxiety patients (Pitts,1997). Excessive stress- release hormone from epinephrine– inhibits calcium metabolism-low calcium-Anxiety. High level of prolactin and cortisol amongst anxiety patients. Not fully accepted theory.

Personality Factors-

This theory tells us about the personality of the individual which is very important to develop anxiety. We all know that personality pattern is unique to every individual. Typical personality patterns of suggestibility, inadequacy, submissive nature is very prone to get anxiety disorders. Inadequacy feeling when the patient faces inner & outer stresses.

Parents' model and expectations-

Parents are very susceptible for indulging anxiety to the children. Overprotection, negligence, over indulged parents are responsible for over sensitivity, low stress tolerance, low risk-taking behavior.

Conclusion

When their anxiety level is mild to moderate or with treatment, people with GAD can function socially, have full and meaningful lives, and be gainfully employed. Many with GAD may avoid situations because they have the disorder or they may not take advantage of opportunities due to their worry (social situations, travel, promotions, etc.). Some people can have difficulty carrying out the simplest daily activities when their anxiety is severe.

3.2 Phobia

Introduction

Phobia is a type of anxiety disorder in which you fear and avoid places or situations that might cause you to panic and make you feel trapped, helpless or embarrassed. You fear an actual or

anticipated situation, such as using public transportation, being in open or enclosed spaces, standing in line, or being in a crowd.

The anxiety is caused by fear that there's no easy way to escape or get help if the anxiety intensifies. Most people who have agoraphobia develop it after having one or more panic attacks, causing them to worry about having another attack and avoid the places where it may happen again.

People with agoraphobia often have a hard time feeling safe in any public place, especially where crowds gather. You may feel that you need a companion, such as a relative or friend, to go with you to public places. The fear can be so overwhelming that you may feel unable to leave your home.

Agoraphobia treatment can be challenging because it usually means confronting your fears. But with psychotherapy and medications, you can escape the trap of agoraphobia and live a more enjoyable life.

Epidemiology

The National Institute of Mental Health estimates that the lifetime prevalence of agoraphobia is 1.3%, with an annual incidence rate of 0.9%. Yearly prevalence rates of agoraphobia are similar between males (0.8%) and females (0.9%).

Symptoms

Typical agoraphobia symptoms include fear of:

- Leaving home alone
- Crowds or waiting in line
- Enclosed spaces, such as movie theatres, elevators or small stores
- Open spaces, such as parking lots, bridges or malls
- Using public transportation, such as a bus, plane or train

Panic disorder and agoraphobia

Some people have a panic disorder in addition to agoraphobia. Panic disorder is a type of anxiety disorder in which you experience sudden attacks of extreme fear that reach a peak within a few minutes and trigger intense physical symptoms (panic attacks). You might think that you're totally losing control, having a heart attack or even dying.

Fear of another panic attack can lead to avoiding similar circumstances or the place where it occurred in an attempt to prevent future panic attacks.

Signs and symptoms of a panic attack can include:

- Rapid heart rate
- Trouble breathing or a feeling of choking
- Chest pain or pressure
- Light-headedness or dizziness
- Feeling shaky, numb or tingling
- Excessive sweating
- Sudden flushing or chills
- Upset stomach or diarrhea
- Feeling a loss of control

Etiology

Biological Factors —

including health conditions and genetics — temperament, environmental stress and learning experiences may all play a role in the development of agoraphobia.

This type of agoraphobia can be triggered by a number of different irrational fears (phobias), such as the fear of: being a victim of violent crime or a terrorist attack if you leave your house. becoming infected by a serious illness if you visit crowded places.

Psychological factors

Psychological factors that increase your risk of developing agoraphobia include:

- a traumatic childhood experience, such as the death of a parent or being sexually abused
- experiencing a stressful event, such as bereavement, divorce, or losing your job
- a previous history of mental illnesses, such as depression, anorexia nervosa, or bulimia
- alcohol misuse or drug misuse
- being in an unhappy relationship, or in a relationship where your partner is very controlling

Conclusion

Agoraphobia is an anxiety disorder that causes excessive fear of certain situations. Some people may even resist leaving home. With medication, cognitive behavioral therapy and lifestyle changes, patients can overcome the disorder and participate in things they enjoy. The earlier the condition is diagnosed, the better the treatments will work.

Specific Phobias

Introduction

Fear is a natural emotion triggered by the brain in response to situations that it considers dangerous. Fear protects us from danger, or at least allows us to calculate the risks of a scary situation and take precautions. A phobia is an exaggerated and intense version of fear that leads us to feel extreme anxiety in certain settings (or avoid them altogether) even though the situation poses little or no danger. While occasional fear can protect us, phobias can greatly interfere with your quality of life.

Phobia is a displacement of Anxiety.

Phobia has a protective value. Specific phobias are an overwhelming and unreasonable fear of objects or situations that pose little real danger but provoke anxiety and avoidance. Unlike the brief anxiety you may feel when giving a speech or taking a test, specific phobias are long lasting, cause intense physical and psychological reactions, and can affect your ability to function normally at work, at school or in social settings.

Specific phobias are among the most common anxiety disorders, and not all phobias need treatment. But if a specific phobia affects your daily life, several therapies are available that can help you work through and overcome your fears — often permanently.

Symptoms

A specific phobia involves an intense, persistent fear of a specific object or situation that's out of proportion to the actual risk. There are many types of phobias, and it's not unusual to experience a specific phobia about more than one object or situation. Specific phobias can also occur along with other types of anxiety disorders.

Common categories of specific phobias are a fear of:

- Situations, such as airplanes, enclosed spaces or going to school
- Nature, such as thunderstorms or heights

- Animals or insects, such as dogs or spiders
- Blood, injection or injury, such as needles, accidents or medical procedures
- Others, such as choking, vomiting, loud noises or clowns

Each specific phobia is referred to by its own term. Examples of more common terms include acrophobia for the fear of heights and claustrophobia for the fear of confined spaces.

No matter what specific phobia you have, it's likely to produce these types of reactions:

An immediate feeling of intense fear, anxiety and panic when exposed to or even thinking about the source of your fear

Awareness that your fears are unreasonable or exaggerated but feeling powerless to control them

Worsening anxiety as the situation or object gets closer to you in time or physical proximity

Doing everything possible to avoid the object or situation or enduring it with intense anxiety or fear

Difficulty functioning normally because of your fear

Physical reactions and sensations, including sweating, rapid heartbeat, tight chest or difficulty breathing

Feeling nauseated, dizzy or fainting around blood or injuries

In children, possibly tantrums, clinging, crying, or refusing to leave a parent's side or approach their fear

Types of Phobias

Acro phobia- Fear of high places.

Agora phobia- Fear of open Places.

Claustra phobia – Fear of closed places.

Algo phobia- Fear of pain.

Hemato phobia- Fear of blood.

Miso phobia- Fear of germs.

Astra phobia- Fear of Storms.

Nicto phobia- Fear of Darkness.

Occulo Phobia- Fear of Crowd.

Patho phobia- Fear of Disease.

Pyro phobia – Fear of Fire

Syphilo Phobia – Fear of Syphilis

Hydro Phobia- Fear of Water

Zoo phobia- Fear of Animals

Associated Symptoms: -

Headache, pain, stomach upset, obsessive fear. Writer's Cramp.

Specific phobias are an overwhelming and unreasonable fear of objects or situations that pose little real danger but provoke anxiety and avoidance. Unlike the brief anxiety you may feel when giving a speech or taking a test, specific phobias are long lasting, cause intense physical and psychological reactions, and can affect your ability to function normally at work, at school or in social settings.

Specific phobias are among the most common anxiety disorders, and not all phobias need treatment. But if a specific phobia affects your daily life, several therapies are available that can help you work through and overcome your fears — often permanently.

Epidemiology

Studies indicate that the lifetime prevalence of specific phobias around the world ranges from 3% to 15%, with fears and phobias concerning heights and animals being the most common. The cross-national lifetime and 12-month prevalence rates of specific phobia were, respectively, 7.4% and 5.5%, being higher in females (9.8% and 7.7%) than in males (4.9% and 3.3%) and higher in high and higher-middle income countries than in low/lower-middle income countries. The median age of onset was young (8 years). Of the 12-month patients, 18.7% reported severe role impairment (13.3%–21.9% across income groups) and 23.1% reported any treatment (9.6%–30.1% across income groups). Lifetime comorbidity was observed in 60.2% of those with lifetime specific phobia, with the onset of specific phobia preceding the other disorder in most cases (72.6%). Interestingly, rates of impairment, treatment-use and comorbidity increased with the number of fear subtypes.

Etiology

The reasons why phobias develop are not fully understood. Specific phobias tend to begin in children, whose developing brains are still developing patterns about how to respond to the world around them. A common example of this is a child who develops a phobia of dogs after being bitten by one, but there are many more subtle ways that a child's brain can take in information that teaches them to fear something. For example, they could learn to fear a dog by watching a movie that features a scary dog or watch a family member flinch in response to a dog's bark.

Still, experiences in childhood are only one of many potential reasons why one may go on to develop a specific phobia. Genetics may also play a role.

Many specific phobias may be due to a complex interplay between genetics and life experiences. The same goes for social anxiety disorders and agoraphobia. Teens are more vulnerable to developing social anxiety disorders, likely because the teen years are marked by hormonal changes and new social pressures. Agoraphobia and panic disorders have a lot of overlap, and they both tend to start in young adulthood.

Specific Phobia Risk Factors

Risk factors for developing a specific phobia are temperamental, environmental, and genetic. For instance, negative affectivity (a propensity to feel negative emotions such as disgust, anger, fear, or guilt) or behavioral inhibition are temperamental risk factors for a variety of anxiety disorders, including specific phobias.

Parental overprotectiveness, physical and sexual abuse and traumatic encounters are examples of environmental risk factors that increase the likelihood of an individual developing a specific phobia.

There may also be a genetic susceptibility to a certain category of a specific phobia; for example, if an individual has an immediate relative with a specific situational phobia of flying, the individual is more likely to have the same specific phobia than any other category of phobia.

Conclusion

Specific phobia is an intense, irrational fear of something that poses little or no actual danger. Although adults with phobias may realize that these fears are irrational, even thinking about facing the feared object or situation brings on severe anxiety symptoms.

Selective mutism:

A somewhat rare disorder associated with anxiety is selective mutism. Selective mutism occurs when people fail to speak in specific social situations despite having normal language skills. Selective mutism usually occurs before the age of 5 and is often associated with extreme shyness, fear of social embarrassment, compulsive traits, withdrawal, clinging behavior, and temper tantrums. People diagnosed with selective mutism are often also diagnosed with other anxiety disorders.

3.3 Obsessive Compulsive Disorder (OCD): -

Introduction

It is also known as Obsessive Compulsive Neurosis (OCN). Anxiety and anxiety associated symptoms are so much prevalent in this disorder. The symptoms can reduce anxiety. In this disorder, obsession or compulsion either or both may present. It is a stressful experience to the individual. It interferes significantly with everyday life activities. The symptoms which the patient manifests are persistent, repetitive and unwanted thoughts and images. These are quite illogical or senseless to the individual.

Clinical Features: -

It may be obsessive ideas, images, convictions, rumination, impulses and fear.

Ideas-

repetitive thoughts interrupt normal train of thoughts. These are often words, phrases, or rhythm etc. Images are repetitive, vivid visual imagination. These may be violent in nature, may be sexual or disgusting to the patients. Sometimes hallucination and delusion- insight is not there.

Conviction: -

Thoughts based on magical ideas gives the patient both pain and disbelief.

Rumination: -

Prolonged inconclusive thinking about unanswerable questions. These are metaphysical questions, aimless thoughts.

Impulses: -

This is related to resistant, unwanted urges that often injury to self. Or the others. Obsessional fear- it typically involves disease and contamination even in absence of phobia stimulus. That fear becomes persistent thought to the individual. The action is checking, counting, accounting. Obsessional behavior are categorized are various-rituals in a definite manner, checking and rechecking, sometimes it is associated with numbers.

In addition to anxiety, depression is also formed in OCD. Obsessional traits are also found in the premorbid history of the depressed patients.

Epidemiology of OCD

The prevalence of OCD among general population is 2 to 3%. Among 10% of the patients of Psychiatric Clinics are OCD patients and it is the fourth common psychiatric disorder after phobia, substance-abuse and depression. No variation of prevalence is found among different sexes in adult population but in adolescents, boys are more prone to have OCD compared to girls.

Comorbidity

OCD is associated with Major Depressive Disorder in 67% cases and 25% cases with social phobia. 20 to 30% of OCD cases have tics and Tourette's disorder 5 to 7% cases of prevalence of OCD is there.

Signs and Symptoms

People with OCD may have symptoms of obsessions, compulsions, or both. These symptoms can interfere with all aspects of life, such as work, school, and personal relationships.

Obsessions are repeated thoughts, urges, or mental images that cause anxiety. Common symptoms include:

- Fear of germs or contamination
- Unwanted forbidden or taboo thoughts involving sex, religion, or harm
- Aggressive thoughts towards others or self
- Having things symmetrical or in a perfect order
- Compulsions are repetitive behaviors that a person with OCD feels the urge to do in response to an obsessive thought. Common compulsions include:
- Excessive cleaning and/or handwashing
- Ordering and arranging things in a particular, precise way
- Repeatedly checking on things, such as repeatedly checking to see if the door is locked or that the oven is off
- Compulsive counting

Not all rituals or habits are compulsions. Everyone double checks things sometimes. But a person with OCD generally heck more than usual times. Can't control his or her thoughts or behaviors, even when those thoughts or behaviors are recognized as excessive.

Spends at least 1 hour a day on these thoughts or behaviors

Doesn't get pleasure when performing the behaviors or rituals, but may feel brief relief from the anxiety the thoughts cause

Experiences significant problems in their daily life due to these thoughts or behaviors

Some individuals with OCD also have a tic disorder. Motor tics are sudden, brief, repetitive movements, such as eye blinking and other eye movements, facial grimacing, shoulder shrugging, and head or shoulder jerking. Common vocal tics include repetitive throat-clearing, sniffing, or grunting sounds.

Symptoms may come and go, ease over time, or worsen. People with OCD may try to help themselves by avoiding situations that trigger their obsessions, or they may use alcohol or drugs to calm themselves. Although most adults with OCD recognize that what they are doing doesn't make sense, some adults and most children may not realize that their behavior is out of the ordinary. Parents or teachers typically recognize OCD symptoms in children.

If you think you have OCD, talk to your doctor about your symptoms. If left untreated, OCD can interfere in all aspects of life.

Etiology

Much is still unknown about the actual cause of specific phobias. Causes may include:

Negative experiences. Many phobias develop as a result of having a negative experience or panic attack related to a specific object or situation.

Genetics and environment. There may be a link between your own specific phobia and the phobia or anxiety of your parents — this could be due to genetics or learned behavior.

Brain function. Changes in brain functioning also may play a role in developing specific phobias.

Conclusion

It's normal, on occasion, to go back and double-check that the iron is unplugged or worry that you might be contaminated by germs, or even have an occasional unpleasant, violent thought. But if you suffer from obsessive-compulsive disorder (OCD), obsessive thoughts and compulsive behaviors become so consuming they interfere with your daily life. OCD is an anxiety disorder characterized by uncontrollable, unwanted thoughts and ritualized, repetitive behaviors you feel compelled to perform If you have OCD, you probably recognize that your obsessive thoughts and compulsive behaviors are irrational—but even so, you feel unable to resist them and break free.

Like a needle getting stuck on an old record, OCD causes the brain to get stuck on a particular thought or urge. For example, you may check the stove 20 times to make sure it's really turned off because you're terrified of burning down your house, or wash your hands until they're scrubbed raw for fear of germs. While you don't derive any sense of pleasure from performing these repetitive behaviors, they may offer some passing relief for the anxiety generated by the obsessive thoughts.

3.4 Panic Disorders

Introduction

When there is an intense fear and attack of anxiety followed by feeling of uncertainty is called panic disorder. There are recurrent attacks in a day and it is followed by agora phobia. People find it difficult to come out from fear or anxiety.

Epidemiology of Panic Disorder

If an individual's full life span is taken into consideration, panic disorder is of 1 to 4%. If we take 6 months span, panic attacks in men is 0.50 to 1.00% in males and 3.50 to 5.60% in females. Women are 3 to 4 times more prone to have panic attacks compare to men. Among children and adolescents, panic attacks are more common but it has not been properly diagnosed in them.

Comorbidity- panic disorder is commonly associated with other psychiatric disorders. It is closely related to depression, Post Traumatic Stress Disorder (PTSD), anxiety disorders, obsessive compulsive disorder (OCD) and hypochondriasis.

Symptoms of Panic Disorder (DSM-V)

1. Palpitation
2. Sweating
3. Trembling or shaking
4. Shortness of breath
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal distress
8. Feeling of dizziness, light headed, unsteady or faint
9. Chills or heat sensation
10. Paresthesia (numbness)
11. Derealization, depersonalization
12. Fear of losing control or 'going crazy'
13. Fear of dying

Etiology of Panic Disorder

Biological Factors

Some researchers pointed out that dysfunction in non-adrenergic system has been found in those patients. Others opined that dysfunction in both peripheral and central nervous system (CNS) pathways have been found among panic disorder patients. Serotonin dysfunction is quite evident in those patients.

Panic-Inducing Substances-

Carbon dioxide, sodium lactate, sodium bicarbonate is called panic inducing substances or pathogens which trigger panic attacks.

Brain Imaging

MRI reports abnormalities in brain mainly cortical atrophy in right temporal lobe of those patients. In PET studies, it has been shown that dysfunction in the central blood flow.

Genetic Factors

Research studies showed that panic disorders are common amongst first degree relatives. In twin studies, it has been found that MZ twins are more prone to have panic disorders compared to DZ twins.

Psychosocial Factors

Freudian View-

According to him, Panic attacks come from unrepressed libidinal impulses break into parts and ego fails to control it and piecemeal recurrent panic attacks occur.

Learning Theory

According to this theory, panic disorder is the result of learned helplessness. Person becomes helpless to avail the desired goal, after recurrent failures, he/she feels helpless and it is conditioned.

Conclusion

Panic attacks can happen anytime, anywhere, and without warning. You may live in fear of another attack and may avoid places where you have had an attack. For some people, fear takes over their lives and they cannot leave their homes.

Panic disorder is more common in women than men. It usually starts when people are young adults. Sometimes it starts when a person is under a lot of stress. Most people get better with treatment. Therapy can show you how to recognize and change your thinking patterns before they lead to panic. Medicines can also help.

3.5 Post-Traumatic Stress Disorder (PTSD)

Introduction

In recent years we have heard a great deal about the severe and long-lasting emotional disorders that can occur after a variety of traumatic events. Perhaps the most impressive traumatic event is war, but emotional disorders also occur after physical assault (particularly rape), car accidents, natural catastrophes or the sudden death of a loved one. The emotional disorder that follows a trauma is known as Post Traumatic Stress Disorder (PTSD). PTSD was first named in 1980 in DSM III (APA 1980). DSM-V describes the setting event for PTSD as expressing a stressful incident during which one feels fear, helplessness or horror. Afterwards, victims re-experience the event through memories and nightmares. When memories occur very suddenly and the patient tries to relive within the event, they are having a flashback. Patients negate anything which recall the trauma. They display a qualitative withholding or numbing of emotional expressions, which may be very disruptive to interpersonal relationships. They are occasionally incapable to recollect some portions of the incident. It is possible that the victims unknowingly try not to show the experience of emotion, like people with panic disorder, because intense emotion could bring back memories of the trauma. Finally, victims typically or chronically over stimulated, normally surprised and rush to aggression (Barlow,1988)

Epidemiology

Many different types of traumas have been found to result in PTSD. These types and the proportion of PTSD cases they make up include:

●Sexual relationship violence – 33 percent (e.g., rape, childhood sexual abuse, intimate partner violence).

●Interpersonal-network traumatic experiences – 30 percent (e.g., unexpected death of a loved one, life-threatening illness of a child, other traumatic event of a loved one).

●Interpersonal violence – 12 percent (e.g., childhood physical abuse or witnessing interpersonal violence, physical assault, or being threatened by violence).

●Exposure to organized violence – 3 percent (e.g., refugee, kidnapped, civilian in war zone).

●Participation in organized violence – 11 percent (e.g., combat exposure, witnessing death/serious injury or discovered dead bodies, accidentally or purposefully caused death or serious injury).

●Other life-threatening traumatic events – 12 percent (e.g., life-threatening motor vehicle collision, natural disaster, toxic chemical exposure).

Epidemiologic studies show that prevalence of trauma and posttraumatic stress disorder (PTSD) is substantial in modern society. Most people will experience a traumatic event at some point in their life, and up to 25% of them will develop the disorder.

Symptoms

Post-traumatic stress disorder symptoms may start within one month of a traumatic event, but sometimes symptoms may not appear until years after the event. These symptoms cause significant problems in social or work situations and in relationships. They can also interfere with your ability to go about your normal daily tasks.

PTSD symptoms are generally grouped into four types: intrusive memories, avoidance, negative changes in thinking and mood, and changes in physical and emotional reactions. Symptoms can vary over time or vary from person to person.

Intrusive memories

- Symptoms of intrusive memories may include:
- Recurrent, unwanted distressing memories of the traumatic event
- Reliving the traumatic event as if it were happening again (flashbacks)
- Upsetting dreams or nightmares about the traumatic event
- Severe emotional distress or physical reactions to something that reminds you of the traumatic event

Avoidance

- Symptoms of avoidance may include:
- Trying to avoid thinking or talking about the traumatic event
- Avoiding places, activities or people that remind you of the traumatic event

Negative changes in thinking and mood

- Symptoms of negative changes in thinking and mood may include:
- Negative thoughts about yourself, other people or the world
- Hopelessness about the future
- Memory problems, including not remembering important aspects of the traumatic event
- Difficulty maintaining close relationships
- Feeling detached from family and friends
- Lack of interest in activities you once enjoyed

- Difficulty experiencing positive emotions
- Feeling emotionally numb

Changes in physical and emotional reactions

Symptoms of changes in physical and emotional reactions (also called arousal symptoms) may include:

- Being easily startled or frightened
- Always being on guard for danger
- Self-destructive behavior, such as drinking too much or driving too fast
- Trouble sleeping
- Trouble concentrating
- Irritability, angry outbursts or aggressive behavior
- Overwhelming guilt or shame

For children 6 years old and younger, signs and symptoms may also include:

- Re-enacting the traumatic event or aspects of the traumatic event through play
- Frightening dreams that may or may not include aspects of the traumatic event

Older children and teens are more likely to show symptoms similar to those seen in adults. They may also develop disruptive, disrespectful, or destructive behaviors. Older children and teens may feel guilty for not preventing injury or deaths. They may also have thoughts of revenge.

Intensity of symptoms

PTSD symptoms can vary in intensity over time. You may have more PTSD symptoms when you're stressed in general, or when you come across reminders of what you went through. For example, you may hear a car backfire and relive combat experiences. Or you may see a report on the news about a sexual assault and feel overcome by memories of your own assault.

PTSD includes a variety of symptoms ranging from hyper arousal, anxiety, depressive mood, low frustration tolerance, insomnia, headache, aggressiveness, emotional instability, low self-esteem.

To meet a diagnosis of Acute PTSD, symptoms must occur between 2 and 4 weeks after the traumatic experience. If the symptoms persist after 4 weeks, then a diagnosis of Acute PTSD should be considered. If the symptoms persist after 6 months, it is registered as Chronic PTSD (Tsabery,2005)

Risk of PTSD

If anyone had anxiety or depression in the past and did not get support from family and closed one, they are susceptible to PTSD. If parents have mental health problems, it has an increased probability of getting PTSD. Some factors that increase risk for PTSD include:

- Living through dangerous events and traumas.
- Getting hurt.
- Seeing another person hurt, or seeing a dead body.
- Childhood trauma.
- Feeling horror, helplessness, or extreme fear.
- Having little or no social support after the event.

Etiology of PTSD

PTSD may originate among the individual after the occurrence of stressful, frightening or disturbing event and also a prolonged traumatic experience which include-

1. Serious accidents

2. Physical or sexual assault
3. Child abuse or domestic abuse
4. Exposure to traumatic events at work
5. Serious health issues
6. Child birth; losing a baby
7. War or conflict

Survival Mechanism-

It is said that PTSD symptoms are the product of instinctive mechanism for helping individual to be prepared for further trauma. But actually, this preparedness is not at all healthy in reality which mat deteriorate physical and mental functioning of the individual.

High Adrenaline Levels-

High release of stress hormones like adrenaline stimulates a reaction in the victim's body which causes hyper arousal and at the same time emotional numbness.

Changes in the Brain-

It has been found among the victims of PTSD that their hippocampus is smaller in size which depicts the malfunctioning of hippocampus due to recurrent flashback.

Can post-traumatic stress disorder (PTSD) be prevented?

There are certain factors that can help reduce the risk of developing PTSD. These are known as resilience factors, and they include

- Seeking out support from other people, such as friends, family, or a support group
- Learning to feel good about your actions in the face of danger
- Having a coping strategy or a way of getting through the bad event and learning from it
- Being able to act and respond effectively despite feeling fear

Researchers are studying the importance of the resilience and risk factors for PTSD. They are also studying how genetics and neurobiology can affect the risk of PTSD. With more research, someday it may be possible to predict who is likely to develop PTSD. This could also help in finding ways to prevent it.

Conclusion

PTSD is a serious disorder that results from exposure to a traumatic event. The concept was formulated during the Vietnam War. An event is considered traumatic if it is extreme, death threatening or causes serious injury, and the response involves severe fear, helplessness and horror. Clearly our patient experienced a major traumatic event.

Most people who go through traumatic events may have temporary difficulty adjusting and coping, but with time and good self-care, they usually get better. If the symptoms get worse, last for months or even years, and interfere with your day-to-day functioning, you may have PTSD.

People with PTSD have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear or anger; and they may feel detached or estranged from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

A diagnosis of PTSD requires exposure to an upsetting traumatic event. However, the exposure could be indirect rather than first hand. For example, PTSD could occur in an individual learning about the violent death of a close family or friend. It can also occur as a result of repeated exposure to horrible details of trauma such as police officers exposed to details of child abuse cases.

Summary

Anxiety is a normal emotion. It's your brain's way of reacting to stress and alerting you of potential danger ahead.

Everyone feels anxious now and then. For example, you may worry when faced with a problem at work, before taking a test, or before making an important decision.

Occasional anxiety is OK. But anxiety disorders are different. They're a group of mental illnesses that cause constant and overwhelming anxiety and fear. The excessive anxiety can make you avoid work, school, family get-togethers, and other social situations that might trigger or worsen your symptoms.

If you have an anxiety disorder, you may respond to certain things and situations with fear and dread. You may also experience physical signs of anxiety, such as a pounding heart and sweating.

It's normal to have some anxiety. You may feel anxious or nervous if you have to tackle a problem at work, go to an interview, take a test or make an important decision. And anxiety can even be beneficial. For example, anxiety helps us notice dangerous situations and focuses our attention, so we stay safe

Anxiety disorders are a type of mental health condition. Anxiety makes it difficult to get through your day. Symptoms include feelings of nervousness, panic and fear as well as sweating and a rapid heartbeat. Treatments include medications and cognitive behavioral therapy.

Keywords

Generalized Anxiety Disorder, Panic disorder, Agora phobia, Epidemiology, repression, Genetic loading, hypochondriasis, obsessive compulsive disorder, Selective mutism, comorbidity, Avoidance learning.

Self-Assessment

1. DSM-V has classified five types of anxiety disorders (T/F).
2. Men are more prone to have anxiety than women (T/F).
3. Broken sleep is a symptom of anxiety disorder (T/F).
4. Anxiety is a failed repression (T/F).
5. Phobia is a displacement of anxiety (T/F).
6. The concept, 'learned helplessness' was given by-------

a. Freud
b. Seligman
c. Brown
d. None of them

7. Which is a panic inducing substance?

a. Oxygen
b. Hydrogen
c. Carbon-dioxide
d. None of them

8. Twin studies of anxiety disorders was conducted by --------

a. Brown

b. Pitts
c. Seligman
d. None of them
9. Panic attack is followed by------
a. Astra phobia
b. Nicto phobia
c. Agora phobia
d. None of them
10. Women are -------- time more prone to panic attacks compared to men.
a. 1 to 2
b. 3 to 4
c. 5 to 6
d. None of them
11. Symptoms of Generalized anxiety disorder was given by------
a. Tyror
b. Pitts
c. Seligman
d. None of them
12. -------- phobia is a fear of pain.
a. Hydro
b. Miso
c. Algo
d. None of them
13. Prolonged inconclusive thinking about unanswerable question is --------
a. Conviction
b. Rumination
c. Compulsion
d. None of them
14. ---------- is responsible for the occurrence of OCD.
a. Dopamine
b. Serotonin
c. Acetylcholine
d. None of them
15. --------- and ---------- are the common defenses in OCD.
a. Isolation, displacement
b. Repression, regression
c. Projection, sublimation
d. None of them

Scoring Key

1T, 2F, 3T, 4T, 5T, 6B, 7C, 8A, 9C, 10B, 11A, 12C, 13B, 14B, 15A

Explanatory Questions

1. Briefly discuss about the clinical features and etiology of anxiety disorder.
2. How Panic disorder is related to agoraphobia?

3. Elucidate the symptoms and causes of OCD.
4. Elaborate different types of phobias with their clinical features.
5. What are the prevalence and symptoms of Agora phobia?
6. Briefly discuss the symptoms and etiology of panic disorder.
7. Elucidate the causes and symptoms of specific phobia.
8. Write about the prevalence and risk factors of specific phobias.
9. What are the causes of Agoraphobia?
10. What is the prevalence of panic disorder?

Further/Suggested Readings

1. Fish's Clinical Psychopathology: Signs and Symptoms by Patricia Casey and Brenden Kelly. 3rd ed. RCPsych Publication.2007.

2. Clinical Psychopathology: A very short Introduction by Susan Llewelyn and Katie Aafjes-van Doom. 1st ed. Oxford University Press,2017.

Mood Disorders

CONTENTS

Objectives

After completion of this chapter, the students will be able to:

- Understand different types of Mood Disorders
- Know the symptoms and cause of these disorders
- Familiarize with the psychiatric implications of these disorders

Introduction

It is characterized by persistent depressed mood, loss of interest in activities, causing significant impairment in daily life activities. Everyone feels sad or low sometimes, but these feelings usually pass with a little time. Depression (also called major depressive disorder or clinical depression) is different. It can cause severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. It is an illness that can affect anyone—regardless of age, race, income, culture, or education. Research suggests that genetic, biological, environmental, and psychological factors play a role in depression.

Depression may occur with other mental disorders and other illnesses, such as diabetes, cancer, heart disease, and chronic pain. Depression can make these conditions worse, and vice versa. Sometimes medications taken for these illnesses cause side effects that contribute to depression symptoms.

4.1 Major & Minor Depressive Disorders- (DSM-V)

1. Major Depressive Disorder (MDD)
2. Persistent Depressive Disorder (PDD)
3. Bipolar Disorder
4. Postpartum Depression (PPD)
5. Premenstrual Dysphoric Disorder (PMDD)

6. Seasonal Affective Disorder (SAD).
7. Atypical Depression
8. Psychotic Depression
9. Situational Depression (Reactive Depression/Adjustment Disorder)
10. Disruptive Mood Dysregulation Disorder (DMDD)

Major Depressive Disorder (Single Episode)

According to DSM-V, there are two distinct categories of Major Depressive Disorder. One category has only one episode of depression and it is going on. In another category, the patient has one episode and then no psychiatric symptoms are found for two months then again depressive episode starts- this is termed as Major Depressive Disorder (Recurrent episodes).

It has been found that single episode patients show depressive symptoms consistently over time and it is facilitated by having relatives of depressive disorders compare to those who do not have relatives of depressive disorders. If affectively ill relatives are there, the patient of Major Depressive Disorder shows more prominence of symptoms compare to those whose relatives have fewer depressive symptoms.

