Final term notes 404

Abnormal psychology (Virtual University of Pakistan)

1: Dissociative disorder:

Types of dissociative disorders

There are three primary types of dissociative disorders:

- Dissociative identity disorder
- Depersonalization/derealization disorder
- Dissociative amnesia

Acute stress disorder and post-traumatic stress disorder (PTSD) are closely related to dissociative disorders, sharing such symptoms as memory loss, depersonalization, or derealization.

What causes dissociative disorders?

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.

What are the symptoms of dissociative disorders?

Once known as multiple personality disorder, dissociative identity disorder usually stems from catastrophic experiences, abuse or trauma that occurred when the person was a child. Among people with this disorder, about 90% have been the victim of childhood abuse (physical or sexual) or neglect.

Symptoms of dissociative identity disorder include:

The existence of two or more distinct identities or "personality states." Each identity has a particular set of behaviors, attitudes, preferences, memories, and ways of thinking that are observable by others and may even be reported by the affected person. Shifting from one identity to another is involuntary, sudden, and can reverse at a moment's notice.

- Long-term gaps in memory concerning everyday events, personal information, or traumatic events of the past.
- Problems in social settings, the workplace, or other areas of functioning in daily life. The seriousness of such problems can range from minimal to significant.

Suicide attempts, self-mutilation, and other self-injuring behaviors are common among those with dissociative identity disorder. More than 70% of outpatients with this condition have attempted suicide

Symptoms of depersonalization/derealization disorder

One or both of the following conditions exist in the same person in a recurring pattern over a long period of time:

- Depersonalization – Feelings of unreality or of being detached from one's own mind, body or self. It is as if one is an observer of rather than a participant in their own life events.
- Derealization – Feelings of unreality or of being detached from one's surroundings. People and things may not seem real.

During these episodes the person is aware of their surroundings, and knows that what they are experiencing is not normal. Even if the person shows little emotion during these episodes, they are usually interpreted as being quite upsetting.

Symptoms may start as early as childhood, with 16 years old being the average age of first experience. Fewer than 20% will have their first experience of the disorder after age 20.

Symptoms of dissociative amnesia

Dissociative amnesia means not being able to recall information about one's past. This is not the same as simply being forgetful, as it is usually related to a traumatic or particularly stressful event or period of time. An episode of amnesia comes on suddenly and can last as little as minutes, or as long as months or years. There is no particular age of onset, and episodes can occur periodically throughout life.

There are three types of amnesia:

- Localized – Cannot remember an event or period of time (most common form of amnesia)
- Selective – Cannot remember certain details of events about a given period of time.
- Generalized – Complete loss of identity of life history (rarest form).

The person may not be aware of their memory loss or have only little awareness. Even when they do realize a loss of memory, the person often downplays the importance of not recalling a particular event or period of time.

How are dissociative disorders diagnosed?

Diagnosis of dissociative disorders involves a review of symptoms and the person's life history. Physical tests may be performed to rule out physical or medical conditions that could cause symptoms such as memory loss or feelings of unreality. Such conditions might include head

injury, brain tumor, sleep problems, or drug or alcohol use. Once physical causes are ruled out, a mental health specialist will step in to analyze the details of the individual's case.

2: Eating and feeding disorder

Eating disorders are behavioral conditions characterized by severe and persistent disturbance in eating behaviors and associated distressing thoughts and emotions. They can be very serious conditions affecting physical, psychological and social function.

Types of eating disorders include anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant restrictive food intake disorder, other specified feeding and eating disorder, pica and rumination disorder.

There are three main types of eating disorders: **anorexia nervosa**, **bulimia nervosa** and **binge eating disorder**. **Anorexia Nervosa**

Anorexia nervosa is characterized by self-starvation and weight loss resulting in low weight for height and age. Anorexia has the highest mortality of any psychiatric diagnosis other than opioid use disorder and can be a very serious condition. Body mass index or BMI, a measure of weight for height, is typically under 18.5 in an adult individual with anorexia nervosa.

Dieting behavior in anorexia nervosa is driven by an intense fear of gaining weight or becoming fat. Although some individuals with anorexia will say they want and are trying to gain weight, their behavior is not consistent with this intent. For example, they may only eat small amounts of low-calorie foods and exercise excessively. Some persons with anorexia nervosa also intermittently binge eat and or purge by vomiting or laxative misuse.

There are two subtypes of anorexia nervosa:

- **restricting type**, in which individuals lose weight primarily by dieting, fasting or excessively exercising, and
- **binge-eating/purging type** in which persons also engage in intermittent binge eating and/or purging behaviors.

Bulimia Nervosa

Individuals with bulimia nervosa typically alternate dieting, or eating only low calorie "safe foods" with binge eating on "forbidden" high calorie foods. Binge eating is defined as eating a large amount of food in a short period of time associated with a sense of loss of control over what, or how much one is eating. Binge behavior is usually secretive and associated with feelings of shame or embarrassment. Binges may be very large and food is often consumed rapidly, beyond fullness to the point of nausea and discomfort.

Binges occur at least weekly and are typically followed by what are called "compensatory behaviors" to prevent weight gain. These can include fasting, vomiting, laxative misuse or compulsive exercise. As in anorexia nervosa, persons with bulimia nervosa are excessively preoccupied with thoughts of food, weight or shape which negatively affect, and disproportionately impact, their self-worth.

Individuals with bulimia nervosa can be slightly underweight, normal weight, overweight or even obese. If they are underweight however, they are considered to have anorexia nervosa binge-eating/purging type not bulimia nervosa. Family members or friends may not know that a person has bulimia nervosa because they do not appear underweight and because their behaviors are hidden and may go unnoticed by those close to them. Possible signs that someone may have bulimia nervosa include:

- Frequent trips to the bathroom right after meals
- Large amounts of food disappearing or unexplained empty wrappers and food containers
- Chronic sore throat
- Swelling of the salivary glands in the cheeks
- Dental decay resulting from erosion of tooth enamel by stomach acid
- Heartburn and gastroesophageal reflux
- Laxative or diet pill misuse
- Recurrent unexplained diarrhea
- Misuse of diuretics (water pills)
- Feeling dizzy or fainting from excessive purging behaviors resulting in dehydration

Bulimia can lead to rare but potentially fatal complications including esophageal tears, gastric rupture, and dangerous cardiac arrhythmias. Medical monitoring in cases of severe bulimia nervosa is important to identify and treat any possible complications.

Outpatient cognitive behavioral therapy for bulimia nervosa is the treatment with the strongest evidence. It helps patients normalize their eating behavior and manage thoughts and feelings that perpetuate the disorder. Antidepressants can also be helpful in decreasing urges to binge and vomit.

Binge Eating Disorder

As with bulimia nervosa, people with binge eating disorder have episodes of binge eating in which they consume large quantities of food in a brief period, experience a sense of loss of control over their eating and are distressed by the binge behavior. Unlike people with bulimia nervosa however, they do not regularly use compensatory behaviors to get rid of the food by inducing vomiting, fasting, exercising or laxative misuse. The binge eating is chronic and can lead to serious health complications, including obesity, diabetes, hypertension and cardiovascular diseases.

