B.Sc PSYCHOLOGY

5th SEM CORE COURSE

UNIVERSITY OF CALICUT

PSY5B01-ABNORMAL PSYCHOLOGY - I

2019 ADMISSION

Prepared by

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COURSE CODE	**PSY5B01**
TITLE OF THE COURSE	**ABNORMAL PSYCHOLOGY - I**
SEMESTER IN WHICH THE COURSE TO BE TAUGHT	**5TH**
NO. OF CREDITS	**3**
NO. OF CONTACT HOURS	**48 (3hrs/week)**

Objectives of the course:

- **To enable students to understand the concepts of abnormal behaviour**
- **To develop awareness about different types of anxiety and stress disorders**
- **To encourage the students to know different techniques in management of anxiety and stress disorders**
- **Course Details**

MODULE NO.	NAME OF MODULE	MODULE HOURS
1	Basic Concepts	8hrs
2	Stress disorders and anxiety disorders	10hrs
3	Somatoform and dissociative disorder	16hrs
4	Personality disorders	14hrs

MODULE-1

Basic Concepts:

Mental disorder

- 1 in every 8 people in the world live with a mental disorder
- Mental disorders involve significant disturbances in thinking, emotional regulation, or behaviour
- There are many different types of mental disorders
- Effective prevention and treatment options exist
- Most people do not have access to effective care
- A mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour.
- It is usually associated with distress or impairment in important areas of functioning.
- There are many different types of mental disorders.
- Mental disorders may also be referred to as mental health conditions.
- The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm.
- This fact sheet focuses on mental disorders as described by the International Classification of Diseases 11th Revision (ICD-11).

Classification:

3 major classifications

1. ICD 10 (international statistical classification of disease and related health problems)-1992
2. DSM IV (diagnostic and statistical manual)-1994

3. Indian Classification

ICD 10 (international statistical classification of disease and related health problems)-1992

WHO'S classification

- It is for all diseases and related health problems
- The code system of classification, which is alphanumeric.
- A00-Z99
- FIRST published – 1994
- Replaced by ICD-11 on Jan 2022
- It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases
- A00-B99 - Certain infectious and parasitic diseases
- C00-D49 - Neoplasms
- D50-D89 -Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
- E00-E89 -Endocrine, nutritional and metabolic diseases
- F01-F99 -Mental, Behavioral and Neurodevelopmental disorders
- G00-G99 -Diseases of the nervous system
- H00-H59 -Diseases of the eye and adnexa
- H60-H95 -Diseases of the ear and mastoid process
- I00-I99 -Diseases of the circulatory system
- J00-J99 -Diseases of the respiratory system
- K00-K95 -Diseases of the digestive system
- L00-L99 -Diseases of the skin and subcutaneous tissue
- M00-M99 -Diseases of the musculoskeletal system and connective tissue

- N00-N99 -Diseases of the genitourinary system
- O00-O9A -Pregnancy, childbirth and the puerperium
- P00-P96 -Certain conditions originating in the perinatal period
- Q00-Q99 -Congenital malformations, deformations and chromosomal abnormalities
- R00-R99 -Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
- S00-T88 -Injury, poisoning and certain other consequences of external causes
- U00-U85 -Codes for special purposes
- V00-Y99 -External causes of morbidity
- Z00-Z99 -Factors influencing health status and contact with health services

Mental, Behavioral and Neurodevelopmental disorders

- F01-F09 -Mental disorders due to known physiological conditions
- F10-F19 -Mental and behavioral disorders due to psychoactive substance use
- F20-F29 -Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
- F30-F39 -Mood [affective] disorders
- F40-F48 -Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
- F50-F59 -Behavioral syndromes associated with physiological disturbances and physical factors
- F60-F69 -Disorders of adult personality and behavior
- F70-F79 -Intellectual disabilities
- F80-F89 -Pervasive and specific developmental disorders
- F90-F98 -Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- F99-F99 -Unspecified mental disorder

DSM IV (Diagnostic and Statistical Manual)-1994

- Classification by APA (American Psychiatric Association)
- Classification of mental disorder
- DSM IV is of Multiaxial system- 1944
- A mental disorder is a mental condition that
- (a) causes significant distress
- (b) is not merely an expectable response to a particular event
- (c) is a manifestation of a mental dysfunction

DSM HISTORY

- DSM-I – 102 categories of diagnoses
- DSM II – 182
- DSM III- 265
- DSM IV – 297
- DSM-III – Introduced multiaxial or multidimensional approach

5 multiaxial system

- Axis I and II make up of the entire classification which contains more than 300 specific disorder

DSM-IV-TR

The five axes of the DSM-IV-TR.