Major Depressive Disorder (Recurrent Episodes)

If the patient shows at least second episode of depression, it can be termed as recurrent. The criteria of diagnosis of recurrent episodes stands that in between two episodes, there should be a gap period where the patient will not show any symptoms of depression or other psychiatric disorders.

Depression symptoms in children and teens

Common signs and symptoms of depression in children and teenagers are similar to those of adults, but there can be some differences.

In younger children, symptoms of depression may include sadness, irritability, clinginess, worry, aches and pains, refusing to go to school, or being underweight.

In teens, symptoms may include sadness, irritability, feeling negative and worthless, anger, poor performance or poor attendance at school, feeling misunderstood and extremely sensitive, using recreational drugs or alcohol, eating or sleeping too much, self-harm, loss of interest in normal activities, and avoidance of social interaction.

Depression symptoms in older adults

Depression is not a normal part of growing older, and it should never be taken lightly. Unfortunately, depression often goes undiagnosed and untreated in older adults, and they may feel reluctant to seek help. Symptoms of depression may be different or less obvious in older adults, such as:

- Memory difficulties or personality changes
- Physical aches or pain
- Fatigue, loss of appetite, sleep problems or loss of interest in sex — not caused by a medical condition or medication
- Often wanting to stay at home, rather than going out to socialize or doing new things
- Suicidal thinking or feelings, especially in older men

Epidemiology

Depression is a common illness worldwide, with more than 264 million people affected. Depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life. Especially when long-lasting and with moderate or severe intensity, depression may become a serious health condition. It can cause the affected person to suffer greatly and function

poorly at work, at school and in the family. At its worst, depression can lead to suicide. Close to 800 000 people die due to suicide every year. Suicide is the second leading cause of death in 15-29-year-olds.

Although there are known, effective treatments for mental disorders, between 76% and 85% of people in low- and middle-income countries receive no treatment for their disorder. Barriers to effective care include a lack of resources, lack of trained health-care providers and social stigma associated with mental disorders.

Risk Factors of Depressive Disorders

Genetics

A history of depression in your family may make it more likely for you to get it. It's thought that the condition can be passed down. The exact way this happens, though, isn't clear.

Death or loss

Sadness and grief are normal reactions. Sometimes, though, such big stresses can bring serious symptoms of depression, like thoughts of suicide or feelings of worthlessness.

Conflict

Personal turmoil or disputes with family or friends may lead to depression.

Abuse

Past physical, sexual, or emotional abuse can bring it on, as well.

Life events

Even good things, like moving or graduating, could make you depressed. Other changes that can do that include:

- A new job
- Loss of employment or income
- Marriage
- Divorce
- Retirement
- Having a baby

Etiology

There is no one single cause for the onset of depression because a combination of genetic, biological, environmental, and psychological factors all play a role. These include:

The brain's physical structure or chemistry

In some people with depression, brain scans indicate a smaller hippocampus, which plays a role in long-term memory. Research shows that ongoing exposure to stress can impair the growth of nerve cells in this part of the brain.

Serotonin levels are out of balance

Here's another thing that's going on in the brain that may be connected, the serotonin receptors act differently than in someone without depression. This is why some of the treatment drugs work with serotonin.

History of depression in the family

Someone with a parent or sibling with MDD has a two or three-times greater risk of developing depression than the average person (or a 20-30% chance vs. 10%).

Genetic code is different

When you're born you get either a short or a long gene from each parent. These are called alleles. It turns out having one or more short ones is linked to having more of a proclivity towards being depressed when something bad happens.

History of other disorders or concurrent mental health conditions

Post-traumatic stress, substance use disorders, and learning disabilities are commonly associated with or can perpetuate depression. Anxiety is a big one: Up to 50% of people who have depression also have an anxiety disorder.

Stressful or major life events

Abuse, financial issues, the death of a loved one, the loss of a job—these situations can all trigger depression. But even positive events like a big move, getting married, graduating, or retiring can make you feel depressed, too. For one these events alter your routine, but they can also trigger feelings that whatever the success or happy occasion is, isn't deserved.

Hormone changes

Menstrual cycles, pregnancy, and giving birth can cause bouts of depression.

Certain physical conditions

Like chronic pain or headaches, show a correlation with—or may spur on—depression.

Certain medication

Like sleeping aids and blood pressure medication, may also cause symptoms of depression.

4.6 Conclusion

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems. You may have trouble doing normal day-to-day activities, and sometimes you may feel as if life isn't worth living.

More than just a bout of the blues, depression isn't a weakness and you can't simply "snap out" of it. Depression may require long-term treatment. But don't get discouraged. Most people with depression feel better with medication, psychotherapy or both.

4.2 Bipolar Disorder

Bipolar-I Disorder

Introduction

According to DSM-V, Bipolar-I Disorder should meet the criteria by the presence of a single Manic phase. This type of disorder was previously known as bipolar disorder with Manic Episode. There should be clear Manic symptoms in Bipolar-I disorder, nothing will be accepted as Manic -like symptoms.

4.3 Manic Disorder

Bipolar-I Disorder (Manic Episode)-

From the criteria of DSM-V, it is evident that Manic symptoms should persist over time, it cannot be included those patients with end of depressive episodes, they are exhibiting Manic Episodes or the patient had a history of Major Depressive Disorder. A person affected by bipolar I disorder has had at least one manic episode in their life. A manic episode is a period of abnormally elevated or irritable mood and high energy, accompanied by abnormal behavior that disrupts life.

Most people with bipolar I disorder also suffer from episodes of depression. Often, there is a pattern of cycling between mania and depression.

Bipolar-I Disorder (Recurrent Episodes)

Here the end of depressive episode also applies- so that after showing Manic symptoms or hypomanic symptoms (which is in case of Bipolar-II disorder) there should be a gap of two months without any symptoms of Mania or Hypomania.

Epidemiology

Epidemiological studies have suggested a lifetime prevalence of around 1% for bipolar type I in the general population. A large cross-sectional survey of 11 countries found the overall lifetime prevalence of bipolar spectrum disorders was 2.4%, with a prevalence of 0.6% for bipolar type I and 0.4% for bipolar type II. Although findings varied across different countries, this suggested a lower prevalence of bipolar type I and II than previous studies

Etiology

The exact cause of bipolar disorder is unknown, but several factors may be involved, such as:

- Biological differences. People with bipolar disorder appear to have physical changes in their brains. The significance of these changes is still uncertain but may eventually help pinpoint causes.
- Genetics. Bipolar disorder is more common in people who have a first-degree relative, such as a sibling or parent, with the condition. Researchers are trying to find genes that may be involved in causing bipolar disorder.

Risk factors

Factors that may increase the risk of developing bipolar disorder or act as a trigger for the first episode include:

- Having a first-degree relative, such as a parent or sibling, with bipolar disorder
- Periods of high stress, such as the death of a loved one or another traumatic event
- Drug or alcohol abuse.

Complications

Left untreated, bipolar disorder can result in serious problems that affect every area of your life, such as:

- Problems related to drug and alcohol use
- Suicide or suicide attempts
- Legal or financial problems
- Damaged relationships
- Poor work or school performance

Co-occurring conditions

If you have bipolar disorder, you may also have another health condition that needs to be treated along with bipolar disorder. Some conditions can worsen bipolar disorder symptoms or make treatment less successful. Examples include:

- Anxiety disorders
- Eating disorders
- Attention-deficit/hyperactivity disorder (ADHD)

- Alcohol or drug problems
- Physical health problems, such as heart disease, thyroid problems, headaches or obesity

Conclusion

It is possible to lower the risk of episodes of mania or depression once bipolar disorder has developed. Regular therapy sessions with a psychologist or social worker can help people to identify factors that can destabilize mood (such as poor medication adherence, sleep deprivation, drug or alcohol abuse, and poor stress management), leading to fewer hospitalizations and feeling better overall. Taking medicine on a regular basis can help to prevent future manic or depressive episodes.

Bipolar-II Disorder-

Introduction

Bipolar II disorder (pronounced "bipolar two") is a form of mental illness. Bipolar II is similar to bipolar I disorder, with moods cycling between high and low over time.

However, in bipolar II disorder, the "up" moods never reach full-blown mania. The less-intense elevated moods in bipolar II disorder are called hypomanic episodes, or hypomania.

Here the hypomanic symptoms are being taken care of including its vigor, frequency and duration. The characteristics of this disorder differentiate patients with Major Depressive Disorder and restricts overdiagnosis of hypomanic disorder.

A person affected by bipolar II disorder has had at least one hypomanic episode in their life. Most people with bipolar II disorder suffer more often from episodes of depression. This is where the term "manic depression" comes from.

In between episodes of hypomania and depression, many people with bipolar II disorder typically live normal lives.

Epidemiology

In the past 5 years, several important studies have been conducted in the bipolar II field. The World Mental Health Survey initiative provides us with prevalence rate across 11 countries, while several meta-analyses on suicide and neurocognition directly compared bipolar I with bipolar II, informing us on the severe consequences of bipolar II disorder. Results from studies showed that the lifetime prevalence rate of bipolar II disorder in adults across 11 countries was 0.4%. Rates of bipolar II disorder in prospective studies of adolescents are substantially greater, with lifetime rates approaching 3-4%.

Symptoms of Bipolar-II Disorder

Symptoms with Psychotic Features-

If the patient has psychotic features of mood congruence, it will go with mood disorder and psychotic features with mood incongruence will go with schizoaffective disorder.

These characteristics are linked with poor prognosis of mood disorder patients. It also relates long duration episodes and poor premorbid history of adjustment.

Symptoms with Melancholic Features

The term 'Melancholia' was used by Hippocrates in 4th Century which characterizes negative mood of depression. Nowadays also it is featured as severe anhedonia, early morning awaking, weight loss, guilt feeling but no suicidal ideation is there. It also shows changes in autonomic nervous system and endocrine functions. It sometimes refers to as 'endogenous depression' which arises without any precipitating factors. These features are included in Major Depressive Disorder, Bipolar-I and Bipolar II disorders.

Symptoms with Atypical Features

Some typical features like overeating, oversleeping is present in depressive patients. In DSM-V, these features have been included in Bipolar-I, Bipolar-II, Major Depressive Disorder and dysthymic disorder.

Rapid Cycling

Females are showing more rapid cycling of symptoms of Bipolar-I and Bipolar-II disorder. According to DSM-V, the patient should have minimum four episodes within twelve months.

Etiology

The exact cause of bipolar disorder is unknown. Experts believe there are a number of factors that work together to make a person more likely to develop it.

These are thought to be a complex mix of physical, environmental and social factors.

Chemical imbalance in the brain

Bipolar disorder is widely believed to be the result of chemical imbalances in the brain.

The chemicals responsible for controlling the brain's functions are called neurotransmitters, and include noradrenaline, serotonin and dopamine.

There's some evidence that if there's an imbalance in the levels of 1 or more neurotransmitters, a person may develop some symptoms of bipolar disorder.

For example, there's evidence that episodes of mania may occur when levels of noradrenaline are too high, and episodes of depression may be the result of noradrenaline levels becoming too low.

Genetics

It's also thought bipolar disorder is linked to genetics, as it seems to run in families.

The family members of a person with bipolar disorder have an increased risk of developing it themselves.

But no single gene is responsible for bipolar disorder. Instead, a number of genetic and environmental factors are thought to act as triggers.

Conclusion

If left untreated, bipolar disorder usually worsens. However, with a good treatment plan including psychotherapy, medications, a healthy lifestyle, a regular schedule and early identification of symptoms, many people live well with the condition.

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4.4 Disruptive Mood Dysregulation Disorder

Disruptive mood dysregulation disorder (DMDD) is a condition in which a child is chronically irritable and experiences frequent, severe temper outbursts that seem out of proportion to the situation at hand. Children diagnosed with DMDD struggle to regulate their emotions in an age-appropriate way. In between outbursts they are irritable most of the time.

DMDD is a new disorder created to more accurately diagnose children who were previously diagnosed with pediatric bipolar disorder, even though they did not experience the episodic mania or hypomania characteristic of bipolar disorder.

This disorder was first identified in DSM-V. It characterizes with aggression, frequent outburst and severe irritability. It is most common with children and adolescents. They express irritation in home, school and with peers. As a consequence of their symptoms, they have to face severe problems like suspension from school, hospitalization and so on.

Diagnostic Criteria (DSM-V)

(1) severe, recurrent (≥3 times/week) temper outbursts (verbally and/or behaviorally) that are grossly out of proportion in intensity or duration to the situation, and inconsistent with the developmental level;

(2) the mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and observable by others;

(3) the symptoms must be present for 12 or more months, with no more than 3 consecutive months of symptom-free period;

(4) the symptoms/behaviors must be present at least in two of three settings (i.e., at home, at school, with peers), and to a severe degree at least in one setting;

(5) the diagnosis should not be made for the first time before age 6 years or after 18 years; and

(6) by history or observation, the age at onset is before 10 years.

Epidemiology

Three-month prevalence rates for meeting criteria for disruptive mood dysregulation disorder ranged from 0.8% to 3.3%, with the highest rate in preschoolers. Rates dropped slightly with the strict application of the exclusion criterion, but they were largely unaffected by the application of onset and duration criteria. Disruptive mood dysregulation co-occurred with all common psychiatric disorders. The highest levels of co-occurrence were with depressive disorders (odds ratios between 9.9 and 23.5) and oppositional defiant disorder (odds ratios between 52.9 and 103.0). Disruptive mood dysregulation occurred with another disorder 62%-92% of the time, and it occurred with both an emotional and a behavioral disorder 32%-68% of the time. Affected children displayed elevated rates of social impairments, school suspension, service use, and poverty.

DMDD is thought to occur more often in boys than girls.

Etiology

Proper etiology is not clear in this disorder but different determinants have a significant role in this disorder which include genetical, temperamental, coexisting psychological conditions and experiences in childhood.

This disorder is preferably seen in pre-school years and also co-existing with other psychological disorders such as depressive disorders and oppositional defiant disorder.

Some personality traits of the kids are susceptible to develop this disorder-

1. Irritability
2. Moody behavior
3. Anxiety

Other psychological factors also important for the development of this disorder, like-

1. Lack of support from parents
2. If parents are hostile and substance user
3. Conflicts in the family
4. Issue of discipline in school set up

DMDD: Risk Factors

Children with a history of chronic irritability are more likely to be diagnosed with disruptive mood dysregulation disorder. This includes children who from a very young age have struggled to deal with frustration or adapt to change without losing their temper.

Sometimes children with an earlier diagnosis of ADHD or anxiety can get an alternative or additional diagnosis of DMDD.

Conclusion

Disruptive mood dysregulation disorder is relatively uncommon after early childhood, frequently co-occurs with other psychiatric disorders, and meets common standards for psychiatric "caseness." This disorder identifies children with severe levels of both emotional and behavioral dysregulation.

The treatment for DMDD will be individualized to the needs of the particular child and his or her family. It may include individual therapy, as well as work with the child's family and/or school. It may also include the use of medication to help address specific symptoms.

Parents of children with DMDD should learn as much as they can about the disorder. They should ask lots of questions about the risks and benefits of specific treatment options before deciding what is best for their child. If they have questions or concerns about the diagnosis or treatment alternatives, they should always feel free to get a second opinion.

Having a child with DMDD can be a challenging experience. Appropriate treatment for your child is important. However, it is also important to make sure you have the information, support, and assistance you need.

4.5 Premenstrual Dysphoric Disorder

Introduction

This disorder is seen among women in the preceding weeks of their menstruation which include severe headaches, excessive worries, depressive moods and fluctuation of mood. Ideas of suicide are also common in this disorder. Remission of symptoms occur after some days of initiation of menstruation flow but these symptoms hamper normal life activities. It is prevalent with 10% of women with menstruation.

Premenstrual syndrome, the recurrent luteal phase deterioration in quality of life due to disruptive physical and psychiatric symptomatology, is a distinct clinical condition caused by an abnormal central nervous system response to the hormonal changes of the female reproductive cycle. Better definition and research based on strict inclusion/ exclusion criteria have allowed the development of successful treatments that are tailored to the severity of the lifestyle disruption and the specific individual constellation of symptoms. Charting and simple lifestyle changes may improve coping skills for many women. However, more severely affected individuals often require medical interventions to augment central serotonin/ norepinephrine levels or to suppress the hormonal changes of the menstrual cycle.

Risk Factors

Health Risk Factors

Some women are more susceptible to mood changes during hormonal fluctuation due to a combination of genetics, stress, and chronic medical conditions.

Genetics

There is a genetic basis for the hormonal sensitivities that appear to be at work in PMDD. Researchers at the National Institute of Health found that women with PMDD have changes in one of the gene complexes that control how they respond to estrogen and progesterone.

This discovery can be extremely validating if you have PMDD. It gives concrete scientific evidence that something biological and beyond your control is causing your mood changes.

Immune Activation and Inflammation

Mood disorders are linked to the immune system. Infections and other causes of systemic inflammation can trigger a worsening of symptoms in patients with mental health issues.

Early research in this area suggests that women with more significant premenstrual symptoms may have an increased inflammatory response during the luteal phase compared to women with minimal symptoms. The link between PMDD and inflammation, however, is still unclear.

Stress

This may help explain why some, but not all, women with PMDD also have a history of significant stress exposure, such as childhood physical, emotional, or sexual abuse.8 Chronic everyday stress can also trigger symptoms or make them worse.

The correlation between stress and worsening PMDD symptoms is currently an area of active investigation. Certainly, the possibility of a connection between your stress response and PMDD supports the common sense first-line treatment interventions for PMDD, including lifestyle modifications and stress reduction.

History of Mood Disorders

Research shows that 50% of women diagnosed with PMDD also have an anxiety disorder, compared with 22% of women without PMDD. In addition, 30% of women with PMDD were also diagnosed with depressive disorder, compared to 12% of women without PMDD.

Having a family history of mood disorders increases the likelihood of PMDD as well.

Smoking

Cigarette smoking is linked to an increased risk of severe PMS and PMDD, according to a study published in the American Journal of Epidemiology.

Researchers tracked more than 3,000 women ages 27 to 44 over 10 years and found that those with a history of smoking were twice as likely to develop PMS than those who never smoked. What's more, those who started smoking before age 15 were 2.5 times more likely. PMDD risk may follow suit

Epidemiology

Premenstrual dysphoric disorder (PMDD), as defined by the American Psychiatric Association (APA) Diagnostic and Statistical Manual, Fifth Edition (DSM-5), can be differentiated from premenstrual syndrome (PMS) by the presence of at least five symptoms, including one affective symptom, such as mood swings, irritability, and/or depression. Although it is common to have one or a few premenstrual symptoms, clinically significant PMS occurs in only 3 to 8 percent of women, while PMDD affects approximately 2 percent of women.

Symptoms of Premenstrual Dysphoric Disorder

These signs and symptoms start one or two weeks before menstruation and stops after some days when menstruation occurs. These are-

1. Expression of angry mood
2. Excessive worries, anxiety and panic attacks
3. Symptoms of depression and suicidal ideas
4. Lack of concentration
5. Fatigability and lack of initiation
6. Craving for food or binge eating
7. Headache
8. Fluctuation of mood
9. Lack of sleep

Etiology

The real cause of Premenstrual Dysphoric Disorder is still unknown. If the female hormone, estrogen and progesterone lower down after ovulation and before the initiation of menstruation may facilitate this disorder. It has been observed that serotonin level disrupts during menstruation which is responsible for the controlling of mood, hunger and sleep pattern.

The etiology of PMDD is an active area of investigation. Potential biological contributors include central nervous system (CNS) sensitivity to reproductive hormones, genetic factors, and psychosocial factors such as stress. The timing of symptom onset and offset in PMDD suggests that hormonal fluctuation is a key component in PMDD's pathogenesis. Paradoxically, women with PMDD cannot be distinguished from asymptomatic women in terms of peripheral ovarian hormone levels. Instead, recent research suggests that women with PMDD have altered sensitivity to normal hormonal fluctuations, particularly estrogen and progesterone, neuroactive steroids that influence CNS function.

Conclusion

Premenstrual dysphoric disorder (PMDD) is a health problem that is similar to premenstrual syndrome (PMS) but is more serious. PMDD causes severe irritability, depression, or anxiety in the week or two before period starts. Symptoms usually go away two to three days after period starts. One may need medicine or other treatment to help with symptoms.

Recently designated as a disorder in the DSM-5, premenstrual dysphoric disorder (PMDD) presents an array of avenues for further research. PMDD's profile, characterized by cognitive–affective symptoms during the premenstrual, is unique from that of other affective disorders in its symptoms and cyclicity. Neurosteroids may be a key contributor to PMDD's clinical presentation and etiology, and represent a potential avenue for drug development. This review will present recent literature on potential contributors to PMDD's pathophysiology, including neurosteroids and stress, and explore potential treatment targets.

The subspecialties of psychiatry and gynecology have developed overlapping but distinct diagnoses that qualify as a premenstrual disorder; these include premenstrual syndrome and premenstrual dysphoric disorder. These conditions encompass psychological and physical symptoms that cause significant impairment during the luteal phase of the menstrual cycle, but resolve shortly after menstruation. Patient-directed prospective recording of symptoms is helpful to establish the cyclical nature of symptoms that differentiate premenstrual syndrome and premenstrual dysphoric disorder from other psychiatric and physical disorders. Physicians should tailor therapy to achieve the greatest functional improvement possible for their patients. Select serotonergic antidepressants are first-line treatments. They can be used continuously or only during the luteal phase. Oral contraceptives and calcium supplements may also be used. There is insufficient evidence to recommend treatment with vitamin D, herbal remedies, or acupuncture, but there are data to suggest benefit from cognitive behavior therapy.

Etiology of Mood Disorders

Endocrinological factors

Many studies showed that depression may occur due to cyclic variation, menstrual complaints (Penal,1963). At the menopausal stage some of the female complaints of depression.

Early developmental contribution

Parental death, separation, deprivation and overprotection can cause depression. Analytical investigation claims that adult depressive reaction is an expression of intense distortion of childhood experience (Jacobson,1985). Spitz et. al (1986) reported that infants deprived of maternal interaction developed sadness and withdrawal behavior.

Psycho-analytic Theory

Freud's major contribution was an analysis of the differentiation between grief and depression. Grief occurs over time in uncomplicated cases grief moves through a sequence of shock and characteristic symptoms occur. This process of grief movement involves gradual relinquishment

(passing of) of the intense attachment of the lost object and reappearance of the interest in the capacity for new relationship (Buss- Psychopathology).

Depression on the other hand is characterized by miscarriage

The melancholic is unable to move to a new attachment successfully. Sometimes mood off to the proportionate to the loss. Total surrender to the lost object. Environmental change affects the ego, super ego bites him negatively. He does not have any self-regard and starts helplessness. He does not get any support from conscience. It is as if the loss object has taken up residence within the ego. According to Freud, depressives show a tone of both anger toward a significant person in his life and angry criticism of a significant person towards him (Freud, Scope of Psychotherapy).

Depression and Self –esteem

Injury of one sense of personal warmth leads to a feeling of inferiority and worthlessness. Most superimposed feeling of helplessness leads to a feeling of loss of self-esteem. High self-aspirations are noted among these persons and most of the cases failure to keep up their aspirations. According to the Freudian thinkers, these aspirations are of different nature. It may be said that in the form of oral dependent, the wish to be loved. It may be anal aggressiveness- i.e., wish to be loving, good, clean. It may be phallic desire-Wish to be admire, strong, independent. Depression occurs when he fails in fulfilling those desires and wishes.

Learning Theory

Depression is a learned helplessness (Seligman,1976). Depression is learned from the society. From childhood the individual believes that he cannot control elements of life. he fails in exerting himself. From this he learns that he cannot control those elements of life that can provide himself relief and gratification. He develops a definite cognitive model which from family and other social interactions. He feels helpless. A negative concept of the past and a negative approval of the future. As a result of these negative feelings, withdrawal happens.

Summary

Mood disorders such as depression and bipolar disorder may recur or be ongoing and therefore may require long-term or lifetime treatment. It is important to take medications as prescribed. After starting medications, it may take two to six weeks to begin to notice a change in symptoms. It is advised not to stop medication.

Psychotherapy has been shown to be helpful treatment approach and is often used together with medication or brain stimulation therapy. Minor forms of depression can be treated with psychotherapy alone. Brain stimulation therapies are usually tried when other treatment options have not been successful, in people with severe symptoms, and in those who cannot tolerate the side effects of drug therapy. Every therapy has its potential role, as each patient with a mood disorder is unique.

Keywords

Persistent Depressive Disorder, Bipolar Disorder, morbid thoughts, recurrent episodes, epidemiology, Bipolar-I disorder, Bipolar-II disorder, Manic episodes, etiology, co-occurrent condition, cyclothymic disorder, self-esteem.

Self-Assessment

1. According to DSM-V, there are ten types of depression (T/F).
2. Major depressive disorder has three episodes (T/F).
3. Suicide is the second cause of death among 15-29 years (T/F).
4. Bipolar-I disorder has two episodes (T/F).
5. Cyclothymic disorder is severe from Bipolar-II disorder (T/F).
6. Common signs and symptoms in children and teenagers are --------- those of adults.

a. Similar

b. Different

c. Opposite

d. None of them

7. Depression often goes--------- in older adults.

a. Diagnosed

b. Undiagnosed

c. Overprotected

d. None of them

8. Depression requires------- term treatment.

a. Long

b. Short

c. Package

d. None of them

9. Genetic Bipolar disorder is more common in people who have a ---------- with the condition.

a. Friends

b. First degree relatives

c. Second degree relatives

d. None of them

10. The full form of ADHD is ----------

a. Altered depression and heightened depression

b. Acquired dementia and hyperactivity disorder

c. Attention deficit and hyperactivity disorder

d. None of them

11. The prevalence of Bipolar-II disorder in adults is ----------

a. 0.1%

b. 0.2%

c. 0.4%

d. None of them

12. The term 'Melancholia" was used by ----------

a. Hyppocrates

b. Buss

c. Freud

d. None of them

13. ---------- are showing more rapid cycling of symptoms of Bipolar-I and Bipolar-II disorder.

a. Males

b. Females

c. Children

d. None of them

14. According to Learning theory, depression is ---------- from the society.

a. Learned

b. Inherited

c. Attenuated

d. None of them

15. Mood disorder patients require --------- treatment.

a. Short-term

b. Long term

c. 2 years

d. None of them

4.3 Scoring Key

1T,2F,3T, 4T, 5F, 6A, 7B, 8A, 9B, 10C, 11C, 12A, 13B, 14A, 15B.

Review Questions

1. Define depression. What are the different types of depression, according to DSM?
2. What are the causes of Major Depressive Disorder?
3. Elaborate the types and symptoms of Major Depressive Disorder.
4. What are the risk factors of depressive disorders?
5. Define Bipolar Disorder. State its risk factors and complications.
6. Briefly discuss the etiology and co-occurring conditions.
7. Elaborate the symptoms and prevalence of Bipolar-II disorder.
8. What are the causes of Bipolar-II disorder?
9. Write a note of Cyclothymic Disorder.
10. What are the main causes of Mood Disorders?

Further/Suggested Readings

1. Fish's Clinical Psychopathology: Signs and Symptoms by Patricia Casey and Brenden Kelly. 3rd ed. RCPsych Publication.2007.

2. Clinical Psychopathology: A very short Introduction by Susan Llewelyn and Katie Aafjes-van Doom. 1st ed. Oxford University Press,2017.

Psychosomatic Disorders

CONTENTS

Objectives

After completion of this chapter, the students will be able to:

- understand different types of Somatic Disorders
- know different components of Somatic Disorders
- familiarize with the Psychiatric application of those disorders

Psychosomatic Disorders

Introduction

DSM-V has emphasized some disorders where no medical explanation is required to explain the disorders and it has been named as, "medically unexplained symptoms"- which should have access to treatment. Somatic Symptom Disorder is in this category. Here the patients are expressing symptoms which are very much somatic in nature but no medical explanation can be made for those symptoms.

Types of Somatic Disorder: -

1. Somatic Symptom Disorder
2. Illness Anxiety Disorder
3. Conversion Disorder
4. Factitious Disorder
5. Other Specified Somatic Symptom and Related Disorder (Pseudocyesis)
6. Pain Disorder

Somatic Symptom Disorder-

This disorder is also termed as Hypochondriasis. In this disorder, the patient complaints about preoccupation with fear for a serious disease the person has. It arises from the misinterpretation of somatic symptoms. This fear is general and no delusional content is there. The patient should complain for 6 months or more.

Epidemiology-

Among the clinical population, the prevalence of this disorder is 4 to 6% but it may go up to 15%. Both sexes are equally affected in this disorder. It can occur at any age. It is more common in Blacks compare to White population. Temporary symptoms of this disorder are seen among medical students during first 2 years of their studies.

Clinical Features

They start believing that they have a serious disease which has not diagnosed and that cannot be cured. According to them, they may be transferred to other diseases. They do not rely on laboratory reports and are not convinced by the reassurance of the physicians. They do not have any delusion regarding this. It is triggered by the coexistence of anxiety and depression.

Etiology-

1. Persons with this disorder are found to be less tolerant towards physical unrest.

2. According to Social Learning Theory, the persons show sick role to avoid to face tremendous stressful situations, it is an escape for them to fulfill unusual duties and responsibilities.

3. In this disorder, almost in 80% cases, anxiety and depressive disorders coexist.

4. Psychoanalytic thought described that aggressive and hostile feelings towards others are transformed in the form of repression and displacement into somatic symptoms. Past aggression, rejection and losses people express those in present by seeking support from the others and refuse them as ineffective.

5. This disorder is also the expression as a defense against guilt, low self-esteem. It is perceived as punishment or wrong behavior (real or imagined).

Conclusion

Somatic symptom disorder (SSD) occurs when a person feels extreme, exaggerated anxiety about physical symptoms. The person has such intense thoughts, feelings, and behaviors related to the symptoms, that they feel they cannot do some of the activities of daily life. They may believe routine medical problems are life threatening. This anxiety may not improve despite normal test results and reassurance from the health care provider.

A person with SSD is not faking their symptoms. The pain and other problems are real. They may be caused by a medical problem. Often, no physical cause can be found. However, it is the extreme reaction and behaviors about the symptoms that are the main problem.

Illness Anxiety Disorder

Introduction

In this type of disorder, the patient has few or no somatic symptoms but they do not primarily feel that they are ill. They do not have any medical illness but they are showing excessive anxiety and imagine the worst possible outcome.

Epidemiology-

Proper prevalence is not known but in one survey, it has pointed out that 15% of the general population have worries about becoming sick. No such data have been found about the differences among sex, race, education and marital status.

Clinical Features

They have a persistent belief that they have a serious disease and with time it may be transferred into another disease. They do not rely on laboratory findings and on the confirmation of the physicians. They search information from books, journals and internet and conclude the worst of it from that information in a wrong way.

Etiology-

No specific cause has been properly identified. The causes of Somatic Symptoms Disorder may apply in this type.

If parent died with an illness may instigate the fear of transmitting the illness among the offspring of that parent. It may be the symbolic representation of unconscious conflicts which has been projected to this illness.

Conclusion

Illness anxiety disorder is a persistent fear of having a grave medical illness. A person with this disorder pays excessive attention to health. He or she can become easily alarmed by anything that might be interpreted as a sign of illness, including normal sensations, bodily functions and mild symptoms.

Conversion Disorder

Introduction

This disorder was previously named as Hysteria. The term has undergone several modifications. The term was derived from Greek Word 'Uterus'. Hypocrites believed that it is woman's disease. Moving of the uterus. Frustrated uterus related to child bearing activity. It was not a man's disease.

In the second phase- Hysteria can occur because of suggestion.

In the third phase- Freud said that it is related to sexual conflicts. He tried to differentiate between hysteria and conversion. He coined the term conversion to permit dissociation between symptoms of conversion and hysterical personality disorders.

Symptoms: -

1. A loss of or alteration of physical functioning. It appears the way patient said that it gives rise to physical disorders.

2. Psychological factors are considered to be etiological symptoms. There is a temporal relationship between an environmental symptom that is apparently related to psychological conflict.

