Lecture 19

Short Notes on Obsessive-Compulsive and Related Disorders

1. Obsessive-Compulsive Disorder (OCD)

Obsessions: Recurrent, intrusive thoughts, urges, or images causing anxiety (e.g., fear of contamination, symmetry, aggressive impulses).

Compulsions: Repetitive behaviors (e.g., washing, checking, ordering) or mental acts (e.g., praying, counting) performed to reduce anxiety.

DSM-5 Changes: Moved from Anxiety Disorders to its own category.

2. Body Dysmorphic Disorder (BDD)

Definition: Preoccupation with perceived physical flaws not noticeable to others.

Behaviors: Mirror checking, excessive grooming, comparing with others, and seeking reassurance.

Impact: Causes significant distress and impairs social and occupational functioning.

DSM-5 Insight Levels: Good, poor, or absent (delusional beliefs).

3. Hoarding Disorder

Definition: Persistent difficulty discarding possessions due to a perceived need to save them.

Features: Accumulation of clutter that compromises living spaces and creates safety hazards.

Impact: Causes distress and functional impairment in daily life.

Insight Levels: Good, poor, or absent.

4. General Features of OCD and Related Disorders

Anxiety plays a central role in driving compulsions and repetitive behaviors.

Repetitive behaviors temporarily reduce anxiety but are excessive and time-consuming.

Disorders cause distress and impair functioning in social, occupational, and personal areas.

5. DSM-5 Diagnostic Criteria for OCD

Presence of obsessions, compulsions, or both.

Symptoms are time-consuming (e.g., >1 hour daily) or cause significant distress/impairment.

Not due to substances, medical conditions, or other mental disorders.

Short Questions (3 Marks)

4. What are some examples of obsessions in OCD?

Examples include fears of contamination, intrusive thoughts about symmetry, aggressive impulses, or unwanted religious or sexual ideas.

5. What are common compulsions in OCD?

Compulsions include hand washing, ordering objects, checking repeatedly, counting, and praying to reduce anxiety caused by obsessions.

6. What changes were made in DSM-5 regarding OCD and related disorders?

In DSM-5, OCD was moved from the Anxiety Disorders category to its own category, and new disorders like hoarding, trichotillomania, and excoriation disorders were added.

7. What role does anxiety play in OCD?

Anxiety is a key factor in OCD; obsessions cause anxiety, and compulsions temporarily reduce it, creating a repetitive cycle.

8. What are the common preoccupations seen in Body Dysmorphic Disorder?

Common preoccupations include perceived flaws in skin, facial features, body size, or symmetry, often minor or unnoticeable to others.

Long Questions (5 Marks)

3. Discuss the differences between OCD obsessions and compulsions.

Obsessions are intrusive, recurrent thoughts or urges that cause significant anxiety. These thoughts are perceived as irrational but uncontrollable. Compulsions, on the other hand, are repetitive behaviors or mental acts performed to alleviate anxiety caused by obsessions. While obsessions disrupt normal thought processes, compulsions involve physical or mental actions often done rigidly or ritualistically.

4. Outline the diagnostic criteria for Body Dysmorphic Disorder (BDD) as per DSM-5.

BDD diagnosis involves preoccupation with perceived physical defects, repetitive behaviors like mirror checking or grooming, significant distress in daily functioning, and exclusion of concerns tied to eating disorders. The degree of insight (good, poor, or absent) and presence of muscle dysmorphia are also specified.

5. Describe the concept of hoarding disorder and its implications.

Hoarding disorder involves difficulty discarding items regardless of value, leading to clutter that disrupts the intended use of living spaces. This behavior often results in distress, social withdrawal, and safety hazards like fire risks or unsanitary conditions. The disorder may involve excessive acquisition and varying levels of insight about the problem.

6. Explain the role of repetitive behaviors in OCD and their impact on daily life.

Repetitive behaviors, such as checking locks or washing hands, are performed to neutralize obsessive thoughts and reduce anxiety. However, these behaviors are time-consuming and often interfere with daily life, relationships, and work, creating a significant functional impairment for the individual.

Lecture 20

Obsessive-Compulsive and Related Disorders II

1. Trichotillomania (Hair-Pulling Disorder)

Recurrent hair-pulling from specific body areas (e.g., scalp, eyebrows).

Often triggered by stress or anxiety; may involve rituals.

Diagnostic Criteria:

Persistent hair-pulling leading to hair loss.

Attempts to stop the behavior fail.

Causes distress or impairment in functioning.

2. Excoriation (Skin-Picking) Disorder

Persistent skin-picking leading to sores or wounds.

Triggered by anxiety or stress.

Diagnostic Criteria:

Causes significant distress or impairment.

Not explained by other medical or mental disorders.

3. Substance/Medication-Induced OCD

Symptoms of OCD caused by substance use or medication.

Diagnostic Criteria:

Onset occurs during or after substance use.

Symptoms cause significant distress or impairment.

4. OCD Related to Medical Conditions

Obsessions/compulsions caused by medical conditions.

Diagnostic Criteria:

Symptoms linked to the medical condition.

Causes distress or impairment.

5. Other Specified/Unspecified OCD

Symptoms causing distress but not meeting criteria for specific OCD-related disorders.

Etiology of Disorders

1. OCD

Genetic Factors: Linked to hyperactivity in the orbitofrontal cortex, anterior cingulate cortex, and caudate nucleus.

Environmental Factors: Associated with trauma or stress.

Temperament: Internalizing symptoms, negative emotionality.

Behavioral Theory: Compulsions reduce anxiety, reinforcing the behavior.

2. Body Dysmorphic Disorder

Genetic: Common among relatives of OCD patients.

Environmental: Childhood neglect/abuse, societal standards via media.

3. Hoarding Disorder

Genetic: Familial patterns observed.

Cognitive Model: Poor organization, emotional attachment to possessions, avoidance behaviors.

4. Trichotillomania & Excoriation Disorder

Genetic: Higher prevalence among OCD patients and their relatives.

Here are short and long questions based on the content from Lesson 20:

Short Questions (3 Marks Each)

Q1: What is trichotillomania?
Answer: Trichotillomania, or hair-pulling disorder, is characterized by recurrent pulling out of one's hair, resulting in noticeable hair loss. It often centers on specific body areas like the scalp, eyebrows, or eyelashes and may be triggered by stress or anxiety.

Q2: What are the main triggers of excoriation disorder?
Answer: Excoriation disorder, or skin-picking, is typically triggered by anxiety or stress, leading individuals to pick at their skin, resulting in significant sores or wounds.

Q3: How does substance/medication-induced OCD differ from primary OCD?
Answer: Substance/medication-induced OCD is caused by substance intoxication, withdrawal, or medication exposure, whereas primary OCD arises independently without such external causes.

Q4: What is the role of genetic factors in obsessive-compulsive disorder (OCD)?
Answer: OCD has a moderate genetic component. Studies link the disorder to increased activity in specific brain areas like the orbitofrontal cortex, anterior cingulate cortex, and caudate nucleus.

Q5: What are the common cognitive issues faced by individuals with hoarding disorder?

Answer: Individuals with hoarding disorder struggle with poor organizational abilities, excessive attachment to possessions, difficulties categorizing objects, and avoidance behaviors.

Long Questions (5 Marks Each)

Q1: Describe the diagnostic criteria for trichotillomania.
Answer: The criteria for trichotillomania include:

1. Recurrent pulling out of hair, leading to noticeable hair loss.

2. Repeated attempts to reduce or stop the behavior.

3. Significant distress or impairment in social, occupational, or other important areas of functioning.

4. Hair pulling not attributed to another medical condition.

5. Symptoms not better explained by another mental disorder.

Q2: Discuss the behavioral explanation of OCD.
Answer: The behavioral explanation of OCD focuses on operant conditioning. Compulsions are reinforced as they reduce anxiety associated with obsessions. For example, compulsive handwashing alleviates fear of contamination, and checking behaviors reduce fear of danger (e.g., house fire). These actions lower anxiety temporarily, encouraging repetition, which sustains the cycle of OCD.

Q3: Explain the role of environmental factors in body dysmorphic disorder.
Answer: Environmental factors like childhood neglect or abuse can increase the risk of body dysmorphic disorder. Additionally, societal standards propagated through media encourage unrealistic physical ideals, leading individuals to compare themselves unfavorably, which can trigger the disorder.

Q4: What is the cognitive-behavioral model of hoarding disorder?
Answer: The cognitive-behavioral model explains hoarding disorder as a result of poor organizational skills, unusual beliefs about possessions, and avoidance behaviors. Individuals

often feel extreme emotional attachment to their belongings, struggle to categorize them, and avoid making decisions about discarding items due to fear of loss or making mistakes.

Q5: Discuss the etiology of excoriation disorder.
Answer: Excoriation disorder is influenced by genetic and environmental factors. It is more common in individuals with OCD and their relatives. Environmental stressors, such as trauma or anxiety-inducing situations, can trigger the behavior, which becomes reinforced as it temporarily alleviates anxiety or distress.

Lecture 21

Short Notes on Trauma and Stress-Related Disorders (Lesson 21)

1. Stress and Trauma

Stress: A response to events demanding changes and adaptation.

Stressor: Event causing stress (e.g., traffic jams, financial setbacks, natural disasters).

Stress Response: Physical and emotional reaction to a stressor.

Trauma: Intense stress from significant events (e.g., terror attacks, abuse, natural disasters).

2. Biological Response to Stress

Hypothalamus activates:

Autonomic Nervous System:

Sympathetic: Triggers "fight or flight" response.

Parasympathetic: Calms the body post-danger.

Endocrine System:

Releases stress hormones (e.g., cortisol via HPA pathway).

3. General Features of Stress-Related Disorders

Triggered by exposure to traumatic or stressful events.

Symptoms: Anhedonia, dysphoria, aggression, or dissociation (e.g., depersonalization, derealization).

4. Types of Disorders

Reactive Attachment Disorder (RAD):

Affects children under five due to neglect or inconsistent care.

Symptoms: Emotional withdrawal, lack of comfort-seeking behavior.

Disinhibited Social Engagement Disorder (DSED):

Opposite of RAD; overly friendly behavior with strangers.

Caused by insufficient care or neglect.

Post-Traumatic Stress Disorder (PTSD):

Persistent symptoms after trauma (e.g., nightmares, avoidance, hypervigilance).

Criteria include prolonged distress and functional impairment for over a month.

Acute Stress Disorder (ASD):

PTSD-like symptoms lasting 3–30 days.

Adjustment Disorder:

Stress-related emotional or behavioral symptoms following a significant life event.

5. Key Symptoms of PTSD

Intrusion: Flashbacks, nightmares.

Avoidance: Efforts to avoid trauma-related stimuli.

Mood Changes: Negative beliefs, emotions, or detachment.

Arousal: Sleep disturbances, hypervigilance, irritability.

Short Questions (3 Marks Each)

1. Define a stressor and provide examples.
A stressor is an event that demands the utilization of resources and creates pressure. Examples include daily hassles (e.g., traffic jams), major life events (e.g., financial setbacks), or traumatic events (e.g., natural disasters, abuse).

2. What is the role of the hypothalamus in stress response?
The hypothalamus activates the autonomic nervous system and the endocrine system during stress, triggering "fight or flight" responses and releasing stress hormones like cortisol.

3. Differentiate between sympathetic and parasympathetic nervous systems.
The sympathetic system triggers "fight or flight" reactions during danger, while the parasympathetic system calms the body after the danger has passed.

4. What is Reactive Attachment Disorder (RAD)?
RAD occurs in children under five who fail to form secure bonds with caregivers due to neglect or frequent changes in caregivers. Symptoms include emotional withdrawal and lack of seeking comfort during distress.

5. What is the primary cause of Disinhibited Social Engagement Disorder (DSED)?
DSED arises from insufficient care or neglect, leading to overly friendly behavior toward strangers and a lack of selective attachment to caregivers.

6. List the four major symptom categories of PTSD.

Intrusive re-experiencing (e.g., flashbacks, nightmares).

Avoidance (e.g., avoiding trauma-related stimuli).

Negative mood and cognitive changes.

Increased arousal and reactivity (e.g., hypervigilance, sleep disturbances).

7. What distinguishes Acute Stress Disorder (ASD) from PTSD?
ASD symptoms last between 3 to 30 days, while PTSD symptoms persist for more than a month.

8. What are dissociative symptoms in PTSD?
Dissociative symptoms include depersonalization (feeling detached from oneself) and derealization (feeling that surroundings are unreal or distorted).

Long Questions (5 Marks Each)

1. Explain the role of the autonomic nervous system and endocrine system in stress response.
The autonomic nervous system (ANS) has two parts:

Sympathetic System: Activates during danger, causing increased heartbeat, faster breathing, and heightened alertness (fight or flight response).

Parasympathetic System: Calms the body once the danger has passed, restoring normal functions.
The endocrine system, via the hypothalamic-pituitary-adrenal (HPA) axis, releases stress hormones like cortisol, which prepare the body for prolonged arousal.

2. Discuss the diagnostic criteria for Reactive Attachment Disorder (RAD).
RAD is diagnosed based on:

Emotionally withdrawn behavior, including lack of seeking or responding to comfort.

Social and emotional disturbances (e.g., limited responsiveness, minimal positive affect).

Evidence of neglect, deprivation, or repeated caregiver changes.

Symptoms must appear before age five and not meet criteria for autism spectrum disorder.

3. Describe the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD).

Exposure: Direct experience, witnessing, or learning about traumatic events.

