B. Psychological Disorders and Specific Symptoms

TOS-BASED 2025 | ABPSY | NOT FOR SALE

OUTLINE

1. **Dissociative Disorders**
2. **Unipolar Depressive Disorders**
3. **Bipolar Depressive Disorders**
4. **Eating And Sleeping Disorders**

DISSOCIATIVE DISORDERS

DISSOCIATIVE IDENTITY DISORDER (DID)

Dissociative Identity Disorder – presence of two or more distinct personality states (or experience of possession) and recurrent episodes of amnesia

- Individuals with DID commonly minimize the impact of their dissociative and posttraumatic symptoms
- Full disorder may first manifest at almost any age (from earliest childhood to late life)
- Children present primarily with overlap and interference among mental states
- Prevalence across genders was 1.6% for males and 1.4% for females

DID	PTSD
Amnesias for many everyday events Dissociative flashbacks that may be followed by amnesia for the content of the flashback Disruptive intrusions by dissociated identity states into the individual's sense of self and agency Infrequent, full-blown changes among different identity states	Amnesia for some aspects of trauma Dissociative flashbacks relating to traumatic event Symptoms of intrusion and avoidance, negative alterations in cognition and mood, and hyperarousal that are focused around the traumatic event

DEPERSONALIZATION/DEREALIZATION DISORDER

Depersonalization/Derealization Disorder – persistent depersonalization and/or derealization accompanied by intact reality testing

- **Depersonalization**:unreality or detachment from oneself
- **Derealization**: unreality or detachment from one's surroundings
- The mean age at onset of depersonalization/derealization disorder is 16 years but can start in early or middle childhood

DISSOCIATIVE AMNESIA

Dissociative Amnesia – inability to recall autobiographical information which may be generalized, localized, or selective, and may or may not involve dissociative fugue

- Individuals tend to be frequently unaware/partially aware of their memory problems
- Some may report depersonalization and auto-hypnotic symptoms
- Common in women (2.6%) than men (1.0%)

Types of Amnesia

- **Localized Amnesia**: failure to recall events during a circumscribed period of time; most common
- **Selective Amnesia**: can recall selected events but not others
- **Generalized Amnesia**: complete loss of memory for one's life history; rarest form
  - Has an acute onset
  - Causes disorientation that may lead them to wander purposelessly
  - In this case, they may require the attention of the police or psychiatric emergency services
  - Common among combat veterans, sexual assault victims, and individuals experiencing extreme emotional stress or conflict
- **Systematized Amnesia**: loss of memory in a specific category of information (ex. Identity, person, childhood abuse)
- **Continuous Amnesia**: loss of memory in each new event as it occurs
- **Global Amnesia**: cannot recall both past and present; total memory loss

Memory Disorders

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

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

- **Procedural**: skills and habits
- **Semantic**: general knowledge and facts, logic
- **Episodic**: events that occur in a particular time, place, or context

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

- **Sensory**: initial storage of information, perceived by the senses
- **Short-Term Memory**: holds info for 15 to 20 seconds
- **Long-Term Memory**: stores on a relatively permanent basis, although, at times, it can be difficult to retrieve

Levels-Of-Processing Theory – degree to which new materials is mentally analyzed
- **Implicit Memory**: can be recalled automatically
- **Explicit Memory**: requires conscious retrieval of information

Constructive Processes – memories are influenced by the meaning we give to them
- **Autobiographical**: episodes from our own lives
- **Flashbulb Memories**: specific or surprising events that are so vivid in memory it as if they represented a snapshot of the event

Forgetting – permits us to form general impressions and recollections
- Helps us avoid being burdened and distracted by trivial stores of meaningless data
- **Failure of Encoding**: failure to pay attention and place information in memory
- **Decay**: loss of information due to non-use
- **Cue-Dependent Forgetting**: insufficient retrieval cues
- **Proactive Interference**: learned earlier disrupts the recall of newer material; you forget the new info
- **Retroactive Interference**: difficulty in recalling info learned earlier because of later exposure to different material; you forget the old info

UNIPOLAR DEPRESSIVE DISORDERS

★ ***Unipolar Depressive Disorders*** *– disorders in which a person experiences only depressive episodes*
★ *Include MDD, PDD, and DD*

DISORDER	KEY FEATURE	DURATION	TYPICAL ONSET
MDD	5+ depressive symptoms including mood / anhedonia	≥ 2 weeks	Mid-20s avg
PDD	Chronic low mood + 2 symptoms	≥ 2 years (1 in kids)	Early onset
DMDD	Severe temper outbursts + chronic irritability	≥ 12 months	Ages 6–18 (before 10 years)
PMDD	Severe mood symptoms before menstruation	2+ cycles	Teens–30s

DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD)

Disruptive Mood Dysregulation Disorder – chronic, severe persistent (non-episodic) irritability through frequent verbal and/or behavioral temper outbursts in response to frustration and persistent irritable or angry mood between the outbursts
- Should not be applied to children with a developmental age of less than 6 years
- Must be before age 10 years and likely to change as children mature

Key Features
- Severe recurrent temper outbursts
  - Inconsistent with developmental level
  - Occur 3 or more times per week
- Mood between temper outbursts is persistently irritable or angry most of the day nearly every day
- Symptoms are present **(at least 2 settings)** and severe in at least 1 setting
  - Home
  - School
  - With peers
- **Duration**: 12 or more months with no 3-month gap
- Diagnosis should not be made for the first time before age 6 years or after age 18 years
- No manic or hypomanic episode lasted more than 1 full day

DIFFERENTIAL DIAGNOSIS	
DMDD	**Bipolar Disorders**
- Temper outbursts are persistent	- Episodic with discrete episodes of mood perturbation - Presence of elevated or expansive mood and grandiosity
DMDD	**ODD**
- Verbal / behavioral and occur in more than 1 setting	- Typically verbal and target authorities
DMDD	**IED**

- Require persistent disruption in mood between outbursts	- Does not require persistent disruption in mood between outbursts - Requires only 3 months of active symptoms

Common Comorbidities

- Strongest overlap is ODD
- Diagnosis of DMDD should not be assigned if the symptoms occur only in an anxiety provoking context, when the routines of a child with ASD or OCD are disturbed, or in the context of a MD episode.