3. Symptoms are controlled voluntarily

4. No physiological basis can be traced.

5. The symptoms are not limited to pain or sexual disturbance or not due to schizophrenia or other disorders.

Intracycle conflict: -

Primary Gain & Secondary Gain: - Primary Gain is a sort of release and secondary gain is the attention getting behavior. Secondary gain implies all of the advantages that increase all of the situations of being guilt, dependency care, support, sympathy, excuse and avoidance to adult responsibility.

Clinical Description: -

1. The patients describe unusual symptoms and dramatizes to make the people convince.
2. La Belle indifference- the patient is indifferent to the potential threat.
3. Somatic Complaints.

4. Hysterical Identification

5. Sensory loss, including all modalities, feet, knee, hands are affected, hysterical blindness, aphonia, motor disturbances.

6. Astasia-Abasia- The patient can't walk or move.

7. Hysterical Fits.

Etiology

Psychoanalytic point of view

In his first theory of Neurosis, Freud said about traumatic theory of neurosis. In this he assumed that the patient is the passive victim of childhood parental incest but later this theory of neurosis gave way to institutional theory of motivation. It was postulated that conflicted infantile wishes laid to conversion reaction. Freud himself postulated that hysterical patients were fixated at the phallic genital level of development. Threat of castration he assumed was a danger situation associated with this disorder. The conflict may be related to unconscious sexual wishes. Conflict may be related to aggressive impulses. Manifestation of symptoms may represent a punishment for such a prohibited aggressive or sexual wish.

Psycho-social aspect

From psychosocial adaptation point of view, conversion reaction is to obtain special attention, sympathy and support. Other suggests secondary gain.

Personality

From personality point of view, these individuals are found to be immature and dependent personality. Some of them might be passive aggressive and so they find in their symptom a powerful weapon to influence their environment.

Other factors

Motivation of patients will vary depending upon the personality structure, intelligence and psychological capacity of adaptation of patients. Education and socio-economic status seem to have a significant role to play in it. Mostly in uneducated population, true hysterical manifestation is more but conversion may find in some educated people as well. Similarly, hysterical manifestation is more common in rural areas than urban areas.

Cultural Factors

Cultural and sub-cultural factors are also important. In North and South India, the prevalence of this disease is more compared to other parts of India.

Conclusion

Conversion disorder, also called functional neurological symptom disorder, is a medical problem involving the function of the nervous system; specifically, the brain and body's nerves are unable to send and receive signals properly. As a result of this "communication" problem, patients with conversion disorders may have difficulty moving their limbs or have problems with one or more of their senses.

In the past, conversion disorder was thought to be an entirely psychological disorder, where psychological problems get "converted" into physical symptoms. Today, conversion disorder is recognized as its own distinct disorder. Psychological issues (for example, trauma, personal conflicts, life stressors) are often seen in patients with conversion disorder symptoms, but are not always present in all patients.

Care of patients with conversion disorder overlaps the fields of psychiatry and neurology. However, it is important to note that the symptoms are real; they are not made up and patients are not faking them.

Factitious Disorder

Introduction

In this type of disorder, patient creates illness to attain medical service. They forcefully injure themselves, introduce pain voluntarily, showing some deformity to them and children to seek medical attention and be a part of clinical system.

It may go to serious illness and even death. Though it is wrongfully implemented, it is to be taken serious medical attention.

Epidemiology-

No specific prevalence has been found; very limited researches pointed out that 0.8 to 1.0% patients have this type of illness among psychiatric population. People seek medical attention in different names and with different illnesses in different places.

Comorbidity-

Many persons have been identified with comorbid disorders like mood disorders, personality disorders, substance- abuse disorders along with Factitious disorder.

Clinical Features-

They try to produce symptoms in order to be hospitalized. They are familiar with common serious diseases and give excellent reasons to deceive clinicians. Some symptoms are related to hematoma, hyper or hypoglycemia, hemoptysis, nausea, vomiting, dizziness, scissure. They request doctors for surgery. When the laboratory findings are coming with negative findings, they accuse doctors for incompetence. They insist doctors for specific medication.

Etiology-

Psychological Factors-

According to psychoanalytic point of view, the persons had traumatic childhood experiences, it is an escape from those experience and is getting a number of caregivers in Hospitals. They also have rejection from parents, either one or both of them. To introduce the symptoms, they want to recreate the parent-child relationship.

In the painful procedure, the finds a masochistic method by inflicting pains as a punishment of past guilt either real or imagined. It is stimulating to them, those who are hospitalized with the same complaints and their relatives. They identify themselves very quickly.

Most of them have very low self-esteem and self-distortion- it is quite reasonably to borderline personality disorders. The most common defense mechanisms are repression, identification with the aggressor, regression and symbolization.

Biological Factors-

Some of the researchers pointed about the dysfunction of the brain as a causative element. Impaired information processing is the resultant of this disorder. No EEG abnormality have been identified.

Conclusion

Factitious disorder is a condition in which a patient intentionally falsifies medical or psychiatric symptoms. Symptoms can be self-induced or fabricated. This activity describes the evaluation and management of factitious disorder and reviews the role of the inter-professional team in improving

care for patients with this condition.

Pseudocyesis

Introduction

It is a Greek word, which means 'false pregnancy'. In this disorder, the individual shows some clinical features related to pregnancy but she is not physiologically confirmed that she is pregnant. The person has a strong belief that she is carrying a baby which includes secretion from the breast, delayed menstruation, feeling that the fetus is moving and growth in the abdominal region.

Epidemiology-

Among 80% of the females who have pseudocyesis are married. This disorder is also culture specific, where more than one child is expected along with a male child. This disorder is more common in developing countries. Here women with infertility are being abused, blamed and discrimination. Here women have to bear a child to get share in her husband's property. The prevalence of this disorder in developing countries is 0.3%.

Clinical Features

Amenorrhea, Galactorrhea or milk from the breast, enlarged breast, increased body weight, growth in abdominal region, feeling that the fetus is moving- these symptoms are common in Pseudocyesis.

Etiology-

The real cause of this disorder is not known. Some psychological and endocrinal factors play an important role. They experience stress, anxiety, phobia and emotional instability which increase the prolactin level, subsequently appearance of the symptoms like- amenorrhea, galactorrhea and enlargement of breast. CNS abnormalities may cause abdominal growth and false fetal movement.

16% of these patients have a history of medical and surgical abnormalities like gallstones, tumors in abdomen, constipation, increased prolactin level.

Conclusion

Pseudocyesis is defined by the DSM-5 as a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy, which may include abdominal enlargement, reduced menstrual flow, amenorrhea, subjective sensation of fetal movement, nausea, breast engorgement and secretions, and labor .

Pain Disorder-

Introduction

In this disorder, pain is focused in one or more body parts and it is so prominent that it seeks medical attention. This pain is originating from psychological distress and the impairment of the body function is due to that pain. This disorder has many names like- psychogenic pain disorder, idiopathic pain disorder, somatoform pain disorder and atypical pain disorder. In the DSM category, it is also termed as, "Unspecified Somatic Symptoms Disorder".

Epidemiology-

6 months and lifetime prevalence of his disorder is 5 and 12% respectively. It can occur at any age. Sex ratio has not been identified. Comorbidity with anxiety and depressive disorders are prominent.

Clinical Features-

Pain characterizes in different parts of the body and in different forms like- low back pain, headache, chronic pelvic pain, neurological, posttraumatic, musculoskeletal in nature.

They may have a past history of medical and surgical intervention. They are more preoccupied with pain. Mostly it coexists with depression, anergia, anhedonia, diminished libido, insomnia and irritability.

Etiology-

Psychoanalytic View

It is the symbolic expression of interpsychic conflict through the body. It is also a process of gaining love, a punishment for guilt. The most common defense mechanisms are expressed like- displacement, substitution, and repression. Identification can also take part when the patient takes the role of the parent.

Behavioral Factors

The behaviors of pain symptoms are increased like attention of the others and decreased by the punishment like avoidance of others.

Interpersonal Factors

Some patients show symptoms which give advantage to the interpersonal relationship in the form of sympathy.

Biological Factors

Serotonin and endocrines play an important role in pain relief. Endocrine deficiency can facilitate pain in our body. Among patients of pain disorder, some persons have sensory, limbic structure or chemical abnormalities, they are more prone to this disorder.

Conclusion

Before treating a patient, a psychologist must learn as many facts as possible about the patient and the situation. A history of physical symptoms and a psychosocial history help narrow down possible correlations and causes. Psychosocial history covers the family history of disorders and worries about illnesses, chronically ill parents, stress and negative life events, problems with family functioning, and school difficulties (academic and social). These indicators may reveal whether there is a connection between stress-inducing events and an onset or increase in pain, and the removal in one leading to the removal in the other. They also may show if the patient gains something from being ill and how their reported pain matches medical records. Physicians may refer a patient to a psychologist after conducting medical evaluations, learning about any psychosocial problems in the family, discussing possible connections of pain with stress, and assuring the patient that the treatment will be a combination between medical and psychological care. Psychologists must then do their best to find a way to measure the pain, perhaps by asking the patient to put it on a number scale. Pain questionnaires, screening instruments, interviews, and inventories may be conducted to discover the possibility of somatoform disorders. Projective tests may also be used.

Psychological factors affecting other Medical Conditions:

1. Gastro-intestinal Disorder
2. Cardio-Vascular Disorder
3. Respiratory Disorder
4. Endocrinological Disorder
5. Skin Disorder

5.1 Bronchial Asthma-

Introduction

It is a chronic disorder characterized by shortening of respiratory pathways. Chest congestion, coughing, wheezing, dyspnea. Symptoms are exaggerated at night. It has been observed that 30% of Asthma patients have panic disorders and Agoraphobia. They also show lack of tolerance and emotional apathy.

It is seen that family members of these patients have mood disorders, post-traumatic stress disorder and substance abuse disorder. Emotional disturbance in the family during adolescence is also a major cause of this disorder.

Gastro-intestinal disorder

Introduction

This disorder is closely linked with psychiatric disorder. A major portion of it is functional disorder where psychological and psychiatric factors determine its onset, severity and outcome.

Release of catecholamines increase the anxiety levels. Acute stress also intensifies in several gastrointestinal organs. Anxiety present in almost 67% of the patients with Gastrointestinal disorder.

5.2 Peptic Ulcer-

It consists of mucus ulceration in in the stomach and proximal areas of duodenum. Burning sensation in the stomach, nausea, vomiting dyspepsia are the prominent symptoms.

Role of psychological factors are prominent in the ulcer production. Stressful life events cause high susceptibility of this disease.

Ulcerative Colitis

It is a swallowing bowel disorder in the large intestine. The etiology of this disorder is not known.

It is believed that psychological factors produce a key role in the etiology of this disorder. In some research report, it has been suggested that mostly these types of patients show dependent personalities.

Conclusion

Disorders of unknown etiology have historically been linked to psychosomatic causes. In gastroenterology, one example is ulcerative colitis (UC) before the advent of flexible endoscopy. Historically, UC was linked to Freudian anal regression caused by a difficult dilemma facing the patient. The psychosomatic hypothesis in UC remained prominent for many decades. Evaluations were conducted to assess the psychosomatic theory almost concurrently with classic evaluations of immunomodulating agents. As recent as twenty years ago, a well-conducted systematic review failed to find an association between psychological factors and UC. As UC was slowly legitimized as an organic disease process, the role of stress and psychological contributions took a back seat to theories of immune dysfunction and potential environmental factors.

Skin Disorders

5.3 Trichotillomania

Interest in the aspects of Skin disorder can be traced as early as 1891 when Brock and Jacket (1891) coined the term, "Neurodermatitis". Some of the manifestations are – e.g., hyperhidrosis (excessive sweating) – excessive fear and tension can cause increase in sweat secretion. Perspiration in the

human in two distinct forms- 1) thermal, 2) emotional. Emotional sweating appears primarily on the pals and soles whereas thermal sweating is most evident in forehead, neck and trunk. The sensitivity of the emotional sweating response serves as the basis for the measurement of sweat by GSR. Sympathetic Nervous System recording through skin conductance functions when giving stimulus. It is a function of emotional stability. Excessive sweating may under condition of emotional stress led to secondary changes in the skin. Emotional factors have been associated to different dermatological conditions. It is the disease where the person is voluntarily and in habitual manner picking up hairs from head.

Atopic Dermatitis-

Of the many varieties of eczema dermatitis, this has been regarded as the one which is most strongly influenced by the emotional life of the individual. It is accompanied by itching which is often inappropriate in severity to the visible lesions. Some authors considered itching to be primary and skin lesion is secondary. Such as lesion comes as a reaction to scratching, that is often called neurodermatitis. It is found in both children and adults may appear frequently in same person with an intermittent interval of several years. The term 'atopic' signifies that it is an allergic disorder.

5.4 Alopecia Areata-

This condition is characterized by excessive hair loss. Dermatologists described this condition where an emotional factor plays an important role. Mehumen (1968) and his colleagues described a psychodynamic constellation that characterizes even in children, sometimes birth trauma, sibling rivalry are found.

Etiology

There is a relevance of emotional factors to dermatological disorders but it has not yet been possible to generalize the nature of emotional problem.

One factor may be important in the etiology of atopic dermatitis – where another factor may responsible for Alopecia. Along with this, it has also been reported that constitutional factors cannot be totally overlooked. Thus, allergy is not usually allotted to constitutional factor. In atopic dermatitis, exposure to substances generally proteins, act as allergens. Particularly in case of atopic dermatitis, the patient gives a history of past or present allergies involving different symptoms-i.e., a digestive allergy to certain foods in infancy, then asthma, hay fever, drug reaction etc. Frequently a strong history of allergic responsiveness is elicited. By experience, patient learns onto which substance must be avoided.

Psychological Factors-

Many authors suggested that there is an association between emotional disturbance originating from family interaction and dermatitis.

Smith and others (1998) agreed that certain personality structures and psychodynamic factors are common to patients with different allergic disorders. The most prominent is a strong longing for love and affection. A longing for an infantile dependent kind that arises from a sense of deprivation. Deprivation once again originates from deprivation of love in childhood. This leads to a passive dependent relationship with the mother and the same time the child develops a sense of fear being separated from mother and a fear of being left alone are found to participate in many allergic reactions.

Conclusion

Skin diseases have an adverse impact on psychosocial well-being and can lead to more depressive symptoms, social isolation, loneliness and decreased quality of life. The psychological impact of skin diseases is often underestimated compared to that of other chronic diseases

5.5 Cardiovascular Disorder(CVD)

6.35 Introduction

There is a general saying that cardiovascular dysfunction is the resultant of intense arousal or sustained arousal (especially autonomic arousal). Life situation that makes heavy adaptive demands on the person. Thus, intense and sustained psychological stress is taken as determinants of cardiovascular pathology.

Individual difference in perception of stress-

When the person is attaching some personal significance to that event. When an incident or event causes stress to us, we attach some personal significance to the input we receive fr4om environmental stimuli. Attaching stimuli to a given input has symbolic significance to the individual. Once learned means this has become his habitual mode of ANS response (individual is learned to attach to that stimuli) (arousal is the indicator of stress)

From the above, the cardiovascular disease is learned as a result of conditioning (operant).

Epidemiology

Coronary Heart Disease is the most prevalent and lethal epidemic disease mostly in technological society. The morbidity is very high in Finland. More than 55% of common disease is due to that. In India, the rate is going on day by day for industrialization and nuclear family.

Etiology-

Research has identified the risk of stress- especially associated premature to the onset (before 60-65 years). The most important is-

Dietary factor- high in saturated fat, cholesterol and calories.

Blood chemistry- elevated syndrome, hyperglycemia, organ system pathology, diabetes, hyperthyroidism, neural disease,

Living habits- physical inactivity, overactivity, cigarette smoking.

Familial history- hypertensive disease and death thereof.

Psychological factors-

There is not any single factor in this but attempts have been found out some personality factors- Friedman and Rosenman reported two different patterns of personality. A. type-A and 2. Type-B

Type-A personality is designated by an overt life style characterized by extreme competitiveness, drive for success, impatience, hyper alertness, a subjective sense of time congruency, presence of commitments and responsibilities. People lacking these behavioral characteristics have been designated as 'Type-B'.

Conclusion

A large and growing body of research shows that mental health is associated with risk factors for heart disease before a diagnosis of a mental health disorder and during treatment. These effects can arise both directly, through biological pathways, and indirectly, through risky health behaviors.

People experiencing depression, anxiety, stress, and even PTSD over a long period of time may experience certain physiologic effects on the body, such as increased cardiac reactivity (e.g., increased heart rate and blood pressure), reduced blood flow to the heart, and heightened levels of cortisol. Over time, these physiologic effects can lead to calcium buildup in the arteries, metabolic disease, and heart disease.

Evidence shows that mental health disorders—such as depression, anxiety, and PTSD—can develop after cardiac events, including heart failure, stroke, and heart attack. These disorders can

be brought on after an acute heart disease event from factors including pain, fear of death or disability, and financial problems associated with the event.

Some literature notes the impact of medicines used to treat mental health disorders on cardiometabolic disease risk. The use of some antipsychotic medications has been associated with obesity, insulin resistance, diabetes, heart attacks, atrial fibrillation, stroke, and death.

Mental health disorders such as anxiety and depression may increase the chance of adopting behaviors such as smoking, inactive lifestyle, or failure to take prescribed medications. This is because people experiencing a mental health disorder may have fewer healthy coping strategies for stressful situations, making it difficult for them to make healthy lifestyle choices to reduce their risk for heart disease

Anxiety, depression, and asthma need to be accepted widely as common concurrences with respiratory diseases. Next, respiratory disease patients should be screened for anxiety, depression, PTSD, and other disorders as soon as possible. Then appropriate treatment, whether individual or group therapy should be provided.

Summary

The somatoform disorders are a group of psychiatric disorders that cause unexplained physical symptoms. They include somatization disorder (involving multisystem physical symptoms), undifferentiated somatoform disorder (fewer symptoms than somatization disorder), conversion disorder (voluntary motor or sensory function symptoms), pain disorder (pain with strong psychological involvement), hypochondriasis (fear of having a life-threatening illness or condition), body dysmorphic disorder (preoccupation with a real or imagined physical defect), and somatoform disorder not otherwise specified (used when criteria are not clearly met for one of the other somatoform disorders). These disorders should be considered early in the evaluation of patients with unexplained symptoms to prevent unnecessary interventions and testing. Treatment success can be enhanced by discussing the possibility of a somatoform disorder with the patient early in the evaluation process, limiting unnecessary diagnostic and medical treatments, focusing on the management of the disorder rather than its cure, using appropriate medications and psychotherapy for comorbidities, maintaining a psychoeducational and collaborative relationship with patients, and referring patients to mental health professionals when appropriate.

Keywords

Somatic Disorders, Hypochondriasis, etiology, epidemiology, Conversion Disorders, Illness Anxiety Disorder, Factitious Disorder, Pain Disorder, Pseudocyesis, Unspecified Somatic Symptoms Disorders, Peptic Ulcer, Ulcerative Colitis, Cardiovascular Disorder, Asthma, Endocrinological Disorders, Hyperthyroidism, Hypothyroidism, Diabetes Mellitus, Atopic Dermatitis, Alopecia Areata.

Self-Assessment

1. There are six types of Somatic Disorders (T/F).
2. Somatic Symptom Disorder is also termed as Hypochondriasis (T/F).
3. Hysteria cannot occur because of suggestion (T/F).
4. Pseudocyesis means false pregnancy (T/F).
5. Endocrine deficiency can facilitate Pain disorder (T/F).
6. In Somatic Symptom Disorder, almost in-------- cases, anxiety and depressive disorders coexist.

a. 60%

b. 80%

c. 90%

d. None of them

7. In Conversion Disorder, primary gain is a sort of ----------

a. Excitement

b. Stupor

c. Release

d. None of them

8. In Conversion Disorder, secondary gain is the ---------- behavior.

a. Attention getting

b. Pleasure seeking

c. Conscience

d. None of them

9. In Conversion Disorder, the patient cannot walk or move. This is called------

a. Paraplegia

b. Astasia-Abasia

c. Dyspareunia

d. None of them

10. In --------- disorder, patient creates illness to attend medical service.

a. Factitious Disorder

b. Conversion Disorder

c. Illness Anxiety Disorder

d. None of them

11. In Ulcerative Colitis, the patients show-------- personalities.

a. Authoritative

b. Dependent

c. Suggestive

d. None of them

12. Type ----- personality is more susceptible to Cardiovascular disorder.

a. A

b. B

c. C

d. None of them

13. -------- is characterized by excessive hair loss.

a. Trichotillomania

b. Alopecia Areata

c. Hyperhidrosis

d. None of them

14. -------- is also known as Grave's Disease.

a. Hyperthyroidism

b. Hypothyroidism

c. Diabetes Mellitus

d. None of them

15. -------- is a chronic disorder characterized by shortening of respiratory pathways.

a. Dyspareunia

b. Asthma

c. Dementia

d. None of them

6.50 Scoring Key

1T, 2T, 3F, 4T, 5T, 6B, 7C, 8A, 9B, 10A, 11B, 12A, 13B, 14A, 15B.

Review Questions

1. What are the causes of Somatic Symptom Disorder?
2. Write a note on Illness Anxiety Disorder.
3. What are the symptoms of Conversion Disorder?
4. What are the causes of Conversion Disorder?
5. What is the prevalence and causes of Factitious Disorder?
6. Write a note on Pseudocyesis.
7. What are the causes of Pain Disorder?
8. Write a note on Cardiovascular Disorder.
9. Write a note on Endocrinological Disorder.
10. State different types of Skin Disorders. Narrate its causes.

Further/Suggested Readings

1. Fish's Clinical Psychopathology: Signs and Symptoms by Patricia Casey and Brenden Kelly. 3rd ed. RCPsych Publication.2007.

2. Clinical Psychopathology: A very short Introduction by Susan Llewelyn and Katie Aafjes-van Doom. 1st ed. Oxford University Press,2017.

Dissociative Disorders

CONTENTS

Objectives

After completion of this chapter, the students will be able to:

- Understand different types of Dissociative Disorders
- Know different components of those disorders
- Familiarize with the Psychiatric implication of those disorders

Introduction

Dissociation is an unconscious defense mechanism in which the individual separates some parts of his/her mental activity from the other. In this disorder, it has been found that some disturbances in the person's memory, identity, perception and motor activity. The progress of this disorder may be acute or insidious or chronic and the clinical features of this disorder are often caused psychological distress.

The word "dissociation" means to be disconnected from others, from the world around you, or from yourself.

The term "dissociative disorders" describes a persistent mental state that is marked by feelings of being detached from reality, being outside of one's own body, or experiencing memory loss (amnesia).

6.1 Types of Dissociative Disorders (DSM-V)

1. Dissociative Amnesia
2. Depersonalization/Derealization Disorder
3. Dissociative Fugue
4. Dissociative Identity Disorder
5. Other Specified or Unspecified Dissociative Disorder

Dissociative Amnesia

Introduction

The chief features of this disorder are that the person cannot recall important personal information, generally the incidence related to trauma or stress. This disorder is not related to substance- abuse disorder or the symptoms do not relate to any other medical conditions.

Dissociative amnesia has been linked to overwhelming stress, which may be caused by traumatic events such as war, abuse, accidents, or disasters. The person may have suffered the trauma or just witnessed it. There also seems to be a genetic (inherited) connection in dissociative amnesia, as close relatives often have the tendency to develop amnesia.

Epidemiology

Research reports suggest that this disorder prevails approximately 2 to 6% of the population. No sex variation has been observed in this disorder. It can be diagnosed at least in adolescence, before that the child cannot describe their own experience properly.

Clinical Features

- Impairment of memory (predominantly recent memory).
- Impairment of judgement and impulse control
- Impairment of abstract thinking
- Emotional lability (marked variation in emotional expression)
- Catastrophic reaction (when confronted with anything which is beyond the intellectual capacity, patient may go into a sudden rage)
- Thought abnormalities (delusion, perseveration)
- Urinary and fecal inconsistencies may develop in late stages.
- Disorientation in time, place and person also develop in late stages.
- According to ICD-10 the following features are required for diagnosis: -
- Decline in memory and thinking.
- Recent and remote memory impairment.
- Thinking is impaired, flow of ideas is reduced.
- Presence of clear consciousness (if delirium is associated, consciousness can be impaired)
- Duration of at least 06 months.

Depersonalization/ Derealization Disorder

Introduction

Many people experience symptoms of a depersonalization/derealization disorder during their life. You may feel disconnected from yourself or your surroundings. These feelings may not be cause for alarm. But if they interfere with your life, talk to your healthcare provider so you can get treatment.

The term "dissociative disorders" describes a persistent mental state that is marked by feelings of being detached from reality, being outside of one's own body, or experiencing memory loss (amnesia).

It refers to permanent or frequent sense of separation or detachment from the person's own self. The person may observe that a film is going on automatically and he/she is acting on that without their own wills. It is somewhat a feeling of unreality and they report about the incidence of the world outside. They do not show any proper emotion on that as if they are dreaming or they are being dead.

Epidemiology

These symptoms are very common in general population and in psychiatric patients. One report suggests that the prevalence of this disorder is 19% in general population. It is predominant in epilepsy and migrant patients, persons taking LSD and marijuana and also in some cases where there is some side effects of some medications. It has also been observed in different types of head injuries. It is also common on life threatening experiences. This disorder has been reported 2 to 4 times more in females compared to males.

Clinical Features

Some bodily changes have observed along with dual character- one is the observer and another is the actor. They are detached from their own emotions and also from others. They feel very hard to describe their feelings. They may report, 'I am now outside of my own self', 'nothing real is happening', 'I am dead'. They cannot convey the depressed feelings but they complain that these are damaging their lives. They remain appearing as if they are not distressed.

The main symptom of depersonalization/derealization disorder is feeling disconnected. You may feel:

- Disconnected from your thoughts, feelings and body (depersonalization).
- Disconnected from your surroundings or environment (derealization).
- Robot-like.
- As if you're observing yourself from outside your body.
- As if you're living in a dream world.
- Depressed, anxious, panicky or like you're going crazy.

Some people experience mild, short-lived symptoms. Others have chronic (ongoing) symptoms that may last for years. The symptoms may interfere with your ability to function. They may even lead to a disability.

Dissociative Fugue

Introduction

Dissociative fugue, formerly called psychogenic fugue, is one of a group of conditions called dissociative disorders. The word fugue comes from the Latin word for "flight." People with dissociative fugue temporarily lose their sense of personal identity and impulsively wander or travel away from their homes or places of work. They often become confused about who they are and might even create new identities. Outwardly, people with this disorder show no signs of illness, such as a strange appearance or odd behavior.

It has been categorized in DSM-V as a sub-type of Dissociative Amnesia. It is characterized by a sudden, unprepared travel away from home or one's place of daily duties because of lack of recall of some or all about the patient's past life. It is also featured with confusion about own identity as well as the new identity the person wants to take.

Dissociative fugue is a rare form of dissociative amnesia.

A dissociative fugue may last from hours to months, occasionally longer. If the fugue is brief, people may appear simply to have missed some work or come home late. If the fugue lasts several days or longer, people may travel far from home, form a new identity, and begin a new job, unaware of any change in their life.

Many fugues appear to represent disguised wish fulfillment or the only permissible way to escape from severe distress or embarrassment. For example, a financially distressed executive leaves a hectic life and lives as a farm hand in the country.

Thus, dissociative fugue is often mistaken for malingering (faking physical or psychologic symptoms to obtain a benefit) because both conditions can give people an excuse to avoid their responsibilities (as in an intolerable marriage), to avoid accountability for their actions, or to reduce

their exposure to a known hazard, such as a battle. However, dissociative fugue, unlike malingering, occurs spontaneously and is not faked. Doctors can usually distinguish the two because malingerers typically exaggerate and dramatize their symptoms and because they have obvious financial, legal, or personal reasons (such as avoiding work) for faking memory loss.

Epidemiology

It is associated with disaster, war, in some social violence but no prominent factor has been identified. No data about sex ratio have been traced. Most of the reported cases are adult men.

Clinical Features

The symptoms of this disorder elongate from some minutes to months. In some cases, more than one fugue is present. In dissociative Identity Disorder, chronic fugue is present. In acute PTSD, the patients report waking fugue from one place to another inside the house. Children and adolescents travel a short distance compare to adults.

During the fugue, people may appear and act normal or appear only mildly confused and attract no attention. However, when the fugue ends, people suddenly find themselves in a new situation with no memory of how they came to be there or what they have been doing. At this point, many people feel ashamed or upset that they cannot remember what happened. Some people are frightened. If they are confused, they may come to the attention of medical or legal authorities.

After the fugue ends, many people remember their past identity and life up to when the fugue began. However, for others, remembering takes longer and occurs more gradually. Some people never remember parts of their past. A very few people remember nothing or almost nothing about their past for the rest of their life.

Dissociative Identity Disorder (DID)

Introduction

Dissociative identity disorder (DID) is a mental health condition. People with DID have two or more separate identities. These personalities control their behavior at different times. Each identity has its own personal history, traits, likes and dislikes. DID can lead to gaps in memory and hallucinations (believing something is real when it isn't).

Dissociative identity disorder used to be called multiple personality disorder or split personality disorder.

DID is one of several dissociative disorders. These disorders affect a person's ability to connect with reality. Other dissociative disorders include:

Depersonalized or derealization disorder, which causes a feeling of detachment from your actions.

Dissociative amnesia, or problems remembering information about yourself.

Its previous name was Multiple Personality Disorder. Here patients report two or more prominent identities or personality conditions. In this disorder, it is commonly found- fugue, amnesia, depersonalization and other allied clinical features.

Epidemiology

Very few researches have been conducted for this disorder. Among the psychiatric population, the female to male ratio is 5:1 and in diagnosed cases it is 9:1.

Clinical Features

The most distinct feature is the presence of two or more prominent personality conditions.

DID is usually the result of sexual or physical abuse during childhood. Sometimes it develops in response to a natural disaster or other traumatic events like combat. The disorder is a way for someone to distance or detach themselves from trauma.

A person with DID has two or more distinct identities. The "core" identity is the person's usual personality. "Alters" are the person's alternate personalities. Some people with DID have up to 100 alters.

Alters tend to be very different from one another. The identities might have different genders, ethnicities, interests and ways of interacting with their environments.

Other common signs and symptoms of DID can include:

- Anxiety.
- Delusions.
- Depression.
- Disorientation.
- Drug or alcohol abuse.
- Memory loss.
- Suicidal thoughts or self-harm.

The most distinct feature is the presence of two or more prominent personality conditions.

DID is usually the result of sexual or physical abuse during childhood. Sometimes it develops in response to a natural disaster or other traumatic events like combat. The disorder is a way for someone to distance or detach themselves from trauma

Other Specified or Unspecified Dissociative Disorders

This category includes the presence of dissociative response which does not fit to any of the features of disorders mentioned earlier in DSM-V as Dissociative Disorders.

Dissociative Trance Disorder

Introduction

It is characterized by a transient altered state of consciousness or loss of sense of personal identity without any effect of that identity. The patient is in a trance i.e., periodic change in consciousness usually with divine power or another person. Individual shows stereotyped behavior or his behavior is controlled by that influenced person. There should be partial or full loss of memory for the event. That trance behavior is not being affected to the norms of that culture. It is not associated with any psychiatric illness or any condition related to substance -abuse or due to any substance under medical condition.

Dissociative Trance Disorder is uncommon, particularly in the eastern part of the world. Complexity and uniqueness of the symptoms, triggers, as well as the management strategy of this disease, make it an exceptional burden for the family.

A dissociative disorder characterized by involuntary alterations in consciousness, identity, awareness or memory, and motor functioning that result in significant distress or impairment. The two subtypes of the disorder are distinguished by the individual's identity state. In possession trance, the individual's usual identity is replaced by a new identity perceived to be an external force, such as a ghost, another person, or a divine being, and there is loss of memory for the episode of trance. In trance disorder, individuals retain their usual identity but have an altered perception of their milieu. These types of dissociative experiences are common in various cultures and may be part of customary religious practice; they should not be regarded as pathological unless considered abnormal within the context of that cultural or religious group. Also called possession trance disorder; trance and possession disorder (TPD).