Symptoms: Intrusion (flashbacks, nightmares), avoidance, negative mood changes, and hyperarousal.

Duration: Symptoms persist for over a month.

Impairment: Significant distress or dysfunction in daily life.

Must not result from substance use or other medical conditions.

4. Compare Reactive Attachment Disorder (RAD) and Disinhibited Social Engagement Disorder (DSED).

RAD: Emotionally withdrawn behavior, lack of attachment, difficulty managing emotions, often caused by neglect.

DSED: Overly familiar behavior with strangers, diminished caution in unfamiliar settings, due to lack of caregiver bonding.
Both disorders result from neglect but present opposite behavioral patterns.

5. Explain the impact of trauma on the brain and body.
Trauma activates the hypothalamus, triggering the ANS and endocrine system.

The sympathetic system prepares the body for immediate action.

The HPA axis releases cortisol, leading to heightened arousal.
Prolonged trauma can cause chronic stress, impair cognitive functions, and increase vulnerability to psychological disorders like PTSD.

Lecture 22

Short Notes on Trauma and Stress-Related Disorders (Lesson 22)

1. Acute Stress Disorder (ASD)

Fear and related symptoms occur soon after trauma and last less than a month.

Symptoms: Intrusion, negative mood, dissociation, avoidance, and arousal.

Symptoms must persist for 3 days to a month.

Causes distress and impairs daily functioning.

2. Adjustment Disorder

Emotional/behavioral symptoms in response to a stressor within 3 months.

Symptoms are less severe than PTSD or anxiety disorders.

Types include:

With depressed mood: Feelings of sadness or hopelessness.

With anxiety: Nervousness or worry.

With mixed anxiety and depressed mood.

With disturbance of conduct.

3. Etiology of Trauma and Stress Disorders

Pre-Trauma Factors:

Temperamental issues (e.g., childhood anxiety).

Prior mental disorders (e.g., depression).

Environmental issues like childhood poverty or abuse.

Genetic predisposition (e.g., female gender, certain genotypes).

Peri-Trauma Factors:

Severity and type of trauma.

Negative appraisals and maladaptive coping strategies (emotion-focused or problem-focused).

Post-Trauma Factors:

Lack of social support.

Neurobiological changes (e.g., smaller hippocampus).

Personal factors like neuroticism and avoidance coping.

4. Role of Neurobiology in PTSD

Overactive amygdala and diminished prefrontal cortex activity.

Smaller hippocampus volume affects emotional memory processing.

Short Questions (3 Marks Each)

1. What is Acute Stress Disorder (ASD)?
Acute Stress Disorder is characterized by fear and related symptoms occurring soon after a traumatic event and lasting between 3 days and 1 month.

2. How is Adjustment Disorder different from PTSD?
Adjustment Disorder arises from a significant stressor (e.g., job loss), while PTSD is caused by traumatic events like violence or disasters. Adjustment Disorder symptoms are less severe.

3. What are the main symptoms of Acute Stress Disorder?
Symptoms include intrusion (e.g., flashbacks), negative mood, dissociation, avoidance, and arousal (e.g., hypervigilance).

4. List the types of Adjustment Disorder.

With depressed mood.

With anxiety.

With mixed anxiety and depressed mood.

With disturbance of conduct.

With mixed emotions and conduct.

5. What are peri-trauma factors?
These are factors present during trauma, such as the severity of the trauma, negative appraisals, or inappropriate coping strategies.

6. What is the role of the hippocampus in PTSD?
The hippocampus, responsible for emotional memory, shows reduced volume in PTSD patients, impairing their ability to manage trauma-related memories.

7. What is the impact of lack of social support on PTSD development?
Lack of social support after trauma increases the risk of developing PTSD as it impairs emotional and psychological recovery.

8. What are maladaptive coping strategies?
Maladaptive strategies, such as avoidance or emotion-focused coping, fail to resolve the stressor and can increase vulnerability to stress-related disorders.

Long Questions (5 Marks Each)

1. Explain the diagnostic criteria for Acute Stress Disorder (ASD).

Exposure: Direct or indirect exposure to trauma.

Symptoms: At least nine symptoms from intrusion, negative mood, dissociation, avoidance, and arousal categories.

Duration: Symptoms last between 3 days and 1 month.

Impact: Causes significant distress or functional impairment.

Exclusions: Not due to substance use or another medical condition.

2. Discuss the etiological factors of PTSD.

Pre-Trauma Factors: Childhood anxiety, poverty, prior mental disorders, and genetic predisposition.

Peri-Trauma Factors: Trauma severity, negative appraisals, and inappropriate coping strategies.

Post-Trauma Factors: Lack of social support, subsequent stressors, and neurobiological changes (e.g., hippocampus volume reduction).

3. Describe the types of Adjustment Disorder.

With depressed mood: Dominant sadness and hopelessness.

With anxiety: Predominantly nervousness and worry.

With mixed mood: Combination of anxiety and depression.

With disturbance of conduct: Behavioral issues like aggression.

With mixed emotions and conduct: Both emotional and behavioral symptoms.

4. What is the role of neurobiology in PTSD development?

Amygdala: Overactivity leads to heightened fear and stress responses.

Prefrontal Cortex: Reduced activity impairs fear regulation.

Hippocampus: Smaller volume affects emotional memory and stress management.

5. How do coping strategies influence stress-related disorders?

Problem-Focused Coping: Aims to resolve the source of stress.

Emotion-Focused Coping: Attempts to manage emotional responses but may lead to maladaptive patterns (e.g., avoidance).
Ineffective coping increases the risk of PTSD and other disorders.

Lecture 23

Short Notes on Dissociative Disorders (Lesson 23)

1. Overview of Dissociative Disorders

Definition: Disorders involving disruptions in memory, identity, or consciousness, triggered by trauma.

Symptoms include positive dissociation (e.g., fragmentation of identity) and negative dissociation (e.g., amnesia).

Common disorders: Dissociative Identity Disorder, Dissociative Amnesia, and Depersonalization/Derealization Disorder.

2. Dissociative Identity Disorder (DID)

Previously known as Multiple Personality Disorder.

Presence of two or more distinct personality states.

Symptoms: Memory gaps, changes in behavior, and distress in functioning.

Subpersonalities may differ in traits (e.g., age, sex, abilities) and interact as mutually amnesic, mutually cognizant, or one-way amnesic relationships.

3. Dissociative Amnesia

Definition: Inability to recall personal information due to trauma, not explained by ordinary forgetfulness.

Types:

Localized: Forgetting events from a specific period.

Selective: Remembering some parts but not all events of a specific time.

Generalized: Forgetting events before the trauma, possibly including identity.

Continuous: Forgetting continues into the present.

Systematized: Forgetting specific categories of information.

Dissociative Fugue: Severe amnesia involving identity loss and sudden travel to a new location.

4. Depersonalization/Derealization Disorder

Depersonalization: Feeling detached from oneself, like observing one's life externally.

Derealization: Experiencing the world as unreal or distorted.

No memory loss but causes significant distress.

5. Causes and Impact

Often linked to trauma, such as abuse or accidents.

Affects normal psychological functioning and social or occupational roles.

This notes cover the essential aspects of Dissociative Disorders.

Short Questions (3 Marks Each)

1. What are dissociative disorders?
Dissociative disorders are characterized by disruptions in memory, identity, consciousness, emotion, or behavior, often triggered by trauma.

2. What is the difference between positive and negative dissociative symptoms?

Positive symptoms: Intrusions into awareness, such as fragmentation of identity, depersonalization, or derealization.

Negative symptoms: Inability to access information or mental functions, such as amnesia.

3. What is Dissociative Identity Disorder (DID)?
DID is a disorder marked by the presence of two or more distinct personality states, memory gaps, and impaired functioning.

4. What are the types of memory loss in Dissociative Amnesia?

Localized: Forgetting events of a specific period.

Selective: Partial recall of events.

Generalized: Forgetting life history and identity.

Continuous: Forgetting continues to the present.

Systematized: Forgetting specific categories of information.

5. What is depersonalization?
Depersonalization is feeling detached from one's body or self, as if observing oneself from an external perspective.

6. What is Dissociative Fugue?
Dissociative Fugue is a subtype of amnesia where a person loses memory, leaves their usual environment, and may assume a new identity.

7. How do subpersonalities differ in DID?
Subpersonalities in DID may vary in age, gender, abilities, physiological traits, and even handwriting or preferences.

8. What is derealization?
Derealization is a sense of detachment from the external environment, where the world feels unreal or distorted.

Long Questions (5 Marks Each)

1. Explain the diagnostic criteria for Dissociative Identity Disorder (DID).

Presence of two or more distinct personality states, with disruptions in identity and sense of self.

Recurrent memory gaps inconsistent with ordinary forgetting.

Causes significant distress or functional impairment.

Not attributable to cultural practices, substance use, or medical conditions.

2. Describe the types of amnesia in Dissociative Amnesia.

Localized: Forgetting all events during a specific time.

Selective: Remembering only parts of a specific period.

Generalized: Loss of memory for life history and identity.

Continuous: Forgetting extends into the present.

Systematized: Loss of memory related to specific categories.

3. What are the causes and symptoms of Dissociative Fugue?

Causes: Severe stress or trauma, such as abuse or loss.

Symptoms: Sudden travel, loss of memory, and adoption of a new identity. The person may appear normal during the fugue but has no recollection of prior life.

4. Discuss the interaction between subpersonalities in DID.

Mutually amnesic: Subpersonalities are unaware of each other.

Mutually cognizant: Subpersonalities are fully aware of each other.

One-way amnesic: Some subpersonalities are aware of others, but not vice versa.

5. Differentiate between depersonalization and derealization.

Depersonalization: Feeling detached from oneself, as if observing from outside.

Derealization: Perceiving the external world as unreal, distorted, or dreamlike.
Both can occur in Depersonalization/Derealization Disorder without memory loss but cause significant distress.

Lecture 24

Short Notes on Dissociative Disorders (Lesson 24)

1. Depersonalization/Derealization Disorder

Definition: Persistent or recurrent alterations in self-perception or surroundings.

Symptoms:

Depersonalization: Feeling detached from one's body or self, as if observing from outside.

Derealization: Perception of the external world as unreal or dreamlike.

Diagnostic Criteria (DSM-5):

Experiences of depersonalization or derealization while reality testing remains intact.

Significant distress or impairment in functioning.

Not caused by substances, medical conditions, or other mental disorders.

2. Other Specified Dissociative Disorders

Symptoms cause significant distress but do not meet full criteria for a specific dissociative disorder.

Specific reasons for the diagnosis are documented (e.g., dissociative trance).

3. Unspecified Dissociative Disorders

Symptoms do not fully meet criteria for a specific disorder.

Reasons for incomplete diagnosis are not specified (common in emergency settings).

4. Etiology of Dissociative Disorders

Psychodynamic Theory:

Rooted in excessive repression of painful memories.

Often linked to traumatic childhood events, such as abuse.

Behavioral Theory:

Learned response via operant conditioning.

Forgetting provides temporary relief from anxiety, reinforcing the behavior.

Environmental Factors:

Traumas (e.g., abuse) and adverse childhood experiences.

Personal Factors:

Harm-avoidant temperaments and immature defenses increase vulnerability.

Cognitive disconnection and avoidance schemata contribute to the disorder.

Psychological Factors:

Severe psychological stress and conflicts act as predisposing factors.

These concise notes summarize the key points from Lesson 24 on dissociative disorders.

Short Questions (3 Marks Each)

1. What are the key symptoms of depersonalization in Depersonalization/Derealization Disorder?

Feeling detached from one's body or self.

Experiencing perceptual alterations, emotional numbing, or a distorted sense of time.

2. How does derealization differ from depersonalization?

Derealization involves feeling the external world is unreal or dreamlike, while depersonalization is a sense of detachment from oneself.

3. What role does repression play in dissociative disorders according to psychodynamic theory?

Repression unconsciously prevents painful memories, thoughts, or impulses from reaching awareness, often leading to dissociative symptoms.

4. What is the diagnostic criteria for Depersonalization/Derealization Disorder in DSM-5?

Persistent or recurrent depersonalization or derealization with intact reality testing.

Causes significant distress or impairment.

5. What is dissociative trance in Other Specified Dissociative Disorders?

A condition characterized by altered consciousness or identity, often linked to cultural or religious practices.

Long Questions (5 Marks Each)

1. Explain the diagnostic criteria of Depersonalization/Derealization Disorder according to DSM-5.

Presence of persistent or recurrent depersonalization, derealization, or both.

Reality testing remains intact during the episodes.

Symptoms cause significant distress or functional impairment.

Not attributable to substance use, medical conditions, or other mental disorders.

2. Describe the psychodynamic explanation of dissociative disorders.

Rooted in excessive use of repression to block painful memories or impulses.

Dissociative amnesia arises from single episodes of massive repression.

Dissociative identity disorder often results from repeated childhood trauma, leading to the development of alternate identities.

3. Discuss the role of environmental factors in the development of dissociative disorders.

Traumatic events such as physical or sexual abuse are major triggers.

Adverse childhood experiences contribute significantly.

Avoidance of emotions during trauma plays a critical role.

4. How does operant conditioning explain the development of dissociative disorders?

Forgetting trauma provides temporary relief from anxiety, reinforcing the behavior.

Learned response through positive reinforcement (anxiety reduction).

5. What are the personal and psychological factors contributing to dissociative disorders?

Harm-avoidant temperament and immature coping styles.

Cognitive disconnection and overconnection schemata.

Severe psychological stress and unresolved conflicts predispose individuals to dissociative symptoms.