MAJOR DEPRESSIVE DISORDER (MDD)

Major Depressive Disorder – persistent depressed mood and/or loss of interest or pleasure nearly most of the day every day for at least two weeks

- require that a person must be in a major depressive episode and never have had a manic, hypomanic, or mixed episode
  - **Depressive Episode:** person is markedly depressed or loses interest in formerly pleasurable activities (or both) for at least 2 weeks
  - Other symptoms include changes in sleep or appetite, or feelings of worthlessness
- Typically last about 6 to 9 months if untreated
  - **Recurrent Episode**: preceded by one or more previous episodes
  - **Single Episode**: first depressive episode
- While most depressive episodes remit (at least 2 months), depressive episodes often return at some point
  - **Relapse**: return of symptoms within a fairly short period of time
  - **Recurrence**: onset of a new episode of depression
- Likelihood of onset increases markedly with puberty
- Considered as the most common mood disorder and second most prevalent type of disorder following anxiety disorders
- Higher for women than for men at a 2:1 ratio

Key Features

- At least 5 of the following symptoms
  - Depressed mood most of the day
  - Loss of interest/pleasure in activities
  - Significant weight/appetite changes
  - Sleep disturbance (insomnia/hypersomnia)
  - Psychomotor agitation or retardation
  - Fatigue/loss of energy
  - Feelings of worthlessness or guilt
  - Difficulty concentrating
  - Suicidal ideation or behavior
- Has no manic episode or a hypomanic episode
- **Duration**: 12 months or more

SPECIFIER	DESCRIPTION
Chronic	Used when a person meets the criteria for a Major Depressive Episode continuously for the past two years
Anxious Distress	Used when a person also exhibits abnormal movements, immobility, abnormal behaviors, and withdrawal
Melancholic Features	3 of the following: - Early morning awakening - Depression worse in the morning - Marked psychomotor agitation/retardation - Loss of appetite/weight - Excessive guilt - Quantitatively different depressed mood More heritable Associated childhood trauma
Psychotic Features	Delusions or hallucinations (usually mood congruent) Feelings of guilt and worthlessness are common Poorer long-term prognosis
Atypical Features	Mood reactivity: brightens to positive events 2 of the 4 following symptoms: - Weight gain/increase in appetite - Hypersomnia - Leaden paralysis - Acutely sensitive to interpersonal rejection More common in females Responds to different class of antidepressant (MAOI)
Mood-Congruent Psychotic Features	Material of the hallucinations is related to being depressed Ex. seeing demons or dark characters
Mood-Incongruent Psychotic Features	When material of hallucinations has nothing to do with being depressed Ex. delusions of grandeur Associated with poorer prognosis
Catatonic Features	Range of psychomotor symptoms from motoric immobility to extensive psychomotor activity, as well as mutism and rigidity **Catalepsy**: muscles are waxy and semirigid
Peripartum Onset	Used if the onset of MDD occurs

	in close proximity (within 4 weeks) to childbirth mood fluctuations and excessive preoccupation with the infant's well-being
Seasonal Pattern	At least 2 or more episode in the past 2 years that have occurred at the same time (usually fall or winter) Full remission at the same time (usually spring) No other nonseasonal episodes in the same 2-year period Also called seasonal affective disorder
Mixed Features	Experiences of manic symptoms but feel somewhat depressed or anxious at the same time
Peripartum Onset	Feelings of depression a period of time just before and just after the birth Also called peripartum depression

DIFFERENTIAL DIAGNOSIS	
MDD	**Bipolar Disorders**
- No manic or hypomanic episodes	- Has history of manic or hypomanic episodes
MDD	**PDD**
- Shorter duration, more symptoms (1 year or more)	- Longer duration, fewer symptoms (2 years) - Double Depression is diagnosed if both occur
MDD	**Grief / Bereavement**
- Include feelings of worthlessness, guilt, suicidality	- Sadness related to loss - Usually does not include worthlessness, guilt, suicidality

Common Comorbidities
- Substance-Related Disorders
- Panic Disorder
- Obsessive-Compulsive Disorder
- Anorexia Nervosa
- Bulimia Nervosa
- Borderline Personality Disorder

PERSISTENT DEPRESSIVE DISORDER (PDD)

Persistent Depressive Disorder – depressed mood most of the day, for more days than not, for at least 2 years
- If MDD and PDD co-occur, Double Depression must be diagnosed
    - People with Double Depression are moderately depressed on a chronic basis (PDD) but undergo increased problems from time to time (MDD)
    - Classified as a form of persistent depressive disorder
- Chronic stress has been shown to increase the severity of symptoms
- Often begins during adolescence, and over 50 percent of those who present for treatment have an onset before age 21

Key Features
- Depressed mood for most of the day
- Additional Symptoms **(at least 2)**
    - Poor appetite or overeating
    - Insomnia or hypersomnia
    - Low energy or fatigue
    - Low self-esteem
    - Poor concentration or difficulty making decisions
    - Feelings of hopelessness
- Has no manic episode or a hypomanic episode
- Never symptom-free for more than 2 months
- **Duration**
    - **Children and Adolescents**: 1 year or more
    - **Adults**: 2 years or more
- No manic or hypomanic episodes
- **Onset**
    - **Early onset**: If onset is before age 21 years
    - **Late onset**: If onset is at age 21 years or older

SPECIFIERS FOR PDD + MDD	
Intermittent Major Depressive Episodes, With Current Episode	Symptoms currently meet full criteria for a major depressive episode
With Persistent Major Depressive Episode	Major depressive episode has persisted for at least a 2-year duration and remains present
With Intermittent Major Depressive Episodes, Without Current Episode	Full major depressive episode criteria are not currently met but there has been at least one previous episode of major depression in the context of at least 2 years of persistent depressive symptoms
With Pure Dysthymic Syndrome	No experience of an episode of major depression in the last 2 years