The diagnosis of binge eating disorder requires frequent binges (at least once a week for three months), associated with a sense of lack of control and with three or more of the following features:

- Eating more rapidly than normal
- Eating until uncomfortably full
- Eating large amounts of food when not feeling hungry
- Eating alone because of feeling embarrassed by how much one is eating
- Feeling disgusted with oneself, depressed or very guilty afterward

As with bulimia nervosa, the most effective treatment for binge eating disorder is cognitive behavioral psychotherapy for binge eating. Interpersonal therapy has also been shown to be effective, as have several antidepressant medications.

Other Specified Feeding and Eating Disorder

This diagnostic category includes eating disorders or disturbances of eating behavior that cause distress and impair family, social or work function but do not fit the other categories listed here. In some cases, this is because the frequency of the behavior dose not meet the diagnostic threshold (e.g., the frequency of binges in bulimia or binge eating disorder) or the weight criteria for the diagnosis of anorexia nervosa are not met.

An example of other specified feeding and eating disorder is "atypical anorexia nervosa". This category includes individuals who may have lost a lot of weight and whose behaviors and degree of fear of fatness is consistent with anorexia nervosa, but who are not yet considered underweight based on their BMI because their baseline weight was above average.

Since speed of weight loss is related to medical complications, individuals who lose a lot of weight rapidly by engaging in extreme weight control behaviors can be at high risk of medical complications, even if they appear normal or above average weight.

Avoidant Restrictive Food Intake Disorder

Avoidant/restrictive food intake disorder (ARFID) is a recently defined eating disorder that involves a disturbance in eating resulting in persistent failure to meet nutritional needs and extreme picky eating. In ARFID, food avoidance or a limited food repertoire can be due to one or more of the following:

- Low appetite and lack of interest in eating or food.
- Extreme food avoidance based on sensory characteristics of foods e.g. texture, appearance, color, smell.
- Anxiety or concern about consequences of eating, such as fear of choking, nausea, vomiting, constipation, an allergic reaction, etc. The disorder may develop in response to

a significant negative event such as an episode of choking or food poisoning followed by the avoidance of an increasing variety of foods.

The diagnosis of ARFID requires that difficulties with eating are associated with one or more of the following:

- Significant weight loss (or failure to achieve expected weight gain in children).
- Significant nutritional deficiency.
- The need to rely on a feeding tube or oral nutritional supplements to maintain sufficient nutrition intake.
- Interference with social functioning (such as inability to eat with others).

The impact on physical and psychological health and degree of malnutrition can be similar to that seen in people with anorexia nervosa. However, people with ARFID do not have excessive concerns about their body weight or shape and the disorder is distinct from anorexia nervosa or bulimia nervosa. Also, while individuals with autism spectrum disorder often have rigid eating behaviors and sensory sensitivities, these do not necessarily lead to the level of impairment required for a diagnosis of avoidant/restrictive food intake disorder.

ARFID does not include food restriction related to lack of availability of food; normal dieting; cultural practices, such as religious fasting; or developmentally normal behaviors, such as toddlers who are picky eaters.

Food avoidance or restriction commonly develops in infancy or early childhood and may continue in adulthood. It can however start at any age. Regardless of the age of the person affected, ARFID can impact families, causing increased stress at mealtimes and in other social eating situations.

Pica

Pica is an eating disorder in which a person repeatedly eats things that are not food with no nutritional value. The behavior persists over for at least one month and is severe enough to warrant clinical attention.

Typical substances ingested vary with age and availability and might include paper, paint chips, soap, cloth, hair, string, chalk, metal, pebbles, charcoal or coal, or clay. Individuals with pica do not typically have an aversion to food in general.

The behavior is inappropriate to the developmental level of the individual and is not part of a culturally supported practice. Pica may first occur in childhood, adolescence, or adulthood, although childhood onset is most common. It is not diagnosed in children under age 2. Putting small objects into their mouth is a normal part of development for children under 2. Pica often occurs along with autism spectrum disorder and intellectual disability, but can occur in otherwise typically developing children.

A person diagnosed with pica is at risk for potential intestinal blockages or toxic effects of substances consumed (e.g. lead in paint chips).

Treatment for pica involves testing for nutritional deficiencies and addressing them if needed. Behavior interventions used to treat pica may include redirecting the individual from the nonfood items and rewarding them for setting aside or avoiding nonfood items.

Rumination Disorder

Rumination disorder involves the repeated regurgitation and re-chewing of food after eating whereby swallowed food is brought back up into the mouth voluntarily and is re-chewed and re-swallowed or spat out. Rumination disorder can occur in infancy, childhood and adolescence or in adulthood. To meet the diagnosis the behavior must:

- Occurs repeatedly over at least a 1-month period
- Not be due to a gastrointestinal or medical problem
- Not occur as part of one of the other behavioral eating disorders listed above
- Rumination can also occur in other mental disorders (e.g. intellectual disability) however the degree must be severe enough to warrant separate clinical attention for the diagnosis to be made.

3: Sleep-Wake Disorders

There are several different types of sleep-wake disorders, of which insomnia is the most common. Other sleep-wake disorders include **obstructive sleep apnea, parasomnias, narcolepsy, and restless leg syndrome**. Sleep difficulties are linked to both physical and emotional problems.

There are many different types of sleep disorders. Some may be caused by other underlying health conditions.

Insomnia

Insomnia refers to the inability to fall asleep or to remain asleep. It can be caused by jet lag, stress and anxiety, hormones, or digestive problems. It may also be a symptom of another condition.

Insomnia can be problematic for your overall health and quality of life, potentially causing:

- depression
- difficulty concentrating
- irritability
- weight gain
- impaired work or school performance

Unfortunately, insomnia is extremely common. Up to 50 percent of American adults experience it at some point in their lives.

The disorder is most prevalent among older adults and women.

Insomnia is usually classified as one of three types:

- chronic, when insomnia happens on a regular basis for at least 1 month
- intermittent, when insomnia occurs periodically
- transient, when insomnia lasts for just a few nights at a time

Sleep apnea

Sleep apnea is characterized by pauses in breathing during sleep. This is a serious medical condition that causes the body to take in less oxygen. It can also cause you to wake up during the night.

There are two types:

- obstructive sleep apnea: where the flow of air stops because airway space is obstructed or too narrow, and
- central sleep apnea: where there is a problem in the connection between the brain and the muscles that control your breath.

Parasomnias

Parasomnias are a class of sleep disorders that cause abnormal movements and behaviors during sleep. They include:

- sleepwalking
- sleep talking
- groaning
- nightmares
- bedwetting
- teeth grinding or jaw clenching

Restless leg syndrome

Restless leg syndrome (RLS) is an overwhelming need to move the legs. This urge is sometimes accompanied by a tingling sensation in the legs. While these symptoms can occur during the day, they are most prevalent at night.

RLS is often associated with certain health conditions, including attention deficit hyperactivity disorder (ADHD) and Parkinson's disease, but the exact cause isn't always known.

Narcolepsy

Narcolepsy is characterized by "sleep attacks" that occur while awake. This means that you will suddenly feel extremely tired and fall asleep without warning.

The disorder can also cause sleep paralysis, which may make you physically unable to move right after waking up. Although narcolepsy may occur on its own, it is also associated with certain neurological disorders, such as multiple sclerosis.