Ganser Syndrome

Introduction

Ganser syndrome, as it is now known, has been the subject of much debate since this original paper. Questions about its etiology, definition, and classification, as well as its status as a true mental illness versus a specific form of malingering has been the subject of multiple journal articles and book chapters. The syndrome is not listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as it had been in previous editions.

In 1898, German psychiatrist SigbertGanser first published a lecture, delivered the previous year, describing 3 patients who exhibited a set of symptoms that he felt described a new hysterical syndrome.

It is a confused condition featured with giving approximate answer (Para logia) along with alteration of consciousness. The symptoms are present with hallucinations, dissociation, somatoform and conversion symptoms.

Epidemiology

The patients report with a cluster of symptoms. Male-Female ratio is 2:1, 75% of the reported cases are convicts.

Clinical Features

In this disorder, the patient gives the incorrect answer confidently as if the patient is passing over the question. Like a 20-year-old female, if asked about her age, may report, "I am not five". Clouding of consciousness accompanies like amnesia, disorientation, lack of personal information. At least 50% of the cases, visual and auditory hallucination are present.

6.2 Cause of Dissociative Disorders

Etiology of Dissociative Amnesia

The main cause of this disorder is interpersonal conflict and the person experiences excessive guilt, despair, aggression and separation which leads to compulsion in violent sexual, suicidal and aggressive behavior. Traumatic episodes of physical and sexual abuse may facilitate this disorder. Sometimes refusal from a trustworthy person can cause this disorder where the betrayal has been influenced.

Dissociative disorders often first develop as a way to deal with a catastrophic event or with long-term stress, abuse, or trauma. This is particularly true if such events take place early in childhood. At this time of life there are limitations on one's ability to fully understand what is happening, coping mechanisms are not fully developed, and getting support and resources depends on the presence of caring and knowledgeable adults.

Mentally removing oneself from a traumatic situation — such as an accident, natural disaster, military combat, being a crime victim, or repeated physical, mental or sexual abuse — can be a coping mechanism that helps one escape pain in the short term. It becomes a problem if over the long term it continues to separate the person from reality, and blanks out memories of entire periods of time.

Etiology of Depersonalization Disorder

Psycho-analytical View

According to this view, ego has been distorted and shows these symptoms like depersonalization as a defense. More traumatic incidents facilitate the symptoms.

Traumatic Stress

At least 33% of the patients with these disorders have the history of trauma in their lives. Among accident survivors. Persons in military training show this type of symptoms arise from stress and tiredness which can affect their performance.

Neurobiological Theories

Serotonin uptake plays an important role in depersonalization disorder. One sub-type of glutamate receptor (NMDA) responsible for production of these symptoms.

Etiology of Dissociative Fugue

All types of traumatic experience like rape, child abuse, natural disaster, etc. lead to altered state of consciousness and the person wants to move away from the place. In some cases, patients exhibit symptoms due to excessive fear, guilt, shame or disgust, severe sexual, suicidal or aggressive impulses. They do it as a consequence of conflict with super-ego.

Patients who experience a fugue are usually brought to the emergency department to exclude alcohol intoxication or drug overdose, two common causes of bizarre and abnormal behavior.

History taking is an essential tool in establishing the diagnosis of dissociative fugue because the diagnostic criteria per DSM-5 are largely based on the clinical features of the disorder.

Patients are usually confused and have amnesia. Amnesia can be associated with the creation of a new identity.

Fugue differs from dissociative amnesia in that patients with fugue usually travel suddenly, away from their home, and are unable to recall recent past events in their lives. Patients with dissociative amnesia do not show this kind of behavior. Therefore, cases of severe amnesia without unexpected travel are diagnosed as overt dissociative amnesia rather than fugue. Suicidal risk should be assessed in any patient with dissociative fugue.

Etiology of Dissociative Identity Disorder

It is severely linked with childhood trauma. The reported childhood trauma in this disorder is 85 to 97%, among them physical and sexual abuse in childhood is very common. No genetic factor is found contributing to this disorder.

The development of dissociative identity disorder is understood to be a result of several factors:

- Recurrent episodes of severe physical, emotional or sexual abuse in childhood.
- Absence of safe and nurturing resources to overwhelming abuse or trauma.
- Ability to dissociate easily.
- Development of a coping style that helped during distress and the use of splitting as a survival skill.
- While abuse is frequently present, it cannot be assumed that family members were involved in the abuse

Some medications may help with certain symptoms of DID, such as depression or anxiety. But the most effective treatment is psychotherapy. A healthcare provider with specialized training in mental health disorders, such as a psychologist or psychiatrist, can guide you toward the right treatment. You may benefit from individual, group or family therapy.

Therapy focuses on:

- Identifying and working through past trauma or abuse.
- Managing sudden behavioral changes.
- Merging separate identities into a single identity.

Etiology of Ganser Syndrome

Little is known about this unusual disorder, but it is believed to be a reaction to extreme stress. There are also physical problems that may cause the symptoms of Ganser syndrome such as alcoholism, head injury, and stroke.

Most people with this condition also have a personality disorder, usually antisocial personality disorder or histrionic personality disorder. Antisocial personality disorder is characterized by irresponsible and aggressive behavior that often involves a disregard for others and an inability to abide by society's rules. People with antisocial personality disorder are sometimes referred to as "sociopaths" or "psychopaths." For people with histrionic personality disorder, their self-esteem depends on the approval of others and does not arise from a true feeling of self-worth. They have an overwhelming desire to be noticed, and often behave dramatically or inappropriately to get attention.

Some researchers put stressed on personal conflicts and financial crisis whereas others emphasized on organic brain syndrome, head injuries, epilepsy, psychiatric disorders for the cause of this disease. Psychoanalytic view is the same for the other dissociative disorders. Organic theories narrated that stress factors can cause neuronal and chemical disturbances in the brain can cause this disorder. In some cases, childhood maladjustment has been reported.

Dissociative disorders usually develop as a way to cope with trauma. The disorders most often form in children subjected to long-term physical, sexual or emotional abuse or, less often, a home environment that's frightening or highly unpredictable. The stress of war or natural disasters also can bring on dissociative disorders.

Personal identity is still forming during childhood. So, a child is more able than an adult to step outside of himself or herself and observe trauma as though it's happening to a different person. A child who learns to dissociate in order to endure a traumatic experience may use this coping mechanism in response to stressful situations throughout life.

How Is Ganser Syndrome Diagnosed?

Diagnosing Ganser syndrome is challenging. Doctors must rule out any possible physical problems, such as stroke or head injury, or other psychological conditions as the cause of the symptoms before considering a diagnosis of Ganser syndrome.

If the doctor finds no physical reason for the symptoms, they may refer the person to a psychiatrist or psychologist, mental health professionals who are specially trained to diagnose and treat mental illnesses. Psychiatrists and psychologists use specially designed interviews and assessment tools to evaluate a person for psychiatric conditions. The doctor bases their diagnosis on the use of these tools as well as the exclusion of other physical or mental illnesses and their observation of the patient's attitude and behavior.

Summary

Dissociative amnesia is a condition in which a person cannot remember important information about his or her life. This forgetting may be limited to certain specific areas (thematic), or may include much of the person's life history and/or identity (general).

Dissociative amnesia is one of a group of conditions called "dissociative disorders." Dissociative disorders are mental illnesses in which there is a breakdown of mental functions that normally operate smoothly, such as memory, consciousness or awareness, and identity and/or perception.

Dissociative symptoms can be mild, but they can also be so severe that they keep the person from being able to function, and can also affect relationships and work activities.

With appropriate treatment, many people are successful in addressing the major symptoms of dissociative identity disorder and improving their ability to function and live a productive, fulfilling life.

Depersonalization/derealization disorder is a type of dissociative disorder that consists of persistent or recurrent feelings of being detached (dissociated) from one's body or mental processes, usually with a feeling of being an outside observer of one's life (depersonalization), or of being detached from one's surroundings (derealization). The disorder is often triggered by severe

stress. Diagnosis is based on symptoms after other possible causes are ruled out. Treatment consists of psychotherapy plus drug therapy for any comorbid depression and/or anxiety.

Dissociative fugue is a psychiatric disorder characterized by amnesia coupled with sudden unexpected travel away from the individual's usual surroundings and denial of all memory of his or her whereabouts during the period of wandering. Dissociative fugue is a rare disorder that is infrequently reported.

A dissociative disorder characterized by involuntary alterations in consciousness, identity, awareness or memory, and motor functioning that result in significant distress or impairment. The two subtypes of the disorder are distinguished by the individual's identity state. In possession trance, the individual's usual identity is replaced by a new identity perceived to be an external force, such as a ghost, another person, or a divine being, and there is loss of memory for the episode of trance. In trance disorder, individuals retain their usual identity but have an altered perception of their milieu. These types of dissociative experiences are common in various cultures and may be part of customary religious practice; they should not be regarded as pathological unless considered abnormal within the context of that cultural or religious group. Also called possession trance disorder; trance and possession disorder (TPD).

It is difficult to predict whether and when symptoms of Ganser syndrome are likely to go away. This is partly because people with Ganser Syndrome often present with fake symptoms not just simply in response to a stressful event, but because the condition often reflects someone's limited ability to cope effectively with stresses when they occur.

Treatment typically involves psychotherapy. Therapy can help people gain control over the dissociative process and symptoms. The goal of therapy is to help integrate the different elements of identity. Therapy may be intense and difficult as it involves remembering and coping with past traumatic experiences. Cognitive behavioral therapy and dialectical behavioral therapy are two commonly used types of therapy. Hypnosis has also been found to be helpful in treatment of dissociative identity disorder.

There are no medications to directly treat the symptoms of dissociative identity disorder. However, medication may be helpful in treating related conditions or symptoms, such as the use of antidepressants to treat symptoms of depression.

Keyword

Dissociative Disorders, Dissociative Amnesia, Depersonalization Disorder, Dissociative Fugue, Dissociative Identity Disorder, Dissociative Trance Disorder, Ganser Syndrome.

Self-Assessment

1. The word 'dissociation' means disconnected from others (T/F).
2. There are six types of dissociative disorders (T/F).
3. Dissociative Amnesia prevails 2 to 6% of the population (T/F).
4. Dissociative Fugue is a sub-type of dissociative amnesia (T/F).
5. Previous name of dissociative identity disorder was Multiple Personality Disorder (T/F).
6. The main cause of Dissociative Amnesia is ---------

a. Brain injury
b. Interpsychic conflict
c. Severe mania
d. None of them

7. Depersonalization Disorder is more common in ----------

a. Males
b. Females
c. Children
d. None of them

8. In Depersonalization Disorder, ---------- of the cases have the history of trauma in their lives.

a. 11%
b. 22%
c. 33%
d. None of them

9. Dissociative Fugue is a ---------- form of Dissociative Amnesia.

a. Popular form
b. Rare form
c. Usual form
d. None of them

10. Among Psychiatric population, the female to male ratio of dissociative identity disorder is ----------

a. 3:1
b. 5:1
c. 7:1
d. None of them

11. Most of the reported cases of Ganser Syndrome are ----------

a. Police Personnel
b. Medical Personnel
c. Convicts
d. None of them

12. --------- is a confused condition with giving approximate answer along with alteration of consciousness.

a. Para logia
b. Paraplegia
c. Paresthesia
d. None of them

13. In Dissociative Amnesia, ---------- memory is impaired.

a. Immediate
b. Recent
c. Remote
d. None of them

14. For diagnosing Dissociative Amnesia, the symptoms should persist at least for ------- months.

a. 03
b. 06
c. 09
d. None of them

15. ---------- dysfunction can cause Depersonalization Disorder.

a. Serotonin
b. Dopamine
c. Acetylcholine
d. None of them

Scoring Key

1T, 2F, 3T, 4T, 5T, 6B, 7B, 8C, 9B, 10B, 11C, 12A, 13B, 14B, 15A

Review Questions

1. What are the clinical features of Dissociative Amnesia?
2. Discuss the etiology and prevalence of Depersonalization Disorder.
3. Write the causes of Dissociative Fugue.
4. What do you mean by dissociative identity disorder?
5. Write a note on Dissociative Trance Disorder.
6. What are the clinical features and etiology of Ganser Syndrome?
7. What are Dissociative Disorders? What are the types of Dissociative Disorders?
8. What are the causes of Dissociative Amnesia?
9. What are the clinical features of Depersonalization Disorder?
10. What are the clinical features of Dissociative Fugue?

Further/Suggested Readings

1. Fish's Clinical Psychopathology: Signs and Symptoms by Patricia Casey and Brenden Kelly. 3rd ed. RCPsych Publication.2007.

2. Clinical Psychopathology: A very short Introduction by Susan Llewelyn and Katie Aafjes-van Doom. 1st ed. Oxford University Press,2017.

Unit 7: Eating disorders

CONTENTS

Objectives

1. Tounderstandtheconceptofeating disorders
2. Toidentifythedifferentlevelsofseverity of eating disorders
3. Toknowthecharacteristicsofeating disorders

Introduction

To prevent weight gain or to continue losing weight, people with anorexia usually severely restrict the amount of food they eat. They may control calorie intake by vomiting after eating or by misusing laxatives, diet aids, diuretics or enemas. They may also try to lose weight by exercising excessively. No matter how much weight is lost, the person continues to fear weight gain.

Anorexia isn't really about food. It's an extremely unhealthy and sometimes life-threatening way to try to cope with emotional problems. When you have anorexia, you often equate thinness with self-worth.Anorexia, like other eating disorders, can take over your life and can be very difficult to overcome. But with treatment, you can gain a better sense of who you are, return to healthier eating habits and reverse some of anorexia's serious complications.The physical signs and symptoms of anorexia nervosa are related to starvation. Anorexia also includes emotional and behavioral issues involving an unrealistic perception of body weight and an extremely strong fear of gaining weight or becoming fat.It may be difficult to notice signs and symptoms because what is considered a low body weight is different for each person, and some individuals may not appear extremely thin. Also, people with anorexia often disguise their thinness, eating habits or physical problems.

7.1Anorexia Nervosa

It is often simply called anorexia — is an eating disorder characterized by an abnormally low body weight, an intense fear of gaining weight and a distorted perception of weight. People with anorexia place a high value on controlling their weight and shape, using extreme efforts that tend to significantly interfere with their lives.

Physical symptoms

Physical signs and symptoms of anorexia may include:

- Extreme weight loss or not making expected developmental weight gains
- Thin appearance
- Abnormal blood counts
- Fatigue
- Insomnia
- Dizziness or fainting
- Bluish discoloration of the fingers
- Hair that thins, breaks or falls out
- Soft, downy hair covering the body
- Absence of menstruation
- Constipation and abdominal pain
- Dry or yellowish skin
- Intolerance of cold
- Irregular heart rhythms
- Low blood pressure
- Dehydration
- Swelling of arms or legs
- Eroded teeth and calluses on the knuckles from induced vomiting

Some people who have anorexia binge and purge, similar to individuals who have bulimia. But people with anorexia generally struggle with an abnormally low body weight, while individuals with bulimia typically are normal to above normal weight.

Emotional and behavioral symptoms

Behavioral symptoms of anorexia may include attempts to lose weight by:

- Severely restricting food intake through dieting or fasting
- Exercising excessively
- Bingeing and self-induced vomiting to get rid of food, which may include the use of laxatives, enemas, diet aids or herbal products

Emotional and behavioral signs and symptoms may include:

- Preoccupation with food, which sometimes includes cooking elaborate meals for others but not eating them
- Frequently skipping meals or refusing to eat
- Denial of hunger or making excuses for not eating
- Eating only a few certain "safe" foods, usually those low in fat and calories
- Adopting rigid meal or eating rituals, such as spitting food out after chewing
- Not wanting to eat in public
- Lying about how much food has been eaten
- Fear of gaining weight that may include repeated weighing or measuring the body
- Frequent checking in the mirror for perceived flaws
- Complaining about being fat or having parts of the body that are fat
- Covering up in layers of clothing
- Flat mood (lack of emotion)
- Social withdrawal
- Irritability
- Insomnia
- Reduced interest in sex

Unfortunately, many people with anorexia don't want treatment, at least initially. Their desire to remain thin overrides concerns about their health. If you have a loved one you're worried about, urge her or him to talk to a doctor.

If you're experiencing any of the problems listed above, or if you think you may have an eating disorder, get help. If you're hiding your anorexia from loved ones, try to find a person you trust to talk to about what's going on.

Risk factors

Anorexia is more common in girls and women. However, boys and men have increasingly developed eating disorders, possibly related to growing social pressures.
Anorexia is also more common among teenagers. Still, people of any age can develop this eating disorder, though it's rare in those over 40. Teens may be more at risk because of all the changes their bodies go through during puberty. They may also face increased peer pressure and be more sensitive to criticism or even casual comments about weight or body shape.
Certain factors increase the risk of anorexia, including:

- **Genetics.** Changes in specific genes may put certain people at higher risk of anorexia. Those with a first-degree relative — a parent, sibling or child — who had the disorder have a much higher risk of anorexia.
- **Dieting and starvation.** Dieting is a risk factor for developing an eating disorder. There is strong evidence that many of the symptoms of anorexia are actually symptoms of starvation. Starvation affects the brain and influences mood changes, rigidity in thinking, anxiety and reduction in appetite. Starvation and weight loss may change the way the brain works in vulnerable individuals, which may perpetuate restrictive eating behaviors and make it difficult to return to normal eating habits.
- **Transitions.** Whether it's a new school, home or job; a relationship breakup; or the death or illness of a loved one, change can bring emotional stress and increase the risk of anorexia.

Complications

Anorexia can have numerous complications. At its most severe, it can be fatal. Death may occur suddenly — even when someone is not severely underweight. This may result from abnormal heart rhythms (arrhythmias) or an imbalance of electrolytes — minerals such as sodium, potassium and calcium that maintain the balance of fluids in your body.
Other complications of anorexia include:

- Anemia
- Heart problems, such as mitral valve prolapse, abnormal heart rhythms or heart failure
- Bone loss (osteoporosis), increasing the risk of fractures
- Loss of muscle
- In females, absence of a period
- In males, decreased testosterone
- Gastrointestinal problems, such as constipation, bloating or nausea
- Electrolyte abnormalities, such as low blood potassium, sodium and chloride
- Kidney problems

If a person with anorexia becomes severely malnourished, every organ in the body can be damaged, including the brain, heart and kidneys. This damage may not be fully reversible, even when the anorexia is under control.
In addition to the host of physical complications, people with anorexia also commonly have other mental health disorders as well. They may include:

- Depression, anxiety and other mood disorders
- Personality disorders
- Obsessive-compulsive disorders
- Alcohol and substance misuse
- Self-injury, suicidal thoughts or suicide attempts

Prevention

There's no guaranteed way to prevent anorexia nervosa. Primary care physicians (pediatricians, family physicians and internists) may be in a good position to identify early indicators of anorexia and prevent the development of full-blown illness. For instance, they can ask questions about eating habits and satisfaction with appearance during routine medical appointments.

If you notice that a family member or friend has low self-esteem, severe dieting habits and dissatisfaction with appearance, consider talking to him or her about these issues. Although you may not be able to prevent an eating disorder from developing, you can talk about healthier behavior or treatment options.

8.1 Bulimia (boo-LEE-me-uh) nervosa

Bulimia (boo-LEE-me-uh) nervosa, commonly called bulimia, is a serious, potentially life-threatening eating disorder. People with bulimia may secretly binge — eating large amounts of food with a loss of control over the eating — and then purge, trying to get rid of the extra calories in an unhealthy way.

To get rid of calories and prevent weight gain, people with bulimia may use different methods. For example, you may regularly self-induce vomiting or misuse laxatives, weight-loss supplements, diuretics or enemas after bingeing. Or you may use other ways to rid yourself of calories and prevent weight gain, such as fasting, strict dieting or excessive exercise.

If you have bulimia, you're probably preoccupied with your weight and body shape. You may judge yourself severely and harshly for your self-perceived flaws. Because it's related to self-image — and not just about food — bulimia can be hard to overcome. But effective treatment can help you feel better about yourself, adopt healthier eating patterns and reverse serious complications.

Symptoms

Bulimia signs and symptoms may include:

- Being preoccupied with your body shape and weight
- Living in fear of gaining weight
- Repeated episodes of eating abnormally large amounts of food in one sitting
- Feeling a loss of control during bingeing — like you can't stop eating or can't control what you eat
- Forcing yourself to vomit or exercising too much to keep from gaining weight after bingeing
- Using laxatives, diuretics or enemas after eating when they're not needed
- Fasting, restricting calories or avoiding certain foods between binges
- Using dietary supplements or herbal products excessively for weight loss

The severity of bulimia is determined by the number of times a week that you purge, usually at least once a week for at least three months.

If you have any bulimia symptoms, seek medical help as soon as possible. If left untreated, bulimia can severely impact your health.

Talk to your primary care provider or a mental health professional about your bulimia symptoms and feelings. If you're reluctant to seek treatment, confide in someone about what you're going through, whether it's a friend or loved one, a teacher, a faith leader, or someone else you trust. He or she can help you take the first steps to get successful bulimia treatment.

Helping a loved one with bulimia symptoms

If you think a loved one may have symptoms of bulimia, have an open and honest discussion about your concerns. You can't force someone to seek professional care, but you can offer encouragement and support. You can also help find a qualified doctor or mental health professional, make an appointment, and even offer to go along.

Because most people with bulimia are usually normal weight or slightly overweight, it may not be apparent to others that something is wrong. Red flags that family and friends may notice include:

- Constantly worrying or complaining about being fat
- Having a distorted, excessively negative body image
- Repeatedly eating unusually large quantities of food in one sitting, especially foods the person would normally avoid
- Strict dieting or fasting after binge eating
- Not wanting to eat in public or in front of others
- Going to the bathroom right after eating, during meals or for long periods of time
- Exercising too much
- Having sores, scars or calluses on the knuckles or hands
- Having damaged teeth and gums
- Changing weight

- Swelling in the hands and feet
- Facial and cheek swelling from enlarged glands

Complications

Bulimia may cause numerous serious and even life-threatening complications. Possible complications include:

- Negative self-esteem and problems with relationships and social functioning
- Dehydration, which can lead to major medical problems, such as kidney failure
- Heart problems, such as an irregular heartbeat or heart failure
- Severe tooth decay and gum disease
- Absent or irregular periods in females
- Digestive problems
- Anxiety, depression, personality disorders or bipolar disorder
- Misuse of alcohol or drugs
- Self-injury, suicidal thoughts or suicide

Prevention

Although there's no sure way to prevent bulimia, you can steer someone toward healthier behavior or professional treatment before the situation worsens. Here's how you can help:

- Foster and reinforce a healthy body image in your children, no matter what their size or shape. Help them build confidence in ways other than their appearance.
- Have regular, enjoyable family meals.
- Avoid talking about weight at home. Focus instead on having a healthy lifestyle.
- Discourage dieting, especially when it involves unhealthy weight-control behaviors, such as fasting, using weight-loss supplements or laxatives, or self-induced vomiting.
- Talk with your primary care provider. He or she may be in a good position to identify early indicators of an eating disorder and help prevent its development.
- If you notice a relative or friend who seems to have food issues that could lead to or indicate an eating disorder, consider supportively talking to the person about these issues and ask how you can help.

8.2 Binge Eating Disorder

Binge eating disorder (BED) is a type of feeding and eating disorder that's now recognized as an official diagnosis. It affects almost 2% of people worldwide and can cause additional health issues linked to diet, such as high cholesterol levels and diabetes. Feeding and eating disorders are not about food alone, which is why they're recognized as psychiatric disorders. People typically develop them as a way of dealing with a deeper issue or another psychological condition, such as anxiety or depression. People with BED may eat a lot of food in a short amount of time, even if they aren't hungry. Emotional stress or destress often plays a role and might trigger a period of binge eating. A person might feel a sense of release or relief during a binge but experience feelings of shame or loss of control afterward. For a healthcare professional to diagnose BED, three or more of the following symptoms must be present:

- eating much more rapidly than normal
- eating until uncomfortably full
- eating large amounts without feeling hungry
- eating alone due to feelings of embarrassment and shame
- feelings of guilt or disgust with oneself

People with BED often experience feelings of extreme unhappiness and distress about their overeating, body shape, and weight

How is BED diagnosed?

While some people may occasionally overeat, such as at Thanksgiving or a party, it does not mean they have BED, despite having experienced some of the symptoms listed above. BED typically starts in the late teens to early twenties, although it can occur at any age. People

generally need support to help overcome BED and develop a healthy relationship with food. If left untreated, BED can last for many year. To be diagnosed, a person must have had at least one binge eating episode per week for a minimum of three months . The severity ranges from mild, which is characterized by one to three binge eating episodes per week, to extreme, which is characterized by 14 or more episodes per week. Another important characteristic is not taking action to "undo" a binge. This means that, unlike bulimia, a person with BED does not throw up, take laxatives, or over-exercise to try and counteract a binging episode. Like other eating disorders, it's more common in women than men. However, it's more common among men than other types of eating disorders.

Health risks

BED is associated with several significant physical, emotional, and social health risks. Up to 50% of people with BED have obesity. However, the disorder is also an independent risk factor for gaining weight and developing obesity. This is due to the increased calorie intake during binging episode. On its own, obesity increases the risk of heart disease, stroke, type 2 diabetes, and cancer (However, some studies have found that people with BED have an even greater risk of developing these health problems, compared with people with obesity of the same weight who don't have. Other health risks associated with BED include sleep problems, chronic pain conditions, asthma, and irritable bowel syndrome (IBS). In women, the condition is associated with a risk of fertility problems, pregnancy complications, and the development of polycystic ovary syndrome (PCOS). Research has shown that people with BED report challenges with social interactions, compared with people without the condition. Additionally, people with BED have a high rate of hospitalization, outpatient care, and emergency department visits, compared with those who don't have a feeding or eating disorder. Although these health risks are significant, there are a number of effective treatments for BED.

Treatment options

The treatment plan for BED depends on the causes and severity of the eating disorder, as well as individual goals. Treatment may target binge eating behaviors, excess weight, body image, mental health issues, or a combination of these. Therapy options include cognitive behavioral therapy, interpersonal psychotherapy, dialectical behavior therapy, weight loss therapy, and medication. These may be carried out on a one-to-one basis, in a group setting, or in a self-help format. In some people, just one type of therapy may be required, while others may need to try different combinations until they find the right fit. A medical or mental health professional can provide advice on selecting an individual treatment plan.

Cognitive behavioral therapy

Cognitive behavioral therapy (CBT) for BED focuses on analyzing the relationships between negative thoughts, feelings, and behaviors related to eating, body shape, and weight. Once the causes of negative emotions and patterns have been identified, strategies can be developed to help people change them. Specific interventions include setting goals, self-monitoring, achieving regular meal patterns, changing thoughts about self and weight, and encouraging healthy weight-control habits Therapist-led CBT has been demonstrated to be the most effective treatment for people with BED. One study found that after 20 sessions of CBT, 79% of participants were no longer binge eating, with 59% of them still successful after one year. Alternatively, guided self-help CBT is another option. In this format, participants are usually given a manual to work through on their own, along with the opportunity to attend some additional meetings with a therapist to help guide them and set goals . The self-help form of therapy is often cheaper and more accessible, and there are websites and mobile apps that offer support. Self-help CBT has been shown to be an effective alternative to traditional CBT .

Interpersonal psychotherapy (IPT) is based on the idea that binge eating is a coping mechanism for unresolved personal problems such as grief, relationship conflicts, significant life changes, or underlying social problems. The goal is to identify the specific problem linked to the negative eating behavior, acknowledge it, and then make constructive changes over 12–16 weeks Therapy may either be in a group format or on a one-to-one basis with a trained therapist, and it may sometimes be combined with CBT.

There is strong evidence that this type of therapy has both short- and long-term positive effects on reducing binge eating behavior. It is the only other therapy with long-term outcomes as good

as CBT It may be particularly effective for people with more severe forms of binge eating and those with lower self-esteem.

Dialectical behavior therapy

Dialectical behavior therapy (DBT) views binge eating as an emotional reaction to negative experiences that the person has no other way of coping with. It teaches people to regulate their emotional responses so that they can cope with negative situations in daily life without binging. The four key areas of treatment in DBT are mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. A study including 44 women with BED who underwent DBT showed that 89% of them stopped binge eating by the end of therapy, although this dropped to 56% by the 6-month follow-up. However, there is limited information on the long-term effectiveness of DBT and how it compares with CBT and IPT. While research on this treatment is promising, more studies are needed to determine if it could be applied to all people with BED.

Weight loss therapy

Behavioral weight loss therapy aims to help people lose weight, which may reduce binge eating behavior by improving self-esteem and body image. The intent is to make gradual healthy lifestyle changes in regards to diet and exercise, as well as monitor food intake and thoughts about food throughout the day. Weight loss of about 1 pound (0.5 kg) per week is expected. While weight loss therapy may help improve body image and reduce weight and the health risks associated with obesity, it has not been shown to be as effective as CBT or IPT at stopping binge. As with regular weight loss treatment for obesity, behavioral weight loss therapy has been shown to help people achieve only short-term, moderate weight loss However, it may still be a good option for people who were not successful with other therapies or are primarily interested in losing weight

Medications

Several medications have been found to treat binge eating and are often cheaper and faster than traditional therapy. However, no current medications are as effective at treating BED as behavioral therapies. Available treatments include antidepressants, antiepileptic drugs like topiramate, and drugs traditionally used for hyperactive disorders, such as lisdexamfetamine . Research has found that medications have an advantage over a placebo for the short-term reduction of binge eating. Medications have been shown to be 48.7% effective, while placebos have been shown to be 28.5% effective. They may also reduce appetite, obsessions, compulsions, and symptoms of depression. Although these effects sound promising, most studies have been conducted over short periods, so data on the long-term effects is still needed. In addition, side effects of treatment may include headaches, stomach problems, sleep disturbances, increased blood pressure, and anxiety. Because many people with BED have other mental health conditions, such as anxiety and depression, they may also receive additional medications to treat these.

How to overcome binging

The first step in overcoming binge eating is speaking to a medical professional. This person can help with a diagnosis, determine the severity of the disorder, and recommend the most appropriate treatment. In general, the most effective treatment is CBT, but a range of treatments exists. Depending on individual circumstances, just one therapy or a combination may work best. No matter which treatment strategy is used, it is important to also make healthy lifestyle and diet choices when possible.

Here are some additional helpful strategies:

- Keep a food and mood diary. Identifying personal triggers is an important step in learning how to control binge impulses.
- Practice mindfulness. This can help increase awareness of binging triggers while helping increase self-control and maintaining self-acceptance.
- Find someone to talk to. It is important to have support, whether it is through a partner, family, a friend, binge eating support groups, or online.
- Choose healthy foods. A diet consisting of foods high in protein and healthy fats, regular meals, and whole foods will help satisfy hunger and provide needed nutrients.

- Start exercising. Exercise can help enhance weight loss, improve body image, reduce anxiety symptoms, and boost mood.
- Get enough sleep. Lack of sleep is associated with higher calorie intake and irregular eating patterns. It's recommended to get at least 7–8 hours of good sleep per night

8.3 Causes of Eating Disorders

The exact cause of anorexia and Bulimia is unknown. As with many diseases, it's probably a combination of biological, psychological and environmental factors.

- ***Biological***. Although it's not yet clear which genes are involved, there may be genetic changes that make some people at higher risk of developing anorexia. Some people may have a genetic tendency toward perfectionism, sensitivity and perseverance — all traits associated with anorexia.
- ***Psychological.*** Some people with anorexia may have obsessive-compulsive personality traits that make it easier to stick to strict diets and forgo food despite being hungry. They may have an extreme drive for perfectionism, which causes them to think they're never thin enough. And they may have high levels of anxiety and engage in restrictive eating to reduce it.
- ***Environmental.*** Modern Western culture emphasizes thinness. Success and worth are often equated with being thin. Peer pressure may help fuel the desire to be thin, particularly among young girls.