DIFFERENTIAL DIAGNOSIS	
PDD	**MDD**
- Chronic	- Shorter in duration
PDD	**Cyclothymia**
- No hypomanic or manic	- Alternates between low

symptoms	mood and hypomanic symptoms

Common Comorbidities

- Higher risk for psychiatric comorbidity in general than MDD, and for anxiety disorders and substance use disorders in particular
- Early-onset persistent depressive disorder is strongly associated with DSM-IV Cluster B and C personality disorders

PREMENSTRUAL DYSPHORIC DISORDER

Premenstrual Dysphoric Disorder – mood lability, irritability, dysphoria and anxiety symptoms accompanied by behavioral and physical symptoms that occur repeatedly during premenstrual phase and remit around onset of menses or shortly thereafter

- Onset can occur at any point after menarche
- Many individuals, as they approach menopause, report that symptoms worsen
- Symptoms cease after menopause

Key Features

- Severe mood symptoms tied to menstrual cycle **(at least 5)**
  - Mood swings
  - Irritability or anger
  - Depression
  - Anxiety or tension
  - Decreased interest in usual activities
  - Difficulty in concentration
  - Lethargy or fatigue
  - Change in appetite
  - Hypersomnia or insomnia
  - A sense of being overwhelmed or out of control
  - Physical symptoms such as breast tenderness or swelling, joint or muscle pain, sense of bloating, or weight gain
- Symptoms improve after menstruation
- **Duration**
  - Daily in at least 2 consecutive cycles
  - Symptoms are present in the final week before the onset of menses

Common Comorbidities

- Major depressive episode is the most frequently reported
- Medical (e.g., migraine, asthma, allergies, seizure disorders) or other mental disorders (e.g., depressive and bipolar disorders, anxiety disorders, bulimia nervosa, substance use disorders) may worsen the disorder
- Absence of a symptom-free period during the postmenstrual interval obviates a diagnosis of premenstrual dysphoric disorder

DIFFERENTIAL DIAGNOSIS	
PMDD	**Dysmenorrhea**
- Involves mood - Begin before the onset of menses	- Syndrome of painful menses - Begin during the onset of menses
PMDD	**PMS**
- More severe - With functional impairment	- Minimum of 5 symptoms is not required
PMDD	**MDD**
- Cyclical and resolves after menstruation	- Does not resolve after menstruation
PMDD	**Bipolar Disorder**
- Time-locked to **luteal phase**	- Continuous or episodic

BIPOLAR DISORDERS

BIPOLAR AND RELATED DISORDERS

Bipolar Disorders – mood disturbance in which the experiences both depressive and manic episodes; alternates between depression and mania

DISORDER	KEY FEATURE	DURATION	TYPICAL ONSET
Bipolar I	≥1 Manic episode (± MD)	**Mania**: ≥1 week	Teens–20s
Bipolar II	≥1 Hypomanic + ≥1 MD episode	**Hypomania** : ≥4 days, **MD**: ≥2 weeks	Mid-20s
Cyclothymic	Hypomanic + depressive symptoms (not full episodes)	≥2 years (1 year for kids)	Teens–early adulthood

Manic Episode – abnormal and persistently elevated, expansive or irritable mood for 1 week

- Individuals find extreme pleasure in every activity
- Comparable to a continuous sexual orgasm
- Speech is typically rapid and may become incoherent in an attempt to express so many exciting ideas at once (**flight of ideas**)

Key Features of a Manic Episode

- Abnormally elevated or irritable mood

- Increased energy/activity
- Manic Symptoms **(at least 3; 4 if mood is irritable)**
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative or pressured speech
  - Racing thoughts or flight of ideas
  - Distractibility
  - Increased goal-directed activity
  - Risky behaviors
- **Duration**: 1 week or more, or any duration if hospitalization is needed

Hypomanic Episode – abnormal and persistently elevated, expansive or irritable mood for 4 days
- Hypo = below
- Less severe version of a manic episode
- Does not cause marked impairment in social or occupational functioning

Key Features of a Hypomanic Episode
- Abnormally elevated or irritable mood
- Increased energy/activity
- Manic Symptoms **(at least 3; 4 if mood is irritable)**
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative or pressured speech
  - Racing thoughts or flight of ideas
  - Distractibility
  - Increased goal-directed activity
  - Risky behaviors
- **Duration**: 4 or more consecutive days

Major Depressive Episode – extremely depressed mood state that lasts at least 2 weeks and includes cognitive symptoms and disturbed physical functions
- Typically accompanied by a general loss of interest in things and an inability to experience any pleasure from life
- The most central indicators of a full major depressive episode are the physical changes (sometimes called somatic or vegetative symptoms)

Key Features of a Major Depressive Episode
- Depressive symptoms **(at least 5)**
  - Depressed mood most of the day, nearly every day
  - Loss of interest or pleasure (anhedonia) in most activities
  - Significant weight/appetite change (gain or loss)
  - Sleep disturbance (insomnia or hypersomnia)
  - Psychomotor agitation or retardation (observable by others)
  - Fatigue or loss of energy
  - Feelings of worthlessness or excessive/inappropriate guilt
  - Difficulty concentrating or indecisiveness
  - Recurrent thoughts of death, suicidal ideation, or suicide attempt
- **Duration**
  - At least 2 weeks
  - Must represent a change from previous functioning

SPECIFIER	DESCRIPTION
Anxious Distress	Presence and severity of accompanying anxiety, whether in the form of comorbid anxiety disorder or anxiety symptoms that do not meet all the criteria for disorders Makes suicidal thoughts and completed suicide more likely, and predicts a poorer outcome from treatment
Rapid Cycling	Moving quickly in and out of depressive or manic episodes At least 4 manic or depressive episodes within a year Does not respond well to standard treatments Has a higher probability of suicide attempts and more severe episodes of depression Also called rapid switching or rapid mood switching
Melancholic Features	Applies only if the full criteria for a major depressive episode have been met Severe somatic (physical) symptoms, such as early-morning awakenings, weight loss, loss of libido, excessive or inappropriate guilt, and anhedonia
Atypical Features	Consistently oversleep and overeat during their depression Have considerable anxiety, but they can react with interest or pleasure to some things
Psychotic Features	Experiences hallucinations and delusions alongside depressive episodes **Mood-Congruent**: delusions of grandeur accompanying a manic episode
Catatonia	Catalepsy
Peripartum Onset	Depression a period of time just before and just after the birth
Seasonal Pattern	Episodes that occur during certain seasons