What are the symptoms of sleep disorders?

Symptoms differ depending on the severity and type of sleeping disorder. They may also vary when sleep disorders are a result of another condition.

However, general symptoms of sleep disorders include:

- difficulty falling or staying asleep
- daytime fatigue
- strong urge to take naps during the day
- unusual breathing patterns
- unusual or unpleasant urges to move while falling asleep
- unusual movement or other experiences while asleep
- unintentional changes to your sleep/wake schedule
- irritability or anxiety
- impaired performance at work or school
- lack of concentration
- depression
- weight gain

What causes sleep disorders?

There are many conditions, diseases, and disorders that can cause sleep disturbances. In many cases, sleep disorders develop as a result of an underlying health problem.

How are sleep disorders diagnosed?

Your doctor will first perform a physical exam and gather information about your symptoms and medical history. They may also order various tests, including:

- **Polysomnography (PSG):** This is a lab sleep study that evaluates oxygen levels, body movements, and brain waves to determine how they disrupt sleep vs. home sleep study (HST) that is performed in your own and is used to diagnose sleep apnea.
- **Electroencephalogram (EEG):** This is a test that assesses electrical activity in the brain and detects any potential problems associated with this activity. It's part of a polysomnography.
- **Multiple sleep latency test (MSLT):** This daytime napping study is used in conjunction with a PSG at night to help diagnose narcolepsy.

4: Disruptive, Impulse Control and Conduct Disorders

Disruptive, impulse control and conduct disorders are **a group of disorders that are linked by varying difficulties in controlling aggressive behaviors, self-control, and impulses**. Typically, the resulting behaviors or actions are considered a threat primarily to others' safety and/or to societal norms.

What are Disruptive, Impulse Control and Conduct Disorders?

These are a group of disorders that are linked by varying difficulties in controlling aggressive behaviors, self-control, and impulses. Typically, the resulting behaviors or actions are considered a threat primarily to others' safety and/or to societal norms. Some examples of these issues include fighting, destroying property, defiance, stealing, lying, and rule breaking.

These disorders are:

- Oppositional defiant disorder
- Intermittent explosive disorder
- Conduct disorder
- Pyromania
- Kleptomania
- Other specified disruptive, impulse-control and conduct disorder
- Unspecified disruptive, impulse-control, and conduct disorder

Types of Disorders

Oppositional Defiant Disorder

Oppositional defiant disorder is a common disorder in children and adolescents who are referred to mental health providers for behavioral issues. Individuals with this disorder experience varying levels of dysfunction secondary to oppositionality, vindictiveness, arguments, and aggression.[1]

Symptoms of oppositional defiant disorder include a pattern of:

- Angry/irritable mood—often loses temper, easily annoyed, often angry and resentful.
- Argumentative/defiant behavior—often argues with authority figures or adults, often refuses to comply with requests or rules, deliberately annoys others, blames others for mistakes or misbehavior.
- Vindictiveness—spiteful or vindictive.

Conduct Disorder

Conduct disorder involves severe behaviors that violate the rights of others or societal norms. Behaviors may involve aggression towards others, animals, and/or destruction of property all of which could result in legal consequences.[4] As stated in the oppositional defiant disorder section, many (but not all) children and adolescents with oppositional defiant disorder will eventually meet diagnostic criteria for conduct disorder. However, not all individuals who are diagnosed with Conduct Disorder were first diagnosed with ODD.[5]

Symptoms of conduct disorder include varying patterns of:

- Aggression to people and animals (bullies, intimidates others, initiates fights, use of weapons, cruelty to others, cruelty to animals, stolen while confronting a victim, raped others).
- Destruction of property (deliberate fire setting, vandalization).
- Deceitfulness or theft (broken into properties, manipulates others, stolen).
- Serious violations of rules (runs away from home, truant from school, stays out at night).

Intermittent Explosive Disorder

Intermittent explosive disorder is a disorder associated with frequent impulsive anger outbursts or aggression—such as temper tantrums, verbal arguments, and fights.[2] The observed behaviors result in physical assaults towards others or animals, property destruction, or verbal assaults.[6] The aggressive outbursts:

- Are out of proportion to the event or incident that triggered them.
- Are impulsive.
- Cause much distress for the person.

- Cause problems at work or home.

It is important to note that these aggressive behaviors are not planned, they are impulsive and anger based.[7] They happen rapidly after being provoked and typically do not last longer than 30 minutes.[2] These outbursts must be associated with subjective distress or social or occupational dysfunction.[7] Affected individuals tend to have poor life satisfaction and lower quality of life.[7]

Pyromania

While fire setting can be a common issue among young individuals and a cause of significant destruction in the United States, it is different from pyromania which is a rare disorder that involves repeated impulses or strong desires to set intentional fires.[9] Fire setting is typically motivated by curiosity and tends to occur in unsupervised children with access to lighters and matches.[9] Individuals with pyromania, on the other hand, are fascinated by fire and its uses. Affected individuals engage in repeated and deliberate fire setting that is not motivated by external reasons.[10] They experience strong urges to engage in dangerous fire setting. They also experience internal tension prior to setting fires that is followed by pleasure after fires are lit. These individuals set fires to release built-up inner emotional tension, not for any type of material gain or revenge.

Kleptomania

Kleptomania is a rare disorder that involves involuntary, impulsive, and irresistible stealing of objects that are not needed for personal or other forms of use. This is different from shoplifting in that shoplifters steal for some form of gain and often plan out their actions.[21] However, individuals with Kleptomania do not need what they have stolen. They often give away, return, hide, or hoard the stolen objects.[13] People with kleptomania know what they are doing is wrong but cannot control the impulse to steal, leading to hasty and poorly thought-out stealing.[12] They experience internal tension before stealing that is then relieved after the theft. While they experience pleasure or gratification from stealing, they tend to have guilt or sadness afterwards.[13] Many people with this disorder may try to stop stealing but feel guilt and shame about their inability to do so.[13] Unfortunately, many may be apprehended or jailed for these behaviors.[13]

5: Personality Disorders

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

What are the types of personality disorders?

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), which is the standard reference publication for recognized mental illnesses, organizes the 10 types of personality disorders into three main clusters (categories). Each cluster has different symptoms in common.

Cluster A personality disorders

Cluster A personality disorders involve unusual and eccentric thinking or behaviors. These include:

- **Paranoid personality disorder**: The main feature of this condition is paranoia, which is a relentless mistrust and suspicion of others without adequate reason for suspicion. People with paranoid personality disorder often believe others are trying to demean, harm or threaten them.
- **Schizoid personality disorder**: This condition is marked by a consistent pattern of detachment from and general disinterest in interpersonal relationships. People with schizoid personality disorder have a limited range of emotions when interacting with others.
- **Schizotypal personality disorder**: People with this condition display a consistent pattern of intense discomfort with and limited need for close relationships. Relationships may be hindered by their distorted views of reality, superstitions and unusual behaviors.