Causes of Binge Eating Disorder

The causes of BED are not well understood but likely due to a variety of risk factors, including:

- Genetics. People with BED may have increased sensitivity to dopamine, a chemical in the brain that's responsible for feelings of reward and pleasure. There is also strong evidence that the disorder is inherited.
- Gender. BED is more common in women than in men. In the United States, 3.6% of women experience BED at some point in their lives, compared with 2.0% of men. This may be due to underlying biological factors.
- Changes in the brain. There are indications that people with BED may have changes in brain structure that result in a heightened response to food and less self-
- Body size. Almost 50% of people with BED have obesity, and 25–50% of patients seeking weight loss surgery meet the criteria for BED. Weight problems may be both a cause and result of the disorder.
- Body image. People with BED often have a very negative body image. Body dissatisfaction, dieting, and overeating contribute to the development of the disorder
- Binge eating. Those affected often report a history of binge eating as the first symptom of the disorder. This includes binge eating in childhood and the teenage years .
- Emotional trauma. Stressful life events, such as abuse, death, separation from a family member, or a car accident, are risk factors. Childhood bullying due to weight may also contribute.
- Other psychological conditions. Almost 80% of people with BED have at least one other psychological disorder, such as phobias, depression, post-traumatic stress disorder (PTSD), bipolar disorder, anxiety, or substance abuse An episode of binge eating can be triggered by stress, dieting, negative feelings relating to body weight or body shape, the availability of food, or boredom).

Summary

Eating disorders are serious conditions related to persistent eating behaviors that negatively impact your health, your emotions and your ability to function in important areas of life. The most common eating disorders are anorexia nervosa, bulimia nervosa and binge-eating disorder. Most eating disorders involve focusing too much on your weight, body shape and food, leading to dangerous eating behaviors. These behaviors can significantly impact your body's ability to get appropriate nutrition. Eating disorders can harm the heart, digestive system, bones, and teeth and mouth, and lead to other diseases. Eating disorders often develop in the teen and young adult years, although they can develop at other ages. With treatment, you can return to healthier eating habits and sometimes reverse serious complications caused by the eating disorder.

Keyword:

Eating disorders, physical symptoms, causes, prevention, complication

Self-Evaluation

1) Research of bulimia nervosa has found low levels of:

a) Alpha-dopamine b) Beta-serotonin c) Beta-endorphin d) Alpha-amphetamine

2) In Restricted Type anorexia nervosa, self-starvation isd with which of the following?

a) Concurrent purging

b) Socialising

c) Body dysmorphic issues

d) Eating only certain food types

3) In Binge-Eating/Purging Type anorexia nervosa, self-starvation is associated with:

a) Not eating to help control weight gain b) Not being bothered about weight gain c) Regularly engaging in purging activities to help control weight gain d) Eating only certain food types

4) High rates of comorbidity exist between anorexia and other Axis I and Axis II disorders. What percentage of anorexia sufferers who also have a lifelong diagnosis of major depression?

a) 50-68% b) 30-40% c) 20-30% d) 70-80%

5) In Bulimia Nervosa, the purging sub-type, vomiting is the most common form of purging. What percentage of sufferers present with this type of purging?

a) 50-60% b) 80-90% c) 15-25% d) 50-60%

6) In Bulimia nervosa, the nonpurging sub-type, a behaviour which is used to compensate for binging is

a) Exercise b) Controlling intake of certain food types c) Withdrawing from social interaction d) Controlling carbohydrate intake

7) Individuals with bulimia have a perceived lack of control over their eating behaviour, and often report which of the following?

a) High levels of self-disgust b) Low self-esteem c) High levels of depression d) All of the above

8) Evidence suggests a link between bulimia and Axis II borderline personality disorders (BPD). What percent of women with bulimia meet the criteria for a personality disorder?

a) 45-55% b) 33-61% c) 20-30% d) 60-65%

9) Which of the following figures represents the prevalence of binge-eating disorder in the general population?

a)1-3% b) 5-10% c) 15-18% d) 7-9%

10) St. Catherine of Siena began self-starvation at the age of 16 years and continued until her death in 1380 (at the age of 32). This was termed by Bell (1985) as?

a)Anorexia nervosa b) Religious fervourc) Holy Anorexia d) Saintly anorexia

11) In the 17th century, which of the following terms was used to describe a disorder characterised by large food intake followed by vomiting?

a)Bulimia nervosa b) Vomitoria c) Fames canina d) Nuxcanina

12) Pick one of the following familial factors that plays a role in the development of eating disorders?

a)Parental attitudes to sex b) Parental obesity c) Parental attitudes to the media d) Parental attitudes to education

13) Community based twin studies suggest a heritability component of eating disorders which may be greater than:

a)20% b) 80% c) 50% d) 10%

14) In animal research, lesions to which part of the brain have been shown to cause appetite loss, resulting in a self-starvation syndrome?

a) Lateral hypothalamus b) b) Cerebellum c) c) Amygdala d) d) Basal ganglia

15) Biological accounts of anorexia and bulimia suggest that maintaining a low body weight and self-starvation may be reinforced by:

a)Endogenous opioids b) Serotonin c) Endorphins d) Dopamine

Answer

1C. 2A. 3C. 4A. 4B. 6A. 7D. 8B. 9A. 10C. 11C. 12B. 13C. 14A. 15A

Review Questions

1. What is an eating disorder?
2. How common are eating disorders?
3. What is the difference between anorexia nervosa and bulimia?
4. What causes an eating disorder?

FurtherReadings

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Paraphilic Disorders

CONTENTS

Objectives

1. To understand the concept of Paraphilic Disorders
2. To identify the different types of Paraphilic Disorders
3. To know the characteristics of Paraphilic Disorders

Introduction

The word paraphilia derives from Greek; para means around or beside, and philia means love. The definition of paraphilia is any emotional disorder characterized by sexually arousing fantasies, urges, or behaviors that are recurrent, intense, occur over a period of at least 6 months, and cause significant distress or interfere with the sufferer's work, social function, or other important areas of functioning. This is as opposed to sexual variants, which are sexual behaviors that are not typical but are not a part of any illness.

The number of people who suffer from a paraphilia is difficult to gauge for a number of reasons. Many people with one of these disorders suffer in secret or silence out of shame, and some engage in sexually offensive behaviors and so are invested in not reporting their paraphilia. Therefore, many of the estimates on the prevalence of paraphilic disorders come from the number of people involved with the criminal-justice system due to pedophilia. Most individuals with this sexual deviation are men (3%-5% of the male population), with just 1%-6% of those individuals being women. However, women tend to be under-diagnosed with paraphilias, wrongfully given the benefit of the doubt by those assessing their sexual behaviors.

Except for masochism, which is 20 times more common in women than men, paraphilias are almost exclusively diagnosed in men. Many people who suffer from one paraphilia have more than one.

For example, about one-third of pedophiles also have another paraphilia. More than half engage in three or four such kinds of behaviors rather than just one. Most people who develop a paraphilia begin having fantasies about it before they are 13 years old.

According to the most current standard reference for mental disorders, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), preceded by the DSM-IV and DSM-IV-TR, there are a number of different types of paraphilias, each of which has a different focus of the sufferer's sexual arousal:

8.1 Pedophilia

Sexual offenses against children constitute a significant proportion of reported criminal sexual acts. For older adolescents (ie, 17 to 18 years old), ongoing sexual interest or involvement with a 12- or 13-year-old may not meet the clinical criteria for a disorder. However, legal criteria may be different from psychiatric criteria. For example, sexual activity between a 19-year-old and a 16-year-old may be a crime and not a pedophilic disorder, depending on the jurisdiction. Diagnostic age guidelines apply to Western cultures and not to the many cultures that accept sexual activity, marriage, and childbearing at much younger ages and accept much greater age differences between sex partners than Western cultures do.

Most pedophiles are male. Attraction may be to young boys, girls, or both. But pedophiles prefer opposite-sex to same-sex children 2:1. In most cases, the adult is known to the child and may be a family member, stepparent, or a person with authority (eg, a teacher, a coach). Looking or touching seems more prevalent than genital contact. Pedophiles may be attracted only to children (exclusive form) or also adults (nonexclusive form); some are attracted only to children who are related to them (incest).

Predatory pedophiles, many of whom have antisocial personality disorder, may use force and threaten to physically harm the child or the child's pets if the abuse is disclosed.

The course of pedophilia is chronic, and perpetrators often have or develop substance use disorders or dependence and depression. Pervasive family dysfunction, a personal history of sexual abuse, and marital conflict are common. Other comorbid disorders include attention-deficit/hyperactivity disorder, anxiety disorders, and posttraumatic stress disorder.

Diagnosis of Pedophilic Disorders

- Clinical evaluation

Extensive use of child pornography is a reliable marker of sexual attraction to children and may be the only indicator of the disorder. However, use of child pornography by itself does not meet criteria for pedophilic disorder, although it is typically illegal.

If a patient denies sexual attraction to children but circumstances suggest otherwise, certain diagnostic tools can help confirm such attraction. Tools include penile plethysmography (men), vaginal photoplethysmography (women), and viewing time of standardized erotic materials; however, possession of such material, even for diagnostic purposes, may be illegal in certain jurisdictions.

Clinical criteria for diagnosis (based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-5]) of pedophilic disorder are

- Recurrent, intense sexually arousing fantasies, urges, or behaviors involving a prepubescent child or children (usually ≤ 13 years) have been present for ≥ 6 months.
- The person has acted on the urges or is greatly distressed or impaired by the urges and fantasies. The experience of distress about these urges or behaviors is not a requirement for the diagnosis.
- The person is ≥ 16 years and ≥ 5 years older than the child who is the target of the fantasies or behaviors (but excluding an older adolescent who is in an ongoing relationship with a 12- or 13-year-old).

Identifying a patient as a potential pedophile sometimes poses an ethical crisis for health care practitioners. However, health care practitioners have a responsibility to protect the community of

children. Practitioners should know the reporting requirements in their state. If practitioners have reasonable suspicion of child sexual or physical abuse, the law requires that it be reported to authorities. Reporting requirements vary by state (see Child Welfare Information Gateway).

Treatment of Pedophilic Disorders

- Psychotherapy
- Treatment of comorbid disorders
- Drug treatment (eg, antiandrogens, selective serotonin reuptake inhibitors [SSRIs])

Long-term individual or group psychotherapy is usually necessary and may be especially helpful when it is part of multimodal treatment that includes social skills training, treatment of comorbid physical and mental disorders, and drug treatment.

Treatment of pedophilia is less effective when court ordered, although many adjudicated sex offenders have benefited from treatments, such as group psychotherapy plus antiandrogens.

Some pedophiles who are committed to treatment and monitoring can refrain from pedophilic activity and can be reintegrated into society. These results are more likely when no other psychiatric disorders, particularly personality disorders, are present.

Drugs

In the US, the treatment of choice for pedophilia is

- IM medroxyprogesterone acetate

By blocking pituitary production of luteinizing hormone (LH) and follicle-stimulating hormone (FSH), medroxyprogesterone reduces testosterone production and thus reduces libido. Typical doses are medroxyprogesterone 200 mg IM 2 to 3 times a week for 2 weeks, followed by 200 mg 1 to 2 times a week for 4 weeks, then 200 mg every 2 to 4 weeks.

The gonadotropin-releasing hormone (GnRH) agonist leuprolide, which reduces pituitary production of LH and FSH and thus reduces testosterone production, is also an option and requires less frequent IM injections (at 1- to 6 month- intervals) than medroxyprogesterone. However, the cost is usually considerably higher. Cyproterone acetate, which blocks testosterone receptors, is used in Europe. Serum testosterone should be monitored and maintained in the normal female range (< 62 ng/dL [2.15 nmol/L]) in male patients. Treatment is usually long-term because deviant fantasies usually recur weeks to months after treatment is stopped. Liver function tests should be done, and blood pressure, bone mineral density, and complete blood count should be monitored as required.

The usefulness of antiandrogens in female pedophiles is less well established.

In addition to antiandrogens, SSRIs (eg, high-dose fluoxetine 60 to 80 mg once a day or fluvoxamine 200 to 300 mg orally once a day) may be useful.

Drugs are most effective when used as part of a multimodal treatment program

Fetishistic Disorder, according to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*, is diagnosed when a specific body part that is not a sexual organ or an item—an inanimate article–of another person's gives the individual sexual pleasure. Items that are used for sexual gratification can range from scarves and shoes to pantyhose and blouses, and the person may use the item when a partner is not there. He may feel it or stimulate his genitals with it. The object may cause the arousal of sexual feelings, such as how it feels, smells and looks.

Not considered to be a disorder unless it results in anxiousness and a disruption of everyday life, Fetishistic Disorder is predominantly begun when an individual reaches pubescence or, less frequently, in the teenage years.

- Voyeurism: watching an unsuspecting/non-consenting individual who is either nude, disrobing, or engaging in sexual activity
- Exhibitionism: exposing one's own genitals to an unsuspecting person
- Frotteurism: touching or rubbing against a non-consenting person
- Sexual masochism: being humiliated, beaten, bound, or otherwise suffering
- Sexual sadism: the physical or emotional suffering of another person

- Pedophilia: sexual activity with a child that is prepubescent (usually 13 years old or younger)
- Fetishism: sexual fascination with nonliving objects or highly specific body parts (partialism). Examples of specific fetishisms include somnophilia (sexual arousal by a person who is unconscious) and urophilia (deriving sexual pleasure from seeing or thinking about urine or urinating)
- Transvestism: cross-dressing that is sexually arousing and interferes with functioning
- Autogynephilia is a subtype of transvestism that refers specifically to men who become aroused by thinking or visualizing himself as a woman.
- Other specified paraphilia: some paraphilias do not meet full diagnostic criteria for a paraphilic disorder but may have uncontrolled sexual impulses that cause enough distress for the sufferer that they are recognized. Examples of such specific paraphilias include necrophilia (corpses), scatologia (obscene phone calls), coprophilia (feces and defecation), and zoophilia (animals).

Urges to engage in coercive or otherwise aggressive sex like rape are not symptoms of a mental illness. Such sexual offending is therefore not considered a paraphilia.

Voyeurism

Voyeuristic disorder is a condition that causes a person to act on voyeuristic urges or become so consumed by voyeuristic fantasies that they are unable to function.

Voyeuristic fantasies and urges occur when a person is sexually aroused by watching a person who is unaware that they are being watched engage in sexual activity. This condition typically develops in adolescence or early adulthood and is more common in men than in women.1

Voyeurism in itself isn't a disorder. When a person becomes so consumed by voyeuristic thoughts that they become distressed, unable to function or act on the urges with a person who hasn't given their consent, then it becomes a disorder.

Voyeuristic disorder is a type of paraphilic disorder. A paraphilic disorder is a condition that is characterized by strong and persistent sexual interest, urges, and behaviors that are typically focused around inanimate objects or children.

Some people with this condition might also experience thoughts of harming themselves or others during sexual activities.2

8.2 Necrophilia

Necrophilia is a term derived from the Greek words philios (attraction to/love) and nekros (dead body) and involves the sexual attraction to a dead body. Surprisingly, necrophilia dates back hundreds of years and has been documented in Greek mythology, ancient cultures, the Greco-Roman period, the middle ages, and in the modern era (Aggrawal, 2009). Mortuary attendants and funeral home workers have been known to be caught sexually assaulting corpses, and there have been individuals who have dug up graves in order to obtain a dead body to have sex with. More commonly there are serial murderers such as Ed Gein, Ed Kemper, Jeffery Dahmer, and Garry Ridgeway who have taken sexual advantage of dead victims.

Although the media may give the illusion of a more common prevalence of violent and unusual crimes, necrophilia is even rarer than sexual homicide. However, the true prevalence of necrophilia is unknown given that this paraphilia is most often carried out in secret, with the victim unable to report the act. While it is true that necrophilia is associated with those who commit sexual homicide, it is actually just as rare among sexual homicide offenders reportedly being found in less than 1% of sexual homicides (Stein, Schlesinger, &Pinizzotto, 2010).

Unlike other paraphilia's, necrophilia is not found in the DSM-5 (APA, 2013) under its own heading. Instead it is found under section 302.89, Other Specified Paraphilic Disorder. Like the DSM-5, the ICD-11 (WHO, 2018) also does not have a specific code for necrophilia, instead also including it in a more generalized way under the code 6D35, Other Paraphilic Disorder Involving Non-Consenting Individuals:

Necrophilia (Gknekros, corpse; philia, love) is a paraphilia whereby the perpetrator gets sexual pleasure in having sex with the dead (Aggrawal, 2014). Also known as necrophilism, necrolagnia, necrocoitus, necrochlesis, and thanatophilia, it may be seen by itself or in association with a number of other paraphilias, namely sadism, cannibalism, vampirism (the practice of drinking blood from a person or animal), necrophagia (eating the flesh of the dead), necropedophilia (sexual attraction to the corpses of children), and necrozoophilia (sexual attraction to the corpses of or killing of animals – also known as necrobestiality). Very often the corpses that are used for sexual purposes are not fresh, but rather dug up from graves in a putrefied or mummified condition. Some prefer just bones. Necrophagists actually feed on decaying dead bodies to get sexual pleasure. These are different from cannibals, who prefer fresh meat or who consume dead loved ones for spiritual purposes. A vast spectrum of necrophagists is seen, from those who merely want to lick the genitals or breasts of a dead person, to persons who just want to devour specific parts, to necrophiles who would eat a whole body. Necrophilia is mostly seen in males. It is possible for a necrophile to have normal sexual relations with living beings. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5) does not assign any specific or unique code to necrophilia. Instead, along with several other uncommon paraphilias (seven of which are specifically named), necrophilia is grouped under 'code 302.9' (Paraphilias Not Otherwise Specified). The International Classification of Diseases (ICD)-10 Classification of Mental and Behavioural Disorders, published by WHO, gives it a 'code F65.8.'

8.3 Transvestism

Transvestism involves recurrent, intense sexual arousal from cross-dressing. Transvestic disorder is transvestism that causes significant distress or substantially interferes with daily functioning.

Most cross-dressers have transvestism rather than transvestic disorder.

Doctors diagnose transvestic disorder when people are greatly distressed by or cannot function well because of their desire to cross-dress.

No drugs are reliably effective, but psychotherapy, when needed, may help people accept themselves and control behaviors that could cause problems in their life.

(See also Overview of Paraphilias and Paraphilic Disorders.)

Transvestism is a form of fetishism (the clothing is the fetish), which is a type of paraphilia. In transvestism (cross-dressing), men prefer to wear women's clothing, or, far less commonly, women prefer to wear men's clothing. However, they do not have an inner sense of belonging to the opposite sex or wish to change their sex, as do some people with severe gender dysphoria do. However, men who cross-dress may have feelings of gender dysphoria when they are under stress or experience a loss.

The term cross-dressers is usually used to refer to people with transvestism. Transvestite is a less acceptable term.

Heterosexual males who dress in women's clothing typically begin such behavior in late childhood. This behavior is associated, at least initially, with intense sexual arousal.

Cross-dressers may cross-dress for reasons other than sexual stimulation—for example, to reduce anxiety, to relax, or, in the case of male cross-dressers, to experiment with the feminine side of their otherwise male personalities.

Later in life (sometimes in their 50s or 60s), some men who were cross-dressers only in their teens and twenties develop gender dysphoria. They may seek to change their body through hormones and genital (sex-reassignment) surgery.

When a partner is cooperative, cross-dressing may not hurt a couple's sexual relationship. In such cases, cross-dressing men may engage in sexual activity in partial or full feminine attire.

When a partner is not cooperative, cross-dressers may feel anxious, depressed, guilty, and ashamed about their desire to cross-dress. In response to these feelings, these men often purge their wardrobe of female clothing. This purging may be followed by additional cycles of accumulating female clothes, wigs, and makeup, with more feelings of guilt and shame, followed by more purges.

Diagnosis of Transvestism

A doctor's evaluation, based on specific criteria

Doctors diagnose transvestic disorder when

People have been repeatedly and intensely aroused by cross-dressing, and the arousal has been expressed in fantasies, intense urges, or behaviors.

As a result, people feel greatly distressed or become less able to function well (at work, in their family, or in interactions with friends).

They have had the condition for 6 months or more.

Most cross-dressers do not have transvestic disorder.

Treatment of Transvestism

Social and support groups

Sometimes psychotherapy

Transvestism is considered a disorder and thus requires treatment only if it causes distress, interferes with functioning, or leads to behavior likely to result in injury, loss of a job, or imprisonment.

Only a few people with transvestism seek medical care. Those who do may be motivated by an unhappy spouse or by worry about how the cross-dressing is affecting their social life and work. Or they may be referred by courts for treatment. Some seek medical care for other problems, such as a substance use disorder or depression.

Social and support groups for men who cross-dress are often very helpful.

Psychotherapy, when needed, is focused on helping people accept themselves and control behaviors that could cause problems.

No drugs are reliably effective.

8.4 Fetishistic Disorder

Fetishistic Disorder is found to be almost always in men. Twenty-five percent of men with the disorder are homosexual. The disorder can be lifelong, or it can come and go during different time periods.

Signs of Fetishistic Disorder DSM-5 302.81 F65.0

The following are the criteria for the disorder.

- During half a year, the person has had desires that are fixated on a part of the body that doesn't include the genatalia or on a particular item, where he derived sexual impulses, imaginings or gratification.
- Anxiousness and a disruption of everyday life is a result of the fetish.
- The item that the person uses for sexual desires is not used because of cross dressing. The item is not sexual stimulation paraphernalia, such as a vibrator.

Is There Treatment for Fetishistic Disorder DSM-5 302.81 F65.0?

Cognitive Behavioral Therapy is thought to be helpful in Fetishistic Disorder. Sometimes the therapist will work with the individual to gradually dull the response toward the object that causes the sexual desire. This helps to lessen or completely rid the individual of his sexual feelings toward the object.

For many people with Fetishistic Disorder, it can cause problems in relationships. When the item the individual has the fetish toward is not present or removed from the room, he may not be able to complete the sexual act.

There is a belief that there is a relation to the disorder if a person has been physically abused in the past or has less education. In addition, abuse of alcohol and drugs, as well as if a person is undergoing treatment for substances, or other mental disorders may have a connection.

8.5 Frotteuristic disorder

Frotteuristic disorder or frotteurism, is a rare and poorly researched type of paraphilia. It involves the act of touching or rubbing one's genitals against another non-consenting individual in a sexual manner, to attain sexual gratification. This activity reviews the evaluation and treatment of this disorder and highlights the interprofessional team's role in evaluating and treating patients with this condition.

he Diagnostic and Statistical Manual of Mental Disorders V (DSM-5) distinguishes between paraphilia and a paraphilic disorder.

The term paraphilia is defined as "an intense and persistent sexual interest which is not a sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physiologically mature, consenting human partners."

The term disorder was added specifically to DSM-5 to indicate paraphilic behaviors. The term paraphilic disorder is explained as "a disorder that causes clinically significant distress or impairment to the individual or involved harm or risk to others while gaining sexual gratification."

Frotteurism is one such disorder that is subsumed within paraphilic disorder; it is one of eight such paraphilias listed in the DSM-V. Frotteurism is the act of touching or rubbing one's genitals up against a non-consenting person in a sexual manner.[1]

The term frottage is derived from the French word "frotter," which means "to rub." Kraft-Ebbing is credited by many for first describing this behavior in detail in the book PsychopathiaSexualis in 1886, while Clifford Allen coined the term frotteurism in the 1960s.

Summary

In the Diagnostic and Statistical Manual of Mental Disorders (DSM), paraphilic disorders are often misunderstood as a catch-all definition for any unusual sexual behavior. In the upcoming fifth edition of the book, DSM-5, the Sexual and Gender Identity Disorders Work Group sought to draw a line between atypical human behavior and behavior that causes mental distress to a person or makes the person a serious threat to the psychological and physical well-being of other individuals. While legal implications of paraphilic disorders were considered seriously in revising diagnostic criteria, the goal was to update the disorders in this category based on the latest science and effective clinical practice. Through careful consideration of the research as well as of the collective clinical knowledge of experts the field, several important changes were made to the criteria of paraphilic disorders, or paraphilias as they have been called in previous editions of the manual. Paraphilic DisordersMost people with atypical sexual interests do not have a mental disorder. To be diagnosed with a paraphilic disorder, DSM-5 requires that people with these interests: feel personal distress about their interest, not merely distress resulting from society's disapproval; or have a sexual desire or behavior that involves another person's psychological distress, injury, or death, or a desire for sexual behaviors involving unwilling persons or persons unable to give legal

consent. To further define the line between an atypical sexual interest and disorder, the Work Group revised the names of these disorders to differentiate between the behavior itself and the disorder stemming from that behavior (i.e., Sexual Masochism in DSM-IV will be titled Sexual Masochism Disorder in DSM-5). It is a subtle but crucial difference that makes it possible for an individual to engage in consensual atypical sexual behavior without inappropriately being labeled with a mental disorder. With this revision, DSM-5 clearly distinguishes between atypical sexual interests and mental disorders involving these desires or behaviors.

Keyword:

Paraphilic Disorders, causes, characteristics, symptoms

Self-Evaluation

1) Sexual dysfunction is one category of disorders of sexuality and sexual functioning. The term sexual dysfunction refers to:

a) Problems with the normal sexual response cycle

b) Sexual urges or fantasies involving unusual sources of gratification problems

c) An individual is dissatisfied with their own biological sex and have a strong desire to be a member of the opposite sex.

d) Problems with sexual fantasies

2) In disorders of sexuality and sexual functioning, the term paraphilias refers to:

a) Problems with the normal sexual response cycle

b) Sexual urges or fantasies involving unusual sources of gratification problems

c) An individual is dissatisfied with their own biological sex and have a strong desire to be a member of the opposite sex.

d) Problems with sexual fantasies

3) In disorders of sexuality and sexual functioning, the term gender identity disorder refers to:

a) Problems with the normal sexual response cycle

b) Sexual urges or fantasies involving unusual sources of gratification problems

c) Problems with sexual fantasies

d) An individual is dissatisfied with their own biological sex and have a strong desire to be a member of the opposite sex

4) Sexual aversion disorder is associated with which of the following?

a) Anxiety

b) Disgust

c) Fear

d) All of the above

5) Female Sexual Arousal Disorder is defined primarily in terms of a deficiency in a physical or physiological response, and as a result may be caused by a range of physical or physiological factors, including:

a) Hormone imbalances

b) Diabetes

c) Medications being taken for other disorders

d) All of the above

6) Which of the following is characteristic of Male Erectile Disorder?

a) A failure to attain an erection from the outset of sexual activity,

b) First experiencing an erection but then losing tumescence prior to penetration

c) Losing tumescence during penetration but prior to orgasm

d) All of the above

7) The term performance anxiety refers to:

a) Fear of failing to achieve a sustained erection

b) Fear of having sex in a public place

c) Fear of criticism from the sexual partner

d) Fear of not achieving orgasm

Check your answer

8) Which of the following is the term for the experience of persistent or recurrent delay in or absence of orgasm following normal sexual excitement which causes the individual marked distress or interpersonal difficulty?

a) Dysfunctional Orgasmic Disorder

b) Aclimactic Disorder

c) Female Orgasmic Disorder

d) Female Climactic Disorder

9) Genital pains that can occur before, during or after sexual intercourse, and can occur in both males and females are known as:

a) Dyspareunia

b) Dysmenhorea

c) Dyskinesia

d) Dyspraxia

10) The involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration is attempted is termed:

a) Perinealitis

b) Perivaginitis

c) Vaginitis

d) Vaginismus

11) In men, erectile dysfunction is associated with high levels of which of the following?

a) Testosterone

b) Prolactin

c) Estrogen

d) Prostaglandin

12) Which of the following is a direct treatment method which deals with symptoms of erectile dysfunction or male and female orgasmic disorder?

a) Squeeze technique

b) Tickle technique

c) Tease technique.

d) Stroke technique

13) A common drug treatment for sexual dysfunction is Viagra. What is the generic term for this?

a) Fluoxitine

b) Metronydasol

c) Diclofenac

d) Sildenafil citrate

14) Yohimbine is a drug used to treat erectile dysfunctions, it works by:

a) Facilitating dopamine production brain

b) Facilitating norepinephrine excretion in the brain

c) Facilitating serotonin excretion in the brain

d) Facilitating testosterone production

15) Which of the following can be used to treatment erectile dysfunction?

a) Hoover erection device (HED)

b) Vacuum erection device (VED)

c) Piston erection tool (PET)

d) Erectile dysfunction pump (EDP)

Scoring Key

1A. 2B. 3D. 4D. 5D. 6D. 7A. 8C. 9A. 10D. 11B. 12C. 13D. 14B. 15B.

Review Questions

1. What are paraphilic disorders?

2. Discuss different types of paraphilic disorders.

3. What are the causes of paraphilic disorders?

4. Discuss the treatment of paraphilic disorders

Further Readings

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Unit 09: Schizophrenia and Paranoia

Content

Objectives

1. To understand the concept of schizophrenia and paranoia
2. To understand the different types of schizophrenia
3. To know the characteristics of schizophrenia

9.1 Introduction

Schizophrenia is a serious mental disorder in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning, and can be disabling.

People with schizophrenia require lifelong treatment. Early treatment may help get symptoms under control before serious complications develop and may help improve the long-term outlook.

9.2 Symptoms

Schizophrenia involves a range of problems with thinking (cognition), behavior and emotions. Signs and symptoms may vary, but usually involve delusions, hallucinations or disorganized speech, and reflect an impaired ability to function. Symptoms may include:

- **Delusions.** These are false beliefs that are not based in reality. For example, you think that you're being harmed or harassed; certain gestures or comments are directed at you; you have exceptional ability or fame; another person is in love with you; or a major catastrophe is about to occur. Delusions occur in most people with schizophrenia.
- **Hallucinations.** These usually involve seeing or hearing things that don't exist. Yet for the person with schizophrenia, they have the full force and impact of a normal experience. Hallucinations can be in any of the senses, but hearing voices is the most common hallucination.
- **Disorganized thinking (speech).** Disorganized thinking is inferred from disorganized speech. Effective communication can be impaired, and answers to questions may be partially or completely unrelated. Rarely, speech may include putting together meaningless words that can't be understood, sometimes known as word salad.
- **Extremely disorganized or abnormal motor behavior.** This may show in a number of ways, from childlike silliness to unpredictable agitation. Behavior isn't focused on a goal, so it's hard to do tasks. Behavior can include resistance to instructions, inappropriate or bizarre posture, a complete lack of response, or useless and excessive movement.

- **Negative symptoms.** This refers to reduced or lack of ability to function normally. For example, the person may neglect personal hygiene or appear to lack emotion (doesn't make eye contact, doesn't change facial expressions or speaks in a monotone). Also, the person may lose interest in everyday activities, socially withdraw or lack the ability to experience pleasure.

Symptoms can vary in type and severity over time, with periods of worsening and remission of symptoms. Some symptoms may always be present.

In men, schizophrenia symptoms typically start in the early to mid-20s. In women, symptoms typically begin in the late 20s. It's uncommon for children to be diagnosed with schizophrenia and rare for those older than age 45.

Symptoms in teenagers

Schizophrenia symptoms in teenagers are similar to those in adults, but the condition may be more difficult to recognize. This may be in part because some of the early symptoms of schizophrenia in teenagers are common for typical development during teen years, such as:

- Withdrawal from friends and family
- A drop in performance at school
- Trouble sleeping
- Irritability or depressed mood
- Lack of motivation

Also, recreational substance use, such as marijuana, methamphetamines or LSD, can sometimes cause similar signs and symptoms.