BIPOLAR I DISORDER

Bipolar I Disorder – at least one lifetime manic episode (hypomanic episode or major depressive episode may occur but not required)

- One of the most common features of a manic episode is a decreased need for sleep
- Speech can be rapid, pressured, loud, and difficult to interrupt
- Symptoms of mania in BP1 occur in distinct episodes and typically begin in late adolescence or early adulthood
  - There must be a symptom free period of at least 2 months between manic and major depressive episodes
  - First episode is usually depressive and its symptoms are the most frequent symptoms experienced
- Peaks between 20 and 30 years, but onset occurs throughout the lifespan

Key Features

- At least one **manic episode** is met
  - Abnormally elevated or irritable mood
  - Increased energy/activity
  - Manic Symptoms **(at least 3; 4 if mood is irritable)**
    - Inflated self-esteem or grandiosity
    - Decreased need for sleep
    - More talkative or pressured speech
    - Racing thoughts or flight of ideas
    - Distractibility
    - Increased goal-directed activity
    - Risky behaviors
  - **Duration**: 1 week or more
- May occur with or without major depressive episodes

BIPOLAR II DISORDER

Bipolar II Disorder – at least one hypomanic episode and at least one major depressive episode, never been a manic episode

- Can begin in late adolescence and throughout adulthood, slightly later than bipolar disorder but earlier than MDD
- Often begins with depressive episodes
- Highly recurrent, also have seasonal variation in mood compared to those with BP1
- The number of lifetime episodes tends to be higher for BP2 than for MDD or BP1
- Once the hypomanic episode has occurred, it never reverts back to MDD

Key Features

- At least one **hypomanic episode** is met
  - Abnormally elevated or irritable mood
  - Increased energy/activity
  - Manic Symptoms **(at least 3; 4 if mood is irritable)**
    - Inflated self-esteem or grandiosity
    - Decreased need for sleep
    - More talkative or pressured speech
    - Racing thoughts or flight of ideas
    - Distractibility
    - Increased goal-directed activity
    - Risky behaviors
  - **Duration**: 4 or more consecutive days
- At least one **major depressive episode** is also met
  - Depressive symptoms **(at least 5)**
    - Depressed mood most of the day, nearly every day
    - Loss of interest or pleasure (anhedonia) in most activities
    - Significant weight/appetite change (gain or loss)
    - Sleep disturbance (insomnia or hypersomnia)
    - Psychomotor agitation or retardation (observable by others)
    - Fatigue or loss of energy
    - Feelings of worthlessness or excessive/inappropriate guilt
    - Difficulty concentrating or indecisiveness
    - Recurrent thoughts of death, suicidal ideation, or suicide attempt
  - **Duration**
    - At least 2 weeks
    - Must represent a change from previous functioning
- No occurrence of a manic episode

Common Comorbidities

- Anxiety Disorders
- Substance Use Disorders

CYCLOTHYMIC DISORDER

Cyclothymic Disorder – numerous distinct sub-criteria periods with hypomanic symptoms and periods of depressive symptoms present at least half the time for at least 2 years

- Chronic alternation of mood elevation and depression that does not reach the severity of manic or major depressive episodes
- Has not been without symptoms for more than 2 months at a time
- Considered as a chronic version of a bipolar disorder
- Pattern must last for at least 2 years (1 year for children and adolescents) to meet criteria for the disorder
- Do not meet the complete criteria for depressive symptoms and hypomanic symptoms

- Usually begins in adolescence or early adult life and is sometimes considered to reflect a temperamental predisposition to other disorders
- Experience onset of mood symptoms before
- the age of 10

Key Features

- Numerous periods with **hypomanic symptoms**
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative or pressured speech
  - Racing thoughts or flight of ideas
  - Distractibility
  - Increased goal-directed activity
  - Risky behaviors
- Numerous periods with **depressive symptoms**
  - Depressed mood most of the day, nearly every day
  - Loss of interest or pleasure (anhedonia) in most activities
  - Significant weight/appetite change (gain or loss)
  - Sleep disturbance (insomnia or hypersomnia)
  - Psychomotor agitation or retardation (observable by others)
  - Fatigue or loss of energy
  - Feelings of worthlessness or excessive/inappropriate guilt
  - Difficulty concentrating or indecisiveness
  - Recurrent thoughts of death, suicidal ideation, or suicide attempt
- Criteria for a major depressive, manic, or hypomanic episode have never been fully met
- Symptoms are present 50% or more of the time, no symptom-free interval of more than 2 months
- **Duration**
  - ≥ 2 years (adults)
  - ≥ 1 year (children)

EATING AND SLEEPING DISORDERS

PICA DISORDER

Feeding and Eating Disorders – characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food

- Significantly impairs physical health or psychosocial functioning
- The classification scheme is mutually exclusive
  - During a single episode, only one of these diagnoses can be assigned

Pica – eating of one or more non-nutritive, nonfood substances on a persistent basis over a period of at least 1 month

- Prevalence of pica appears to increase with the severity of intellectual disability
- Onset of pica can occur in childhood, adolescence, or adulthood, although childhood onset is most commonly reported
- May also manifest in pregnancy as cravings
- Abdominal flat plate radiography, ultrasound, and other scanning methods may reveal obstructions related to pica
- Blood tests and other laboratory tests can be used to ascertain levels of poisoning or the nature of infection
- Pica can significantly impair physical functioning
- Rarely the sole cause of impairment in social functioning
- Often occurs with other disorders associated with impaired social functioning

Key Features

- Persistent eating of nonnutritive, nonfood substances
- Inappropriate to the developmental level of the individual
- Not culturally supported or socially normative
- **Duration**: at least 1 month