Lecture 25

Short Notes on Feeding and Eating Disorders (Lesson 25)

1. General Features

Disorders involve persistent disturbances in eating behavior that impair health or psychosocial functioning.

Strong links between obesity and mental health disorders like depression.

Examples include Pica, Rumination Disorder, Anorexia Nervosa, and Bulimia Nervosa.

2. Pica

Eating non-nutritive, non-food substances (e.g., dirt, paint).

Common in children and pregnant women; may cause medical issues like lead poisoning.

Diagnostic Criteria: Persistent behavior for at least one month, inappropriate for developmental level, not culturally supported.

3. Rumination Disorder

Re-chewing or regurgitation of partially digested food.

Mostly occurs in children; not linked to gastrointestinal or other medical conditions.

May occur in individuals with intellectual disabilities.

4. Avoidant/Restrictive Food Intake Disorder

Selective eating habits or disturbed feeding patterns leading to significant nutritional deficiencies.

Symptoms: Weight loss, nutritional deficiencies, reliance on supplements, or psychosocial interference.

Not linked to body image issues like in Anorexia or Bulimia.

5. Anorexia Nervosa

Restriction of energy intake leading to significantly low body weight.

Intense fear of gaining weight or distorted body image.

Subtypes:

Restricting Type: Weight loss via dieting, fasting, or excessive exercise.

Binge-eating/Purging Type: Recurrent binge eating or purging episodes.

6. Bulimia Nervosa

Repeated binge-eating episodes with compensatory behaviors like vomiting or laxative use.

Occurs mostly in young females; weight remains within normal range.

Diagnostic Criteria: At least one binge and compensatory behavior per week for 3 months.

Short Questions (3 Marks Each)

1. What are feeding and eating disorders?

Persistent disturbances in eating behavior that impair physical health or psychosocial functioning.

2. What is Pica?

Eating non-food substances (e.g., dirt, hair) for at least one month, inappropriate to developmental level, and not culturally supported.

3. What is the main feature of Rumination Disorder?

Repeated regurgitation and re-chewing of partially digested food for at least one month.

4. What distinguishes Avoidant/Restrictive Food Intake Disorder from Anorexia Nervosa?

It is not associated with body image concerns but involves selective eating habits leading to nutritional deficiencies.

5. What are the two subtypes of Anorexia Nervosa?

Restricting Type: Weight loss through dieting or fasting.

Binge-eating/Purging Type: Involves binge eating or purging behaviors.

Long Questions (5 Marks Each)

1. Explain the diagnostic criteria of Pica.

Persistent eating of non-nutritive substances for at least one month.

Behavior inappropriate for developmental level.

Not part of cultural or social norms.

Requires additional clinical attention if related to other disorders (e.g., intellectual disabilities).

2. Discuss the diagnostic criteria of Bulimia Nervosa according to DSM-5.

Recurrent binge-eating episodes, characterized by eating large amounts of food in a short time with a loss of control.

Compensatory behaviors (e.g., vomiting, laxative use, fasting) to prevent weight gain.

Occurs at least once a week for three months.

Self-evaluation heavily influenced by body shape or weight.

3. What are the symptoms and consequences of Avoidant/Restrictive Food Intake Disorder?

Symptoms: Failure to meet nutritional/energy needs, weight loss, nutritional deficiency, reliance on supplements, and psychosocial interference.

Consequences: Growth faltering in children, energy deficiency, and impaired daily functioning.

4. Describe the severity levels of Anorexia Nervosa based on BMI.

Mild: BMI > 17 kg/m^2

Moderate: BMI 16-16.99 kg/m^2

Severe: BMI 15-15.99 kg/m^2

Extreme: BMI < 15 kg/m^2

5. What are the key features and subtypes of Anorexia Nervosa?

Features: Energy intake restriction, low body weight, fear of weight gain, distorted body image.

Subtypes: Restricting type and binge-eating/purging type.

Lecture 26

Here are short notes based on the provided document (Lesson 26) on Feeding and Eating Disorders II:

Binge-Eating Disorder

Characteristics:

Repeated binge eating without compensatory behaviors.

Often leads to overweight/obesity (BMI > 30).

Psychological and sociocultural factors contribute.

Associated with depression, anxiety, body dissatisfaction, and substance abuse.

Diagnostic Criteria:

Recurrent binge episodes (eating a large amount of food in a short time, feeling a lack of control).

Associated with behaviors like eating rapidly, feeling uncomfortably full, or eating alone due to embarrassment.

Marked distress; occurs at least once a week for 3 months.

Severity:

Mild (1-3 episodes/week) to Extreme (14+ episodes/week).

Other Specified Feeding and Eating Disorders

Includes presentations not meeting full criteria for specific disorders, e.g.:

Atypical Anorexia Nervosa: Weight within/above normal despite weight loss.

Low-Frequency Disorders: Bulimia/binge-eating less frequent or shorter duration.

Purging Disorder: Purging without binge eating.

Night Eating Syndrome: Eating during the night with awareness, causing distress.

Etiological Factors

Pica: Caused by neglect, lack of supervision, or developmental delays.

Rumination Disorder: Linked to neglect, lack of stimulation, or stressful life situations.

Avoidant/Restrictive Disorder: Associated with childhood disorders (anxiety, autism, OCD), gastrointestinal issues, or familial anxiety.

Anorexia Nervosa:

Influenced by sociocultural ideals, genetics, and childhood traits like anxiety or obsession.

Twin studies suggest genetic factors.

Bulimia Nervosa:

Factors include low self-esteem, depression, social anxiety, childhood abuse, and familial transmission.

First-degree relatives of affected individuals are more prone.

Binge-Eating Disorder:

Runs in families, indicating genetic influences.

Here are short questions (3 marks) and long questions (5 marks) based on Lesson 26:

Short Questions (3 Marks)

1. Q: What is the primary difference between binge-eating disorder and bulimia nervosa?
A: Binge-eating disorder involves repeated binge eating without compensatory behaviors like purging, which is a key feature of bulimia nervosa.

2. Q: List two psychological factors associated with binge-eating disorder.
A: Depression and anxiety.

3. Q: Define "atypical anorexia nervosa."
A: It meets all criteria for anorexia nervosa except the individual's weight remains within or above the normal range despite significant weight loss.

4. Q: What are two examples of behaviors seen in purging disorder?
A: Self-induced vomiting and misuse of laxatives or diuretics.

5. Q: Name two etiological factors of pica.
A: Neglect and developmental delays.

6. Q: What is the frequency criteria for diagnosing binge-eating disorder?
A: Episodes occur at least once a week for 3 months.

7. Q: Mention two disorders that often co-occur with avoidant/restrictive eating disorder.
A: Anxiety disorders and autism spectrum disorder.

8. Q: What sociocultural factor contributes to anorexia nervosa?
A: Societal idealization of thinness and body image.

9. Q: What genetic factor increases the risk of anorexia nervosa?
A: First-degree relatives of individuals with the disorder are at higher risk.

10. Q: What is night eating syndrome?
A: Recurrent eating episodes during the night, causing distress and impairment.

Long Questions (5 Marks)

1. Q: Explain the diagnostic criteria for binge-eating disorder in detail.
A:

Recurrent episodes of eating a larger amount of food in a short time than normal.

Feeling a lack of control during the episode.

Episodes associated with behaviors like eating rapidly, feeling uncomfortably full, or eating alone due to embarrassment.

Significant distress about binge eating.

Occurs at least once a week for 3 months.

Not associated with compensatory behaviors like purging.

2. Q: Describe the etiological factors of anorexia nervosa.
A:

Anxiety and obsessional traits in childhood increase the risk.

Sociocultural ideals of thinness and body image pressures.

Genetic predisposition, as shown by higher prevalence among first-degree relatives.

Twin studies suggest a hereditary influence.

Cultural and occupational pressures, such as modeling, which value thinness.

3. Q: What is "other specified feeding and eating disorders"? Provide examples.
A:

Disorders causing significant distress or impairment but not meeting full criteria for specific feeding or eating disorders.

Examples include atypical anorexia nervosa, low-frequency bulimia nervosa, purging disorder, and night eating syndrome.

4. Q: Outline the etiological factors of bulimia nervosa.
A:

Weight concerns and low self-esteem.

Depression and social anxiety disorder.

Childhood abuse or adverse experiences.

Familial transmission and genetic vulnerabilities.

Early pubertal maturation and societal pressures.

5. Q: Explain the concept of severity levels in binge-eating disorder.
A:

Severity is based on the frequency of binge-eating episodes.

Mild: 1-3 episodes per week.

Moderate: 4-7 episodes per week.

Severe: 8-13 episodes per week.

Extreme: 14 or more episodes per week.

Lecture 27

Here are short notes on Lesson 27 covering Sleep-Wake Disorders:

Sleep-Wake Disorders Overview

Definition: Issues with sleep quality, timing, and amount, causing daytime distress and dysfunction.

Common Disorders:

Insomnia Disorder: Difficulty initiating or maintaining sleep.

Hyper-somnolence Disorder: Excessive daytime sleepiness despite adequate sleep.

Narcolepsy: Sudden, uncontrollable sleep episodes.

Breathing-related Disorders: Obstructive sleep apnea, central sleep apnea, hypoventilation.

Circadian Rhythm Disorders: Misalignment of sleep-wake cycles with societal demands.

Parasomnias: Abnormal behaviors during sleep (e.g., nightmares, sleepwalking).

Substance/Medication-induced Sleep Disorders.

Insomnia Disorder

Key Features: Difficulty falling/staying asleep, early awakening.

Criteria: Symptoms occur ≥3 nights/week for ≥3 months.

Types: Acute, chronic, episodic, persistent, recurrent.

Hyper-Somnolence Disorder

Definition: Excessive sleepiness despite ≥7 hours of sleep.

Symptoms: Non-refreshing prolonged sleep, daytime naps, difficulty awakening.

Severity Levels: Mild (1-2 days/week), Moderate (3-4 days/week), Severe (5-7 days/week).

Narcolepsy

Features: Irrepressible need to sleep, cataplexy (muscle weakness).

Types: With or without cataplexy.

Severity: Based on cataplexy frequency and sleep disturbances.

Breathing-related Disorders

Types:

Obstructive Sleep Apnea: Airway blockage during sleep.

Central Sleep Apnea: Breathing stops and starts.

Hypoventilation: Slow, shallow breathing causing low oxygen levels.

Circadian Rhythm Disorders

Types:

Delayed Sleep Phase: Late sleep onset and awakening.

Non-24-Hour Sleep-Wake: Misalignment with the 24-hour day.

Shift Work Disorder: Sleep issues due to irregular work hours.

Short Questions (3 Marks Each)

1. Question: What are Sleep-Wake Disorders?
Answer: Sleep-Wake Disorders involve issues with sleep quality, timing, or amount, causing daytime dysfunction and distress. Examples include insomnia, hypersomnolence, narcolepsy, and circadian rhythm disorders.

2. Question: What are the diagnostic criteria for insomnia disorder?

Answer: Insomnia is characterized by difficulty initiating or maintaining sleep, or early awakening, occurring ≥3 nights per week for ≥3 months, causing significant distress or impairment.

3. Question: Define hyper-somnolence disorder.
Answer: Hyper-somnolence is excessive sleepiness despite adequate sleep, with prolonged, non-refreshing sleep episodes or frequent daytime lapses, occurring ≥3 times per week for ≥3 months.

4. Question: What distinguishes narcolepsy from other sleep disorders?
Answer: Narcolepsy is marked by sudden, uncontrollable sleep episodes during waking hours, often with cataplexy (sudden muscle weakness).

5. Question: What is obstructive sleep apnea?
Answer: Obstructive sleep apnea is a breathing-related sleep disorder where airway obstruction causes repeated pauses in breathing or shallow breaths during sleep.

Long Questions (5 Marks Each)

1. Question: Describe the diagnostic criteria and types of insomnia disorder.
Answer: Insomnia disorder involves dissatisfaction with sleep quality or quantity, characterized by difficulty initiating or maintaining sleep or early morning awakening. It occurs ≥3 nights per week for ≥3 months, causing distress or impairment. Types include:

Episodic: Symptoms last 1-3 months.

Persistent: Symptoms last >3 months.

Recurrent: Two or more episodes within a year.

2. Question: Explain the diagnostic features and types of circadian rhythm sleep-wake disorders.
Answer: Circadian rhythm sleep-wake disorders occur when there is a mismatch between a person's internal sleep-wake cycle and societal demands. Types include:

Delayed Sleep Phase Type: Sleep onset delayed by 2+ hours.

Non-24-Hour Type: Sleep patterns drift progressively.

Shift Work Disorder: Caused by irregular work hours, with excessive sleepiness and impaired sleep.

3. Question: Discuss the symptoms and diagnostic criteria for hyper-somnolence disorder.
Answer: Hyper-somnolence disorder involves excessive daytime sleepiness despite 7+ hours of sleep. Symptoms include prolonged, non-refreshing sleep, difficulty waking, and daytime lapses into sleep. Occurs ≥3 times per week for ≥3 months and causes significant distress or impairment.

4. Question: Compare and contrast obstructive sleep apnea and central sleep apnea.
Answer: Both are breathing-related sleep disorders.

Obstructive Sleep Apnea: Airway blockage causes breathing pauses, often with snoring or gasping.

Central Sleep Apnea: Brain fails to signal muscles to breathe, leading to repeated awakenings.
Both disrupt sleep and cause daytime fatigue.