Cluster B personality disorders

Cluster B personality disorders involve dramatic and erratic behaviors. People with these types of conditions display intense, unstable emotions and impulsive behaviors. Cluster B personality disorders include:

- **Antisocial personality disorder (ASPD)**: People with ASPD show a lack of respect toward others and don't follow socially accepted norms or rules. People with ASPD may break the law or cause physical or emotional harm to others around them. They may refuse to take responsibility for their behaviors and/or display disregard for the negative consequences of their actions.
- **Borderline personality disorder (BPD)**: This condition is marked by difficulty with emotional regulation, resulting in low self-esteem, mood swings, impulsive behaviors and subsequent relationship difficulties.
- **Histrionic personality disorder**: This condition is marked by intense, unstable emotions and a distorted self-image. For people with histrionic personality disorder, their self-esteem depends on the approval of others and doesn't come from a true feeling of self-worth. They have an overwhelming desire to be noticed by others, and may display dramatic and/or inappropriate behaviors to get attention.

- **Narcissistic personality disorder**: This condition involves a consistent pattern of perceived superiority and grandiosity, an excessive need for praise and admiration and a lack of empathy for others. These thoughts and behaviors often stem from low self-esteem and a lack of self-confidence.

Cluster C personality disorders

Cluster C personality disorders involve severe anxiety and fear. They include:

- **Avoidant personality disorder**: People with this condition have chronic feelings of inadequacy and are highly sensitive to being negatively judged by others. Though they

would like to interact with others, they tend to avoid social interaction due to the intense fear of being rejected.

- **Dependent personality disorder**: This condition is marked by a constant and excessive need to be cared for by someone else. It also involves submissiveness, a need for constant reassurance and the inability to make decisions. People with dependent personality disorder often become very close to another person and spend great effort trying to please that person. They tend to display passive and clinging behavior and have a fear of separation.
- **Obsessive-compulsive personality disorder (OCPD)**: This condition is marked by a consistent and extreme need for orderliness, perfectionism and control (with no room for flexibility) that ultimately slows or interferes with completing a task. It can also interfere with relationships.

This is a separate condition from obsessive-compulsive disorder (OCD), which is classified as an anxiety disorder. While people with OCD usually are aware that OCD is causing their behavior and accept they need to change, people with OCPD usually have little, if any, self-awareness of their behaviors.

What causes personality disorders?

Personality disorders are among the least understood mental health conditions. Scientists are still trying to figure out the cause of them.

So far, they believe the following factors may contribute to the development of personality disorders:

- **Genetics**: Scientists have identified a malfunctioning gene that may be a factor in obsessive-compulsive personality disorder. Researchers are also exploring genetic links to aggression, anxiety and fear, which are traits that can play a role in personality disorders.
- **Brain changes**: Researchers have identified subtle brain differences in people with certain personality disorders. For example, findings in studies on paranoid personality disorder point to altered amygdala functioning. The amygdala is the part of your brain that's involved with processing fearful and threatening stimuli. In a study on schizotypal personality disorder, researchers found a volumetric decrease in the frontal lobe of their brain.
- **Childhood trauma**: One study revealed a link between childhood traumas and the development of personality disorders. People with borderline personality disorder, for example, had especially high rates of childhood sexual trauma. People with borderline and antisocial personality disorders have issues with intimacy and trust, both of which may be related to childhood abuse and trauma.
- **Verbal abuse**: In one study, people who experienced verbal abuse as children were three times as likely to have borderline, narcissistic, obsessive-compulsive or paranoid personality disorders in adulthood.
- **Cultural factors**: Cultural factors may also play a role in the development of personality disorders, as demonstrated by the varying rates of personality disorders between different

countries. For example, there are remarkably low cases of antisocial personality disorders in Taiwan, China and Japan, along with significantly higher rates of cluster C personality disorders.

What are the symptoms of personality disorders?

Each of the 10 types of personality disorders has its own specific signs and symptoms.

But, in general, personality disorders involve problems with:

- **Identity and a sense of self**: People with a personality disorder generally lack a clear or stable image of themselves, and how they see themselves often changes depending on the situation or the people they're with. Their self-esteem may be unrealistically high or low.
- **Relationships**: People with a personality disorder struggle to form close, stable relationships with others due to their problematic beliefs and behaviors. They may lack empathy or respect for others, be emotionally detached or be overly needy of attention and care.

Another distinguishing sign of personality disorders is that most people who have one often have little to no insight or self-awareness of how their thoughts and behaviors are problematic.

How do you know if someone has a personality disorder?

You can't know for sure if someone has a personality disorder unless they receive a professional, medical diagnosis.

It's important to understand the difference between personality types and personality disorders. A person who is shy or likes to spend time alone doesn't necessarily have an avoidant or schizoid personality disorder.

The difference between personality style and a personality disorder can often be determined by assessing how the person's personality affects different parts of their life, including:

- Work.
- Relationships.
- Feelings/emotions.
- Self-identity.
- Awareness of reality.
- Behavior and impulse control.

How are personality disorders diagnosed?

Personality disorders can be difficult to diagnose since most people with a personality disorder don't think there's a problem with their behavior or way of thinking.

Because of this, people with a personality disorder typically don't seek help or a diagnosis for their condition. Instead, their loved ones or a social agency may refer them to a mental health professional because their behavior causes difficulty for others.

When they do seek help, it's often due to conditions such as anxiety, depression or substance use, or because of the problems created by their personality disorder, such as divorce or unemployment, not the disorder itself.

Healthcare providers base the diagnosis of a specific personality disorder on criteria provided in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.

When a mental health professional, like a psychologist or psychiatrist, suspects someone might have a personality disorder, they often ask broad, general questions that won't create a defensive response or hostile environment. They ask questions that will shed light on:

- Past history.
- Relationships
- Previous work history.
- Reality testing.
- Impulse control.

Because a person suspected of having a personality disorder may lack insight into their behaviors, mental health professionals often work with the person's family, friends and/or parole officers to collect more insight about their behaviors and history.

Personality disorders are generally underdiagnosed because providers sometimes focus on the symptoms of anxiety or depression, which are much more common in the general population than personality disorder. These symptoms may overshadow the features of any underlying personality disorder.

6: Psychosexual Disorders/ Paraphilic disorders

There are three main categories of psychosexual disorder: **sexual dysfunction, paraphilias and gender identity disorders**. Sexual dysfunction is characterised by a lack of sexual desire, erectile dysfunction, premature ejaculation, painful sex, lack of sexual enjoyment, sexual addiction and sexual aversion.

Sexual problems can be physiological and psychological or a combination of both in origin. Psychosexual disorders can also vary in severity and intensity, some will be temporary, others more long term.

Up to 54% of women and 35% of men may experience sexual problems, and yet many can find these issues difficult to talk about. Suffering from a sexual disorder can have a very detrimental effect on relationships and on self-esteem, and become the source of **anxiety**, **depression** and **stress**, so it is important to seek treatment wherever possible.

CAUSES

The causes of a psychosexual disorder can lie in feelings of guilt, stress, nervousness, fear, anxiety, or in previous emotional or physical trauma. Other factors based on psychosocial and cultural aspects, such as ignorance or improper sex education, conflicts of values to do with family or religion (for example, the attitude that sex is dirty or sinful) can also be a cause of psychosexual disorder symptoms.

SYMPTOMS

There are three main categories of psychosexual disorder: sexual dysfunction, paraphilias and gender identity disorders.