RUMINATION DISORDER

Rumination Disorder – repeated regurgitation of food occurring after feeding or eating over a period of at least 1 month

- Previously swallowed food that may be partially digested is brought up into the mouth without apparent nausea, involuntary retching, or disgust
- Weight loss and failure to make expected weight gains are common features in infants
- Malnutrition may occur
- Onset of rumination disorder can occur in infancy, childhood, adolescence, or adulthood
- Age at onset in infants is usually between ages 3 and 12 months
- Potentially fatal among infants
- Can have an episodic course or occur continuously until treated

Key Features

- Persistent regurgitation of food
- May be re-chewed, re-swallowed, or spit out
- **Duration**: at least 1 month

AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER

Avoidant/Restrictive Food Intake Disorder – avoidance or restriction of food intake causing significant weight loss / nutritional deficiency

- Also called **functional dysphagia** and **globus hystericus**
- Replaced and extended the DSM-IV diagnosis of feeding disorder of infancy or early childhood
- Food avoidance or restriction may be based on the sensory characteristics of qualities of food

- May also represent a conditioned negative response associated with food intake following, or in anticipation of, an aversive experience
- Commonly develops in infancy or early childhood and may persist in adulthood

Key Features
- Feeding or eating disturbance marked by failure to meet nutritional or energy needs
- Results **(1 or more)**
  - Significant weight loss (or faltering growth in children)
  - Nutritional deficiency
  - Dependence on enteral feeding or supplements
  - Marked psychosocial interference
- No distortion of body weight or shape perception

ANOREXIA NERVOSA

Anorexia Nervosa Disorder – person eats only minimal amounts of food or exercises vigorously to offset food intake so body weight sometimes drops dangerously
- Decreased body weight is the most notable feature
- "Nervous loss of appetite"
- They are so successful at losing weight that they put their lives in considerable danger
- Both anorexia and bulimia are characterized by a morbid fear of gaining weight and losing control over eating
- Individuals with anorexia are never satisfied with their weight loss
- Requires that the individual's weight be significantly low
- Commonly begins during adolescence or young adulthood
  - Rarely begins before puberty or after age 40
  - Occasionally occur in children under the age of 11
  - They are likely to restrict fluid intake, as well as food intake
- Less common than bulimia; many individuals with bulimia have a history of anorexia

Key Features
- Restriction of energy intake
- Intense fear of gaining weight or becoming fat
- Disturbance in self-perceived weight or shape
- **Subtypes**
  - **Restricting Type**: weight loss is achieved through dieting, fasting, or excessive exercise
  - **Binge-Eating/Purging Type**: recurrent episodes of binge eating or purging (ex. self-induced vomiting, misuse of laxatives, diuretics, or enemas)
- **Duration**
  - at least once a week
  - 3 months

Severity Specifiers (BMI for adults)
- **Mild**: BMI ≥ 17
- **Moderate**: BMI 16–16.99
- **Severe**: BMI 15–15.99
- **Extreme**: BMI < 15

Medical Consequences
- **Amenorrhea**: cessation of menstruation
- Dry skin, brittle hair or nails, and sensitivity to or intolerance of cold temperatures
- **Lanugo**: downy hair on the limbs and cheeks
- Cardiovascular problems, such as chronically low blood pressure and heart rate
- If vomiting is part of the anorexia, electrolyte imbalance and resulting cardiac and kidney problems

BULIMIA NERVOSA

Bulimia Nervosa – binges are followed by self-induced vomiting, excessive use of laxatives, or other attempts to purge
- Vomiting is the most common inappropriate compensatory behavior
- Caloric intake for binges varies significantly from person to person
- Amount of food eaten and eating is experienced as out of control
- Individual attempts to compensate for the binge eating and potential weight gain, almost always by purging technique
- 57% of a group of patients with bulimia nervosa exercised excessively while 81% of a group with anorexia did
- **DSM-IV-TR**
  - Purging type (e.g., vomiting, laxatives, or diuretics)
  - Non-purging type (e.g., exercise and/or fasting); very rare
- No weight loss is typically accomplished unlike anorexia; many are at normal weight
- Usually present with anxiety and mood disorders
  - 80.6% of individuals with bulimia had an anxiety disorder at some point
  - 66% of adolescents with bulimia presented with a co-occurring anxiety disorder
- The median age of onset for all eating-related disorders occurred in a narrow range of 18 to 21 years

Key Features
- Recurrent binge eating episodes, which involve:
  - Eating an unusually large amount of food in a short time (ex. within 2 hours)
  - Feeling a lack of control over eating during the episode

- Recurrent inappropriate compensatory behaviors to prevent weight gain, such as:
  - Self-induced vomiting
  - Misuse of laxatives, diuretics, or other medications
  - Fasting
  - Excessive exercise
- **Duration**
  - at least once a week
  - 3 months
- Self-esteem is overly influenced by body shape and weight
- The behavior does not occur exclusively during episodes of Anorexia Nervosa.

Severity Specifiers (Compensatory Behaviors)
- **Mild**: 1–3 episodes
- **Moderate**: 4–7 episodes
- **Severe**: 8–13 episodes
- **Extreme**: 14 or more episodes

Medical Consequences
- Salivary gland enlargement
- Eroding in the dental enamel on the inner surface of the front teeth
- Tearing of the esophagus
- **Electrolyte Imbalance**: chemical imbalance, including sodium and potassium levels
- Intestinal problems such as severe constipation or permanent colon damage
- Marked calluses on fingers or the backs of hands

BINGE-EATING DISORDER

Binge-Eating Disorder – recurrent episodes binge eating that must occur, on average, at least once per week for 3 months
- Individuals may binge repeatedly and find it distressing, but they do not attempt to purge the food
- Often found in weight-control programs
- **Episode of Binge-Eating**: eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat
- Occurs in normal-weight/overweight and obese individuals
- Those who begin binging first become more severely affected by BED and are more likely to have additional disorders