5. Question: Describe narcolepsy and its associated symptoms.
Answer: Narcolepsy involves sudden, uncontrollable sleep episodes during waking hours.
Symptoms include excessive daytime sleepiness, cataplexy (sudden muscle weakness), sleep paralysis, and hallucinations. Types include narcolepsy with or without cataplexy, differentiated by the presence of muscle tone loss.

Lecture 28

Short Notes on Lesson 28: Sleep-Wake Disorders II

Parasomnias

Definition: Abnormal behaviors/events during sleep or sleep-wake transitions.

Key Types:

NREM Sleep Arousal Disorders: Sleepwalking and sleep terrors during the first third of sleep.

REM Sleep Behavior Disorder: Acting out vivid dreams with vocalizations or movements.

Features: Episodes cause distress/impairment and are not due to substances or other conditions.

Nightmare Disorder

Definition: Repeated, dysphoric, and well-remembered dreams about threats.

Features: Occurs in the second half of sleep; causes distress but the individual awakens fully alert.

Severity: Based on frequency (mild: <1/week; severe: nightly).

Restless Legs Syndrome (RLS)

Definition: Strong urge to move legs due to uncomfortable sensations, improving with movement.

Criteria:

Symptoms worsen during rest, at night, or evening.

Occurs ≥3 times/week for ≥3 months.

Causes significant distress/impairment.

Substance/Medication-Induced Sleep Disorder

Definition: Sleep disturbance caused by substances or medications.

Features:

Sleep issues develop during/after substance use or withdrawal.

Symptoms are not explained by other sleep disorders.

Etiology of Sleep-Wake Disorders

Physical Issues: Pain, breathing problems, medical conditions (e.g., asthma).

Psychological Factors: Depression, anxiety.

Environmental Factors: Stress, alcohol, inadequate sleep environment.

Other Causes: Genetic predisposition, night shifts, medications, aging.

Short Questions (3 Marks Each)

1. Question: What are parasomnias?
Answer: Parasomnias are disorders involving abnormal behaviors, experiences, or physiological events during sleep, sleep stages, or sleep-wake transitions, such as sleepwalking or night terrors.

2. Question: What is Nightmare Disorder?
Answer: Nightmare Disorder involves recurring dysphoric dreams about threats, typically occurring during the second half of sleep, causing distress and full alertness upon waking.

3. Question: Define Restless Legs Syndrome (RLS).
Answer: RLS is a condition characterized by an urge to move the legs, often due to uncomfortable sensations, which worsen during rest and improve with movement, especially at night.

4. Question: What are the diagnostic features of REM sleep behavior disorder?
Answer: REM sleep behavior disorder includes acting out vivid dreams through vocalizations or physical movements during REM sleep, typically occurring over 90 minutes after sleep onset.

5. Question: List any two causes of sleep-wake disorders.
Answer: Causes include physical issues like chronic pain, breathing problems, or psychological factors such as anxiety and depression.

Long Questions (5 Marks Each)

1. Question: Describe the diagnostic criteria and types of NREM Sleep Arousal Disorders.
Answer: NREM Sleep Arousal Disorders include incomplete awakening episodes, such as sleepwalking (walking with a blank face, unresponsiveness) or sleep terrors (intense fear, panicky screams). These occur in the first third of sleep, with no memory of the episodes. Types include:

Sleepwalking Type: May involve sleep-related eating or sexual behavior.

Sleep Terror Type: Abrupt awakenings with intense fear.

2. Question: Explain the etiology of sleep-wake disorders.
Answer: Sleep-wake disorders arise from various factors, including:

Physical Disturbances: Chronic pain, breathing issues.

Psychiatric Conditions: Anxiety, depression.

Environmental Stressors: Poor sleep environment, alcohol use.

Genetics: Predispositions like narcolepsy.

Lifestyle: Night shift work disrupting biological clocks.

Aging: Increased risk due to medical or psychological issues.

3. Question: Discuss the diagnostic criteria for Restless Legs Syndrome (RLS).
Answer: RLS is characterized by:

Urge to move legs due to unpleasant sensations.

Symptoms worsen during rest, improve with movement, and are worse at night.

Occurs ≥3 times per week for ≥3 months, causing distress/impairment.

Symptoms are not caused by other medical conditions or substance use.

4. Question: Compare and contrast Nightmare Disorder and REM Sleep Behavior Disorder.
Answer:

Nightmare Disorder: Involves vivid, dysphoric dreams during the second half of sleep, causing distress but full alertness upon waking.

REM Sleep Behavior Disorder: Involves acting out dreams physically or vocally during REM sleep, often with vivid and unpleasant dream content.

5. Question: What are the key features of Substance/Medication-Induced Sleep Disorder?
Answer: This disorder involves prominent sleep disturbances caused by substance use, intoxication, or withdrawal. The symptoms develop soon after substance use and cause significant distress, not explained by other sleep disorders or medical conditions.

Lecture 29

Short Notes on Lesson 29: Disruptive, Impulse-Control, and Conduct Disorders I

Overview

Definition: Disorders characterized by difficulty in controlling emotions and behaviors, often violating others' rights or societal norms.

Common Disorders: Oppositional Defiant Disorder (ODD), Intermittent Explosive Disorder (IED), Conduct Disorder (CD), Pyromania, and Kleptomania.

Prevalence: More common in males, typically onset in childhood or adolescence.

Oppositional Defiant Disorder (ODD)

Symptoms:

Angry/Irritable Mood: Often loses temper, easily annoyed, resentful.

Argumentative/Defiant Behavior: Often argues, defies authority, annoys others, blames others.

Vindictiveness: Spiteful at least twice in 6 months.

Onset: Usually between 8-12 years; affects family, school, and social relationships.

Severity: Mild (1 setting), Moderate (2 settings), Severe (3+ settings).

Intermittent Explosive Disorder (IED)

Symptoms:

Recurrent outbursts of verbal or physical aggression out of proportion to provocation.

At least 3 episodes causing harm/damage within a year.

Features: Impulsive, non-premeditated aggression; causes distress or functional impairment.

Criteria: Chronological age ≥6 years; not explained by other disorders or substances.

Short Questions (3 Marks Each)

1. Question: What are disruptive, impulse-control, and conduct disorders?
Answer: These disorders involve difficulties in controlling emotions and behaviors, often leading to violations of others' rights or societal norms, such as aggression or destruction of property.

2. Question: Define Oppositional Defiant Disorder (ODD).
Answer: ODD is characterized by a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least six months, significantly affecting social and family interactions.

3. Question: What are the main symptoms of Intermittent Explosive Disorder (IED)?
Answer: IED involves impulsive verbal or physical aggression, with outbursts disproportionate to the provocation. These episodes can cause damage or harm.

4. Question: What is the usual age of onset for ODD?
Answer: ODD typically becomes evident between the ages of 8 and 12, often more common in pre-adolescent boys.

5. Question: What distinguishes IED outbursts from planned aggression?
Answer: IED outbursts are impulsive, non-premeditated, and out of proportion to any provocation or stress.

Long Questions (5 Marks Each)

1. Question: Describe the diagnostic criteria for Oppositional Defiant Disorder (ODD).
Answer:

Duration: At least six months.

Symptoms: Four or more symptoms from categories:

Angry/Irritable Mood: Frequent temper loss, touchiness, resentment.

Argumentative/Defiant Behavior: Arguing with authority, defying rules, annoying others.

Vindictiveness: Being spiteful/vindictive at least twice in six months.

Severity: Mild (1 setting), Moderate (2 settings), Severe (3+ settings).

Impact: Causes distress or negatively impacts social, educational, or occupational functioning.

2. Question: Explain the features and criteria of Intermittent Explosive Disorder (IED).
Answer:

Features: Impulsive aggression, verbal/physical outbursts, disproportionate to provocation.

Criteria:

Aggressive episodes at least twice weekly for 3 months OR 3 harmful/damaging episodes in a year.

Outbursts cause distress, functional impairment, or legal consequences.

Must occur in individuals aged 6 or older.

Not better explained by other mental disorders or substances.

3. Question: Compare and contrast ODD and IED.
Answer:

ODD: Persistent defiance, anger, and vindictiveness lasting six months, often directed at authority figures.

IED: Impulsive, non-premeditated outbursts of aggression, often disproportionate to provocation.

Key Difference: ODD involves ongoing behavior patterns, while IED is characterized by episodic aggression.

4. Question: What are the common causes of disruptive and impulse-control disorders?
Answer: Causes include genetic predisposition, environmental stressors, ineffective parenting, exposure to violence, and neurobiological factors affecting emotional regulation.

5. Question: Discuss the impact of ODD on social and family relationships.
Answer: ODD significantly disrupts family dynamics and school performance. Children often lose respect from teachers and peers, leading to social isolation, feelings of inadequacy, and depression.

Lecture 30

Short Notes on Disruptive, Impulse-Control, and Conduct Disorders II

Conduct Disorder

Definition: Severe behavior disorder where children violate others' basic rights. Acts include aggression, theft, property destruction, and rule violations.

Prevalence: 5-10% of children (mostly boys); onset between ages 7-15.

Severity:

Mild: Minor harm, e.g., lying, truancy.

Moderate: Intermediate, e.g., stealing, vandalism.

Severe: Significant harm, e.g., forced sex, physical cruelty.

Diagnostic Criteria

Behavior Patterns (3+ in the last year, 1+ in the past 6 months):

Aggression to people/animals (e.g., fights, weapon use).

Property destruction (e.g., fire setting).

Deceit/theft (e.g., shoplifting, breaking in).

Serious rule violations (e.g., truancy, running away).

Pyromania

Definition: Repeated, intentional fire setting for emotional relief or gratification.

Key Features:

Pre-fire tension/arousal.

Fascination with fire.

Not motivated by financial gain or criminal intent.

Kleptomania

Definition: Compulsive urge to steal objects of no personal or monetary value.

Key Features:

Pre-theft tension; post-theft relief.

No intent of anger, vengeance, or delusions.

These disorders highlight externalizing behavior problems (aggression, impulsiveness) and require differentiation from other psychological conditions.

Short Questions (3 Marks Each)

1. Q: What are the key behavioral symptoms of conduct disorder?
A: Aggression towards people/animals, property destruction, deceit/theft, and serious violations of rules.

2. Q: Differentiate between pyromania and arson.
A: Pyromania involves fire setting for emotional relief or gratification, while arson is fire setting for monetary gain or criminal intent.

3. Q: What is the typical age of onset for conduct disorder?
A: The disorder usually begins between the ages of 7 and 15.

4. Q: Name the three onset types of conduct disorder.
A: Childhood-onset, adolescent-onset, and unspecified onset.

5. Q: What differentiates kleptomania from ordinary theft?

A: Kleptomania involves stealing without the need or desire for the object or its monetary value, driven by compulsive urges.

6. Q: Define externalizing disorders.
A: Disorders characterized by outward-directed behaviors like aggressiveness, impulsiveness, and noncompliance (e.g., ADHD, conduct disorder).

7. Q: What emotions are typically associated with kleptomania?
A: Tension before stealing and relief or gratification afterward.

8. Q: What is the gender prevalence of pyromania?
A: The majority of individuals with pyromania are male.

Long Questions (5 Marks Each)

1. Q: Explain the diagnostic criteria for conduct disorder in detail.
A:

A repetitive and persistent pattern of behavior violating the basic rights of others or societal norms.

Requires at least three symptoms in the past year (e.g., aggression, deceit, rule violations) and one in the past six months.

Symptoms include bullying, fighting, fire setting, stealing, truancy, or running away.

Significant impairment in social, academic, or occupational functioning.

2. Q: Discuss the differences between childhood-onset and adolescent-onset conduct disorder.
A:

Childhood-Onset: Symptoms appear before age 10, associated with worse outcomes and progression to severe disorders.

Adolescent-Onset: Symptoms emerge after age 10, with less severe behavioral issues.

Unspecified Onset: Insufficient information to determine onset timing.

3. Q: Describe the diagnostic criteria for pyromania.
A:

Deliberate fire setting on multiple occasions.

Tension or arousal before the act.

Fascination with fire and relief or gratification during or after the act.

Exclusion of financial motives, anger, or delusions.

4. Q: How are externalizing disorders different from internalizing disorders?
A:

Externalizing disorders involve outward behaviors like aggression and impulsiveness (e.g., ADHD, conduct disorder).

Internalizing disorders involve inward-focused behaviors like anxiety, depression, and social withdrawal.

These categories address different aspects of emotional and behavioral regulation.

5. Q: Elaborate on kleptomania and its diagnostic criteria.
A:

Recurrent failure to resist stealing impulses, even when objects have no personal or monetary value.

Associated with tension before theft and relief/gratification afterward.

Stealing is not driven by anger, delusions, or other psychological conditions.

Differentiated from conduct disorder and antisocial personality disorder.

Lecture 31

Short Notes on Disruptive, Impulse-Control, and Conduct Disorders III

Other Specified & Unspecified Disorders

Other Specified Disorder: Symptoms cause significant distress or impairment but don’t meet full criteria for specific disorders. Specific reasons are recorded (e.g., "recurrent behavioral outbursts of insufficient frequency").

Unspecified Disorder: Symptoms cause distress or impairment, but reasons for not meeting criteria are not specified (e.g., insufficient information in emergency settings).

Etiology of Conduct Disorder

1. Genetic & Biological Factors:

Genetic predisposition, lower verbal IQ, abnormalities in prefrontal cortex and amygdala.

Higher risk if family members have mental health issues or substance abuse problems.

2. Personal Factors:

Difficult infant temperament, impulsivity, and emotional regulation issues.

3. Family Factors:

Parental rejection/neglect, abuse, harsh discipline, and inconsistent parenting.