- Sexual dysfunction is characterized by a lack of sexual desire, erectile dysfunction, premature ejaculation, painful sex, lack of sexual enjoyment, sexual addiction and sexual aversion.
- Paraphilias is unusual or abnormal sexual behavior, including sexual attraction to unusual objects or activity, such as fetishism, exhibitionism, sadism and voyeurism, amongst others.
- Gender identity disorders manifest as a variation between a person's biological sexual identity and their own sense of sexual identity, causing difficulties in adjusting to a normal lifestyle and a desire to alter sexual orientation by becoming a member of the opposite sex.

Fetishism and transvestic fetishism

Fetishism is a disorder that is characterized by a sexual fixation, fantasies or behaviors toward an inanimate object, these objects frequently are articles of clothing. It is only through this object which the individual can achieve sexual gratification. It is not rare that an individual will rub or smell the object. This disorder is more common in males and it is not understood why.[3]

Transvestic fetishism also commonly known as transvestism

Sexual sadism and sexual masochism

The disorders known as sexual sadism and sexual masochism are oftentimes confused or hard to separate when their definitions are compared but diagnostic criteria differ slightly between the two and allows for more easy classification.[4] Sexual sadism disorder and sexual masochism are defined as receiving sexual arousal from the humiliation, pain and or suffering of an individual and are thought to overlap with multiple other conditions due to its description along with diagnostic criteria.[4]

Voyeurism, exhibitionism and frotteurism[edit]

Voyeurism is self-reported sexual arousal from spying on others or the observation of others who are engaged in sexual interaction.[5]

Exhibitionism are public acts of exposing parts of one's body that are not socially acceptable to be exposed.[5] Exhibitionistic acts are among the most common of the potentially law-breaking sexual behaviors.[5] Examples of this would include "streaking" during a professional sporting event or protesting a political event in the nude.

Frotteurism is considered a rare paraphilia that revolves around an individual's sexual satisfaction being derived from rubbing upon another non-consenting individual.[6] The term frotteurism itself can be broken down and derived from the French verb *frotter* which means rubbing.[5]

Gender Dysphoria

Previously known as gender identity disorder, the term gender dysphoria refers to distress that may accompany the incongruence between a person's experienced or expressed gender and that person's assigned gender. Before getting into the details of the disorder, we need to get familiarized with the following few terminologies**:**

Transgender:

It refers to the broad spectrum of individuals who transiently or persistently identifies with a gender different from their natal gender**.**

Transsexual

This denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery i.e. Reassignment Surgery**.**

Gender Dysphoria

It is an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category.

Not everyone experiences distress as the result of this incongruence but, importantly, many people are distressed if they are unable to receive treatment through hormones and/or surgery. Thus, in the current criteria for disorder, the individual experiences identification with the other sex. The feeling that they are "in the wrong body" causes feelings of discomfort and a sense of inappropriateness about their assigned gender. Both of these conditions must be present for a clinician to assign the diagnosis. Thus, the clinical problem is the dysphoria, not the individual's gender identity.

7: Neurocognitive Disorders I

What Are Neurocognitive Disorders?

Neurocognitive disorders are a group of conditions that frequently lead to impaired mental function. **Organic brain syndrome** used to be the term to describe these conditions, but **neurocognitive disorders** is now the more commonly used term.

Neurocognitive disorders most commonly occur in older adults, but they can affect younger people as well. Reduced mental function may include:

- problems with memory
- changes in behavior
- difficulty understanding language
- trouble performing daily activities

These symptoms may be caused by a neurodegenerative condition, such as Alzheimer's disease or dementia. Neurodegenerative diseases cause the brain and nerves to deteriorate over time, resulting in a gradual loss of neurological function. Neurocognitive disorders can also develop as a result of brain trauma or substance abuse. Healthcare providers can usually determine the underlying cause of neurocognitive disorders based on the reported symptoms and the results of diagnostic tests. The cause and severity of neurocognitive disorders can help healthcare providers determine the best course of treatment.

The long-term outlook for people with neurocognitive disorders depends on the cause. When a neurodegenerative disease causes the neurocognitive disorder, the condition often gets worse over time. In other cases, decreased mental function may only be temporary, so people can expect a full recovery.

What Are the Symptoms of Neurocognitive Disorders?

The symptoms of neurocognitive disorders can vary depending on the cause. When the condition occurs as a result of a neurodegenerative disease, people may experience:

- memory loss
- confusion
- anxiety

Other symptoms that may occur in people with neurocognitive disorders include:

- headaches, especially in those with a concussion or traumatic brain injury
- inability to concentrate or focus
- short-term memory loss
- trouble performing routine tasks, such as driving
- difficulty walking and balancing
- changes in vision

What Causes Neurocognitive Disorders?

The most common cause of neurocognitive disorders is a neurodegenerative disease. Neurodegenerative diseases that can lead to the development of neurocognitive disorders include:

- Alzheimer's disease
- Parkinson's disease
- Huntington's disease
- dementia
- prion disease
- multiple sclerosis

In people under age 60, however, neurocognitive disorders are more likely to occur after an injury or infection. Nondegenerative conditions that may cause neurocognitive disorders include:

- a concussion
- traumatic brain injury that causes bleeding in the brain or space around the brain
- blood clots

- meningitis
- encephalitis
- septicemia
- drug or alcohol abuse
- vitamin deficiency

How Are Neurocognitive Disorders Diagnosed?

Neurocognitive disorders aren't caused by a mental disorder. However, many of the symptoms of neurocognitive disorders are similar to those of certain mental disorders, including schizophrenia, depression, and psychosis. To ensure an accurate diagnosis, healthcare providers will perform various diagnostic tests that can differentiate symptoms of neurocognitive disorders from those of a mental disorder. These tests often include:

- cranial CT scan: This test uses a series of X-ray images to create images of the skull, brain, sinuses, and eye sockets. It may be used to examine the soft tissues in the brain.
- head MRI scan: This imaging test uses powerful magnets and radio waves to produce detailed images of the brain. These pictures can show signs of brain damage.
- positron emission tomography (PET) scan: A PET scan uses a special dye that contains radioactive tracers. These tracers are injected into a vein and then spread throughout the body, highlighting any damaged areas.
- electroencephalogram (EEG): An EEG measures the electrical activity in the brain. This test can help detect any problems associated with this activity.

8: Substance Related and Addictive Disorders

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.

Characteristic Symptoms

Substance dependence is a repeated pattern of substance abuse that can result in tolerance, withdrawal, and compulsive drug-taking behaviors.

- **Dependence** is what most people are referring to when they use the term addiction.
- **Tolerance** is present when the individual has to use progressively more of the substance over time to achieve a particular high.
- **Withdrawal** is a set of unpleasant physical symptoms that are opposite of the effects of the drug. If using the drug causes a decrease in heart rate, a potential withdrawal symptom might be an increase in heart rate. Withdrawal symptoms are a result of the body's compensatory responses and appear when use of the drug is abruptly discontinued.

Compulsive drug-taking behaviors include uncontrolled use of the drug, craving the drug, excessive amounts of time devoted to obtaining the drug, unsuccessful attempts to cut down or control substance use, and giving up important and pleasurable activities in order to obtain the drug.