Key Features
- Recurrent episodes of binge eating, which involve:
  - Eating an unusually large amount of food in a short period of time (ex. within 2 hours)
  - Feeling a lack of control over eating during the episode (ex. unable to stop or control what/how much is eaten)
- Binge eating episodes **(at least 3)**
  - Eating much more rapidly than normal
  - Eating until uncomfortably full
  - Eating large amounts of food when not physically hungry
  - Eating alone due to embarrassment about how much one is eating
  - Feeling disgusted with oneself, depressed, or very guilty afterward
- The person feels distressed about binge eating
- **Duration**
  - at least once a week
  - 3 months
- No regular use of inappropriate compensatory behaviors
- Does not occur exclusively during the course of Bulimia Nervosa or Anorexia Nervosa

Severity Specifiers (Binge Episodes)
- **Mild**: 1–3 episodes
- **Moderate**: 4–7 episodes
- **Severe**: 8–13 episodes
- **Extreme**: 14 or more episodes

ENURESIS

Elimination Disorders – involve the inappropriate elimination of urine or feces and are usually first diagnosed in childhood or adolescence
- Based on developmental age and not solely on chronological age
- Both disorders may be voluntary or involuntary
- May co-occur

Enuresis – repeated voiding of urine into inappropriate places
- **Monosymptomatic Enuresis**
  - Most common subtype
  - Involves incontinence only during nighttime sleep
  - Typically occurs during the first one-third of the night
- **Urinary Incontinence**
  - Occurs in the absence of nocturnal enuresis
  - Also called diurnal-only subtype
  - **Urge Incontinence**: have sudden urge symptoms and detrusor instability
  - **Voiding Postponement**: consciously defer micturition urges until incontinence results
  - May be associated with symptoms of disruptive behavior
  - Child defers voiding until incontinence occurs
- **Nonmonosymptomatic Enuresis**
  - Also called nocturnal-and-diurnal subtype
  - Combination of the two subtypes
- Voiding of urine must occur at least twice a week for at least 3 consecutive months
- Must cause clinically significant distress or impairment in social, academic

- Individual must have reached an age at which continence is expected
- Voiding typically takes place during rapid eye movement (REM) sleep
    - Child may recall a dream that involved the act of urinating

Key Features
- Repeated urination into bed or clothes (involuntary or intentional)
- **Duration**
    - At least twice a week
    - For 3 consecutive months
- The individual is at least 5 years old (or equivalent developmental level)
- Not due to a substance (ex. diuretic) or another medical condition (ex. diabetes, spina bifida)
- **Specify Type**
    - Nocturnal only (during sleep)
    - Diurnal only (during waking hours)
    - Both nocturnal and diurnal

ENCOPRESIS

Encopresis – repeated passage of feces into inappropriate places
- Leakage can be infrequent to continuous, occurring mostly during the day and rarely during sleep
- Many children with encopresis suffer from constipation
    - Feces in the with constipation and overflow incontinence subtype are characteristically (but not invariably) poorly formed
- Usually associated with the presence of oppositional defiant disorder or conduct disorder or may be the consequence of anal masturbation
- Most often the passage is involuntary but occasionally may be intentional

Key Features
- Repeated passage of feces into inappropriate places (voluntary or involuntary)
- **Duration**
    - At least once a month
    - For 3 months
- The individual is at least 4 years old (or equivalent developmental level)
- Not due to the physiological effects of a substance or another medical condition (except through a mechanism involving constipation)
- **Specify Type**
    - With constipation and overflow incontinence
    - Without constipation and overflow incontinence

SLEEP-WAKE DISORDERS

Sleep and Wake Disorders – sleep-wake complaints of dissatisfaction regarding the quality, timing, and amount of sleep
- Resulting daytime distress and impairment are core features shared by all sleep-wake disorders
- Sleep disorders are often accompanied by depression, anxiety, and cognitive changes
- **Rapid Eye Movement (REM) Sleep**
    - Also called dream sleep
    - Involves the brain circuit in the limbic system
    - This mutual neurobiological connection suggests that anxiety and sleep may be interrelated in important way
    - **NREM Sleep Stage 1 (N1)**: transition from wakefulness to sleep and occupies about 5% of time spent asleep in healthy adults
    - **NREM Sleep Stage 2 (N2)**: characterized by specific electroencephalographic waveforms (sleep spindles and K complexes), occupies about 50% of time spent sleep
    - **NREM Sleep Stage 3 (N3)**: slow wave sleep; deepest level of sleep
- **Sleep Continuity**: overall balance of sleep and wakefulness during night of sleep
    - **Sleep Latency**: amount of time required to fall asleep
    - **Wake After Asleep Onset**: amount of awake time between initial sleep onset and final awakening
    - Number of awakenings
    - **Sleep Efficiency**: ratio of actual time spent asleep to time spent in bed
- Sleep abnormalities are preceding signs of serious clinical depression
- **Major Categories**
    - **Dyssomnias**: involve difficulties in getting enough sleep, problems with sleeping when you want to, and complaints about the quality of sleep
    - **Parasomnias**: characterized by abnormal behavioral or physiological events that occur during sleep
- **Polysomnographic (PSG) Evaluation**: determines the clearest and most comprehensive picture of sleep habits; usually shows impairments of sleep continuity
    - **Electroencephalogram**: measures brain wave activity
    - **Electrooculogram**: measures eye movements
    - **Electromyogram**: measures muscle movements
    - **Electrocardiogram**: measures heart activity
    - **Actigraph**: records the number of arm movements; alternative to PSG
- **Sleep Efficiency (SE)**: percentage of time actually spent asleep

- Calculated by dividing the amount of time sleeping by the amount of time in bed
- SE of 100% would mean you fall asleep as soon as your head hits the pillow