Early institutional living and large family size.

4. Community Factors:

Peer rejection, delinquent peer groups, exposure to violence, and neighborhood maltreatment.

Etiology of Oppositional Defiant Disorder

Personal: High emotional reactivity, difficulty regulating emotions.

Environmental: Harsh or inconsistent parenting practices.

Genetic & Physiological: Abnormalities in brain regions like the prefrontal cortex and amygdala.

Etiology of Intermittent Explosive Disorder

Environmental: History of physical/emotional trauma in early life.

Genetic: Family history of impulsive aggression increases risk.

Etiology of Kleptomania

Higher rates of obsessive-compulsive disorder and substance use disorders in first-degree relatives.

These disorders are influenced by a combination of personal, familial, genetic, and environmental factors. Addressing these root causes is crucial for effective intervention and treatment.

Short Questions (3 Marks Each)

1. Q: What is the "Other Specified Disruptive, Impulse-Control, and Conduct Disorder"?
A: It refers to cases where symptoms cause significant distress but do not meet full criteria for a specific disorder. The clinician specifies the reason for this categorization.

2. Q: What is the role of family factors in the etiology of conduct disorder?
A: Factors like parental rejection, neglect, abuse, harsh discipline, and lack of supervision increase the risk of conduct disorder.

3. Q: What is the significance of emotional regulation in oppositional defiant disorder?
A: Difficulty in emotional regulation, such as reacting excessively, can lead to oppositional defiant disorder.

4. Q: Name two community factors contributing to conduct disorder.
A: Peer rejection and exposure to community violence.

5. Q: How does genetic predisposition influence intermittent explosive disorder?
A: Family history of impulsive aggression increases the likelihood of developing intermittent explosive disorder.

6. Q: What differentiates "Unspecified Disruptive, Impulse-Control, and Conduct Disorder"?
A: It applies when symptoms cause distress, but there is insufficient information to make a specific diagnosis.

7. Q: Mention one biological factor linked to conduct disorder.
A: Abnormalities in the prefrontal cortex and amygdala.

8. Q: How is kleptomania linked to obsessive-compulsive disorder?
A: First-degree relatives of kleptomania patients have higher rates of OCD and substance use disorders.

Long Questions (5 Marks Each)

1. Q: Explain the role of genetic and biological factors in the etiology of conduct disorder.
A:

Genetic predisposition increases susceptibility to conduct disorder.

Abnormalities in the prefrontal cortex and amygdala are associated with emotional and impulse control issues.

Low verbal IQ and difficult temperament from infancy are common risk factors.

Family history of mental health issues (e.g., ADHD, depression, substance abuse) exacerbates risk.

2. Q: Describe the influence of family and community factors on the development of conduct disorder.
A:

Family: Parental rejection, neglect, harsh discipline, abuse, and lack of supervision are significant contributors. Early institutional living and frequent changes of caregivers also increase risk.

Community: Peer rejection, delinquent peer groups, and exposure to violence in the neighborhood heavily impact mental health and behavior.

3. Q: Discuss the environmental and genetic causes of intermittent explosive disorder.
A:

Environmental: History of physical or emotional trauma during the first two decades of life is a strong risk factor.

Genetic: A substantial genetic influence for impulsive aggression has been identified, especially if first-degree relatives display similar tendencies.

4. Q: Outline the etiology of oppositional defiant disorder.
A:

Personal: High emotional reactivity and inability to regulate emotions.

Environmental: Harsh, inconsistent parenting practices increase risk.

Genetic and Physiological: Abnormalities in the brain's prefrontal cortex and amygdala play a significant role.

5. Q: How do personal, familial, and genetic factors contribute to kleptomania?
A:

Personal: Individuals feel tension before stealing and relief afterward.

Familial: First-degree relatives often have obsessive-compulsive or substance use disorders.

Genetic: There is a hereditary component to kleptomania, linking it to other impulse-control issues.

Lecture 32

Short Notes on Personality Disorders I

Personality Disorders Overview

Definition: Enduring, rigid patterns of behavior that deviate from cultural expectations, causing distress or impairment in social, occupational, or personal functioning.

Key Features: Inflexibility, pervasive patterns, onset in adolescence or early adulthood, and comorbidity with other disorders.

Clusters:

Cluster A (Odd/Eccentric): Paranoid, Schizoid, Schizotypal.

Cluster B (Dramatic/Emotional): Antisocial, Borderline, Histrionic, Narcissistic.

Cluster C (Anxious/Fearful): Avoidant, Dependent, Obsessive-Compulsive.

Diagnostic Criteria (Common to All)

Deviations in two or more areas:

Cognition (perception of self and others).

Affectivity (emotional range and intensity).

Interpersonal functioning.

Impulse control.

Inflexibility across situations, significant distress, long duration (since adolescence), not due to substance use or medical conditions.

Cluster A Disorders

1. Paranoid Personality Disorder:

Distrust and suspicion of others' motives.

Symptoms: Suspects harm, doubts loyalty, reads hidden meanings, bears grudges, etc.

2. Schizoid Personality Disorder:

Detachment from social relationships and restricted emotional expression.

Symptoms: Prefers solitude, little interest in relationships, indifferent to praise or criticism.

3. Schizotypal Personality Disorder:

Discomfort in close relationships, odd thinking, and eccentric behavior.

Symptoms: Ideas of reference, odd beliefs, unusual perceptions, and excessive social anxiety.

These disorders are challenging to treat due to the ingrained nature of maladaptive patterns.

Short Questions (3 Marks Each)

1. Q: What are the three clusters of personality disorders?
A:

Cluster A: Odd/Eccentric (e.g., Paranoid, Schizoid, Schizotypal).

Cluster B: Dramatic/Emotional (e.g., Antisocial, Borderline).

Cluster C: Anxious/Fearful (e.g., Avoidant, Dependent).

2. Q: Define personality disorder.
A: A personality disorder is an enduring, inflexible pattern of behavior deviating from cultural expectations, causing distress or impairment in social, occupational, or personal functioning.

3. Q: What is comorbidity in personality disorders?
A: Comorbidity refers to the coexistence of a personality disorder with another psychological disorder, such as depression or anxiety.

4. Q: What are the key features of paranoid personality disorder?
A: Distrust and suspicion of others, finding hidden meanings in benign remarks, bearing grudges, and quick anger.

5. Q: Name two symptoms of schizoid personality disorder.
A: Preference for solitude and lack of interest in close relationships or social interactions.

6. Q: How does schizotypal personality disorder differ from schizophrenia?
A: Schizotypal personality disorder involves odd thinking and behavior but lacks the delusions and hallucinations of schizophrenia.

7. Q: What is the onset period for personality disorders?
A: Personality disorders typically begin in adolescence or early adulthood.

8. Q: How is personality disorder diagnosed?
A: Diagnosis requires enduring patterns affecting cognition, affectivity, interpersonal functioning, and impulse control, with significant distress or impairment.

Long Questions (5 Marks Each)

1. Q: Explain the diagnostic criteria for personality disorders.
A:

Enduring patterns of behavior deviating from cultural norms in at least two areas: cognition, affectivity, interpersonal functioning, or impulse control.

Patterns are inflexible, pervasive, and cause significant distress or impairment.

Must be stable, with onset in adolescence or early adulthood, and not due to substance use or a medical condition.

2. Q: Compare and contrast schizoid and schizotypal personality disorders.
A:

Schizoid: Preference for solitude, restricted emotional expression, indifferent to praise or criticism.

Schizotypal: Extreme discomfort in relationships, odd beliefs or magical thinking, unusual perceptual experiences, and eccentric behavior.

Schizotypal is more severe, often involving cognitive distortions not present in schizoid.

3. Q: Describe the symptoms and characteristics of paranoid personality disorder.
A:

Symptoms: Distrust of others, doubts about loyalty, reluctance to confide, hidden meanings in benign remarks, grudges, and quick anger.

Beliefs are not delusional but inappropriate and cause significant impairment in relationships and functioning.

4. Q: Discuss the common features of Cluster A personality disorders.
A:

Cluster A includes Paranoid, Schizoid, and Schizotypal personality disorders.

Common traits: Odd or eccentric behavior, social withdrawal, and suspicion.

Symptoms are less severe than schizophrenia but share similar themes of mistrust or cognitive distortions.

5. Q: How are personality disorders grouped in DSM-5, and why?
A:

Grouped into three clusters based on shared characteristics:

Cluster A: Odd/Eccentric.

Cluster B: Dramatic/Emotional.

Cluster C: Anxious/Fearful.

This grouping helps categorize disorders based on patterns of behavior, aiding in diagnosis and treatment planning.

Lecture 33

Short Notes on Personality Disorders from Lesson 33

Cluster B: Dramatic Personality Disorders

Includes Antisocial, Borderline, Histrionic, and Narcissistic personality disorders.

Behaviors are dramatic, emotional, or erratic, making relationships difficult.

1. Antisocial Personality Disorder

Persistent disregard for others' rights; often linked to criminal behavior.

Traits: lying, impulsivity, aggression, irresponsibility, lack of remorse.

Diagnostic criteria include behaviors like deceitfulness, recklessness, and evidence of conduct disorder before age 15.

2. Borderline Personality Disorder

Features: mood instability, impulsive behavior, unstable relationships, and fear of abandonment.

Common behaviors: self-harm, chronic feelings of emptiness, intense anger, and identity disturbance.

Diagnostic criteria involve impulsivity in self-damaging activities, affective instability, and intense anger.

3. Histrionic Personality Disorder

Excessive emotionality and attention-seeking behavior.

Traits: theatricality, impressionistic speech, reliance on physical appearance to draw attention, and shallow emotions.

Diagnostic criteria include being uncomfortable when not the center of attention and inappropriate seductive behavior.

4. Narcissistic Personality Disorder

Grandiosity, need for admiration, and lack of empathy.

Traits: exaggerated self-importance, preoccupation with success or beauty, exploitative behavior, and arrogance.

Diagnostic criteria include excessive admiration needs, entitlement, and lack of empathy.

Cluster C: Anxious Personality Disorders

Includes Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders.

1. Avoidant Personality Disorder

Social inhibition, feelings of inadequacy, and hypersensitivity to criticism.

Traits: avoiding social interaction, fear of rejection, and low self-esteem.

Diagnostic criteria include avoiding relationships due to fear of criticism and being unwilling to take personal risks.

2. Dependent Personality Disorder

Excessive need for care; clinging and submissive behavior.

Traits: difficulty making decisions, fear of abandonment, and reliance on others for support.

Diagnostic criteria include an inability to make decisions independently and fear of being alone.

3. Obsessive-Compulsive Personality Disorder

Preoccupation with orderliness, perfectionism, and control.

Traits: rigidity, excessive devotion to work, reluctance to delegate, and miserly spending habits.

Diagnostic criteria include being overly conscientious, inflexible, and preoccupied with rules and schedules.

Short Questions (3 Marks Each)

1. What are the main characteristics of Antisocial Personality Disorder?

Persistent disregard for others' rights, deceitfulness, impulsivity, aggressiveness, and lack of remorse. Linked to conduct disorder before age 15.

2. How does Borderline Personality Disorder affect relationships?

Causes unstable and intense relationships due to fear of abandonment, mood swings, and impulsivity.

3. What is the key feature of Histrionic Personality Disorder?

Excessive emotionality and attention-seeking behavior, often with theatrical gestures and dramatic expressions.

4. Why is Narcissistic Personality Disorder linked to lack of empathy?

Individuals fail to recognize or care about others' feelings, focusing instead on their own grandiosity and admiration needs.

5. What is the core issue in Avoidant Personality Disorder?

Social inhibition and hypersensitivity to criticism, leading to avoidance of interpersonal relationships.

6. How does Dependent Personality Disorder manifest?

Excessive reliance on others for decision-making and support, with intense fear of separation.

7. What distinguishes Obsessive-Compulsive Personality Disorder from OCD?

OCPD involves a pervasive focus on perfectionism and control, affecting personality, unlike the intrusive thoughts seen in OCD.

8. What are the primary behaviors seen in Histrionic Personality Disorder?

Self-dramatization, reliance on physical appearance for attention, and shallow, rapidly shifting emotions.

9. How does fear of rejection affect individuals with Avoidant Personality Disorder?

Leads to withdrawal from social situations and reluctance to form relationships, even when they desire intimacy.

10. Why is impulsivity a significant issue in Borderline Personality Disorder?

It leads to self-damaging behaviors, unstable emotions, and strained relationships.

Long Questions (5 Marks Each)

1. Describe the diagnostic criteria for Antisocial Personality Disorder according to DSM-5.

A pervasive pattern of disregard for others' rights since age 15, shown by deceitfulness, impulsivity, aggression, irresponsibility, lack of remorse, and conduct disorder in childhood. It excludes behaviors during schizophrenia or bipolar disorder.

2. Explain the diagnostic features of Borderline Personality Disorder.

Includes instability in interpersonal relationships, self-image, and emotions; impulsive actions; fear of abandonment; recurrent suicidal behaviors; chronic emptiness; inappropriate anger; and transient paranoid or dissociative symptoms.

3. Discuss the attention-seeking behavior in Histrionic Personality Disorder.

Individuals exhibit extreme emotionality, theatrical gestures, impressionistic speech, reliance on appearance for attention, and a constant need to be the center of attention. They may exaggerate physical issues or emotions to manipulate others.

4. What are the behavioral patterns observed in Narcissistic Personality Disorder?

Grandiosity, need for admiration, entitlement, lack of empathy, exploitative tendencies, envy of others, and arrogant behaviors. These patterns affect relationships and emotional stability.