Types of Substance-Related Disorders

The DSM-5 lists ten classes of substances for which the diagnoses of a substance-related disorder can be given:

- Alcohol
- Caffeine
- Cannabis (Marijuana)
- Hallucinogens (e.g., LSD)
- Inhalants (e.g., paint thinner)

- Opioids (e.g., heroin)
- Sedatives, Hypnotic and Anxiolytic Substances (e.g., Valium, barbituates, sleeping pills)

- Stimulants
- Tobacco
- Other Substances

Sedatives:

Sedative are the medicines which slower the central nervous system and brain, hence body becomes slow. These include hypnotics and anxiolytics**.**

Stimulants:

Stimulants are opposite to the sedatives and accelerate the functioning of Central nervous system,

Tobacco:

It is the most widely used substance and is highly addictive**.**

Caffeine:

Caffeine is a natural stimulant most commonly found in tea, coffee and cacao plants and works by stimulating central nervous system, keeping one alert**.**

Alcohol:

Alcohol is another depressant and sedative, is most commonly used in different countries, not permissible in Pakistan though.

Cannabis:

Cannabis, also known as marijuana among other names, is a psychoactive drug from the Cannabis plant used primarily for medical or recreational purposes.

Hallucinogens:

Hallucinogens are a class of drugs that cause profound distortions in a person's perceptions of reality, otherwise known as hallucinations**.**

Inhalants:

Inhalants are various products easily bought and found for example spray paints, markers, glues, and cleaning fluids. They contain dangerous substances that have psychoactive properties when inhaled.

Opioids:

Opioids, comes from poppy plants, are substances e.g. heroine that act on opioid receptors to produce morphine-like effects. Medically they are primarily used for pain relief, including anesthesia.

Other (or unknown) Substances.

There are many other substances which people use.

Following are the types of substances commonly being used

Benzodiazepines

Benzodiazepines are the most common group of antianxiety drugs, which includes Valium and Xanax. They are generally safer and less likely to lead to intoxication, tolerance effects, and withdrawal reactions.

Opioids:

Opioids include opium, which is taken from the sap of the opium poppy; drugs derived from opium, such as heroin, morphine, and codeine; and similar synthetic (laboratory-blended) drugs**.**

Endorphins:

Endorphins are neurotransmitters that help relieve pain and reduce emotional tension and elevating mood. These are sometimes referred to as the body’s own opioids.

Gambling:

Though it is not a substance, gambling is also included in addictive disorders as it is highly addictive. Gambling behavior activates reward systems similar to those activated by drugs. It produces some behavioral symptoms comparable to the substance use disorders.

Broadly, the substance-related disorders are divided into two groups:

1. Substance Use Disorders

2. Substance Induced Disorders

A substance use disorder (SUD) is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications. Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs.

Substance-induced disorders include, among other disorders, substance/medication-induced mental disorders. Substance/medication-induced mental disorders refer to depressive, anxiety, psychotic, or manic symptoms that occur as a physiological consequence of the use of substances of abuse or medications.

Different Types of Substance-Induced Disorders

The *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-V), expanded upon the fourth edition's list of 9 SIDs to include states of intoxication and withdrawal. As a result, experts recognize 11 different categories of substance-induced disorders. These are:

- **Intoxication** – occurs when a person is under the influence of drugs or alcohol exhibiting slurred speech, euphoria, impaired thinking, loss of coordination, and lowered inhibitions.
- **Withdrawal** – symptoms that occur when someone who is dependent on a substance stops using. These can include depression, insomnia, body aches, nausea, vomiting, and more.
- **Substance-induced depressive disorder** – experiencing symptoms of depression, sadness, worthlessness, low energy, difficulty concentrating, isolation, and suicidal thoughts that are provoked by substance abuse and do not occur without substances in the body.

- **Substance-induced anxiety disorder** – similar to anxiety disorder, but individuals only experience symptoms of panic, anxiety, irritability, and insomnia while using substances.
- **Substance-induced bipolar disorder** – symptoms are similar to that of bipolar disorder, but the manic highs and depressing lows are not present when substances are not being used.
- **Substance-induced psychosis** – a condition characterized by auditory and/or visual hallucinations and/or delusions that are occurring as a result of substance abuse and are not normally present without substances in the body.
- **Substance-induced obsessive-compulsive disorder** – when using substances, individuals feel compelled to act out on certain unnecessary behaviors or actions in order to soothe their anxiety, such as locking doors multiple times before leaving the house or washing hands two times before leaving the restroom.
- **Substance-induced sexual dysfunction** – issues with sexual arousal, desire, orgasm, or pain that are induced by substance abuse and are far worse than the normal side effects of substance abuse on libido.
- **Substance-induced sleep disorder** – sleep disturbances ranging from insomnia to hypersomnia that doesn't normally occur when a substance isn't being used.
- **Substance-induced delirium** – a condition characterized by disorientation, loss of inhibitions, and mental confusion that is provoked directly by drug or alcohol misuse.
- **Substance-induced neuro-cognitive disorders** – leads to impaired cognitive function including aphasia, memory loss, and speech issues that are induced by substance abuse.

Alcohol-Related Disorder

Alcohol use is associated with several categories of disorders. WHO regards alcohol use as one of the top 10 risk factors for morbidity and mortality. To understand how alcohol affects an individual's behavior, it is important to understand that, from a physiological standpoint, alcohol is a nervous system depressant. The way that it affects the individual depends, however, on how much the drinker ingests. In small amounts, alcohol has sedating effects, and the drinker therefore feels more relaxed. In larger and larger amounts, drinkers may begin to feel more outgoing, self-confident, and uninhibited. Beyond that point, the depressant effects become apparent, leading users to experience sleepiness, lack of physical coordination, dysphoria, and

irritability. In larger and larger amounts, alcohol can be fatal, leading the individual's vital functions to shut down

Following disorder fall under this category:

- Alcohol Use Disorder
- Alcohol Intoxication
- Alcohol Withdrawal
- Other Alcohol-induced Disorders
- Unspecified Alcohol-Related Disorder

Alcohol Use Disorder:

Alcohol use disorder, or alcoholism, is an addiction to alcohol. According to DSM 5following the diagnostic criteria of this disorder:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.

2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.

3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

4. Craving, or a strong desire or urge to use alcohol.

5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.

A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- **Alcohol intoxication** results as the amount of alcohol in your bloodstream increases. The higher the blood alcohol concentration is, the more likely you are to have bad effects. Alcohol intoxication causes behavior problems and mental changes. These may include inappropriate behavior, unstable moods, poor judgment, slurred speech, problems with attention or memory, and poor coordination. You can also have periods called "blackouts," where you don't remember events. Very high blood alcohol levels can lead to coma, permanent brain damage or even death.
- **Alcohol withdrawal** can occur when alcohol use has been heavy and prolonged and is then stopped or greatly reduced. It can occur within several hours to 4 to 5 days later. Signs and symptoms include sweating, rapid heartbeat, hand tremors, problems sleeping, nausea and vomiting, hallucinations, restlessness and agitation,

anxiety, and occasionally seizures. Symptoms can be severe enough to impair your ability to function at work or in social situations.

Caffeine-Related Disorders

Caffeine is a stimulant found in coffee, tea, chocolate, energy drinks, diet pills, and headache remedies. By activating the sympathetic nervous system through increasing the production of adrenaline, caffeine increases an individual's perceived level of energy and alertness. Caffeine also increases blood pressure and may lead to increases in the body's production of cortisol, the stress hormone.