Compared with schizophrenia symptoms in adults, teens may be:

- Less likely to have delusions
- More likely to have visual hallucinations
- Doctors who specialize in mental health used to divide schizophrenia into different subtypes:
-
- Catatonic
- Disorganized
- Paranoid
- Residual
- Undifferentiated.
- But that system didn’t work well. Now, experts talk about schizophrenia as a spectrum disorder that includes all the previous subtypes. It's a group of related mental disorders that share some symptoms. They're like variations on a theme in music. They affect your sense of what's real. They change how you think, feel, and act.
-
- It's a psychosis, which means that what seems real to you isn't. You could have:
-
- Hallucinations: Seeing or hearing things that aren't there.
- Delusions: Mistaken but firmly held beliefs that are easy to prove wrong, like thinking you have superpowers, are a famous person, or people are out to get you.
- Disorganized speech: Using words and sentences that don't make sense to others.
- Strange behavior: Acting in an odd or repetitive way, like walking in circles or writing all the time, or sitting perfectly still and quiet for hours on end.
- Withdrawn and lifeless: Showing no feelings or motivation, or lacking interest in normal daily activities.

9.3 When to see a doctor

People with schizophrenia often lack awareness that their difficulties stem from a mental disorder that requires medical attention. So it often falls to family or friends to get them help.

If you think someone you know may have symptoms of schizophrenia, talk to him or her about your concerns. Although you can't force someone to seek professional help, you can offer encouragement and support and help your loved one find a qualified doctor or mental health professional.

If your loved one poses a danger to self or others or can't provide his or her own food, clothing, or shelter, you may need to call 911 or other emergency responders for help so that your loved one can be evaluated by a mental health professional.

In some cases, emergency hospitalization may be needed. Laws on involuntary commitment for mental health treatment vary by state. You can contact community mental health agencies or police departments in your area for details.

Suicidal thoughts and behavior

Suicidal thoughts and behavior are common among people with schizophrenia. If you have a loved one who is in danger of attempting suicide or has made a suicide attempt, make sure someone stays with that person. Call 911 or your local emergency number immediately. Or, if you think you can do so safely, take the person to the nearest hospital emergency room.

9.4 Causes - Schizophrenia

The exact causes of schizophrenia are unknown. Research suggests a combination of physical, genetic, psychological and environmental factors can make a person more likely to develop the condition.

Some people may be prone to schizophrenia, and a stressful or emotional life event might trigger a psychotic episode. However, it's not known why some people develop symptoms while others do not.

9.5 Increased risk

9.6 Genetics

Schizophrenia tends to run in families, but no single gene is thought to be responsible.

It's more likely that different combinations of genes make people more vulnerable to the condition. However, having these genes does not necessarily mean you'll develop schizophrenia.

Evidence that the disorder is partly inherited comes from studies of twins. Identical twins share the same genes.

In identical twins, if a twin develops schizophrenia, the other twin has a 1 in 2 chance of developing it, too. This is true even if they're raised separately.

In non-identical twins, who have different genetic make-ups, when a twin develops schizophrenia, the other only has a 1 in 8 chance of developing the condition.

While this is higher than in the general population, where the chance is about 1 in 100, it suggests genes are not the only factor influencing the development of schizophrenia.

9.7 Brain development

Studies of people with schizophrenia have shown there are subtle differences in the structure of their brains.

These changes are not seen in everyone with schizophrenia and can occur in people who do not have a mental illness. But they suggest schizophrenia may partly be a disorder of the brain.

9.8 Neurotransmitters

Neurotransmitters are chemicals that carry messages between brain cells.

There's a connection between neurotransmitters and schizophrenia because drugs that alter the levels of neurotransmitters in the brain are known to relieve some of the symptoms of schizophrenia.

Research suggests schizophrenia may be caused by a change in the level of 2 neurotransmitters: dopamine and serotonin.

Some studies indicate an imbalance between the 2 may be the basis of the problem. Others have found a change in the body's sensitivity to the neurotransmitters is part of the cause of schizophrenia.

9.9 Pregnancy and birth complications

Research has shown people who develop schizophrenia are more likely to have experienced complications before and during their birth, such as:

- a low birthweight
- premature labour
- a lack of oxygen (asphyxia) during birth

It may be that these things have a subtle effect on brain development.

Triggers are things that can cause schizophrenia to develop in people who are at risk.

These include:

9.10 Stress

The main psychological triggers of schizophrenia are stressful life events, such as:

- bereavement
- losing your job or home
- divorce
- the end of a relationship
- physical, sexual or emotional abuse

These kinds of experiences, although stressful, do not cause schizophrenia. However, they can trigger its development in someone already vulnerable to it.
Drugs do not directly cause schizophrenia, but studies have shown drug misuse increases the risk of developing schizophrenia or a similar illness.
Certain drugs, particularly cannabis, cocaine, LSD or amphetamines, may trigger symptoms of schizophrenia in people who are susceptible.
Using amphetamines or cocaine can lead to psychosis, and can cause a relapse in people recovering from an earlier episode.
Research has shown that teenagers and young adults who use cannabis regularly are more likely to develop schizophrenia in later adulthood.

9.11 Paranoia and paranoid reaction

Paranoia is the feeling that you're being threatened in some way, such as people watching you or acting against you, even though there's no proof that it's true. It happens to a lot of people at some point. Even when you know that your concerns aren't based in reality, they can be troubling if they happen too often. Clinical paranoia is more severe. It's a rare mental health condition in which you believe that others are unfair, lying, or actively trying to harm you when there's no proof. You don't think you're paranoid at all because you feel sure it's true. As the old saying goes, "It isn't paranoia if they're really out to get you." Anxiety vs. Paranoid Thoughts A paranoid thought is a type of anxious thought. Anxiety can cause paranoia, affecting what you're paranoid about and how long the feeling lasts. But paranoid thoughts can also make you anxious It's normal to be anxious sometimes, especially if you're going through something hard like losing a job or the end of a relationship. When in large groups of people, you may worry that others will judge the things you say or the way you dress or behave. You might walk into a party by yourself and think, "Everyone is wondering why I'm alone." Some call this paranoid, but we all have thoughts like this from time to time. Just because you're worried that people might be talking about you doesn't mean you have a mental illness. Clinical paranoia happens when you're 100% convinced of it, even when facts prove that it isn't true. If you worry that your thoughts are paranoid, you probably have some anxiety rather than paranoia. If your anxiety isn't linked to anything obvious and it never seems to get better or go away, you may need to talk to a doctor about it. Feelings of anxiety and panic that last a long time or get in the way of your daily life might be signs of an anxiety disorder. Symptoms of paranoia may be more severe. An individual who has fixed systematized delusions, is suspicious, has a persecution complex, is resentful and bitter, and is a megalomaniac. Many states approach true paranoia and resemble it but lack one or more of its distinguishing features. Some of these are transitory paranoid states caused by toxic conditions, a paranoid type of schizophrenia, and paranoid states due to alcoholism.

9.12 Summary

Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves.Symptoms of schizophrenia usually start between ages 16 and 30. Men often develop symptoms at a younger age than women. People usually do not get schizophrenia after age 45. There are three types of symptoms: Psychotic symptoms distort a person's thinking. These include hallucinations (hearing or seeing things that are not there), delusions (beliefs that are not true), trouble organizing thoughts, and strange movements "Negative" symptoms make it difficult to show emotions and to function normally. A person may seem depressed and withdrawn. Cognitive symptoms affect the thought process. These include trouble using information, making decisions, and paying attention. No one is sure what causes schizophrenia. Your genes, environment, and brain chemistry may play a role.There is no cure. Medicine can help control many of the symptoms. You may need to try different medicines to see which works best. You should stay on your medicine for as long as your

doctor recommends. Additional treatments can help you deal with your illness from day to day. These include therapy, family education, rehabilitation, and skills training.

9.13 Keyword:

Schizophrenia, causes, treatment, symptoms

9.14 Self Eveluation

1) the phenomenon in Schizophrenia, known as 'downward drift' means which of the following?

a) Falling to the bottom of the social ladder
b) Become homeless
c) Inability to hold down a job
d) All of the above

2) Historically, Dementia praecox was a disease first identified by?

a) Freud
b) Beck
c) Watson
d) Kraepelin

3) In Schizophrenia psychotic symptoms such as hallucinations delusions, disorganised speech and grossly disorganised or catatonic behaviours are known as:

a) Negative symptoms
b) Positive symptoms
c) Mediating symptoms
d) Catastrophic symptoms

4) Misinterpretation of perceptions or experiences in Schizophrenia are known as:

a) Hallucinations
b) Misperceptions
c) Delusions
d) Avolition

5)In Schizophrenia when an individual believes they are in danger, this is referred to as:

a) Delusions of grandeur
b) Delusions of persecution
c) Delusions of control
d) Nihilistic delusions

6) Which of the following refers to when an individual with Schizophrenia believes they are someone with fame or power?

a) Delusions of grandeur
b) Delusions of control
c) Delusions of reference
d) Nihilistic delusions

7) In Schizophrenia the when an individual believes that messages are being sent directly to him or her, this is referred to as:

a) Delusions of persecution
b) Nihilistic delusions
c) Delusions of reference
d) Delusions of persecution

8) Which of the following ways might hallucinations be experienced in Schizophrenia,?

a) Auditory
b) Olfactory
c) Gustatory
d) All of the above

9) In Schizophrenia a reality-monitoring deficit refers to which of the following:

a) Problems distinguishing between thoughts and ideas they generated themselves
b) Problems with memory loss
c) Problems with spatial ability
d) Problems distinguishing between what actually occurred and what did not

10) Which of the following come under the term disorganised speech In Schizophrenia?

a) Derailment
b) Loose associations
c) Word salads
d) All of the above

11) In schizophrenia when an individual has disorganised speech the term 'clanging' refers to:

a) Individuals only communicate with words that rhyme
b) Answers to questions may not be relevant
c) Individuals communicate without completing their sentences.
d) Speech may be neither structured nor comprehensible

12) 'poverty of content' in Schizophrenia is when::

a) Speech appears to be detailed in terms of numbers of words, but is grammatically incorrect
b) A tendency to jump from one topic to another within a sentence
c) Poor use of vocabulary
d) Poor use of grammar

13) Catatonic Behaviour in Schizophrenia is characterised by which if the following:

a) Resisting attempts to be moved
b) Maintaining rigid, immobile postures
c) Decrease in reactivity to the environment
d) All of the above

14) Grossly Disorganised Behaviour in Schizophrenia is characterised by which of the following?

a) Behaviour may be childlike and silly and inappropriate for the perso's chronological age
b) Behaviour may be inappropriate to the context
c) Behaviour may be unpredictable and agitated
d) All of the above

15) Affective flattening in Schizophrenia Is characterised by which of the following

a) Expressionless and unresponsive facial appearance
b) Lack of eye contact
c) Monotonous voice tone
d) All of the above

Answers
1D. 2D. 3B. 4C. 5B. 6A. 7C. 8D. 9D. 10D. 11A. 12A. 13D. 14D. 15D

9.15 Review Questions

1. What is schizophrenia?
2. Discuss different types of schizophrenia.
3. What are the causes of schizophrenia?
4. Discuss the treatment of schizophrenia.

9. 16 Further Readings

https://www.psychiatry.org/patients-families/schizophrenia/what-is-

schizophrenia#:~:text=Schizophrenia%20is%20a%20chronic%20brain,thinking%20and%20lack%20of%20motivation.

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Unit 10: Personality Disorders

Content

Objectives

Objectives

1. To understand the concept of personality disorders
2. To identify and understand the different types of personality disorders
3. To know the characteristics of personality disorders

10.1 Introduction

A personality disorder is a type of mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving. A person with a personality disorder has trouble perceiving and relating to situations and people. This causes significant problems and limitations in relationships, social activities, work and school.

In some cases, you may not realize that you have a personality disorder because your way of thinking and behaving seems natural to you. And you may blame others for the challenges you face.

Personality disorders usually begin in the teenage years or early adulthood. There are many types of personality disorders. Some types may become less obvious throughout middle age.

10.2 Paranoid personality disorder

Paranoid personality disorder (PPD) is one of a group of conditions called Cluster A or eccentric personality disorders. People with these disorders often appear odd or peculiar. The essential characteristic of people with PPD is paranoia, a relentless mistrust and suspicion of others without adequate reason to be suspicious. This disorder often begins in childhood or early adolescence and appears to be more common in men than in women. Studies estimate that PPD affects between 2.3% and 4.4% of the general population.

10.3 Symptoms And Causes

The exact cause of PPD is not known, but it likely involves a combination of biological and psychological factors. The fact that PPD is more common in people who have close relatives with schizophrenia and delusional disorder suggests a genetic link between the two disorders (may run in the family). It is also believed that early childhood experiences, including physical or emotional trauma, play a role in the development of PPD.

10.4 symptoms of paranoid personality disorder

People with PPD are always on guard, believing that others are constantly trying to demean, harm, or threaten them. These generally unfounded beliefs, as well as their habits of blame and distrust, interfere with their ability to form close or even workable relationships. People with this disorder:

- Doubt the commitment, loyalty, or trustworthiness of others, believing others are exploiting or deceiving them.
- Are reluctant to confide in others or reveal personal information because they are afraid the information will be used against them.
- Are unforgiving and hold grudges.
- Are hypersensitive and take criticism poorly.
- Read hidden meanings in the innocent remarks or casual looks of others.
- Perceive attacks on their character that are not apparent to others; they generally react with anger and are quick to retaliate.
- Have persistent suspicions, without reason, that their spouses or lovers are being unfaithful.
- Are generally cold and distant in their relationships with others, and might become controlling and jealous to avoid being betrayed.
- Cannot see their role in problems or conflicts, believing they are always right.
- Have difficulty relaxing.
- Are hostile, stubborn, and argumentative.
- Tend to develop negative stereotypes of others, especially those from different cultural groups.

10.5 Diagnosis And Tests

If a person has symptoms, the doctor will begin an evaluation by performing a complete medical history and physical examination. Although there are no laboratory tests to specifically diagnose personality disorders, the doctor might use various diagnostic tests to rule out physical illness as the cause of the symptoms. For example, difficulty hearing or long-lasting substance abuse may be confused with PPD.

If the doctor finds no physical reason for the symptoms, he or she might refer the person to a psychiatrist or psychologist, health care professionals who are specially trained to diagnose and treat mental illnesses. PPD is different from psychotic disorders such as schizophrenia, paranoid type or delusional disorder, persecutory type, in that the person with PPD lacks the perceptual distortions (for example, hearing voices) or bizarre delusional thinking (for example, being followed everywhere by the FBI). Psychiatrists and psychologists use specially designed interview and assessment tools to evaluate a person for a personality disorder.

10.6 Management And Treatment

People with PPD often do not seek treatment on their own because they do not see themselves as having a problem. The distrust of others felt by people with PPD also poses a challenge for health care professionals because trust is an important factor of psychotherapy (a form of counseling). As a result, many people with PPD do not follow their treatment plan and may even question the motives of the therapist.

When a patient seeks treatment for PPD, psychotherapy is the treatment of choice. Treatment likely will focus on increasing general coping skills, especially trust and empathy, as well as on improving social interaction, communication, and self-esteem.

Medication generally is not used to treat PPD. However, medications—such as anti-anxiety, antidepressant, or anti-psychotic drugs—might be prescribed if the person's symptoms are extreme, or if he or she also suffers from an associated psychological problem, such as anxiety or depression.

10.7 What are the complications of paranoid personality disorder?

The thinking and behaviors associated with PPD can interfere with a person's ability to form and maintain relationships, as well as their ability to function socially and in work situations. In many cases, people with PPD become involved in legal battles, suing people or companies they believe are "out to get them."

10.8 Prevention

Although it might not be possible to prevent PPD, treatment can sometimes allow a person who is prone to this disorder to learn more productive ways of dealing with situations.

10.9 Outlook / Prognosis

The outlook for people with PPD varies. It is a chronic disorder, which means it tends to last throughout a person's life. Although some people can function fairly well with PPD and are able to

marry and hold jobs, others are completely disabled by the disorder. Because people with PPD tend to resist treatment, the prognosis often is poor.

10.10 Overview

Schizoid personality disorder is an uncommon condition in which people avoid social activities and consistently shy away from interaction with others. They also have a limited range of emotional expression.

If you have schizoid personality disorder, you may be seen as a loner or dismissive of others, and you may lack the desire or skill to form close personal relationships. Because you don't tend to show emotion, you may appear as though you don't care about others or what's going on around you.

The cause of schizoid personality disorder is unknown. Talk therapy, and in some cases medications, can help.

Symptoms

If you have schizoid personality disorder, it's likely that you:

- Prefer being alone and choose to do activities alone
- Don't want or enjoy close relationships
- Feel little if any desire for sexual relationships
- Feel like you can't experience pleasure
- Have difficulty expressing emotions and reacting appropriately to situations
- May seem humorless, indifferent or emotionally cold to others
- May appear to lack motivation and goals
- Don't react to praise or critical remarks from others

Schizoid personality disorder usually begins by early adulthood, though some features may be noticeable during childhood. These features may cause you to have trouble functioning well in school, a job, socially or in other areas of life. However, you may do reasonably well in your job if you mostly work alone.

Schizotypal personality disorder and schizophrenia

Although a different disorder, schizoid personality disorder can have some similar symptoms to schizotypal personality disorder and schizophrenia, such as a severely limited ability to make social connections and a lack of emotional expression. People with these disorders may be viewed as odd or eccentric.

Even though the names may sound similar, unlike schizotypal personality disorder and schizophrenia, people with schizoid personality disorder:

- Are in touch with reality, so they're unlikely to experience paranoia or hallucinations
- Make sense when they speak (although the tone may not be lively), so they don't have conversational patterns that are strange and hard to follow

When to see a doctor

People with schizoid personality disorder usually only seek treatment for a related problem, such as depression.

If someone close to you has urged you to seek help for symptoms common to schizoid personality disorder, make an appointment with a health care or mental health professional.

If you suspect a loved one may have schizoid personality disorder, gently suggest that the person seek medical attention. It might help to offer to go along to the first appointment.

Causes

Personality is the combination of thoughts, emotions and behaviors that makes you unique. It's the way you view, understand and relate to the outside world, as well as how you see yourself. Personality forms during childhood, shaped through an interaction of inherited tendencies and environmental factors.

In normal development, children learn over time to accurately interpret social cues and respond appropriately. What causes the development of schizoid personality disorder is unknown, although a combination of genetic and environmental factors, particularly in early childhood, may play a role in developing the disorder.

Risk factors

Factors that increase your risk of developing schizoid personality disorder include:

- Having a parent or other relative who has schizoid personality disorder, schizotypal personality disorder or schizophrenia
- Having a parent who was cold, neglectful or unresponsive to emotional needs

Complications

People with schizoid personality disorder are at an increased risk of:

- Developing schizotypal personality disorder, schizophrenia or another delusional disorder

- Other personality disorders
- Major depression
- Anxiety disorders

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Complications

People with schizoid personality disorder are at an increased risk of:

- Developing schizotypal personality disorder, schizophrenia or another delusional disorder
- Other personality disorders
- Major depression
- Anxiety disorders

Antisocial personality disorder, sometimes called sociopathy, is a mental disorder in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others. People with antisocial personality disorder tend to antagonize, manipulate or treat others harshly or with callous indifference. They show no guilt or remorse for their behavior.
Individuals with antisocial personality disorder often violate the law, becoming criminals. They may lie, behave violently or impulsively, and have problems with drug and alcohol use. Because of these characteristics, people with this disorder typically can't fulfill responsibilities related to family, work or school.

10.11 Histrionic personality disorder

Histrionic personality disorder is one of a group of conditions called "Cluster B" or "dramatic" personality disorders. People with these disorders have intense, unstable emotions and distorted self-images. For people with histrionic personality disorder, their self-esteem depends on the approval of others and does not arise from a true feeling of self-worth. They have an overwhelming desire to be noticed, and often behave dramatically or inappropriately to get attention. The word histrionic means "dramatic or theatrical."
This disorder is more common in women than in men and usually is evident by adolescence or early adulthood.

What Are the Symptoms of Histrionic Personality Disorder?

In many cases, people with histrionic personality disorder have good social skills; however, they tend to use these skills to manipulate others so that they can be the center of attention.
A person with this disorder might also:

- Be uncomfortable unless they are the center of attention
- Dress provocatively and/or exhibit inappropriately seductive or flirtatious behavior
- Shift emotions rapidly
- Act very dramatically, as though performing before an audience, with exaggerated emotions and expressions, yet appears to lack sincerity
- Be overly concerned with physical appearance
- Constantly seek reassurance or approval
- Be gullible and easily influenced by others
- Be excessively sensitive to criticism or disapproval
- Have a low tolerance for frustration and be easily bored by routine, often beginning projects without finishing them or skipping from one event to another
- Not think before acting
- Make rash decisions
- Be self-centered and rarely show concern for others
- Have difficulty maintaining relationships, often seeming fake or shallow in their dealings with others
- Threaten or attempt suicide to get attention

10.12 What Causes Histrionic Personality Disorder?

The exact cause of histrionic personality disorder is not known, but many mental health professionals believe that both learned and inherited factors play a role in its development. For example, the tendency for histrionic personality disorder to run in families suggests that a genetic susceptibility for the disorder might be inherited. However, the child of a parent with this disorder might simply be repeating learned behavior. Other environmental factors that might be involved include a lack of criticism or punishment as a child, positive reinforcement that is given only when a child completes certain approved behaviors, and unpredictable attention given to a child by their parent(s), all leading to confusion about what types of behavior earn parental approval. Personality disorders also usually develop in relation to individual temperament and psychological styles and ways people learn to cope with stress while growing up.

Narcissistic personality disorder — one of several types of personality disorders — is a mental condition in which people have an inflated sense of their own importance, a deep need for

excessive attention and admiration, troubled relationships, and a lack of empathy for others. But behind this mask of extreme confidence lies a fragile self-esteem that's vulnerable to the slightest criticism.

A narcissistic personality disorder causes problems in many areas of life, such as relationships, work, school or financial affairs. People with narcissistic personality disorder may be generally unhappy and disappointed when they're not given the special favors or admiration they believe they deserve. They may find their relationships unfulfilling, and others may not enjoy being around them.

Treatment for narcissistic personality disorder centers around talk therapy (psychotherapy).

10.13 Causes

It's not known what causes narcissistic personality disorder. As with personality development and with other mental health disorders, the cause of narcissistic personality disorder is likely complex. Narcissistic personality disorder may be linked to:

- **Environment** — mismatches in parent-child relationships with either excessive adoration or excessive criticism that is poorly attuned to the child's experience
- **Genetics** — inherited characteristics
- **Neurobiology** — the connection between the brain and behavior and thinking

Risk factors

Narcissistic personality disorder affects more males than females, and it often begins in the teens or early adulthood. Keep in mind that, although some children may show traits of narcissism, this may simply be typical of their age and doesn't mean they'll go on to develop narcissistic personality disorder.

Although the cause of narcissistic personality disorder isn't known, some researchers think that in biologically vulnerable children, parenting styles that are overprotective or neglectful may have an impact. Genetics and neurobiology also may play a role in development of narcissistic personality disorder.

10.14 Complications

Complications of narcissistic personality disorder, and other conditions that can occur along with it, can include:

- Relationship difficulties
- Problems at work or school
- Depression and anxiety
- Physical health problems
- Drug or alcohol misuse
- Suicidal thoughts or behavior

10.15 Prevention

Because the cause of narcissistic personality disorder is unknown, there's no known way to prevent the condition. However, it may help to:

- Get treatment as soon as possible for childhood mental health problems
- Participate in family therapy to learn healthy ways to communicate or to cope with conflicts or emotional distress
- Attend parenting classes and seek guidance from therapists or social workers if needed

10.16 Avoidant personality disorder

Avoidant personality disorder is characterized by feelings of extreme social inhibition, inadequacy, and sensitivity to negative criticism and rejection. Yet the symptoms involve more than simply being shy or socially awkward. Avoidant personality disorder causes significant problems that affect the ability to interact with others and maintain relationships in day-to-day life. About 1% of the general population has avoidant personality disorder.

Avoidant Personality Disorder Symptoms

Avoidant personality disorder symptoms include a variety of behaviors, such as:

- Avoiding work, social, or school activities for fear of criticism or rejection. It may feel as if you are frequently unwelcome in social situations, even when that is not the case. This is because people with avoidant personality disorder have a low threshold for criticism and often imagine themselves to be inferior to others.
- Low self-esteem
- Self-isolation

When in social situations, a person with avoidant personality disorder may be afraid to speak up for fear of saying the wrong thing, blushing, stammering, or otherwise getting embarrassed. You

may also spend a great deal of time anxiously studying those around you for signs of approval or rejection.

What Is Obsessive-Compulsive Personality Disorder?

Obsessive-compulsive personality disorder (OCPD) is defined by strict orderliness, control, and perfectionism. Someone with OCPD will likely try to stay in charge of the smallest details of their life, even at the expense of their flexibility and openness to new experiences.[1]

OCPD is a personality disorder, which means it involves personality traits that are stable, long-held, atypical, and problematic in some way. In the case of OCPD, people with this condition may find it hard to relate to others, and their devotion to perfectionism and rigid control can make it difficult to function.

OCPD is not the same as obsessive-compulsive disorder (OCD). In the "Diagnostic and Statistical Manual of Mental Disorders, 5th ed (DSM-5)," OCD is organized in its own category of mental conditions called "Obsessive-Compulsive and Related Disorders."[2]

10.17 Symptoms of OCPD

Someone with OCPD may experience symptoms like:[3]

- Acting restrained or restricted with their emotions
- Adherence to rules in an inflexible, rigid way
- Creating order and lists for tasks
- Desire to control their relationships with others
- Difficulty empathizing with others and/or maintaining intimate relationships
- Extreme dedication to their work
- Having trouble giving things to others
- Need for perfection even in the smallest details
- Problems with self-identity and/or self-direction
- Trouble giving up control and delegating tasks

At first glance, OCPD may seem similar to an anal personality type. While someone with an anal personality might share some of these traits, like perfectionism, orderliness, and a need to be in control of their environment, having these quirks isn't the same thing as having a personality disorder.

10.18 Summary

Personality is the way of thinking, feeling and behaving that makes a person different from other people. An individual's personality is influenced by experiences, environment (surroundings, life situations) and inherited characteristics. A person's personality typically stays the same over time. A personality disorder is a way of thinking, feeling and behaving that deviates from the expectations of the culture, causes distress or problems functioning, and lasts over time. There are 10 specific types of personality disorders. Personality disorders are long-term patterns of behavior and inner experiences that differs significantly from what is expected. The pattern of experience and behavior begins by late adolescence or early adulthood and causes distress or problems in functioning. Without treatment, personality disorders can be long-lasting.

10.19 Keyword:

Personality disorders, causes, tests, treatment

10.20 Self Eveluation

1) Personality disorders (PD) consist of a loosely-bound cluster of sub-types. Which of the following common features are evident in PD?

a)they are characterized by an enduring pattern of behaviour that deviates markedly from expectations within that culture

b)they are associated with unusual ways of interpreting events, unpredictable mood swings, or impulsive behaviour

c)they result in impairments in social and occupational functioning

d)All of the above

2) Which of the following is the most well-known of the Personality disorders ?

a)Borderline Personality Disorder

b)Melancholic Personality Disorder

c)Associative Personality Disorder

d)Dissociative Personality Disorder

3) Which of the following is NOT a characteristic of individuals with paranoid personality disorder

a)avoidance of close relationships

b)avoidance of public places

c)are often spontaneously aggressive to others

d)often feel that they have been deeply and irreversibly betrayed by others

4) An Individual with a schizotypal personality disorder will usually exhibit which of the following characteristics?

a)eccentric' behaviour marked by odd patterns of thinking and communication

b)discomfort with close personal relationships

c)often exhibit unusual ideas of reference

d)All of the above

5) Which of the following is a subtype of Dramatic/Emotional Personality Disorders (Cluster B)

a)Paranoid Personality Disorder

b)Schizotypical Personality Disorder

c)Histrionic Personality Disorder

d)Schizoid Personality Disorder

6) The term 'sociopath' or 'psychopath' is sometimes used to describe which type of personality disorder

a)Histrionic Personality Disorder

b)Antisocial Personality Disorder APD

c)Paranoid Personality Disorder

d)Schizotypal Personality Disorder

7) An individual with narcissistic personality disorder will routinely overestimate their abilities and inflate their accomplishments, and this is characterized by which of the following?

a)a pervasive need for admiration

b)An inability to monitor reality

c)impulsive behaviour such as drug abuse

d)unusual ideas of reference

8) The apparent lack of empathy and the tendency to exploit others for self-benefit, has lead psychologists to compare narcissistic personality disorder with which one of the following?

a)Histrionic Personality Disorder

b)Antisocial personality Disorder

c)Paranoid Personality Disorder

d)Schizotypal Personality Disorder

9) Which of the following are considered to be the main features of avoidant personality disorder?

a)persistent social inhibition

b)feelings of inadequacy

c)hypersensitivity to negative evaluation

d)All of the above

10) Some clinicians have come to believe that antisocial personality disorder and social phobia are both components of a broader spectrum called:

a)Social identity spectrum

b)Broad spectrum disorder

c)social anxiety spectrum

d)generalised anxiety disorder

11) An Individual with Dependent Personality Disorder will exhibit which of the following?

a)submissive and clinging behaviour

b)have great difficulty making everyday decisions

c)passive behaviours

d)All of the above

12) An Individual with Obsessive-Compulsive Personality Disorder will exhibit which of the following characteristics?

a)exceptionally perfectionist tendencies

b)a preoccupation with orderliness

c)They will stick to rules

d)All of the above

13) Which of the following is NOT considered to be a risk factors for personality disorders ?

a)living in inner cities

b)low socioeconomic class

c)gender

d)being a young adult

14) The formalistic similarities between Cluster A disorders and schizophrenia have led researchers to argue that they are part of a broader

a)Schizotypical spectrum disorder

b)schizophrenia spectrum disorder

c)social anxiety spectrum

d)Broad spectrum disorder

15) According to psychodynamic theory which of the following is NOT deemed to be characteristic of the parents of an individual with paranoid personality disorder

a)demanding

b)absent

c)distant,

d)over rigid

Answer

1D. 2A. 3B. 4D. 5C. 6B. 7A. 8A. 9D. 10C. 11D. 12D. 13C. 14B. 15C

10.21 Review Questions

1. What are personality disorders?
2. Discuss different types of personality disorders.
3. What are the causes of personality disorders?
4. Discuss the treatment of personality disorders

10.22 Further Readings

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Unit 11: Development and Conduct Disorders

Content

Objectives

1. To understand the concept of ADHD
2. To identify the different types of Intellectual impairment
3. To know the characteristics of ASD

11.1 Introduction

Learning disability, learning disorder, or learning difficulty (British English) is a condition in the brain that causes difficulties comprehending or processing information and can be caused by several different factors. Given the "difficulty learning in a typical manner", this does not exclude the ability to learn in a different manner. Therefore, some people can be more accurately described as having a "learning difference", thus avoiding any misconception of being disabled with a lack of ability to learn and possible negative stereotyping. In the United Kingdom, the term "learning disability" generally refers to an intellectual disability, while difficulties such as dyslexia and dyspraxia are usually referred to as "learning difficulties".

While learning disability and learning disorder are often used interchangeably, they differ in many ways. Disorder refers to significant learning problems in an academic area. These problems, however, are not enough to warrant an official diagnosis. Learning disability, on the other hand, is an official clinical diagnosis, whereby the individual meets certain criteria, as determined by a professional (such as a psychologist, psychiatrist, speech language pathologist, or pediatrician). The difference is in degree, frequency, and intensity of reported symptoms and problems, and thus the two should not be confused. When the term "learning disorder" is used, it describes a group of disorders characterized by inadequate development of specific academic, language, and speech skills. Types of learning disorders include reading (dyslexia), arithmetic (dyscalculia) and writing (dysgraphia).

The unknown factor is the disorder that affects the brain's ability to receive and process information. This disorder can make it problematic for a person to learn as quickly or in the same way as someone who is not affected by a learning disability. People with a learning disability have trouble performing specific types of skills or completing tasks if left to figure things out by themselves or if taught in conventional ways.