5. Compare and contrast Avoidant and Dependent Personality Disorders.

Avoidant Personality Disorder is characterized by social withdrawal due to fear of rejection, while Dependent Personality Disorder involves an excessive need for care and difficulty making

decisions independently. Both exhibit low self-esteem but differ in their primary fears and relational patterns.

Lecture 34

Short Notes on Personality Disorders (Lesson 34)

1. Personality Change Due to Another Medical Condition

Persistent personality disturbance caused by a medical condition (e.g., frontal lobe lesion).

Symptoms: Significant deviation from previous personality, not better explained by mental disorders or delirium.

2. Etiology of Personality Disorders

Pathophysiological Factors: Abnormalities in brain regions (frontal, temporal, parietal lobes) and neurotransmitter imbalances (e.g., serotonin).

Genetic Factors: Increased risk among first-degree relatives of individuals with schizophrenia.

Early dysfunctional environments and developmental issues are key contributors.

3. Etiology of Specific Personality Disorders

Antisocial Personality Disorder:

Genetic predisposition, neurochemical changes (e.g., serotonergic dysregulation), and abnormalities in prefrontal brain systems.

Borderline Personality Disorder:

Linked to childhood abuse, parental separation, and mood disorders in first-degree relatives.

Histrionic Personality Disorder:

Psychodynamic theories suggest dramatic behavior stems from childhood fear of abandonment and cold parental attitudes.

Narcissistic Personality Disorder:

Results from cold, rejecting parents and an imbalance between admiration and idealized adult figures during development.

Avoidant Personality Disorder:

Possible links to early trauma, conditioned fears, and biochemical abnormalities, similar to anxiety disorders.

Dependent Personality Disorder:

Psychodynamic explanations highlight insecure attachment due to clinging parental behavior.

Obsessive-Compulsive Personality Disorder:

Freudian theory suggests anal retentiveness due to harsh toilet training, leading to orderliness and control as defenses.

Short Questions (3 Marks Each)

1. What is personality change due to another medical condition?

It is a persistent personality disturbance caused by the direct physiological effects of a medical condition, such as a frontal lobe lesion.

2. What are the pathophysiological factors involved in personality disorders?

Abnormalities in brain regions (frontal, temporal, and parietal lobes), imbalances in serotonin levels, and diminished monoamine oxidase.

3. What genetic factor is linked to antisocial personality disorder?

A higher prevalence of antisocial behavior in adopted children of biological parents with APD and substance abuse.

4. What role does childhood abuse play in Borderline Personality Disorder?

Early abuse (sexual, physical, or emotional) increases the likelihood of developing BPD, often seen as a variant of posttraumatic stress disorder.

5. What is the psychodynamic explanation for histrionic personality disorder?

Cold and controlling parents lead children to seek attention dramatically to defend against fears of abandonment.

6. What are the causes of avoidant personality disorder?

Early traumas, conditioned fears, and extreme traits of introversion and neuroticism, though no direct biological links are established.

7. What is the Freudian explanation for obsessive-compulsive personality disorder?

Harsh toilet training in the anal stage leads to fixation, resulting in extreme orderliness and control to suppress anger.

8. How does dependent personality disorder manifest?

Through excessive reliance on others, fear of separation, and an inability to make independent decisions.

9. What role does serotonin play in antisocial personality disorder?

Serotonergic dysregulation in the brain contributes to low arousal, poor fear conditioning, and decision-making deficits.

10. How does narcissistic personality disorder relate to self-esteem?

It serves as a defense mechanism against feelings of low self-esteem, with individuals seeking admiration to compensate for rejection and shame.

Long Questions (5 Marks Each)

1. Explain the diagnostic criteria for personality change due to another medical condition.

It involves persistent personality disturbance due to a medical condition, significant deviation from previous personality, no better explanation by mental disorders, and clinically significant impairment in functioning. It excludes delirium-related disturbances.

2. Describe the pathophysiological and genetic factors contributing to personality disorders.

Abnormalities in brain regions (e.g., frontal lobes) and neurotransmitter imbalances (e.g., serotonin). Genetic predisposition is noted, particularly in relatives of individuals with schizophrenia, indicating a hereditary risk.

3. Discuss the etiology of antisocial personality disorder.

Includes genetic predisposition, serotonergic dysregulation, abnormalities in prefrontal brain systems, and developmental issues like low arousal and poor fear conditioning. Adoption studies also highlight a hereditary component.

4. What are the psychosocial factors associated with borderline personality disorder?

Linked to childhood trauma (abuse, parental separation), verbal and emotional abuse, and family history of mood disorders. Early abuse is often seen as a factor for posttraumatic stress-related symptoms.

5. Compare and contrast the etiology of narcissistic and histrionic personality disorders.

Both are linked to cold, rejecting parents, but narcissism arises as a defense against feelings of worthlessness, with a focus on grandiosity. Histrionic traits emerge from fears of abandonment, leading to dramatic behavior to gain attention.

Lecture 35

Short Notes on Psychosexual and Paraphilic Disorders (Lesson 35)

1. Overview of Sexual Disorders

Sexuality varies greatly; abnormal fantasies or desires affect individuals or others negatively.

Two major categories:

Paraphilic Disorders: Recurrent, intense attraction to unusual objects/activities for at least six months.

Gender Dysphoric Disorders: Distress due to incongruence between gender identity and assigned gender.

2. Paraphilic Disorders

Defined by intense, recurrent sexual attraction to non-normative stimuli.

Diagnostic criteria include significant distress, impairment in functioning, or involving non-consenting persons.

Examples:

Voyeuristic Disorder: Sexual arousal from observing others undressing or engaging in sexual activity.

Exhibitionistic Disorder: Gratification from exposing one's genitals to unwilling individuals.

Frotteuristic Disorder: Sexual arousal from rubbing against non-consenting persons.

Sexual Masochism/Sadism Disorders: Arousal through receiving or inflicting pain/humiliation.

Pedophilic Disorder: Attraction to prepubescent children.

Fetishistic Disorder: Arousal from non-living objects or body parts.

Transvestic Disorder: Sexual gratification through cross-dressing.

3. Etiology of Paraphilic Disorders

Neurobiological Factors:

Androgens regulate sexual desire, but their role in paraphilic disorders is unclear.

Psychological Factors:

Risk factors include childhood abuse, poor parent-child relationships, and conditioning experiences.

Alcohol and negative emotions often trigger behaviors.

Social Factors:

Deviant behaviors may substitute for conventional relationships due to inadequate social skills.

Short Questions (3 Marks Each)

1. What are paraphilic disorders?

Paraphilic disorders involve recurrent, intense sexual arousal from non-normative stimuli (e.g., objects, non-consenting individuals) causing distress or functional impairment for at least six months.

2. What are the diagnostic criteria for Voyeuristic Disorder?

Sexual arousal from observing an unsuspecting person undressing or engaging in sexual activity, causing distress or involving non-consenting individuals.

3. What is Exhibitionistic Disorder?

A disorder involving recurrent sexual arousal from exposing one's genitals to an unwilling stranger, causing distress or impairment.

4. What triggers behaviors in Frotteuristic Disorder?

Sexual arousal from touching or rubbing against a non-consenting person, often in crowded places.

5. What distinguishes Sexual Masochism Disorder from Sexual Sadism Disorder?

Masochism involves sexual arousal from being humiliated or in pain, while Sadism involves arousal from inflicting pain or humiliation on others.

6. What are the key features of Pedophilic Disorder?

Recurrent sexual attraction to prepubescent children, causing distress or involving actions with children.

7. What is Fetishistic Disorder?

Intense sexual arousal from non-living objects or specific non-genital body parts, causing distress or impairment.

8. What is Transvestic Disorder?

Recurrent sexual arousal from cross-dressing, associated with distress or impairment in functioning.

9. What role does alcohol play in paraphilic disorders?

Alcohol lowers inhibitions and can trigger deviant sexual behaviors like voyeurism or exhibitionism.

10. What psychological factors contribute to paraphilic disorders?

Risk factors include childhood abuse, poor relationships, and conditioning linking sexual arousal to unusual stimuli.

Long Questions (5 Marks Each)

1. Explain the diagnostic criteria for paraphilic disorders.

Over six months, recurrent, intense sexual arousal from atypical stimuli, involving fantasies, urges, or behaviors. It must cause significant distress or impairment or involve non-consenting individuals.

2. Describe Voyeuristic Disorder and Exhibitionistic Disorder.

Voyeuristic Disorder: Sexual arousal from observing unsuspecting individuals undress or engage in sexual activity.

Exhibitionistic Disorder: Arousal from exposing one's genitals to non-consenting individuals, often triggered by anxiety or arousal.

3. Discuss the etiology of paraphilic disorders.

Factors include neurobiological influences (e.g., androgens), psychological factors like childhood abuse and poor social skills, and environmental triggers such as alcohol or negative emotions.

4. Compare Fetishistic Disorder and Transvestic Disorder.

Fetishistic Disorder: Arousal from non-living objects or specific body parts, excluding cross-dressing items.

Transvestic Disorder: Arousal from wearing clothes of the opposite gender, with distress or impairment in functioning.

5. What are the psychological and social risk factors for paraphilic disorders?

Includes exposure to childhood abuse, inadequate parent-child relationships, poor social skills, and conditioning experiences. Negative affect and alcohol use are immediate triggers.

Lecture 36

Short Notes on Psychosexual Disorders II: Gender Dysphoria (Lesson 36)

1. Gender Dysphoria Overview

Definition: Distress caused by incongruence between experienced/expressed gender and assigned gender.

Key Terms:

Transgender: Individuals identifying with a gender different from their natal gender.

Transsexual: Individuals transitioning socially/medically to another gender, often involving hormone therapy or surgery.

2. Diagnostic Criteria

Duration: At least 6 months.

Impact: Causes significant distress or impairment in social, occupational, or other functional areas.

For Children:

At least 6 manifestations, including a strong desire to be the other gender and preferences in clothing, roles, or play.

Significant dislike of one's anatomy and desire for characteristics of the other gender.

For Adolescents and Adults:

At least 2 manifestations, including marked incongruence with physical sex characteristics and a strong desire for characteristics of the other gender.

3. Etiology of Gender Dysphoria

Biological Factors: Genetic and hormonal influences during fetal development.

Psychological Factors: Early-onset gender dysphoria often persists into adolescence/adulthood in cases of high atypicality.

Environmental Factors:

Common familial trends (e.g., males with gender dysphoria often have older brothers).

High levels of distress in social, school, or work environments.

Association with habitual behaviors like fetishistic transvestism leading to autogynephilia.

Short Questions (3 Marks Each)

1. What is gender dysphoria?

Gender dysphoria refers to distress caused by a mismatch between a person's experienced/expressed gender and their assigned gender.

2. What is the difference between transgender and transsexual?

Transgender refers to individuals identifying with a gender different from their natal gender, while transsexual involves a social/medical transition, often including hormone therapy or surgery.

3. Mention the duration required for a diagnosis of gender dysphoria.

The incongruence must last for at least 6 months for a diagnosis.

4. What is one key diagnostic criterion for gender dysphoria in children?

A strong desire to be of the other gender or an insistence that one is the other gender.

5. List one biological factor contributing to gender dysphoria.

Hormonal influences in the womb during fetal development.

6. What is autogynephilia?

Autogynephilia is sexual arousal associated with the thought or image of oneself as a woman.

7. What psychological factor is linked to early-onset gender dysphoria?

A high degree of atypicality in gender-related behaviors during preschool age.

8. How does gender dysphoria affect adolescents in social settings?

It often causes distress or dysfunction in relationships, school, or work environments.

Long Questions (5 Marks Each)

1. Explain the diagnostic criteria for gender dysphoria in children.

For children, gender dysphoria is marked by a strong incongruence between experienced/expressed gender and assigned gender lasting at least 6 months. At least six criteria must be met, including:

A strong desire to be or insistence on being the other gender.

Preference for cross-dressing or opposite-gender roles in play.

A dislike of one's anatomy and desire for characteristics of the other gender.

Significant distress in functioning at school, home, or social settings.

2. Discuss the diagnostic criteria for gender dysphoria in adolescents and adults.

Adolescents and adults must experience incongruence between expressed and assigned gender for at least 6 months, meeting at least two of the following:

Desire to rid oneself of primary/secondary sex characteristics.

Desire for characteristics of the other gender.

Desire to be or be treated as the other gender.

A conviction of having the typical feelings/reactions of the other gender.

It must cause significant distress or impairment in important areas of functioning.

3. What are the environmental factors contributing to gender dysphoria?

Environmental factors include:

Familial trends, such as males with gender dysphoria often having older brothers.

Distress or dysfunction in home, school, or work environments, especially during adolescence.

Habitual fetishistic behaviors, like transvestism, may develop into autogynephilia.

4. Describe the possible causes of gender dysphoria.

The exact causes are unknown but may include:

Genetic factors: Possible hereditary influences.

Hormonal influences: During prenatal development.

Psychological factors: Early-onset gender dysphoria linked to high gender atypicality.

Environmental factors: Familial and social influences, as well as specific behavioral patterns.

Lecture 37

Short Notes on Neurocognitive Disorders I (Lesson 37)

1. Overview of Neurocognitive Disorders (NCDs)

NCDs involve cognitive decline due to brain damage from trauma, disease, or toxins.

These are acquired disorders, distinct from developmental conditions.

Examples include dementia, delirium, and amnestic disorders.