Following disorders come under this category:

Caffeine Intoxication

Caffeine Withdrawal

Other Caffeine -induced Disorders

Unspecified Caffeine -Related Disorder

Caffeine Intoxication

A caffeine overdose occurs when you take in too much caffeine through drinks, foods, or medications.

Caffeine Withdrawal

Diagnostic Criteria:

Following is the diagnostic criteria of caffeine withdrawal according to DSM 5.

A. Prolonged daily use of caffeine.

B. Abrupt cessation of or reduction in caffeine use, followed within 24 hours by three (or more) of the following signs or symptoms:

1. Headache.
2. Marked fatigue or drowsiness.
3. Dysphoric mood, depressed mood, or irritability

Cannabis-Related Disorders

Cannabis, also known as marijuana among other names, is a psychoactive drug from the Cannabis plant used primarily for medical or recreational purposes. It is consumed in many different forms. Following disorder fall under category of cannabis related disorders: 🎬 Cannabis Use Disorder 🎬 Cannabis Intoxication 🎬 Cannabis Withdrawal 🎬 Other Cannabis -induced Disorders 🎬 Unspecified Cannabis -Related Disorder

Cannabis Use Disorder:

Cannabis use disorder is defined as s the continued use of cannabis despite clinically significant impairment.

Cannabis Intoxication

When smoked, cannabis produces a mixture of hallucinogenic, depressant, and stimulant effects. Many smokers report sharpened perceptions and fascination with the intensified sounds and sights around them. Time seems to slow down, and distances and sizes seem greater than they actually are. This overall "high" is technically called cannabis intoxication

Cannabis Withdrawal:

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

Diagnostic Criteria:

A. Cessation of cannabis use that has been heavy and prolonged (i.e., usually daily or almost daily use over a period of at least a few months).

B. Three (or more) of the following signs and symptoms develop within approximately 1 week after Criterion A:

1. Irritability, anger, or aggression.
2. Nervousness or anxiety.
3. Sleep difficulty (e.g., insomnia, disturbing dreams).
4. Decreased appetite or weight loss.
5. Restlessness.

Hallucinogen-Related Disorders

Hallucinogens i.e. pharmaceutical drugs, such as LSD, are substances that cause powerful changes primarily in sensory perception. People's perceptions are intensified and they may have illusions and hallucinations. LSD apparently causes such effects by disturbing the release of the neurotransmitter. These drugs cause people to experience profound distortions in their perception of reality. Under the influence of hallucinogens, people see images, hear sounds, and feel sensations that they believe to be real but are not.

Following fall under category of these disorders:

- Phencyclidine Use Disorder
- Other Hallucinogen Use Disorder
- Phencyclidine Intoxication
- Other Hallucinogen Intoxication (other than Phencyclidine)
- Hallucinogen Persisting Perception Disorder

- Other Phencyclidine-induced Disorders
- Other Hallucinogen-induced Disorders
- Unspecified Phencyclidine-Related Disorder
- Unspecified Hallucinogen-Related Disorder

Other Hallucinogen Use Disorder
The diagnostic criteria for a substance use disorder were previously reviewed LINK. These criteria apply to other hallucinogen use disorders.

Hallucinogens include a wide variety of substances. These substances create euphoria and have psychedelic effects (visual and auditory perceptual distortions).

Phencyclidine Use Disorder
Phencyclidine (PCP) and related substances (such as ketamine) are taken orally, intravenously, nasally, or smoked. Street names include angel dust, super grass, boat, tic-tac, zoom, and shermans. PCP use disorders are more common in males between the ages of 20 and 40.

PCP addiction usually leads to problems with fulfilling obligations such as wage earner, parent, partner, etc. PCP addiction is also indicated when someone shows little regard for their personal safety. Heavy users of PCP frequently place themselves in dangerous situations. This is because their judgment has become impaired. People who use PCP describe having strong cravings. These powerful urges to use may contribute to their continued use. This use continues despite both psychological and physical problems. Many people with phencyclidine use disorders regularly use other drugs as well.

Phencyclidine Intoxication
Phencyclidine Intoxication typically includes behavioral changes. This may include impulsivity, belligerence, hallucinations, and impaired functioning. Violent behavior can occur during use as intoxicated persons may believe they are being attacked. These perceptual distortions, coupled with a reduced threshold for pain, are a recipe for dangerous behavior. There are physical effects as well. These usually develop less than an hour after use. Physical symptoms include nystagmus; decreased control over body movements; increased blood pressure or lowered heart rate; speech difficulties; and at high doses, even coma. These symptoms may last for several weeks with severe intoxication. They may also progress to more serious cardiovascular, neurological, immune, renal, and respiratory problems.

Hallucinogen Intoxication
Hallucinogen intoxication may create some extreme behavioral and psychological symptoms. These may include severe anxiety, or paranoia; depression; fearfulness; poor judgment; difficulty getting along with, or being close to, other people; panic; and perceptual distortions (including hallucinations). Unfortunately, the combination of these symptoms may result in serious injuries (e.g., trying to fly from a building). Some of the physical effects of hallucinogen intoxication include sweating; nausea; slowed heart rate; dilated pupils; heart palpitations; blurred vision; tremors; and lack of coordination.

Hallucinogen persisting perception disorder
Even after the effects of intoxication have subsided, vivid flashbacks and perceptual disturbances may persist for many months, even years. When perceptual disturbances persist after the cessation of the drug, the correct diagnosis is hallucinogen persisting perception disorder.

Inhalant related disorder

Long-term inhalant users are at increased risk for **tuberculosis, HIV/AIDS, sexually transmitted diseases, depression, anxiety, bronchitis, asthma, and sinusitis**. The use of inhalants can in some cases lead to a range of other psychological conditions as well.

Opioid related disorder

Opioid use disorder (OUD) can involve misuse of prescribed opioid medications, use of diverted opioid medications, or use of illicitly obtained heroin. OUD is typically a chronic, relapsing illness, associated with significantly increased rates of morbidity and mortality.

Following disorders fall under this category:

Opioid Use Disorder

- Opioid Intoxication
- Opioid Withdrawal
- Other Opioid-induced Disorders
- Unspecified Opioid-Related Disorder

Sedative, Hypnotic, or Anxiolytic Related Disorders

A sedative has a soothing or calming effect (e.g. sleeping pills and tranquilizers) and are available as prescription medicines. A hypnotic induces sleep, and an anxiolytic is used to treat anxiety symptoms. These central nervous system depressant drugs can be useful for treating anxiety and sleep disorders. Their sedating effects are due to the fact that they increase the levels of the neurotransmitter GABA, which inhibits brain activity and therefore produces a calming effect.