Individuals with learning disabilities can face unique challenges that are often pervasive throughout the lifespan. Depending on the type and severity of the disability, interventions, and current technologies may be used to help the individual learn strategies that will foster future success. Some interventions can be quite simplistic, while others are intricate and complex. Current technologies may require student training to be effective classroom supports. Teachers, parents, and schools can create plans together that tailor intervention and accommodations to aid the individuals in successfully becoming independent learners. A multi-disciplinary team frequently helps to design the intervention and to coordinate the execution of the intervention with teachers and parents. This team frequently includes school psychologists, special educators, speech therapists (pathologists), occupational therapists, psychologists, ESL teachers, literacy coaches, and/or reading specialists.

11.2 **ADHD**

ADHD is one of the most common neurodevelopmental disorders of childhood. It is usually first diagnosed in childhood and often lasts into adulthood. Children with ADHD may have trouble paying attention, controlling impulsive behaviors (may act without thinking about what the result will be), or be overly active. Mother hugging daughterCOVID-19: Information for parenting children with ADHD Signs and Symptoms It is normal for children to have trouble focusing and behaving at one time or another. However, children with ADHD do not just grow out of these behaviors. The symptoms continue, can be severe, and can cause difficulty at school, at home, or with friends. A child with ADHD might: daydream a lot forget or lose things a lot squirm or fidget talk too much make careless mistakes or take unnecessary risks have a hard time resisting temptation have trouble taking turns have difficulty getting along with others Learn more about signs and symptoms

There are three different types of ADHD, depending on which types of symptoms are strongest in the individual: Predominantly Inattentive Presentation: It is hard for the individual to organize or finish a task, to pay attention to details, or to follow instructions or conversations. The person is easily distracted or forgets details of daily routines. Predominantly Hyperactive-Impulsive Presentation: The person fidgets and talks a lot. It is hard to sit still for long (e.g., for a meal or while doing homework). Smaller children may run, jump or climb constantly. The individual feels restless and has trouble with impulsivity. Someone who is impulsive may interrupt others a lot, grab things from people, or speak at inappropriate times. It is hard for the person to wait their turn or listen to directions. A person with impulsiveness may have more accidents and injuries than others. Combined Presentation: Symptoms of the above two types are equally present in the person. Because symptoms can change over time, the presentation may change over time as well. "Is It ADHD?" in ASL txt iconAudio Description media iconLow Resolution Video american sign language interpreting icon Learn about symptoms of ADHD, how ADHD is diagnosed, and treatment recommendations including behavior therapy, medication, and school support. Causes of ADHD Scientists are studying cause(s) and risk factors in an effort to find better ways to manage and reduce the chances of a person having ADHD. The cause(s) and risk factors for ADHD are unknown, but current research shows that genetics plays an important role. Recent studies link genetic factors with ADHD.1 In addition to genetics, scientists are studying other possible causes and risk factors including: Brain injury Exposure to environmental (e.g., lead) during pregnancy or at a young age Alcohol and tobacco use during pregnancy Premature delivery Low birth weight Research does not support the popularly held views that ADHD is caused by eating too much sugar, watching too much television, parenting, or social and environmental factors such as poverty or family chaos. Of course, many things, including these, might make symptoms worse, especially in certain people. But the evidence is not strong enough to conclude that they are the main causes of ADHD. ADHD Fact Sheet Download and Print this fact sheet pdf icon[PDF – 473 KB] Diagnosis Deciding if a child has ADHD is a process with several steps. There is no single test to diagnose ADHD, and many other problems, like anxiety, depression, sleep problems, and certain types of learning disabilities, can have similar symptoms. One step of the process involves having a medical exam, including hearing and vision tests, to rule out other problems with symptoms like ADHD. Diagnosing ADHD usually includes a checklist for rating ADHD symptoms and taking a history of the child from parents, teachers, and sometimes, the child. Treatments physician speaking to family In most cases, ADHD is best treated with a combination of behavior therapy and medication. For preschool-aged children (4-5 years of age) with ADHD, behavior therapy, particularly training for parents, is recommended as the first line of treatment before medication is tried. What works best can depend on the child and family. Good treatment plans will include close monitoring, follow-ups, and making changes, if needed, along the way.

11.3 Intellectual Disability

Intellectual disability1 involves problems with general mental abilities that affect functioning in two areasintellectual functioning (such as learning, problem solving, judgement) adaptive functioning (activities of daily life such as communication and independent living) Intellectual disability affects about one percent of the population, and of those about 85 percent have mild intellectual disability. Males are more likely than females to be diagnosed with intellectual disability. Diagnosing Intellectual Disability Intellectual disability is identified by problems in both intellectual and adaptive functioning. Intellectual functioning is assessed with an exam by a doctor and through standardized testing. While a specific full-scale IQ test score is no longer required for diagnosis, standardized testing is used as part of diagnosing the condition. A full scale IQ score of around 70 to 75 indicates a significant limitation in intellectual functioning.2 However, the IQ score must be interpreted in the context of the person's difficulties in general mental abilities. Moreover, scores on subtests can vary considerably so that the full scale IQ score may not accurately reflect

overall intellectual functioning. Conceptual – language, reading, writing, math, reasoning, knowledge, memory Social – empathy, social judgment, communication skills, the ability follow rules and the ability to make and keep friendships Practical – independence in areas such as personal care, job responsibilities, managing money, recreation and organizing school and work tasks Adaptive functioning is assessed through standardized measures with the individual and interviews with others, such as family members, teachers and caregivers. Intellectual disability is identified as mild (most people with intellectual disability are in this category), moderate or severe. The symptoms of intellectual disability begin during childhood or adolescence. Delays in language or motor skills may be seen by age two. However, mild levels of intellectual disability may not be identified until school age when a child may have difficulty with academics. Some mental health, neurodevelopmental, medical and physical conditions frequently co-occur in individuals with intellectual disability, including cerebral palsy, epilepsy, ADHD, autism spectrum disorder and depression and anxiety disorders. Identifying and diagnosing co-occurring conditions can be challenging, for example recognizing depression in an individual with limited verbal ability. However, accurate diagnosis and treatment are important for a healthy and fulfilling life for any individual.

11.4 Autism spectrum disorder (ASD)

ASD refers to a neurodevelopment disorder that is characterized by difficulties with social communication and social interaction and restricted and repetitive patterns in behaviors, interests, and activities. By definition, the symptoms are present early on in development and affect daily functioning. The term 'spectrum' is used because of the heterogeneity in the presentation and severity of ASD symptoms, as well as in the skills and level of functioning of individuals who have ASD. See the full criteria for ASD from the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. ASD occurs in all racial and ethnic groups, and across every socioeconomic status level. Boys are about four times more likely to have ASD than girls. According to the Centers for Disease Control and Prevention, it is estimated that 1 in 59 children in the United States meets criteria for ASD. Because it is hoped that early intervention can change the course of ASD, immediate response in terms of provision of treatment is critical when there are early concerns (even under 24 months). The diagnosis of ASD is based on diagnostic evaluations that often involve a team including a physician and a psychologist, and may include other disciplines such as speech and language pathology or occupational therapy. The evaluation should include standardized observations of the individual, assessments of his/her learning and cognitive abilities, and interviews to gather information about behavior across multiple settings and her/his medical and developmental history. There are a number of behavioral treatments for ASD that have been shown to change cognitive level (e.g. IQ), specific skills (e.g. vocabulary, social skills, and joint attention) and behavioral and challenges and mood, though comparative data contrasting different treatments are not available. Medications have been shown to reduce behavioral challenges and mood. There is much interest in identifying treatments that change the core features of ASD. The most well-established treatments used applied behavior analytic techniques, which have typically become more natural, developmental in sequence and more flexible. Recently, parent-mediated treatments, group models and combined treatments (medical and behavioral) are being developed and tested. Involvement of the family in treatment has consistently improved outcomes.

11.5 Conduct disorder

Conduct disorder_is a serious behavioral and emotional disorder that can occur in children and teens. A child with this disorder may display a pattern of disruptive and violent behavior and have problems following rules. It is not uncommon for children and teens to have behavior-related problems at some time during their development. However, the behavior is considered to be a conduct disorder when it is long-lasting and when it violates the rights of others, goes against accepted norms of behavior and disrupts the child's or family's everyday life. What Are the Symptoms of Conduct Disorder? Symptoms of conduct disorder vary depending on the age of the child and whether the disorder is mild, moderate, or severe. In general, symptoms of conduct disorder fall into four general categories: Aggressive behavior: These are behaviors that threaten or cause physical harm and may include fighting, bullying, being cruel to others or animals, using weapons, and forcing another into sexual activity. Destructive behavior: This involves intentional destruction of property such as arson (deliberate fire-setting) and vandalism (harming another person's property).Deceitful behavior: This may include repeated lying, shoplifting, or breaking into homes or cars in order to steal.Violation of rules: This involves going against accepted rules of society or engaging in behavior that is not appropriate for the person's age. These behaviors may include running away, skipping school, playing pranks, or being sexually active at a very young ageIn addition, many children with conduct disorder are irritable, have low self-esteem, and tend

to throw frequent temper tantrums. Some may abuse drugs and alcohol. Children with conduct disorder often are unable to appreciate how their behavior can hurt others and generally have little guilt or remorse about hurting others.The exact cause of conduct disorder is not known, but it is believed that a combination of biological, genetic, environmental, psychological, and social factors play a role. Biological: Some studies suggest that defects or injuries to certain areas of the brain can lead to behavior disorders. Conduct disorder has been linked to particular brain regions involved in regulating behavior, impulse control, and emotion. Conduct disorder symptoms may occur if nerve cell circuits along these brain regions do not work properly. Further, many children and teens with conduct disorder also have other mental illnesses, such as attention-deficit/hyperactivity disorder (ADHD), learning disorders, depression, substance abuse, or an anxiety disorder, which may contribute to the symptoms of conduct disorder. Genetics: Many children and teens with conduct disorder have close family members with mental illnesses, including mood disorders, anxiety disorders, substance use disorders and personality disorders. This suggests that a vulnerability to conduct disorder may be at least partially inherited.Environmental: Factors such as a dysfunctional family life, childhood abuse, traumatic experiences, a family history of substance abuse, and inconsistent discipline by parents may contribute to the development of conduct disorder. Psychological: Some experts believe that conduct disorders can reflect problems with moral awareness (notably, lack of guilt and remorse) and deficits in cognitive processing.Social: Low socioeconomic status and not being accepted by their peers appear to be risk factors for the development of conduct disorder.How Common Is Conduct Disorder?It is estimated that 2%-16% of children in the U.S. have conduct disorder. It is more common in boys than in girls and most often occurs in late childhood or the early teen years. As with adults, mental illnesses in children are diagnosed based on signs and symptoms that suggest a particular problem. If symptoms of conduct disorder are present, the doctor may begin an evaluation by performing complete medical and psychiatric histories. A physical exam and laboratory tests (for example, neuroimaging studies, blood tests) may be appropriate if there is concern that a physical illness might be causing the symptoms. The doctor will also look for signs of other disorders that often occur along with conduct disorder, such as ADHD and depression. If the doctor cannot find a physical cause for the symptoms, they will likely refer the child to a child and adolescent psychiatrist or psychologist, mental health professionals who are specially trained to diagnose and treat mental illnesses in children and teens. Psychiatrists and psychologists use specially designed interview and assessment tools to evaluate a child for a mental disorder. The doctor bases their diagnosis on reports of the child's symptoms and their observation of the child's attitudes and behavior. The doctor will often rely on reports from the child's parents, teachers, and other adults because children may withhold information or otherwise have trouble explaining their problems or understanding their symptoms. Treatment for conduct disorder is based on many factors, including the child's age, the severity of symptoms, as well as the child's ability to participate in and tolerate specific therapies. Treatment usually consists of a combination of the following: Psychotherapy: Psychotherapy (a type of counseling) is aimed at helping the child learn to express and control anger in more appropriate ways. A type of therapy called cognitive-behavioral therapy aims to reshape the child's thinking (cognition) to improve problem solving skills, anger management, moral reasoning skills, and impulse control. Family therapy may be used to help improve family interactions and communication among family members. A specialized therapy technique called parent management training (PMT) teaches parents ways to positively alter their child's behavior in the home. Medication: Although there is no medication formally approved to treat conduct disorder, various drugs may be used (off label) to treat some of its distressing symptoms (impulsivity, aggression, dysregulated mood), as well as any other mental illnesses that may be present, such as ADHD or major depression. What Is the Outlook for Children With Conduct Disorder? If your child is displaying symptoms of conduct disorder, it is very important that you seek help from a qualified doctor. A child or teen with conduct disorder is at risk for developing other mental disorders as an adult if left untreated. These include antisocial and other personality disorders, mood or anxiety disorders, and substance use disorders. Children with conduct disorder are also at risk for school-related problems, such as failing or dropping out, substance abuse, legal problems, injuries to self or others due to violent behavior, sexually transmitted diseases, and suicide. Treatment outcomes can vary greatly, but early intervention may help to reduce the risk for incarcerations, mood disorders, and the development of other comorbidities such as substance abuse. Can Conduct Disorder Be Prevented? Although it may not be possible to prevent conduct disorder, recognizing and acting on symptoms when they appear can minimize distress to the child and family, and prevent many of the problems associated with the condition. In addition, providing a nurturing, supportive, and consistent home environment with a balance of love and discipline may help reduce symptoms and prevent episodes of disturbing behavior.

11.6 Summary

Children who exhibit these behaviors should receive a comprehensive evaluation by an experience mental health professional. Many children with a conduct disorder may have coexisting conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders which can also be treated. Research shows that youngsters with conduct disorder are likely to have ongoing problems if they and their families do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job.

Treatment of children with conduct disorder can be complex and challenging. Treatment can be provided in a variety of different settings depending on the severity of the behaviors. Adding to the challenge of treatment are the child's uncooperative attitude, fear and distrust of adults. In developing a comprehensive treatment plan, a child and adolescent psychiatrist may use information from the child, family, teachers, community (including the legal system) and other medical specialties to understand the causes of the disorder.

Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Special education may be needed for youngsters with learning disabilities. Parents often need expert help to develop and carry out special management and educational programs in the home and at school. Home-based treatment programs such as Multisystemic Therapy (MST) are effective for helping both the child and family.

11.7 Keyword:

ADHD, conduct disorder, intellectual disability, ASD

11.8 Self Eveluation

1) In childhood disorders there are different types of problems such as Symptom-Based Disorders. One such disorder is known as enuresis, which means:
a)Sleepwalking
b)Bedwetting
c)Lack of bowel control
d)Stammering
2) In childhood disorders there are different types of problems such as Symptom-Based Disorders. One such disorder is known as encopresis, which means:
a)Lack of bowel control
b)Bedwetting
c)Stammering
d)Sleepwalking
3) In childhood disorders there are different types of problems such as Symptom-Based Disorders. One such disorder is known as somnambulism, which means:
a)Stammering
b)Bedwetting
c)Lack of bowel control
d)Sleepwalking
4) Which of the following is an area of psychology that is concerned with mapping how early childhood experiences may act as risk factors for later diagnosable psychological disorders, and attempts to describe the pathways by which early experiences may generate adult psychological problems?
a)Clinical psychopathology
b)Developmental psychopathology
c)Applied psychopathology
d)Cognitive psychopathology
5) Attention Deficit Hyperactivity Disorder (ADHD) is a childhood disorder known as:
a)Hypokinetic disorders
b)Hyperactivity disorders
c)Hyperkinetic disorders
d)Hyperstasis disorders
6) Which of the following are risk factors for childhood psychiatric disorders?
a)Parental psychopathology,
b)Repeated early separation from parents

c)Harsh or inadequate parents
d)All of the above
7) Magnetic resonance imaging (MRI) studies of the brains of individuals with ADHD have revealed a number of significant differences between ADHD sufferers and nonsufferers (e.g. Krain & Castellanos, 2006; Seidman, Valera & Makris, 2005). Evidence suggests that the brains of children with ADHD are smaller than those of healthy comparison children, with overall brain volume being smaller by an average of?
a)4.2%
b)3.2%
c)5.2%
d)6.2%
8) Children with ADHD are known to have deficits in which of the following brain areas?
a)Perception
b)Motor functioning
c)Executive functioning
d)Memory
9) Children with ADHD are known to have deficits in executive functioning, and specifically have difficulty inhibiting responses. Which of the following brain areas normally controls these types of functions?
a)The thalamus
b)The amygdala
c)The parietal lobes
d)The frontal lobes
10) Which of the following is an area of the brain that regularly exhibits abnormalities in association with ADHD symptoms?
a)Meninges
b)Corpus callosum
c)Cerebellum
d)Limbic system
11) The term Theory of mind refers to which of the following abilities?
a)Have telepathic abilities
b)Understand one's own and other people's mental states
c)Lack of meta-cognition
d)All of the above
12) Which of the following characteristics are present in conduct disorder?
a)Violent or aggressive behaviour
b)Deliberate cruelty towards people or animals
c)Vandalism or damage to property
d)All of the above
13) Another disruptive behaviour disorder outlined in DSM-IV-TR is known as Oppositional Defiant Disorder (ODD). ODD is a diagnosis usually reserved for those children who do not meet the full criteria for conduct disorder, but display which of the following?
a)Regular temper tantrums
b)Refuse to comply with requests or instructions
c)Appear to deliberately indulge in behaviours that annoy others
d)All of the above
14) Aggressive children also exhibit what is called a "hostile attributional bias" (Naseby, Hayden & DePaulo, 1979), where they will interpret ambiguous cues as signalling hostility, but also many cues which are generated by benign intentions. Once a hostile attribution is made, studies also suggest that the probability of an aggressive response is at what percent?
a)25%
b)70%
c)50%
d)10%
15) When children are exposed to uncertainty and stress early in their lives they may experience a range of emotions, including rejection, fear, confusion, anger, hatred, and misery. Consequently the individual may become withdrawn and inward-looking. This is known as:
a)Externalising disorder
b)Dissocialise disorder
c)Internalising disorder
d)Attachment disorder
Answer

1b, 2a, 3d. 4b, 5c, 6d, 7b, 8c, 9d, 10c, 11b, 12d, 13d, 14b,15c .

11.9 Review Questions

1. What are conduct disorder?
2. Discuss ADHD.
3. What are the causes of ADHD?
4. Discuss the treatment of ADHD.

11. 10 Further Readings

https://kidshealth.org/en/parents/adhd.html#:~:text=ADHD%20stands%20for%20attention%20deficit,at%20home%2C%20and%20in%20friendships.

https://www.webmd.com/mental-health/mental-health-conduct-disorder

https://www.hopkinsmedicine.org/health/conditions-and-diseases/conduct-disorder

Unit 12: Neuro-Cognitive Disorders

Content

Objectives

1. To understand the concept of neuro- cognitive disorders
2. To understand the different types neuro- cognitive disorders
3. To know the characteristics of neuro- cognitive disorders

12.1 Introduction

Dementia is not a single disease; it's an overall term — like heart disease — that covers a wide range of specific medical conditions, including Alzheimer's disease. Disorders grouped under the general term "dementia" are caused by abnormal brain changes. These changes trigger a decline in thinking skills, also known as cognitive abilities, severe enough to impair daily life and independent function. They also affect behavior, feelings and relationships. Alzheimer's disease accounts for 60-80% of cases. Vascular dementia, which occurs because of microscopic bleeding and blood vessel blockage in the brain, is the second most common cause of dementia. Those who experience the brain changes of multiple types of dementia simultaneously have mixed dementia. There are many other conditions that can cause symptoms of dementia, including some that are reversible, such as thyroid problems and vitamin deficiencies. Dementia is often incorrectly referred to as "senility" or "senile dementia," which reflects the formerly widespread but incorrect belief that serious mental decline is a normal part of aging.

12.2 Alzheimer's disease (AD)

AD is a neurodegenerative disease that usually starts slowly and progressively worsens. It is the cause of 60–70% of cases of dementia. The most common early symptom is difficulty in remembering recent events. As the disease advances, symptoms can include problems with language, disorientation (including easily getting lost), mood swings, loss of motivation, self-neglect, and behavioral issues. As a person's condition declines, they often withdraw from family and society. Gradually, bodily functions are lost, ultimately leading to death. Although the speed of progression can vary, the typical life expectancy following diagnosis is three to nine years. The cause of Alzheimer's disease is poorly understood. There are many environmental and genetic risk factors associated with its development. The strongest genetic risk factor is from an allele of APOE. Other risk factors include a history of head injury, clinical depression, and high blood pressure. The disease process is largely associated with amyloid plaques, neurofibrillary tangles, and loss of neuronal connections in the brain. A probable diagnosis is based on the history of the illness and cognitive testing with medical imaging and blood tests to rule out other possible causes. Initial symptoms are often mistaken for normal aging. Examination of brain tissue is needed for a definite diagnosis, but this can only take place after death. Good nutrition, physical activity, and engaging socially are known to be of benefit generally in aging, and these may help in reducing the risk of cognitive decline and Alzheimer's; in 2019 clinical trials were underway to look at these possibilities. There are no medications or supplements that have been shown to decrease risk. No treatments stop or reverse its progression, though some may temporarily improve symptoms. Affected people increasingly rely on others for assistance, often placing a burden on the caregiver. The pressures can include social, psychological, physical, and economic elements. Exercise programs may be beneficial with respect to activities of daily living and can potentially improve outcomes. Behavioral problems or psychosis due to dementia are often treated with antipsychotics, but this is not usually recommended, as there is little benefit and an increased risk of early death.

As of 2015, there were approximately 29.8 million people worldwide with AD[9] with about 50 million of all forms of dementia as of 2020. It most often begins in people over 65 years of age, although up to 10 per cent of cases are early-onset affecting those in their 30's to mid 60's. Women get sick more often than men.It affects about 6% of people 65 years and older. In 2015, all forms of dementia resulted in about 1.9 million deaths.The disease is named after German psychiatrist and pathologist Alois Alzheimer, who first described it in 1906.Alzheimer's financial burden on society is large, on par with the costs of cancer and heart disease, with a 2013 study estimating an annual cost of $200 billion (equivalent to $222 billion in 2020) in the US alone.

The most common early symptom of Alzheimer's is difficulty remembering newly learned information.Just like the rest of our bodies, our brains change as we age. Most of us eventually notice some slowed thinking and occasional problems with remembering certain things. However, serious memory loss, confusion and other major changes in the way our minds work may be a sign that brain cells are failing. Alzheimer's changes typically begin in the part of the brain that affects learning. As Alzheimer's advances through the brain it leads to increasingly severe symptoms, including disorientation, mood and behavior changes; deepening confusion about events, time and place; unfounded suspicions about family, friends and professional caregivers; more serious memory loss and behavior changes; and difficulty speaking, swallowing and walking. People with memory loss or other possible signs of Alzheimer's may find it hard to recognize they have a problem. Signs of dementia may be more obvious to family members or friends. Anyone experiencing dementia-like symptoms should see a doctor as soon as possible. If you need assistance finding a doctor with experience evaluating memory problems, your local Alzheimer's Association can help. Earlier diagnosis and intervention methods are improving dramatically, and treatment options and sources of support can improve quality of life. Two helpful support resources you can tap into are ALZConnected, our message boards and online social networking community, and Alzheimer's Navigator, a web tool that creates customized action plans, based on answers you provide through short, online surveys.

12.3 **Multiple sclerosis**

Multiple sclerosis (MS), also known as encephalomyelitis disseminata, is a demyelinating disease in which the insulating covers of nerve cells in the brain and spinal cord are damaged. This damage disrupts the ability of parts of the nervous system to transmit signals, resulting in a range of signs and symptoms, including physical, mental, and sometimes psychiatric problems. Specific symptoms can include double vision, blindness in one eye, muscle weakness, and trouble with sensation or coordination. MS takes several forms, with new symptoms either occurring in isolated attacks (relapsing forms) or building up over time (progressive forms).Between attacks, symptoms may disappear completely, although permanent neurological problems often remain, especially as the disease advances.

While the cause is unclear, the underlying mechanism is thought to be either destruction by the immune system or failure of the myelin-producing cells. Proposed causes for this include genetics and environmental factors, such as viral infections.MS is usually diagnosed based on the presenting signs and symptoms and the results of supporting medical tests.

There is no known cure for multiple sclerosis. Treatments attempt to improve function after an attack and prevent new attacks. Medications used to treat MS, while modestly effective, can have side effects and be poorly tolerated. Physical therapy can help with people's ability to function. Many people pursue alternative treatments, despite a lack of evidence of benefit. The long-term outcome is difficult to predict; good outcomes are more often seen in women, those who develop the disease early in life, those with a relapsing course, and those who initially experienced few attacks. Life expectancy is five to ten years lower than that of the unaffected population.

Multiple sclerosis is the most common immune-mediated disorder affecting the central nervous system. In 2015, about 2.3 million people were affected globally, with rates varying widely in different regions and among different populations. In that year, about 18,900 people died from MS, up from 12,000 in 1990. The disease usually begins between the ages of twenty and fifty and is twice as common in women as in men. MS was first described in 1868 by French neurologist Jean-Martin Charcot. The name multiple sclerosis refers to the numerous glial scars (or sclerae – essentially

plaques or lesions) that develop on the white matter of the brain and spinal cord. A number of new treatments and diagnostic methods are under development.

12.4 Pick's disease

Pick's disease is a rare condition that causes progressive and irreversible dementia. This disease is one of many types of dementias known as frontotemporal dementia (FTD). Frontotemporal dementia is the result of a brain condition known as frontotemporal lobar degeneration (FTLD). If you have dementia, your brain doesn't function normally. As a result, you may have difficulty with language, behavior, thinking, judgment, and memory. Like patients with other types of dementia, you may experience drastic personality changes.

Many other conditions can cause dementia, including Alzheimer's disease. While Alzheimer's disease can affect many different parts of your brain, Pick's disease only affects certain areas. Pick's disease is a type of FTD because it affects the frontal and temporal lobes of your brain. Your brain's frontal lobe controls important facets of everyday life. These include planning, judgment, emotional control, behavior, inhibition, executive function, and multitasking. Your temporal lobe mainly affects language, along with emotional response and behavior.

12.5 Huntington's disease is a progressive brain disorder caused by a single defective gene on chromosome 4 — one of the 23 human chromosomes that carry a person's entire genetic code.

This defect is "dominant," meaning that anyone who inherits it from a parent with Huntington's will eventually develop the disease. The disorder is named for George Huntington, M.D., the physician who first described it in the late 1800s.

The defective gene codes the blueprint for a protein called huntingtin. This protein's normal function isn't yet known, but it's called "huntingtin" because scientists identified its defective form as the cause of Huntington's disease. Defective huntingtin protein leads to brain changes that cause abnormal involuntary movements, a severe decline in thinking and reasoning skills, and irritability, depression and other mood changes.

Symptoms of Huntington's disease usually develop between ages 30 and 50, but they can appear as early as age 2 or as late as 80. The hallmark symptom of Huntington's disease is uncontrolled movement of the arms, legs, head, face and upper body. Huntington's disease also causes a decline in thinking and reasoning skills, including memory, concentration, judgment, and ability to plan and organize.

Huntington's disease brain changes lead to alterations in mood, especially depression, anxiety, and uncharacteristic anger and irritability. Another common symptom is obsessive-compulsive behavior, leading a person to repeat the same question or activity over and over.

Scientists identified the defective gene that causes Huntington's disease in 1993. A diagnostic genetic test is now available. The test can confirm that the defective gene for huntingtin protein is the cause of symptoms in people with suspected Huntington's disease and can detect the defective gene in people who don't yet have symptoms but are at risk because a parent has Huntington's. Experts strongly recommend professional genetic counseling both before and after genetic testing for Huntington's disease.

12.6 Parkinson's disease

Parkinson's disease is a nervous system disease that affects your ability to control movement. The disease usually starts out slowly and worsens over time. If you have Parkinson's disease, you may shake, have muscle stiffness, and have trouble walking and maintaining your balance and coordination. As the disease worsens, you may have trouble talking, sleeping, have mental and memory problems, experience behavioral changes and have other symptoms.Who gets Parkinson's disease?About 50% more men than women get Parkinson's disease. It is most commonly seen in persons 60 years of age and older. However, up to 10% of patients are diagnosed before age 50.About 60,000 new cases of Parkinson's disease are diagnosed in the United States each year.

12.7 Summary

Cognitive disorders (CDs), also known as neurocognitive disorders (NCDs), are a category of mental health disorders that primarily affect cognitive abilities including learning, memory,

perception, and problem solving. Neurocognitive disorders include delirium and mild and major neurocognitive disorder (previously known as dementia). They are defined by deficits in cognitive ability that are acquired (as opposed to developmental), typically represent decline, and may have an underlying brain pathology. The DSM-5 defines six key domains of cognitive function: executive function, learning and memory, perceptual-motor function, language, complex attention, and social cognition. Although Alzheimer's disease accounts for the majority of cases of neurocognitive disorders, there are various medical conditions that affect mental functions such as memory, thinking, and the ability to reason, including frontotemporal degeneration, Huntington's disease, Lewy body disease, traumatic brain injury (TBI), Parkinson's disease, prion disease, and dementia/neurocognitive issues due to HIV infection. Neurocognitive disorders are diagnosed as mild and major based on the severity of their symptoms. While anxiety disorders, mood disorders, and psychotic disorders can also have an effect on cognitive and memory functions, the DSM-IV-TR does not consider these cognitive disorders, because loss of cognitive function is not the primary (causal) symptom. Additionally, developmental disorders such as autism spectrum disorder are typically developed at birth or early in life as opposed to the acquired nature of neurocognitive disorders.

12.8 Keyword:

neuro- cognitive disorders, parkinsons disease, Huntington's disease

12.9 Self Eveluation

1. Parkinson disease is marked by a lack of which chemical in the brain?
A. Serotonin
B. GABA
C. Dopamine
D. Norepinephrine
E. None of the above
2. How many Americans are affected by Parkinson disease?
A. 100,000 people
B. 200,000 people
C. 500,000 people
D. 1 million people
3. What is the average age when Parkinson disease first appears?
A. 25
B. 50
C. 60
D. 75
4. What is often the first symptom of Parkinson disease?
A. Headache
B. Nausea
C. Shaking of a hand or foot
D. Turning of the head
5. How is Parkinson disease diagnosed?
A. With a blood test
B. With a neurological exam
C. With an X-ray
D. All of the above
6. the phenomenon in Schizophrenia, known as 'downward drift' means which of the following?
A.Falling to the bottom of the social ladder
B. Become homeless
C. Inability to hold down a job
D. All of the above
7. Historically, Dementia praecox was a disease first identified by?
A. Freud
B. Beck
C. Watson
D. Kraepelin
8 In Schizophrenia psychotic symptoms such as hallucinations delusions, disorganised speech and grossly disorganised or catatonic behaviours are known as:

A. Negative symptoms
B. Positive symptoms
C. Mediating symptoms
D. Catastrophic symptoms
9. Misinterpretation of perceptions or experiences in Schizophrenia are known as:
A. Hallucinations
B. Misperceptions
C. Delusions
D. Avolition
10 In Schizophrenia when an individual believes they are in danger, this is referred to as:
A. Delusions of grandeur
B. Delusions of persecution
C. Delusions of control
D. Nihilistic delusions
11. Which of the following refers to when an individual with Schizophrenia believes they are someone with fame or power?
A. Delusions of grandeur
B. Delusions of control
C. Delusions of reference
D. Nihilistic delusions
12 . How is Parkinson disease treated?
A. Medicine
B. Surgery
C. Radiation
D. A and B
13. Alzheimer disease is the most common form of which of these?
A. Malnutrition
B. Dementia
C. Fatigue
D. Psychosis
14. How is Alzheimer disease diagnosed?
A. Mental-status tests
B. Blood tests
C. Neurological tests
D. All of the above
15. Physiologically, what happens to the brain as Alzheimer disease progresses?
A. Tissue swells
B. Fluid collects
C. Many cells die
D. Brain-stem atrophies
Answers

1C,2D,3C,4C, 5B, 6D, 7D, 8B, 9C, 10B,11A,12D,13B,14D,15C

12.10 Review Questions

1. What is Huntington's disease?
2. Discuss different types of neuro cognitive disorders.
3. What are the causes of Multiple sclerosis ?
4. Discuss the treatment of Multiple sclerosis.