2. Types of Neurocognitive Disorders (DSM-5 Subtypes)

Mild/Major NCDs caused by:

Alzheimer’s disease

Traumatic brain injury

Parkinson’s disease, Huntington’s disease

Vascular or Lewy body-related damage

3. Delirium

Definition: Acute disturbance in attention and awareness, often with hallucinations or disorientation.

Causes: Substance intoxication, withdrawal, or another medical condition.

Diagnostic Features:

Rapid onset of cognitive disturbance.

Fluctuating severity.

Not better explained by other conditions.

4. Major and Mild NCDs

Key Features:

Decline in complex attention, memory, language, or executive functions.

Impacts daily functioning.

Progression varies (e.g., gradual in Alzheimer’s, rapid in vascular NCD).

5. NCDs Due to Alzheimer’s Disease

Progressive decline in memory, learning, and cognition.

Diagnostic categories: Probable (genetic mutation evidence) or Possible (no genetic proof).

6. NCDs with Lewy Bodies

Involves protein deposits disrupting cognition and motor skills.

Symptoms include hallucinations, fluctuating alertness, and parkinsonism.

7. Vascular NCDs

Caused by blood supply issues to the brain due to cardiovascular disease.

Symptoms: Decline in attention and executive function, often linked to cerebrovascular events.

Short Questions (3 Marks Each)

1. What are neurocognitive disorders (NCDs)?

NCDs are a group of disorders characterized by cognitive decline due to acquired brain damage from trauma, disease, or toxins, impacting memory, attention, and executive functions.

2. What distinguishes neurocognitive disorders from developmental conditions?

NCDs represent a decline from previously attained cognitive functioning, while developmental conditions are present from birth or early life.

3. What are the two main types of NCDs according to DSM-5?

Mild and Major Neurocognitive Disorders.

4. What is delirium?

Delirium is an acute disturbance in attention and awareness, often accompanied by disorientation, misinterpretations, and hallucinations.

5. List three causes of mild or major NCDs.

Alzheimer’s disease, traumatic brain injury, and Parkinson’s disease.

6. What is a key symptom of Alzheimer’s-related NCD?

Progressive decline in memory, learning, and at least one other cognitive domain.

7. What are Lewy bodies, and how do they affect cognition?

Lewy bodies are protein deposits in nerve cells that disrupt cognitive and motor functions, causing symptoms like hallucinations and parkinsonism.

8. What causes vascular neurocognitive disorders?

They result from cardiovascular issues affecting the brain’s blood supply, often linked to cerebrovascular events.

Long Questions (5 Marks Each)

1. Explain the diagnostic criteria for delirium.

The criteria include:

Disturbance in attention and awareness.

Rapid onset and fluctuating severity over hours or days.

Accompanying cognitive impairments such as memory deficits or disorientation.

Not better explained by other neurocognitive or systemic disorders.

Evidence of a physiological cause, such as substance intoxication or withdrawal.

2. Discuss the key features of major and mild neurocognitive disorders.

Features include:

Decline in one or more cognitive domains (e.g., memory, language, attention).

Impairment in daily functioning.

Gradual onset and progression in many cases, such as Alzheimer’s disease.

Categorization by severity: mild (difficulty with instrumental activities) and major (basic activity impairment).

3. What are the characteristics of Alzheimer’s-related neurocognitive disorder?

Alzheimer’s NCD involves:

Gradual cognitive decline, beginning with memory loss.

Diagnostic categories: probable (genetic mutation) or possible (clinical features only).

Steady progression without extended plateaus.

No evidence of mixed etiology or other conditions causing cognitive deficits.

4. Describe the diagnostic criteria for neurocognitive disorder with Lewy bodies.

The criteria include:

Gradual cognitive decline with fluctuating attention and alertness.

Recurrent visual hallucinations and symptoms of parkinsonism.

Diagnosed as probable (2 core features or 1 core + 1 suggestive feature) or possible (1 core or suggestive feature).

Features not explained by other neurodegenerative or systemic disorders.

Lecture 38

Short Notes on Neurocognitive Disorders II (Lesson 38)

1. Neurocognitive Disorders Due to Traumatic Brain Injury (TBI)

Definition: Cognitive decline following head trauma with symptoms like amnesia, confusion, and seizures.

Key Diagnostic Criteria:

Evidence of head trauma (loss of consciousness, amnesia, or neurological signs).

Symptoms persist past the acute injury period.

2. Substance/Medication-Induced Neurocognitive Disorder

Caused by prolonged substance use or medication.

Symptoms remain even after withdrawal or intoxication phases.

3. Neurocognitive Disorders Due to HIV Infection

Cause: HIV infection damaging subcortical brain regions.

Symptoms cannot be attributed to other brain diseases like meningitis.

4. Neurocognitive Disorders Due to Parkinson's Disease

Occurs with advanced Parkinson's disease.

Gradual cognitive decline alongside motor symptoms like tremors and rigidity.

5. Neurocognitive Disorders Due to Huntington's Disease

Cause: Hereditary condition leading to widespread brain deterioration.

Gradual onset and progression of motor and cognitive impairments.

6. Delirium

Acute disturbance caused by factors like toxins, infections, or metabolic imbalances.

Common in older adults during conditions like UTIs or surgery.

7. Etiology of Neurocognitive Disorders

Alzheimer's Disease: Amyloid plaques and tangles in the brain.

Lewy Body Dementia: Protein clumps affecting cognition and motor control.

Vascular NCD: Caused by strokes or blood vessel damage in the brain.

Substance-Induced NCD: Linked to alcohol, cocaine, and methamphetamine.

8. Risk Factors

Parkinson's Disease: Older age and disease duration.

Huntington's Disease: Genetic inheritance.

HIV NCD: Unprotected sex or drug use.

TBI: Falls, especially in older adults, and motor vehicle accidents.

Short Questions (3 Marks Each)

1. What is neurocognitive disorder due to traumatic brain injury (TBI)?

It refers to cognitive decline caused by head trauma, characterized by symptoms like loss of consciousness, amnesia, confusion, and seizures.

2. What are the key diagnostic criteria for substance/medication-induced neurocognitive disorder?

Cognitive impairment persists beyond intoxication/withdrawal, and the substance/medication is capable of causing the deficits.

3. How does HIV infection cause neurocognitive disorders?

HIV affects subcortical brain regions, leading to cognitive decline not explained by other conditions like meningitis.

4. What are the symptoms of neurocognitive disorder due to Parkinson’s disease?

Gradual cognitive decline along with motor symptoms such as tremors, rigidity, and unsteadiness.

5. What causes neurocognitive disorder due to Huntington’s disease?

It is caused by hereditary brain deterioration affecting motor control and cognition.

6. What is delirium, and how does it present?

Delirium is an acute disturbance in attention and awareness, often with hallucinations or disorientation.

7. What are amyloid plaques, and which disorder are they associated with?

Amyloid plaques are protein deposits in the brain, commonly associated with Alzheimer's disease.

8. What is the primary cause of vascular neurocognitive disorders?

Vascular NCDs are caused by strokes or damage to blood vessels supplying the brain.

Long Questions (5 Marks Each)

1. Explain the diagnostic criteria for neurocognitive disorder due to traumatic brain injury (TBI).

The criteria include:

Evidence of head trauma (e.g., impact or rapid brain movement).

Symptoms such as loss of consciousness, amnesia, confusion, or seizures.

Cognitive decline persisting beyond the acute post-injury phase.

Neurocognitive disorder symptoms appearing immediately after trauma or recovery of consciousness.

2. Discuss the causes and symptoms of neurocognitive disorders due to HIV infection.

Causes:

HIV infection damaging subcortical regions of the brain.

Risk factors include unprotected sex or injection drug use.

Symptoms:

Cognitive decline not explained by other conditions like meningitis.

Memory deficits, attention issues, and reduced executive functioning.

3. What are the major etiological factors for vascular neurocognitive disorders?

Vascular NCDs arise from:

Strokes (silent or symptomatic) blocking brain arteries.

Conditions like high blood pressure, diabetes, atherosclerosis, or brain hemorrhages.

Aging-related damage to blood vessels.

4. Describe the progression and impact of neurocognitive disorder due to Huntington's disease.

Huntington's disease leads to:

Gradual cognitive decline starting with mild impairments.

Progressive damage to subcortical regions and frontal cortex.

Symptoms like motor dysfunction (e.g., involuntary movements) and behavioral changes.

Strong genetic link with family history or genetic testing confirming the condition.

Lecture 39

Short Notes on Lesson 39: Substance-Related and Addictive Disorders I

Introduction

Substances affect both the brain and body, with medical or pleasurable effects.

Misuse leads to societal problems, costing over $600 billion annually in the US.

Substances are categorized into legal, prescription, or illegal.

Definition of Substance (Drug)

Any non-food item that alters the body or mind.

Includes alcohol, tobacco, caffeine, and medications.

Misuse causes biochemical disturbances in the brain.

Substance Intoxication

Temporary undesirable psychological or behavioral changes post-ingestion.

Examples:

Alcohol Intoxication: Poor judgment, mood swings, poor coordination.

LSD (Hallucinogen Intoxication): Hallucinations and perceptual distortions.

Dependence Features:

Tolerance: Need for higher doses.

Withdrawal: Symptoms like cramps, anxiety, and nausea when stopping.

Types of Substances

Sedatives: Slow down the central nervous system (e.g., anxiolytics).

Stimulants: Speed up CNS activity.

Tobacco: Most widely used, highly addictive.

Caffeine: Found in coffee, tea, stimulates alertness.

Alcohol: A depressant, not allowed in certain regions like Pakistan.

Cannabis: Psychoactive drug for medical/recreational use.

Hallucinogens: Cause altered perceptions and reality.

Inhalants: Psychoactive properties (e.g., spray paints, glue).

Opioids: Pain relievers (e.g., heroin, morphine).

Key Substances

Benzodiazepines: Anti-anxiety drugs (e.g., Valium, Xanax).

Opioids: Include opium, morphine, and heroin, derived from the poppy plant.

Endorphins: Body's natural opioids that relieve pain and elevate mood.

Gambling Disorder: Addictive behavior activating reward systems similar to drugs.

Substance-Related Disorders

Divided into:

1. Substance Use Disorders:

Persistent use despite negative effects.

Impaired control, social impairment, and risky use.

Withdrawal and tolerance.

2. Substance-Induced Disorders: Behavioral or psychological changes due to substances.

Characteristics of Substance Use Disorders

Obsession with substance (obtaining, using, recovering).

Craving due to classical conditioning and brain reward system activation.

Neglect of social and occupational responsibilities.

Persistent use despite physical/psychological harm.

Risky behavior and withdrawal symptoms.

Short Questions (3 Marks)

1. What is substance intoxication?
Answer: Substance intoxication refers to temporary undesirable behavioral or psychological changes occurring shortly after consuming a substance. For example, alcohol intoxication can cause poor judgment, mood changes, and poor coordination.

2. Define substance use disorder.
Answer: Substance use disorder is characterized by cognitive, behavioral, and physiological symptoms where an individual continues using a substance despite significant problems like impaired control, social impairment, and risky use.

3. What is tolerance in substance-related disorders?
Answer: Tolerance is the brain and body's need for larger doses of a substance to achieve the same effects as before.

4. Name three types of substances and their effects.
Answer:

Sedatives: Slow down the central nervous system.

Stimulants: Speed up the central nervous system.

Hallucinogens: Cause altered perceptions and hallucinations.

5. What are endorphins, and how are they related to opioids?
Answer: Endorphins are neurotransmitters that relieve pain and elevate mood. They are referred to as the body's natural opioids because they mimic the effects of substances like morphine.

6. How does substance misuse affect the brain?
Answer: Misuse disrupts normal brain function by triggering biochemical changes that disturb the brain's operations, leading to abnormal functioning and addiction.

7. What is the difference between sedatives and stimulants?
Answer: Sedatives slow down the central nervous system, while stimulants accelerate its functioning.

8. Why is gambling included in addictive disorders?
Answer: Gambling activates the brain's reward systems in ways similar to substances and causes behavioral symptoms like those in substance use disorders.

Long Questions (5 Marks)

1. Explain the general features of substance use disorders.
Answer: Substance use disorders involve persistent use of substances despite negative effects. Features include:

Impaired control: Difficulty cutting down or stopping usage.

Social impairment: Neglecting work, school, or family responsibilities.

Risky use: Using substances in hazardous situations.

Pharmacological aspects: Tolerance and withdrawal symptoms.
These disorders can lead to changes in brain circuits, intense cravings, and recurring relapses, requiring long-term treatment approaches.

2. Discuss the different types of substances and their effects.
Answer: Substances and their effects include:

Sedatives: Slow down CNS (e.g., hypnotics, anxiolytics).

Stimulants: Increase CNS activity (e.g., caffeine, nicotine).

Tobacco: Highly addictive and widely used.

Alcohol: A depressant commonly consumed worldwide.

Cannabis: Psychoactive drug for medical and recreational purposes.

Hallucinogens: Cause altered perceptions and hallucinations.

Opioids: Pain relievers derived from the poppy plant, including heroin and morphine.

3. Describe the role of tolerance and withdrawal in substance-related disorders.
Answer: Tolerance and withdrawal are critical components of substance-related disorders:

Tolerance: The body adapts to the substance, requiring higher doses to achieve the same effect.

Withdrawal: Occurs when substance use is reduced or stopped, causing symptoms like nausea, anxiety, and sweating.
These factors perpetuate addiction, making recovery challenging without medical or psychological support.

4. What are the behavioral effects of substance use disorders on individuals?
Answer: Behavioral effects include:

Spending excessive time obtaining, using, or recovering from substances.