INSOMNIA DISORDER

Insomnia Disorder – difficulty initiating and maintaining sleep

- Situational, persistent, or recurrent, episodic
- One of the most common sleep–wake disorders
- **Primary Insomnia**: sleep problems that are not related to other medical or psychiatric problems
- Different manifestations of insomnia can occur at different times of the sleep period
  - **Sleep Onset Insomnia (or initial insomnia)**: involves difficulty initiating sleep at bedtime
  - **Sleep Maintenance Insomnia (or middle insomnia)**: involves frequent or prolonged awakenings throughout the night
  - **Late Insomnia**: involves early-morning awakening with an inability to return to sleep
- Difficulty maintaining sleep is the most common single symptom of insomnia, followed by difficulty falling asleep
  - **Nonrestorative Sleep**: poor sleep quality that does not leave the individual rested upon awakening despite adequate duration
  - **Microsleeps**: sleep that last several seconds or longer; result of being awake for one or two nights
- Often associated with physiological and cognitive arousal and conditioning factors that interfere with sleep
- First episode is more common in young adulthood

Key Features

- Marked by dissatisfaction with sleep quality or quantity
- Symptoms **(at least 1)**
  - Difficulty initiating sleep (children may require caregiver presence)
  - Difficulty maintaining sleep (frequent awakenings or trouble returning to sleep)
  - Early-morning awakenings with inability to fall back asleep
- **Duration**
  - Occurs at least 3 nights per week
  - 3 months
- Occurs despite adequate opportunity to sleep

Specifers

- **Specify if (Comorbidity)**
  - **With non-sleep disorder mental comorbidity** (e.g., depression, anxiety, substance use disorders)
  - **With other medical comorbidity** (e.g., chronic pain, cardiovascular disease)
  - **With other sleep disorder** (e.g., sleep apnea, restless legs syndrome)
- **Specify if (Course Pattern)**
  - **Episodic**: Symptoms last at least 1 month but less than 3 months
  - **Persistent**: Symptoms last 3 months or longer
  - **Recurrent**: Two or more episodes occur within 1 year

HYPERSOMNOLENCE DISORDER

Hypersomnolence Disorder – excessive sleepiness despite having at least 7 hours of main sleep

- Hyper means “in great amount” or “abnormal excess”
- Take longer naps, have trouble waking from naps, and do not feel alert afterward
- Includes symptoms of excessive quantity of sleep, deteriorated quality of wakefulness, and sleep inertia
- **Sleep Inertia**: prolonged impairment of alertness at the sleep-wake transition
- They often snore loudly, pause between breaths, and wake in the morning with a dry mouth and headache
- Has a persistent course, with a progressive evolution in the severity of symptoms
- Has a progressive onset, with symptoms beginning between ages 15 and 25 years, with a gradual progression over weeks to months

Key Features

- Excessive sleepiness despite getting at least 7 hours of sleep
- Symptoms **(at least 1)**
  - Recurrent sleep episodes or lapses into sleep during the day
  - Prolonged main sleep episode (more than 9 hours) that is nonrestorative
  - Difficulty waking up fully after sudden awakening
- **Duration**
  - Occurs at least 3 times per week
  - 3 months
- Causes significant distress or impairment in functioning

NARCOLEPSY

Narcolepsy – irrepressible need to sleep

- Some people with narcolepsy experience **cataplexy**
  - Sudden loss of muscle tone
  - Occurs while the person is awake
  - Can range from slight weakness in the facial muscles to complete physical collapse
  - Appears to result from a sudden onset of REM sleep

- Evidence from polysomnography reveal that REM sleep latency is less than or equal to 15 mins

Key Features
- Repetitive periods of irrepressible need to sleep, lapsing into sleep, or napping occurring within the same day
- Symptoms **(at least 1)**
  - **Episodes of cataplexy**
    - **Long-standing cases**: brief, sudden bilateral loss of muscle tone triggered by laughter or joking, with preserved consciousness
    - **Early onset** (e.g., children or within 6 months of onset): spontaneous grimaces, jaw-opening with tongue thrusting, or generalized hypotonia, without clear emotional triggers
  - **Hypocretin deficiency**
    - CSF hypocretin-1 levels ≤ 110 pg/mL or ≤ 1/3 of normal levels
    - Not due to acute brain injury, infection, or inflammation
  - **Sleep study evidence**
    - REM sleep latency ≤ 15 minutes on nocturnal polysomnography
    - Mean sleep latency ≤ 8 minutes with ≥ 2 sleep-onset REM periods on multiple sleep latency testing (MSLT)
- **Duration**
  - Occurs at least 3 times per week
  - 3 months
- Causes significant distress or impairment in functioning

BREATHING-RELATED SLEEP DISORDERS

Breathing-Related Sleep Disorders – problems with breathing while asleep
- **Characteristics**
  - **Hypoventilation**: constricted and labored breathing
  - **Sleep Apnea**: individual stop breathing altogether
  - **Sleep Attacks**: episodes of falling asleep during the day
- **Types of Breathing-Related Sleep Disorders**
  - **Obstructive Sleep Apnea Hypopnea**
    - Occurs when airflow stops despite continued activity by the respiratory system
    - At least 4 obstructive apneas or hypopneas per hour of sleep
    - Evidence from polysomnography of 15 or more obstructive apneas and/or hypopneas per hour of sleep
    - **Apnea**: absence of airflow
    - **Hypopnea**: reduction in airflow
  - **Central Sleep Apnea**
    - Complete cessation of respiratory activity for brief periods
    - Often associated with certain central nervous system disorders
    - Evidence by polysomnography of 5 or more central apneas per hour of sleep
    - **Cheyne-Stokes Breathing**: an abnormal pattern of breathing characterized by progressively deeper, and sometimes faster, breathing followed by a gradual decrease that results in a temporary stop in breathing
  - **Sleep-Related Hypoventilation**
    - Decrease in airflow without a complete pause in breathing
    - Episodes of decreased respiration associated with elevated CO2 levels

OBSTRUCTIVE SLEEP APNEA HYPOPNEA

Key Features
- Repeated episodes of upper airway obstruction during sleep
- Symptoms **(either 1)**
  - **Nocturnal breathing disturbances**
    - Snoring
    - Snorting/gasping
    - Breathing pauses during sleep
  - **Daytime symptoms**
    - Excessive sleepiness
    - Fatigue
    - Unrefreshing sleep
- Despite adequate sleep opportunities
- Polysomnography shows 15 or more obstructive apneas and/or hypopneas per hour of sleep, regardless of symptoms