12.11 Further Readings

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Unit 13: Substance Abuse Disorders

Objectives

Content

1. To understand the concept of substance abuse disorders
2. To identify the different types of substance abuse disorders
3. To know the characteristics of substance abuse disorders

13.1 Introduction

Drug addiction, also called substance use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication. Substances such as alcohol, marijuana and nicotine also are considered drugs. When you're addicted, you may continue using the drug despite the harm it causes. Drug addiction can start with experimental use of a recreational drug in social situations, and, for some people, the drug use becomes more frequent. For others, particularly with opioids, drug addiction begins with exposure to prescribed medications, or receiving medications from a friend or relative who has been prescribed the medication. The risk of addiction and how fast you become addicted varies by drug. Some drugs, such as opioid painkillers, have a higher risk and cause addiction more quickly than others. As time passes, you may need larger doses of the drug to get high. Soon you may need the drug just to feel good. As your drug use increases, you may find that it's increasingly difficult to go without the drug. Attempts to stop drug use may cause intense cravings and make you feel physically ill (withdrawal symptoms). You may need help from your doctor, family, friends, support groups or an organized treatment program to overcome your drug addiction and stay drug-free.

13.2 Psychotic drugs

Antipsychotics, also known as neuroleptics, are a class of psychotropic medication primarily used to manage psychosis (including delusions, hallucinations, paranoia or disordered thought), principally in schizophrenia but also in a range of other psychotic disorders. They are also the mainstay together with mood stabilizers in the treatment of bipolar disorder.

Recent research has shown that use of any antipsychotic results in smaller brain tissue volumes and that this brain shrinkage is dose dependent and time dependent. A review of the research has also reinforced this effect.

The use of antipsychotics may result in many unwanted side effects such as involuntary movement disorders, gynecomastia, impotence, weight gain and metabolic syndrome. Long-term use can produce adverse effects such as tardive dyskinesia.

First-generation antipsychotics, known as typical antipsychotics, were first introduced in the 1950s, and others were developed until the early 1970s. Second-generation drugs, known as atypical antipsychotics, were introduced firstly with clozapine in the early 1970s followed by others. Both generations of medication block receptors in the brain for dopamine, but atypicals tend to act on serotonin receptors as well. Neuroleptic, originating from Greek: νεῦρον (neuron) and λαμβάνω

(take hold of)—thus meaning "which takes the nerve"—refers to both common neurological effects and side effects

13.3 stimulants

Stimulants (also often referred to as psychostimulants or colloquially as uppers) is an overarching term that covers many drugs including those that increase activity of the central nervous system and the body, drugs that are pleasurable and invigorating, or drugs that have sympathomimetic effects.[Stimulants are widely used throughout the world as prescription medicines as well as without a prescription (either legally or illicitly) as performance-enhancing or recreational drugs. Among narcotics, stimulants produce a noticeable crash or comedown at the end of their effects. The most frequently prescribed stimulants as of 2013 were lisdexamfetamine, methylphenidate (Ritalin), and amphetamine. It was estimated in 2015 that the percentage of the world population that had used cocaine during a year was 0.4%. For the category "amphetamines and prescription stimulants" (with "amphetamines" including amphetamine and methamphetamine) the value was 0.7%, and for Ecstasy 0.4%.

13.4 LSD

LSD (lysergic acid diethylamide), first synthesized in 1938, is an extremely potent hallucinogen. It is synthetically made from lysergic acid, which is found in ergot, a fungus that grows on rye and other grains. It is so potent its doses tend to be in the microgram (mcg) range. It's effects, often called a "trip", can be stimulating, pleasurable, and mind-altering or it can lead to an unpleasant, sometimes terrifying experience called a "bad trip." In the U.S., LSD is illegal and is classified by the Drug Enforcement Agency (DEA) as a Schedule 1 drug, meaning LSD has a high potential for abuse, has no currently accepted medical treatments, and has a lack of accepted safety for use under medical supervision. However, despite being a Schedule 1 substance, there has been a resurgence of interest in potential therapeutic uses for LSD, such as for the treatment of alcoholism and depression. Studies that conform to modern research standards are currently underway that might strengthen our knowledge on the use of LSD.LSD is produced in crystalline form and then mixed with other inactive ingredients, or diluted as a liquid for production in ingestible forms. It is odorless, colorless and has a slightly bitter taste.

13.5 Symptoms

A hallucinogen is a psychoactive agent that often or ordinarily causes hallucinations, perceptual anomalies, and other substantial subjective changes in thought, emotion, and consciousness that are not typically experienced to such degrees with other drug classifications. The term hallucinogen almost invariably refers to any drug which causes what is called a "trip". The common classifications for hallucinogens are psychedelics, dissociatives and deliriants. Although hallucinogens all can induce altered states of consciousness with some overlap in effects, there are quantifiable as well as vast qualitative differences in the induced subjective experiences between the different classes of hallucinogens due to differing and distinct pharmacological mechanisms. Contemporarily, certain potentially hallucinogenic GABAergic drugs such as muscimol, gaboxadol and zolpidem may be grouped into a distinct, separate or new category of hallucinogens that may be referred to as hypnotics despite many hypnotic and GABAergic drugs not being hallucinogenic like the three previously mentioned compounds. Additionally, cannabinergic compounds (such as THC) may also be considered distinct from the other categories as well despite sharing characteristics; specifically with both the psychedelic and dissociative classes.

13. 6 Amphetamines

Amphetamines are psychostimulant drugs, which means they speed up the messages travelling between the brain and the body.Some types of amphetamines are prescribed by doctors to treat conditions such as attention deficit hyperactivity disorder (ADHD) and narcolepsy (where a person has an uncontrollable urge to sleep). Amphetamines have also been used to treat Parkinson's disease.3, 4 Other types of amphetamines, such as speed, are produced and sold illegally. Amphetamines have been also been taken as performance enhancement drugs. The most potent form is crystal methamphetamine.The appearance of amphetamines varies from a powder and tablet form, to crystals and capsules. They may be packaged in 'foils' (aluminium foil), plastic bags

or small balloons when sold illegally.Amphetamine powder can range in colour from white through to brown, sometimes it may have traces of grey or pink. It has a strong smell and bitter taste. Amphetamine capsules and tablets vary considerably in size and colour.7

Illegally produced amphetamines can be a mix of drugs, binding agents, caffeine and sugar. New psychoactive substances may also be added.6

13.7 Substance Induced Delirium

Substance intoxication delirium is the diagnostic name for alcohol or drug-induced delirium.1 The condition is caused by intoxication from a psychoactive substance. Disturbances in focus and attention are normal when people are under the influence of alcohol or drugs, and even when they are overtired. However, loss of focus and attention is usually temporary. Substance intoxication delirium is a more serious state that may last longer than the transient symptoms most people experience when they are intoxicated. In addition, a person who is experiencing substance intoxication delirium will have additional disturbances in their cognition and may become completely unable to attend to the external environment. Here's what you need to know about the symptoms of substance intoxication delirium and what to do if you or someone you know is experiencing it.

13.8 Symptoms of Delirium

Delirium is a change in someone's state of consciousness that significantly disrupts their attention, awareness, and ability to process information about the world around them. Someone who is experiencing delirium becomes less able to direct and focus their attention, keep their attention focused over time, or shift their attention from one thing to another.If you are talking to someone with delirium, you might notice that you need to repeat your questions. The person might continue to focus on giving an answer to the first question even when you have asked another. When a person is delirious, it is easy for them to become distracted by something that has nothing to do with what they have been asked.

13.8 Substance-induced persisting amnestic disorder

Substantial memory problems due to prolonged abuse of substance. Possibility to learn anything new or to remember already learned knowledge is seriously damaged along problems with social functions. See ai.cohol-induci d persisting amnestic DISORDER SUBSTANCE-INDUCED PERSISTING AMNESTIC DISORDER: "Memory problems that happen due to heroin use are good example of substance induced persisting amnestic disorder." The amnestic disorders are characterized by problems with memory function. There is a range of symptoms associated with the amnestic disorders, as well as differences in the severity of symptoms. Some people experience difficulty recalling events that happened or facts that they learned before the onset of the amnestic disorder. This type of amnesia is called retrograde amnesia. Other people experience the inability to learn new facts or retain new memories, which is called ante-rograde amnesia. People with amnestic disorders do not usually forget all of their personal history and their identity, although memory loss of this degree of severity occurs in rare instances in patients with dissociative disorders.

13.9 Symptoms

In addition to problems with information recall and the formation of new memories, people with amnestic disorders are often disoriented with respect to time and space, which means that they are unable to tell an examiner where they are or what day of the week it is. Most patients with amnestic disorders lack insight into their loss of memory, which means that they will deny that there is anything wrong with their memory in spite of evidence to the contrary. Others will admit that they have a memory problem but have no apparent emotional reaction to their condition. Some persons with amnestic disorders undergo a personality change; they may appear apathetic or bland, as if the distinctive features of their personality have been washed out of them. Some people experiencing amnestic disorders confabulate, which means that they fill in memory gaps with false information that they believe to be true. Confabulation should not be confused with intentional lying. It is much more common in patients with temporary amnestic disorders than it is in people with long-term amnestic disorders.

Transient global amnesia (TGA) is characterized by episodes during which the patient is unable to create new memories or learn new information, and sometimes is unable to recall past memories. The episodes occur suddenly and are generally short. Patients with TGA often appear confused or bewildered.

13.10 Causes of Substance Use Disorders

The cause of substance use disorders is still unknown, though genetics are thought to account for 40% to 60% of a person's risk. Substance use often starts as a way to feel good or out of curiosity in childhood or early adolescence. Repeated use of the substance and increased tolerance pave the way to substance use disorder and addiction. Some adults who develop a substance use disorder have a co-occurring mental illness, such as depression, anxiety, or bi-polar disorder, and begin using drugs or alcohol to cope with their symptoms. Other risk factors that may lead to a substance use disorder include:

- Family history of addiction
- Sleep problems
- Chronic pain
- Financial difficulties
- Divorce or the loss of a loved one
- Long-term tobacco habit
- Tense home environment
- Lack of parental attachment in childhood
- Relationship issues

Of course, none of these risk factors guarantees that a person will develop a substance abuse disorder, but a combination of factors plus repeated substance use significantly increase the likelihood of addiction.

Is your loved one struggling with substance abuse? Help is available.

More than 20 million Americans suffer from a chemical dependency on drugs or alcohol. Unfortunately, only a small fraction of those who need treatment actually seek help. At Alvarado Parkway Institute, we understand the challenges and stigma associated with substance use disorders and work diligently to provide effective, evidence-based treatment to the patients who entrust us with their care.

Whether your loved one requires the safe, controlled environment of inpatient drug treatment or the flexibility of an outpatient program, all patients in our care receive the counseling, education, and recovery support services they need to lead a happy, healthy life. For more information on our alcohol and drug treatment programs, please call our 24-hour crisis line at (619) 667-6125.

13.11 Summary

Drug addiction, also called substance use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication. Substances such as alcohol, marijuana and nicotine also are considered drugs. When you're addicted, you may continue using the drug despite the harm it causes. Drug addiction can start with experimental use of a recreational drug in social situations, and, for some people, the drug use becomes more frequent. For others, particularly with opioids, drug addiction begins with exposure to prescribed medications, or receiving medications from a friend or relative who has been prescribed the medication.

13.12 Keyword

Substance abuse disorders, causes, symptoms, treatment,

13.13 Self Eveluation

1) With Barbiturate and Benzodiazepine Abuse and Dependency, sedative intoxication is generally associated with:

a)Slurred speech

b)Uncoordinated motor movements
c)Impairment in attention and memory
d)All of the above

2) Which of the following is derived from the hemp plant "cannabis sativa"?

a)Opium
b)Marijuana
c)MDMA
d)Crack

3) A synthetic form of opium was developed by Germany during WWII. This is known as?

a)Prednisalone
b)Cortisone
c)Methadone
d)Polyheroin

4) A long-term user of cocaine may well develop symptoms of other psychological disorders, such as:

a)Major depression
b)Social phobia
c)Eating disorders
d)All of the above

5) Amotivational syndrome in cannabis users suggests that those who use cannabis regualry are more likely to:

a)Exhibit apathy
b)Exhibit loss of ambition
c)Have difficulty concentrating
d)All of the above

6) Lysergic Acid Diethylamide (LSD) starts to take effect around 30 to 90 minutes after taking it and physical effects include:

a)Raised body temperature
b)Increased heart rate and blood pressure
c)Sleeplessness
d)All of the above

7) Individuals with Hallucinogen Dependency can spend many hours and even days recovering from the effects of the drug some hallucinogens - such as MDMA - are often associated with physical 'hangover' symptoms. Which of the following are MDMA hangovers?

a)Insomnia
b)Fatigue
c)Drowsiness
d)All of the above

8) Which of the following is an important factor in substance abuse?

a)Whether the substances are regularly used by other family members
b)Whether the family environment is rural or urban
c)Whether you are a twin
d)Whether you are born in the winter

9) The alcohol intoxicated individual has less cognitive capacity available to process all on-going information, and so alcohol acts to narrow attention and means that the drinker processes fewer cues less well. This is known as:

a)Alcohol myopia
b)Alcohol dependency
c)Alcohol abuse
d)Alcohol amnesia

10) In substance abuse, the term self-medication refers to?

a)Amelioration of psychological distress thorough substance use
b)Doctors prescribing their own drugs

c)Motive for using a substance
d)Deciding the drug of choice

11) Community-based services to offer support in substance abuse consist of self help services such as?

a)Alcoholics Anonymous
b)Crack Crack
c)Cannabis Collective
d)Hashish Home

12) Drug-prevention schemes targeting young people and their parents who may be specifically at risk provide:

a)24-hour telephone help lines
b)Internet web-sites
c)Treatment, and availability
d)All of the above

13) Local community drug prevention schemes have used which of the following?

a)Peer-pressure resistance training
b)Peer pressure
c)Peer promotion
d)Peer propaganda

14) Which of the following are treatments offered by residential rehabilitation centres?

a)Group work
b)Psychological interventions
c)Social skills training
d)All of the above

15) In aversion therapy clients are given their drug followed immediately by another drug that causes unpleasant physiological reactions such as nausea and sickness. Rather than physically administering these drugs in order to form an aversive conditioned response the client to imagine taking their drug followed by imagining some upsetting or repulsive consequence. The variant on aversion therapy is known as:

a)Covert sensitisation
b)Inverted de-sensitization
c)Overt desensitisation
d)Covert habituation

Answers

1D. 2B. 3C. 4D. 5D. 6D. 7D. 8A. 9A. 10A. 11A. 12D. 13D. 14D. 15A.

13.14 Review Questions

1. What are substance abuse disorders?
2. Discuss different types of substance abuse disorders.
3. What are the causes of substance abuse disorders?
4. Discuss the treatment of substance abuse disorders.

13.15 Further Readings

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Unit 14: Other Addictive Disorders

Content

Objectives

1. To understand the concept of substance additive disorders
2. To identify the different types of substance additive disorders
3. To know the characteristics of substance additive disorders

14.1 Introduction

Substance/Medication-Induced: Psychotic Disorder: Substance/medication-induced psychotic disorder, also known as toxic psychosis, alcohol-induced psychosis, and drug-induced psychosis, is the diagnostic name for a specific mental health condition where an individual experiences hallucinations, delusions, or both within a month of using or withdrawing from prescription drugs, illegal drugs, and/or alcohol.

According to the Diagnostic and Statistical Manual (DSM-5), 7% to 25% of patients treated for their first psychotic episode are reported to have substance/medication-induced psychotic disorder.[1]

If you or a loved one are experiencing symptoms of substance/medication-induced psychotic disorder, know that there are many treatment options and resources available to support you.

14.2 Tobacco

Tobacco is one of the most widely abused substances in the world. It is highly addictive. The Centers for Disease Control and Prevention estimates that tobacco causes 6 million deathsTrusted Source per year. This makes tobacco the leadingTrusted Source cause of preventable death.

Nicotine is the main addictive chemical in tobacco. It causes a rush of adrenaline when absorbed in the bloodstream or inhaled via cigarette smoke. Nicotine also triggers an increase in dopamine. This is sometimes referred to as the brain's "happy" chemical.Dopamine stimulates the area of the brain associated with pleasure and reward. Like any other drug, use of tobacco over time can cause a physical and psychological addiction. This is also true for smokeless forms of tobacco, such as snuff and chewing tobacco.In 2011, about 70 percentTrusted Source of all adult smokers said they wanted to stop smoking.

14.3 Nicotine

Nicotine dependence occurs when you need nicotine and can't stop using it. Nicotine is the chemical in tobacco that makes it hard to quit. Nicotine produces pleasing effects in your brain, but these effects are temporary. So you reach for another cigarette.The more you smoke, the more nicotine you need to feel good. When you try to stop, you experience unpleasant mental and physical changes. These are symptoms of nicotine withdrawal.Regardless of how long you've smoked, stopping can improve your health. It isn't easy but you can break your dependence on nicotine. Many effective treatments are available.

14.4 Alcohol addiction

Alcohol addiction also known as alcoholism, is a disease that affects people of all walks of life. Experts have tried to pinpoint factors like genetics, sex, race, or socioeconomics that may predispose someone to alcohol addiction. But it has no single cause. Psychological, genetic, and behavioral factors can all contribute to having the disease. It's important to note that alcoholism is a real disease. It can cause changes to the brain and neurochemistry, so a person with an alcohol addiction may not be able to control their actions. Alcohol addiction can show itself in a variety of ways. The severity of the disease, how often someone drinks, and the alcohol they consume varies from person to person. Some people drink heavily all day, while others binge drink and then stay sober for a while.Regardless of how the addiction looks, someone typically has an alcohol addiction if they heavily rely on drinking and can't stay sober for an extended period of time.

14.5 A gambling addiction

Gambling addiction is a progressive addiction that can have many negative psychological, physical, and social repercussions. It is classed as an impulse-control disorder.It is included in the American Psychiatric Association (APA's) Diagnostic and Statistical Manual, fifth edition (DSM-5).Problem gambling is harmful to psychological and physical health. People who live with this addiction may experience depression, migraine, distress, intestinal disorders, and other anxiety-related problems. As with other addictions, the consequences of gambling can lead to feelings of despondency and helplessness. In some cases, this can lead to attempts at suicide.The rate of problem gambling has risen globally over the last few years. In the United States in 2012, around 5.77 million people had a gambling disorder that needed treatment.Because of its harmful consequences, gambling addiction has become a significant public health concern in many countries.

14.6 Gadget addiction

Problematic smartphone use is proposed by some researchers to be a form of psychological or behavioral dependence on cell phones, closely related to other forms of digital media overuse such as social media addiction or internet addiction disorder. Other researchers have stated that terminology relating to behavioral addictions in regards to smartphone use can cause additional problems both in research and stigmatization of users, suggesting the term to evolve to problematic smartphone use.[1] Problematic use can include preoccupation with mobile communication, excessive money or time spent on mobile phones, and use of mobile phones in socially or physically inappropriate situations such as driving an automobile. Increased use can also lead to increased time on mobile communication, adverse effects on relationships, and anxiety if separated from a mobile phone or sufficient signal. Technology is an ever growing and advancing industry that has changed the way views and live in the modern world. Phones, which were once considered a luxury item, are now a necessity that can effectively control all aspects of person's lives including

banking information, work life, credit/debit cards, and people social interactions as well with the presence of social media. Depression symptom severity was negatively associated with greater social smartphone use. Process smartphone use was more strongly associated with problematic smartphone use. Finally, process smartphone use accounted for relationships between anxiety severity and problematic smartphone use.

14.7 Symptoms

Symptoms of substance/medication induced psychotic disorder include experiencing delusions, ha llucinations, or both. Individuals experiencing these symptoms may or may not have insight into whether their delusions and/or hallucinations are real.

14.8 Delusions

- **Persecutory**: Thoughts that others, including organizations, are out to get you or are surveilling you
- **Grandiose**: Belief that you are exceptional, special, gifted, and better than others
- **Referential**: Belief that individuals and environmental signals have hidden meanings meant to communicate with you
- **Erotomanic**: Belief that someone or multiple people are in love with you despite contrary evidence
- **Nihilistic**: Thoughts that a disaster will take place
- **Somatic**: Belief that something is wrong with your body

For example, a persecutory delusion may be "my former company is monitoring my every move and is out to get me." An example of an erotomanic delusion may be "Tom Hanks is madly in love with me."

14.9 Hallucinations

If you have a hallucination, you are experiencing something with one or multiple senses that isn't based in reality. If an individual has substance/medication-induced psychosis and their hallucinations are due to drugs and/or alcohol, this symptom does not count toward their diagnostic criteria.

14.10 Substance-Induced Depression

The irony of substance-induced depression is that most people take drugs to feel better, yet those same drugs make them feel worse. When doctors or psychologists give a diagnosis of substance/medication-induced depressive disorder, they check to make sure that the depression wasn't there before the use of alcohol, drugs, or medications thought to be responsible.[1] This is because there are different types of depressive disorders, and if the symptoms were there before the substance use, it isn't the substance/medication-induced type of depression. In some cases, almost immediately. There is even a category "with onset during intoxication," which means that depressive episode actually begins when the individual is high on the drug. It can also occur during withdrawal, during which symptoms of depression are common. However, with depression which is simply a symptom of withdrawal, the person's mood will usually pick up within a few days of ceasing to take the drug, while with substance-induced depression, it can start during withdrawal, and continue or get worse as the person moves through the detox process. Generally, the diagnosis isn't given if the person has a history of depression without substance use, or if the symptoms continue for more than a month after the person becomes abstinent from alcohol, drugs, or medication.

14.11 Drugs that Cause Substance/Medication-Induced Depressive Disorder

A wide variety of psychoactive substances can cause substance-induced depression. The following disorders are recognized:[3]

- Alcohol-induced depressive disorder
- Phencyclidine-induced depressive disorder
- Other hallucinogen-induced depressive disorder
- Inhalant-induced depressive disorder
- Opioid-induced depressive disorder
- Sedative-induced depressive disorder
- Hypnotic-induced depressive disorder
- Anxiolytic-induced depressive disorder
- Amphetamine-induced depressive disorder
- Other stimulant-induced depressive disorder
- Cocaine-induced depressive disorder
- Other substance-induced depressive disorder
- Unknown substance-induced depressive disorder

Many medications are known to cause substance-induced depression. The following disorders are recognized:

- Steroid-induced depressive disorder
- L-dopa-induced depressive disorder
- Antibiotic-induced depressive disorder
- Central nervous system drug-induced depressive disorder
- Dermatological agent-induced depressive disorder
- Chemotherapeutic drug-induced depressive disorder
- Immunological agent-induced depressive disorder

Specific medications that have been implicated in medication-induced depression through surveillance studies, retrospective observational studies, or case reports, which are prone to difficulty in determining the actual cause, include antiviral agents (such as efavirenz), cardiovascular agents (such as clonidine, guanethidine, methyldopa, reserpine), retinoic acid derivatives (such as isotretinoin), antidepressants, anticonvulsants, anti-migraine agents (triptans), antipsychotics, hormonal agents (corticosteroids, oral contraceptives, gonadotropin-releasing hormone agonists, tamoxifen), smoking cessation agents (varenicline), and immunological agents (interferon).

14.12 Substance-induced anxiety disorder

Substance-induced anxiety disorder is nervousness, restlessness, or panic caused by taking a drug or stopping a drug. If you had anxiety before you started using the drug, even if the drug makes your symptoms worse, it is not considered a substance-induced anxiety disorder. The brain makes chemicals that affect thoughts, emotions, and actions. Without the right balance of these chemicals, there may be problems with the way you think, feel, or act. Many drugs change the amounts of these chemicals. Some drugs can cause anxiety while you are taking them. Other drugs can cause anxiety for several weeks after you stop taking them. Drugs and medicines that can cause anxiety include:

- Alcohol and illegal drugs such as cocaine and LSD
- Nonprescription medicines such as some decongestants
- Caffeine
- Prescription medicines such as stimulants, steroids, and medicines to treat asthma, Parkinsonâ€™s disease, and thyroid problems

The symptoms may start while you are taking the drugs or within a few days after you stop taking them. Besides feeling nervous and worried, symptoms may include:

- Thinking that bad things will happen or that you will never get better
- Having trouble falling asleep or waking up often during the night

- Having trouble concentrating or remembering things
- Fearing that you are losing control of yourself and will go crazy or will die
- Losing weight because you don't feel like eating, or because your stomach hurts or you have vomiting or diarrhea
- Having chills, hot flashes, sweating, shaking, numbness, or a pounding heartbeat
- Having trouble breathing, trouble swallowing, or chest pain

Your healthcare provider will ask how much and how often you use nonprescription, prescription, and illegal drugs. Be honest about the medicines and drugs you use. Your provider needs this information to give you the right treatment. He will also ask about your symptoms, medical history and give you a physical exam. You may have tests or scans to help make a diagnosis. See your healthcare provider if you believe that a medicine may be causing anxiety. Your healthcare provider may prescribe a change in medicine or treatment for your symptoms. Do not change the dosage or stop taking any prescribed medicine unless your healthcare provider has given you instructions to do so. Drug abuse and dependence can be treated. For any treatment to be successful, you must want to stop using drugs. Do not try to use alcohol and other drugs to reduce withdrawal symptoms. Your healthcare provider may prescribe medicine to help you get through withdrawal. Self-help groups such as Cocaine Anonymous, support groups, and therapy may be helpful. You might be treated in a substance abuse treatment program. Your healthcare providers and counselors will work with you to develop a treatment program.

14.13 Therapy

Substance-induced anxiety disorder can be treated with either group or individual therapy. Therapy in a group with other people who have substance abuse problems is often very helpful. In some cases, medicines for depression or anxiety may help you to stop substance abuse. Discuss the options with your healthcare provider or therapist.

14.14 Other Treatments

Learning ways to relax may help. Yoga and meditation may also be helpful. You may want to talk with your healthcare provider about using these methods along with medicines and therapy. Claims have been made that certain herbal and dietary products help control cravings or withdrawal symptoms. Supplements are not tested or standardized and may vary in strengths and effects. They may have side effects and are not always safe. Before you take any supplement, talk with your healthcare provider.

14.15 Causes of Substance Use Disorders

The cause of substance use disorders is still unknown, though genetics are thought to account for 40% to 60% of a person's risk. Substance use often starts as a way to feel good or out of curiosity in childhood or early adolescence. Repeated use of the substance and increased tolerance pave the way to substance use disorder and addiction. Some adults who develop a substance use disorder have a co-occurring mental illness, such as depression, anxiety, or bi-polar disorder, and begin using drugs or alcohol to cope with their symptoms. Other risk factors that may lead to a substance use disorder include:

- Family history of addiction
- Sleep problems
- Chronic pain
- Financial difficulties
- Divorce or the loss of a loved one
- Long-term tobacco habit

- Tense home environment
- Lack of parental attachment in childhood
- Relationship issues

Of course, none of these risk factors guarantees that a person will develop a substance abuse disorder, but a combination of factors plus repeated substance use significantly increase the likelihood of addiction. Is your loved one struggling with substance abuse?

More than 20 million Americans suffer from a chemical dependency on drugs or alcohol. Unfortunately, only a small fraction of those who need treatment actually seek help. At Alvarado Parkway Institute, we understand the challenges and stigma associated with substance use disorders and work diligently to provide effective, evidence-based treatment to the patients who entrust us with their care.

Whether your loved one requires the safe, controlled environment of inpatient drug treatment or the flexibility of an outpatient program, all patients in our care receive the counseling, education, and recovery support services they need to lead a happy, healthy life. For more information on our alcohol and drug treatment programs, please call our 24-hour crisis line at (619) 667-6125.

14.16 Summary

Drug addiction, also called substance use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication. Substances such as alcohol, marijuana and nicotine also are considered drugs. When you're addicted, you may continue using the drug despite the harm it causes. Drug addiction can start with experimental use of a recreational drug in social situations, and, for some people, the drug use becomes more frequent. For others, particularly with opioids, drug addiction begins with exposure to prescribed medications, or receiving medications from a friend or relative who has been prescribed the medication.

14.17 Keyword

Substance additive disorders, causes, symptoms, treatment, delirium

14.18 Self Eveluation

1) Behavioural Self-Control Training (BSCT) is based on conditioning principles. These include which of the following?

a)Stimulus control
b)Using rewards to reinforce abstinence
c)Learning to be aware of when and how frequently drug taking occurs
d)All of the above

2) Which of the following is an assumption of controlled drinking, which is a variant of Behavioural Self-Control Training (BSCT)?

a)In moern day western societies it is difficult to avoid alcohol altogether
b)Ensuring that alcohol consumption stays within the legal limit.
c) Making sure one never goes to the pub too late
d)Making one's own alcohol

3) In cognitive behavioural therapy for substance abuse individuals may hold dysfunctional beliefs such as "If I lapse then my treatment will have failed" or "I have had one drink so I may as well get drunk". These are known as:

a)Abstinence violation beliefs

b)Controlled drinking
c)Amotivational syndrome
d)Impulsive drinking

4) Detoxification is a process of systematic and supervised withdrawal from substance use that is either managed in a residential setting or on an outpatient basis. Drug use during detoxification can take which of the following forms?

a)Help reduce withdrawal symptoms
b)Prevent relapse
c)To wean a user onto a weaker substance
d)All of the above

5) In biological treatments of substance abuse an example of a user being weaned onto a weaker substance would be which of the following?

a)Methadone maintenance programmes
b)Controlled drinking
c)Barbiturate ban
d)Amphetamine amnesty

6) Antabuse or disulfiram affects the metabolism of alcohol so that the normal process of converting toxic alcohol products into non-toxic acetic acids is slowed. Which of the following are problems associated with Antabuse?

a)It is rarely effective when patients are given the drug to take unsupervised
b)Drop-out from such programmes are high
c)In some rare cases causes liver disease
d)All of the above

Check your answer

7) Which of the following drugs are used to treat substance use disorders by attaching to endorphin receptor sites in the brain?

a)Naltrexone
b)axolone
c)Buprenorfine
d)All of the above

8) Growing evidence to suggest that nicotine has its effects by:

a)Releasing serotonin into the cerebellum
b)Releasing dopamine in the mesolimbic system of the brain
c)Releasing GABA into the hypothalamus
d)Releasing acetylcholine into the diencephalons

9) Alcohol Dependence is supported specifically by evidence of tolerance effects and withdrawal symptoms that develop within:

a)1-2 hours of restricted consumption
b)3-6 hours of restricted consumption
c)4-12 hours of restricted consumption
d)12-24 hours of restricted consumption

10) The term psychological dependence is used when:

a)It is clear that the individual has changed their life to ensure continued use of the drug
b)Their activities are centred on the drug and its use
c)Leads to neglect of other important activities such as work, social and family commitments
d)All of the above

11) Which of the following is an example of a substance use disorder (SUD)?

a)Alcohol related disorders
b)Caffeine related disorders
c)Inhalant related disorders
d)All of the above

12) Which of the following is not a hallucinogenic?

a)Cannabis

b)MDMA
c)LSD
d)Antibiotics

13) In the UK a male 'hazardous drinker' would consume how many drinks on a typical drinking day?

a)5 or more standard drinks
b)10 or more standard drinks
c)7 or more standard drinks
d)4 or more standard drinks

14) Following withdrawal after extended heavy drinking over a number of years, the drinker may experience:

a)Delirium tremens (DTs)
b)Saccadian Dysrhythmia
c)Homeostasis
d)Leptocurtic reaction

15) Which of the following are the consequences of vitamin and mineral deficiencies which can lead to dementia and memory disorders in alcohol abuse?

a)Smirnoff's syndrome
b)Korsakoff's syndrome
c)Helmert syndrome
d)Huynh-Feldt syndrome

1D. 2A. 3A. 4D. 5A. 6D. 7D. 8B. 9C. 10D. 11D. 12.D. 13A. 14A. 15B

14. 19 Review Questions

1. What are substance additive disorders?
2. Discuss why substance additive disorders are dangerous.
3. What are the causes of substance additive disorders?
4. Discuss the treatment of substance additive disorders along with the advancement in its treatment options.

14. 20 Further Readings

https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/references

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