Disorders within this category include use disorder, intoxication, and withdrawal. The detail as per DSM 5 is as follows:

- Sedative, Hypnotic, or Anxiolytic Use Disorder
- Sedative, Hypnotic, or Anxiolytic Intoxication
- Sedative, Hypnotic, or Anxiolytic Withdrawal

- Other Sedative·, Hypnotic-, or Anxiolytic-Induced Disorders
- Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder

Stimulant Related Disorders

The category of drugs called stimulants includes substances that have an activating effect on the nervous system. These differ in their chemical structure, their specific physical and psychological effects, and their potential danger to the user. Stimulants are associated with disorders involving use, intoxication, and withdrawal. Detail is as follows:

- Stimulant Use Disorder
- Stimulant Intoxication
- Stimulant Withdrawal
- Other Stimulant-Induced Disorders
- Unspecified Stimulant-Related Disorder

Tabaco related disorder:

Smoking causes **cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis**. Smoking also increases risk for tuberculosis, certain eye diseases, and problems of the immune system, including rheumatoid arthritis

Following disorders fall under this category:

- Tobacco Use Disorder
- Tobacco Withdrawal
- Other Tobacco-Induced Disorders
- Unspecified Tobacco-Related Disorder

Non-Substance-Related Disorders

Gambling Disorder:

People who have gambling disorder are unable to resist recurrent urges to gamble despite knowing that the gambling will bring about negative consequences to themselves or others. The diagnosis of gambling disorder in DSM-IV-TR included gambling disorder as an impulse-control disorder. In DSM-5, it is included with substance use disorders as it is now conceptualized as showing many of the same behaviors, such as cravings, increasing needs to engage in the behavior, and negative social consequences. The unique features of gambling disorder include behaviors seen when people engage in chasing a bad bet, lying about how much they have lost, seeking financial bailouts, and committing crimes to support their gambling. : Ethological factors of Substance Related and Addictive Disorders

There is no single factor instead there are multiple interacting factors which influence using addictive behavior. Not all who become dependent experience it same way or motivated by the same factors

Becoming physiologically dependent on a substance is a developmental process for some people. That is, for some people, they begin with a positive attitude toward a substance, then begin to experiment with using it, then begin using it regularly, then use it heavily, and finally become dependent on it. It appears that the factors that contribute to substance use disorders may depend on the point in the process that is being considered.

Following different factors may be more or less important at different stages i.e. earlier stage, sustaining stage and rehabilitation stage:

- Drug availability
- Peer pressure
- Personality
- Biology

Environment Factors:

Among environmental factors, the family is of utmost importance. Family's beliefs, attitudes e.g. acceptability plays a major role in initiation and sustaining these addictive behaviors. For example, developing a positive attitude toward smoking and beginning to experiment with tobacco are strongly related to smoking by other family members.

Exposure to a peer group that encourages drug use is also a major influencer. For example, becoming a regular smoker is more strongly related to smoking by peers and being able to acquire cigarettes readily. Both of these factors seem to play a role in initial drug use.

Etiological Factors

Biological:

Much research has addressed the possibility that there is a genetic contribution to drug and alcohol use disorders. Once started using a drug, the development into addiction may be influenced by inherited (genetic) traits. They may delay or speed up the disease progression.

Neurological Factors:

Researchers have found that changes in structure and neurochemistry transform voluntary drug using into compulsive behavior. There are many neurotransmitters i.e. neurochemicals within the brain, play a significant role in this regard. Following neurotransmitters play a significant role in addictive behaviors:

- Opioid
- Catecholamines

- GABA - Serotonin
- Dopamine

Too little endogenous opioid activity (i.e. low endorphins) or too much endogenous opioid antagonist activity increases the risk of dependence. Brain's normal endogenous receptor are in place. But despite that, if there is long-term drug use, it necessitates adjustment, so our brain needs exogenous (external) substance to maintain homeostasis and to carry on the normal functioning.

Sociocultural Perspective:

A number of sociocultural theorists propose that people are most likely to develop substance use disorders when they live under stressful socioeconomic conditions. Studies have found that regions with higher unemployment levels have higher rates of alcohol or opioid use disorder. People in regions with higher unemployment levels have higher alcoholism rates are more prone to develop these disorders. Similarly, people in lower socioeconomic classes have rates of substance use disorder that are higher than those of the other classes. Unemployment in youth is also a major cause and this population is the most vulnerable to develop these disorders. Sociocultural theorists hold that people confronted regularly by other kinds of stress also have a heightened risk of developing substance use disorders. Theorists propose that people are more likely to develop substance use disorders if they are part of a family or social environment in which substance use is valued or at least accepted.

Psychodynamic Perspective:

Psychodynamic theorists believe that people with substance use disorders have powerful dependency needs that can be traced to their early years. They suggest that when parents fail to satisfy a young child's need for nurturance, the child is likely to grow up depending excessively on others for help and comfort, trying to find the nurturance that was lacking during the early years. If this search for outside support includes experimentation with a drug, the person may well develop a dependent relationship with the substance. Some psychodynamic theorists also believe that certain people respond to their early deprivations by developing a substance abuse personality that leaves them particularly prone to drug abuse. Such individuals have disturbed ego function (inability to deal with reality) and then they use drugs as a defense mechanism (coping).

Cognitive Behavioristic Perspective:

According to cognitive-behavioral theorists, operant conditioning may play a key role in substance use disorders. They argue that the temporary reduction of tension or raising of spirits produced by a drug has a rewarding effect, thus increasing the likelihood that the user will seek this reaction again. Similarly, the rewarding effects may eventually lead users to try higher dosages or more powerful methods of ingestion. According to it, behavior maintained by its consequences as it terminates aversive state (pain, anxiety) and creates a euphoric state.

Biological Perspective:

Over the past few decades, researchers have become clear that biological factors play a major role in drug misuse

1. Genetic Predisposition:

For years, breeding experiments have been conducted to see whether certain animals are genetically predisposed to become addicted to drugs. Two types of studies are conducted in this regard:

Twin Studies:

Research with human twins has suggested that people may inherit a predisposition to misuse substances. Numerous studies have found an alcoholism concordance rate of around 54 percent in identical twins; that is, if one identical twin displays alcoholism, the other twin also does in 54 percent of the cases. In contrast, in these same studies, fraternal twins have a concordance rate of only 28 percent. As you have read, however, such findings do not rule out other interpretations. For one thing, the parenting received by two identical twins may be more similar than that received by two fraternal twins.

Adoptee Studies:

A clearer indication that genetics may play a role in substance use disorders comes from studies of alcoholism rates in people adopted shortly after birth. These studies have compared adoptees whose biological parents abuse alcohol with adoptees whose biological parents do not. By adulthood, the individuals whose biological parents abuse alcohol typically show higher rates of alcoholism than those with nonalcoholic biological parents.

Genetic linkage strategies and molecular biology techniques provide more direct evidence in support of a genetic explanation. One line of investigation has found an abnormal form of the so-called dopamine-2 (D2) receptor gene in a majority of research participants with substance use disorders but in less than 20 percent of participants who do not have such disorders.

Biological Perspective (In continuation to the previous topic0

Neurotransmitters (NT):

Over the past few decades, some researchers have pieced together a neurotransmitter-focused explanation of drug tolerance and withdrawal symptoms. These theorists contend that when a particular drug is ingested, it increases the activity of certain neurotransmitters whose normal purpose is to calm, reduce pain, lift mood, or increase alertness. When a person keeps on taking the drug, the brain apparently makes an adjustment and reduces its own production of the neurotransmitters. Because the drug is increasing neurotransmitter activity or efficiency, the brain’s release of the neurotransmitter is less necessary.