Cravings triggered by drug-related environments.

Social and occupational neglect.

Risky behaviors, like driving under the influence.

Withdrawal from family and recreational activities.
These behaviors significantly impact personal and social life.

5. Compare and contrast sedatives and opioids in their effects and uses.
Answer:

Sedatives: Slow down CNS, used for anxiety relief (e.g., benzodiazepines). They are less likely to cause intoxication or severe withdrawal.

Opioids: Derived from opium, relieve pain and emotional tension (e.g., morphine, heroin). Highly addictive and often abused.
Both have medical uses but differ in their mechanisms and addiction potential.

Lecture 40

Substance-Related and Addictive Disorders II (Topics 224-228)

224: Substance-Induced Disorders

Intoxication: Reversible substance-specific syndrome due to recent ingestion. Behavioral changes affect perception, judgment, etc., excluding tobacco.

Withdrawal: Behavioral and cognitive issues from reduced or stopped substance use. Causes distress in key life areas.

225: Substance-Induced Mental Disorder

CNS syndromes caused by substance abuse or medication, differing from substance use disorders.

Key Features:

Symptoms match mental disorder criteria.

Symptoms occur during or after substance use and are caused by the substance.

Symptoms are not due to independent mental disorders or delirium.

Significant distress or impairment in life areas.

226: Neuro-Adaptation and Tolerance

Neuro-Adaptation: CNS changes causing tolerance/withdrawal.

Tolerance: Need for increased amounts to achieve effects or reduced impact with same amount.

227: DSM-5 Diagnostic Criteria

Common criteria for substance disorders (e.g., Alcohol, Cannabis, Opioid):

Persistent use despite harm, desire to quit, cravings, and neglect of roles.

Tolerance and withdrawal symptoms.

228: Criteria for Intoxication and Withdrawal

Intoxication and withdrawal symptoms are substance-specific.

Symptoms cause significant distress and are not better explained by another condition.

Short Questions (3 Marks)

1. What is substance intoxication?

Intoxication is a reversible substance-specific syndrome caused by recent ingestion of a substance, leading to behavioral and psychological changes due to its effects on the CNS.

2. What are the factors influencing the clinical picture of intoxication?

Factors include the type of substance, dose, route of administration, duration, tolerance, time since last dose, expectations of effects, and contextual variables.

3. Define substance withdrawal.

Withdrawal is a substance-specific syndrome involving problematic behavioral and cognitive changes due to stopping or reducing prolonged substance use, causing distress or impairment in life areas.

4. What is neuro-adaptation?

Neuro-adaptation refers to CNS changes from repeated substance use, leading to tolerance or withdrawal symptoms.

5. What does tolerance mean in substance use?

Tolerance is the need for increased amounts of a substance to achieve the desired effect or a diminished effect with the same amount.

6. How is substance-induced mental disorder different from substance use disorder?

Substance-induced mental disorder involves temporary or persistent CNS syndromes due to substances, while substance use disorder includes a pattern of behavior leading to continued substance use despite problems.

7. What are the main criteria for substance-related disorders in DSM-5?

Persistent use despite harm, unsuccessful attempts to quit, cravings, tolerance, withdrawal, and neglect of major life roles.

8. What are the common symptoms of withdrawal?

Physiological and cognitive symptoms causing significant distress in social, occupational, or other important areas of functioning.

Long Questions (5 Marks)

1. Explain the diagnostic criteria for substance-related disorders according to DSM-5.

DSM-5 outlines criteria such as:

Persistent use despite harm.

Unsuccessful attempts to control usage.

Cravings and neglect of responsibilities.

Tolerance and withdrawal symptoms.

Physical or psychological problems exacerbated by substance use.

A problematic pattern causing significant impairment or distress within a 12-month period.

2. Differentiate between intoxication and withdrawal in substance-related disorders.

Intoxication: A reversible condition caused by recent substance use, affecting perception and behavior.

Withdrawal: Symptoms arising from reduced or stopped substance use, including cognitive and behavioral issues causing distress or impairment.

Both are substance-specific and not caused by other conditions.

3. Describe the common features of substance-induced mental disorders.

These disorders involve severe, often temporary CNS syndromes. Key features include:

Symptoms occur during or after substance use.

The substance is capable of producing the disorder.

Symptoms are not better explained by independent mental disorders or medical conditions.

They cause significant impairment in functioning.

4. What is neuro-adaptation, and how does it relate to substance use?

Neuro-adaptation refers to CNS changes after repeated substance use, leading to tolerance (needing more substance for the same effect) or withdrawal symptoms (physical and psychological distress when stopping use). It underpins the physiological basis of addiction.

5. Discuss the factors that influence the clinical presentation of substance intoxication.

The clinical picture depends on:

Type of substance (e.g., alcohol, opioids).

Dose and route of administration.

Duration and chronicity of use.

Individual tolerance level.

Time since last dose.

User's expectations and context of use.

These factors determine the severity and type of symptoms experienced.

Lecture 41

Here are short notes based on the provided document on "Substance Related and Addictive Disorders III":

1. Alcohol-Related Disorders

Types:

Alcohol Use Disorder

Alcohol Intoxication

Alcohol Withdrawal

Other/Unspecified Alcohol-Induced Disorders

Key Points:

Alcohol is a nervous system depressant.

Small amounts cause sedation; large amounts cause dysphoria and can be fatal.

Alcohol Use Disorder Criteria (DSM-5): Problematic use causing impairment (e.g., cravings, tolerance, withdrawal, social/role issues).

Alcohol Intoxication: Negative behavior (e.g., slurred speech, impaired judgment) after drinking.

Alcohol Withdrawal: Symptoms like tremors, insomnia, and seizures after stopping heavy use.

2. Caffeine-Related Disorders

Types:

Caffeine Intoxication

Caffeine Withdrawal

Other/Unspecified Caffeine-Induced Disorders

Key Points:

Caffeine stimulates adrenaline, increases alertness, and raises cortisol.

Caffeine Intoxication Criteria (DSM-5): Overconsumption (e.g., restlessness, insomnia, rapid heart rate).

Caffeine Withdrawal Criteria: Symptoms (e.g., headache, fatigue, irritability) after stopping prolonged daily use.

3. Cannabis-Related Disorders

Types:

Cannabis Use Disorder

Cannabis Intoxication

Cannabis Withdrawal

Other/Unspecified Cannabis-Induced Disorders

Key Points:

Cannabis has hallucinogenic, stimulant, and depressant effects.

Cannabis Use Disorder Criteria (DSM-5): Problematic use (e.g., cravings, tolerance, withdrawal).

Cannabis Intoxication: Behavioral changes (e.g., impaired motor skills, euphoria).

Cannabis Withdrawal: Symptoms (e.g., irritability, sleep issues, restlessness) after heavy, prolonged use.

Here are short and long questions with answers based on the provided notes:

Short Questions (3 Marks)

1. What is alcohol use disorder?
Alcohol use disorder is an addiction to alcohol characterized by a problematic pattern of alcohol use causing significant impairment or distress, such as cravings, tolerance, withdrawal symptoms, or failure to fulfill obligations.

2. What are the common symptoms of alcohol intoxication?
Symptoms include slurred speech, impaired coordination, mood changes, impaired judgment, and stupor or coma.

3. What is caffeine intoxication?
Caffeine intoxication occurs when a high dose of caffeine (over 250 mg) leads to symptoms such as restlessness, nervousness, insomnia, and tachycardia.

4. Define cannabis use disorder.
Cannabis use disorder involves the continued use of cannabis despite significant impairment, such as cravings, withdrawal symptoms, or neglect of responsibilities.

5. What are the physical effects of cannabis intoxication?
Effects include conjunctival injection, increased appetite, dry mouth, and tachycardia.

Long Questions (5 Marks)

1. Explain the diagnostic criteria for alcohol use disorder according to DSM-5.
Alcohol use disorder is diagnosed if at least two of the following occur within a 12-month period:

Alcohol is consumed in larger amounts or for longer than intended.

Persistent desire or unsuccessful attempts to reduce alcohol use.

Significant time spent obtaining, using, or recovering from alcohol.

Cravings for alcohol.

Failure to fulfill obligations due to alcohol use.

Continued use despite social or interpersonal problems.

Neglect of important activities.

Use in physically hazardous situations.

Tolerance or withdrawal symptoms.

2. Describe the symptoms and effects of caffeine withdrawal.
Caffeine withdrawal symptoms develop within 24 hours of stopping prolonged daily use. Key symptoms include:

Headache.

Fatigue or drowsiness.

Dysphoric mood or irritability.

Difficulty concentrating.

Flu-like symptoms such as nausea, vomiting, or muscle pain.

3. What is cannabis withdrawal, and what are its symptoms?
Cannabis withdrawal occurs after prolonged and heavy cannabis use. Symptoms include irritability, sleep disturbances, decreased appetite, restlessness, depressed mood, and physical discomfort like abdominal pain or tremors.

4. Discuss the diagnostic criteria for alcohol intoxication.
Alcohol intoxication is diagnosed based on:

Recent alcohol consumption.

Behavioral or psychological changes (e.g., impaired judgment or aggression).

Physical symptoms such as slurred speech, unsteady gait, or memory impairment.

Symptoms not attributable to another medical condition.

5. What are the effects of caffeine on the body?
Caffeine stimulates the sympathetic nervous system, increasing adrenaline production, alertness, and energy levels. It also raises blood pressure and cortisol, the stress hormone, but excessive intake can lead to restlessness, insomnia, and other symptoms of intoxication.

Lecture 42

Here are short notes from the document on "Substance Related and Addictive Disorders IV":

---

1. Hallucinogen-Related Disorders

Definition: Hallucinogens (e.g., LSD) cause sensory distortions, hallucinations, and perception changes.

Disorders:

Phencyclidine Use Disorder

Hallucinogen Persisting Perception Disorder

Other/Unspecified Hallucinogen-Induced Disorders

Key Diagnostic Features:

Intoxication includes symptoms like hallucinations, illusions, paranoia, depersonalization, and perceptual changes.

---

2. Inhalant-Related Disorders

Definition: Abuse of substances like glue, paint, and lighter fluid for psychoactive effects.

Types:

Inhalant Use Disorder

Inhalant Intoxication

Key Diagnostic Features:

Intoxication symptoms include dizziness, slurred speech, lethargy, unsteady gait, and euphoria.

---

3. Opioid-Related Disorders

Definition: Disorders involving substances like morphine, heroin, and codeine, used for pain relief but often abused.

Disorders:

Opioid Use Disorder

Opioid Intoxication

Opioid Withdrawal

Key Features:

Use disorder: Cravings, tolerance, withdrawal, and neglect of responsibilities.

Intoxication: Euphoria, drowsiness, slurred speech, and impaired memory.

Withdrawal: Muscle aches, nausea, sweating, insomnia, and dysphoric mood.

Short Questions (3 Marks)

1. What are hallucinogen-related disorders?
Hallucinogen-related disorders involve substances like LSD that cause sensory distortions, hallucinations, and altered perceptions of reality.

2. What are the common symptoms of inhalant intoxication?
Symptoms include dizziness, slurred speech, lethargy, unsteady gait, and euphoria.

3. What is opioid use disorder?
Opioid use disorder is a problematic pattern of opioid use causing significant impairment or distress, such as cravings, withdrawal symptoms, and neglect of responsibilities.

4. Define hallucinogen persisting perception disorder (HPPD).
HPPD involves re-experiencing hallucinations or sensory distortions long after stopping hallucinogen use.

5. What are the withdrawal symptoms of opioids?
Symptoms include muscle aches, nausea, sweating, insomnia, dysphoric mood, and pupillary dilation.

Long Questions (5 Marks)

1. Explain the diagnostic criteria for phencyclidine intoxication.
Phencyclidine intoxication is diagnosed if the following criteria are met:

Recent use of phencyclidine.

Behavioral changes like impulsiveness, agitation, or impaired judgment.

Symptoms such as nystagmus, hypertension, ataxia, muscle rigidity, seizures, or coma.

Symptoms are not due to another medical condition or substance use.

2. Describe the types and effects of inhalant-related disorders.
Inhalant-related disorders include:

Inhalant Use Disorder: Persistent use of substances like glue or paint causing impairment.

Inhalant Intoxication: Short-term exposure causing dizziness, slurred speech, euphoria, or coma.

Other Inhalant-Induced Disorders: Conditions resulting from prolonged abuse.
Inhalants affect the brain by producing psychoactive effects, often causing harm to social and occupational functioning.

3. What is opioid withdrawal, and what are its diagnostic criteria?
Opioid withdrawal occurs after stopping or reducing prolonged opioid use. Criteria include:

Presence of cessation or use of an antagonist.

Symptoms like nausea, vomiting, muscle aches, sweating, insomnia, and fever.

Symptoms cause distress or impairment in daily life.

4. Discuss the diagnostic criteria for hallucinogen intoxication.
Hallucinogen intoxication is diagnosed when:

A person recently used a hallucinogen.

Behavioral changes like paranoia, impaired judgment, or ideas of reference occur.

Perceptual changes include hallucinations, illusions, or derealization.

Symptoms like dilated pupils, tachycardia, sweating, tremors, or blurred vision develop.

5. Explain the effects of opioids and their potential for abuse.
Opioids (e.g., morphine, heroin, codeine) are pain-relieving substances. While effective for managing pain, they are often abused due to their euphoric effects. Abuse leads to tolerance, dependence, and withdrawal symptoms, significantly impairing personal and social functioning.