CENTRAL SLEEP APNEA

Key Features
- Repeated central apneas during sleep
- Polysomnography shows 5 or more central apneas per hour of sleep
- The disturbance is not better explained by another current sleep disorder
- Involves impaired respiratory effort during sleep and differs from obstructive forms by lacking airway blockage

Specifiers
- **Idiopathic Central Sleep Apnea**
  - Repeated apneas/hypopneas due to variability in respiratory effort
  - No evidence of airway obstruction
- **Cheyne-Stokes Breathing**
  - Crescendo-decrescendo breathing pattern in tidal volume
  - Associated with central apneas/hypopneas (≥5 per hour)

    - Often includes frequent arousals from sleep
- **Central Sleep Apnea Comorbid With Opioid Use**
    - Caused by opioid effects on the brain's respiratory rhythm centers
    - Involves altered response to oxygen (hypoxia) and carbon dioxide (hypercapnia) levels

SLEEP-RELATED HYPOVENTILATION

Key Features
- Decreased respiration during sleep, resulting in elevated CO_2 levels
- Polysomnography shows episodes of hypoventilation with elevated CO_2
- If CO_2 is not measured, persistent low oxygen saturation not linked to apneas/hypopneas may indicate hypoventilation
- Not better explained by another current sleep disorder

Specifiers
- **Idiopathic Hypoventilation**
    - No identifiable medical, neurological, or external cause
    - Hypoventilation occurs without explanation
- **Congenital Central Alveolar Hypoventilation**
    - Rare congenital disorder
    - Presents in perinatal period with shallow breathing, cyanosis, or apnea during sleep
- **Comorbid Sleep-Related Hypoventilation**
    - Due to underlying medical conditions such as:
        - Pulmonary disorders (e.g., COPD)
        - Neuromuscular diseases (e.g., ALS)
        - Chest wall abnormalities
        - Medications (e.g., opioids, sedatives)

CIRCADIAN RHYTHM SLEEP-WAKE DISORDERS

Circadian Rhythm Sleep-Wake Disorders – persistent or recurrent pattern of sleep disruption due to alteration of the circadian system or misalignment between the endogenous circadian rhythm
- Brought on by the brain's inability to synchronize its sleep patterns with the current patterns of day and night
- Leads to excessive sleepiness or insomnia, or both

Key Features
- Persistent or recurrent sleep disruption due to a misalignment between the internal circadian rhythm and external demands
- Caused by
    - Alteration in the circadian system or
    - Mismatch between the person's biological clock and required sleep-wake schedule
- Results in excessive sleepiness, insomnia, or both
- Leads to clinically significant distress or impairment in social, occupational, or other areas of functioning

NON-RAPID EYE MOVEMENT (NREM) SLEEP AROUSAL DISORDERS

NREM Sleep Arousal Disorders – repeated occurrence of incomplete arousals, usually beginning during the first third of the major sleep episode
- Characterized by incomplete awakening from sleep – sleepwalking or sleep terrors
- They cannot remember anything when they woke up
- Occur mostly in childhood and non-rem sleeps
- Produce rapid and complete awakening without confusion, amnesia, or motor activity

Key Features
- Persistent episodes of incomplete awakening from sleep, typically during the first third of the major sleep episode
- Accompanied **(at least 1)**
    - **Sleepwalking**
        - Repeated episodes of getting up and walking during sleep
        - Individual has a blank, staring face, is unresponsive, and hard to awaken
    - **Sleep Terrors**
        - Recurrent abrupt arousals from sleep with intense fear
        - Accompanied by signs of autonomic arousal: dilated pupils, rapid heartbeat, breathing, sweating
        - Minimal responsiveness to comfort during the episode
- No or minimal dream recall
- Amnesia follows after

NIGHTMARE DISORDER

Nightmare Disorder – typically lengthy, elaborate, story like sequences of dream imagery that seem real and that incite anxiety, fear, or other dysphoric emotions
- Repeated occurrences of extended, extremely dysphoric, and well-remembered dreams that usually involve efforts to avoid threats to survival, security, or physical integrity
- Upon awakening, they become oriented and alert
- Appear in children exposed to acute or chronic psychosocial stressors
- Occur during REM Sleep

Key Features
- Repeated, vivid, and extremely dysphoric dreams that cause distress

- Dreams typically occur during the second half of the major sleep episode (REM sleep)
- Upon awakening, the individual becomes quickly oriented and alert

RAPID EYE MOVEMENT (REM) SLEEP BEHAVIOR DISORDER

REM Sleep Behavior Disorder – repeated episodes of arousal during sleep associated with vocalization and/or complex motor behaviors

- Upon awakening, the individual is completely awake, alert, and not confused
- Often reflect motor responses to the content of action-filled or violent dreams of being attacked or trying to escape from a threatening situation (**dream enacting behaviors**)
- Onset may be gradual or rapid
- Course is usually progressive
- Overwhelmingly affects males older than 50 years

Key Features

- Repeated episodes of complex motor and/or vocal behaviors that occur
- Behaviors occur during REM sleep
  - Typically ≥90 minutes after sleep onset
  - More frequent in the second half of the night
  - Rare during daytime naps
  - Upon awakening, the individual is fully alert and oriented
- Additional Symptoms **(at least 1)**
  - REM sleep without atonia (muscle paralysis) observed via polysomnography
  - History consistent with REM sleep behavior disorder and diagnosis of a synucleinopathy

RESTLESS LEGS SYNDROME

Restless Legs Syndrome – urge to move the legs, usually accompanied or in response to uncomfortable and unpleasant sensations of the legs

- Occurs during rests
- Individuals experience sense of relief during the movement
- Often worse in the evenings

Key Features

- Urge to move the legs in response to uncomfortable sensations
  - Begins or worsens during periods of rest or inactivity
  - Partially or totally relieved by movement
  - Worse in the evening or at night, or only occurs at night
- **Duration**
  - Occur at least 3 times per week
  - 3 months

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