- **Axis I** Clinical syndromes. (*All mental disorders & criteria for rating them except personality disorders/mental retardation, also abuse/neglect*)
- **Axis II** Personality disorders, Mental retardation. (*Life long deeply ingrained, inflexible & maladaptive*)
- **Axis III** General medical condition. (*Any medical condition that could effect the patients mental state.*)
- **Axis IV** Psychosocial & environmental problems. (*Stressful events that have occurred within the previous year*)
- **Axis V** global assessment functioning. (*How well the patient performed during the previous year*)

DSM V

- No of significant changes made
- Roman numerals to Arabic numbers as DSM-5 , not as DSM-V
- It eliminated the multiaxial system
- Lists the categories of disorders along with the no of different related disorder. Eg- bipolar and other related disorder; OCD and other related disorder

Few other changes

- Asperger syndrome was eliminated as a diagnosis and instead incorporated under the category of autism spectrum disorder
- Disruptive mood dysregulation disorder was added , in part to decrease the over-diagnosis of childhood bipolar disorders.
- Several diagnoses were officially added to the manual , including binge eating disorder, hoarding disorder, and premenstrual dysphoric disorder(PMDD)
- Considered as an important tool
- Those who have received specialized training and possess sufficient experience are qualified to diagnose and treat mental illnesses.

Changes in DSM-5-TR

- Contains revised criteria for more than 70 disorder
- A new diagnosis called prolonged grief disorder
- New codes added, that will allow clinicians to document suicidal behavior and non-suicidal self-injury in patients that don't have another psychiatric diagnosis
- Uses more specific language to avoid reader confusion.

eg- "as manifested by all the following" TO "as manifested by all of the following".

"intellectual disability" TO Intellectual development disorder".

Used in DSM-5

- Desired gender
- Cross-sex medical procedure
- Natal male
- Natal female

Used in DSM-5-TR

- Experienced gender
- Gender affirming medical procedure
- Individual assigned male at birth
- Individual assigned female at birth

DSM-5-TR

- Aimed at reducing racial and cultural biases.
- Term race was replaced with racialized
- Term ethnoracial used to refer to categories like Hispanic, white and African American
- Term Latinx used instead of Latino
- also note show symptoms of certain conditions manifest differently in people from varying demographic groups

Indian classification

- Neki (1963), Wig & Singer (1967), Vahia (1961) & Varma (1971) have attempted some modification of ICD8 to suit Indian Conditions.
- A) Psychosis :

    1. Functional –Schizophrenia
    2. Affective – Mania & Depression
    3. Organic – Acute or Chronic

- B) Neurosis:

- ❖ Anxiety neurosis
- ❖ Depressive neurosis
- ❖ Hysterical Neurosis
- ❖ Obsessive- compulsive neurosis
- ❖ Phobic neurosis

- C) Special disorders:

- ❖ Childhood disorders
- ❖ Personality disorders
- ❖ Substance abuse
- ❖ Psycho physiological disorders
- ❖ Mental retardation

Historical views of abnormal behavior

- People have tried to explain and control abnormal behavior for thousands of years.
- Historically, there have been three main approaches to abnormal behavior: the supernatural, biological, and psychological traditions

Paradigms

- Abnormal psychology revolves around two major paradigms for explaining mental disorders, the psychological paradigm and the biological paradigm.
- The psychological paradigm focuses more on the humanistic, cognitive, and behavioral causes and effects of psychopathology.
- The biological paradigm includes theories that focus more on physical factors, such as genetics and neurochemistry.

Three main approaches

- Super natural
- Biological

- psychological

Historical Eras

1. Stone Age / Pre Historical Age
2. Greek and Rome Civilization
3. Middle Age
4. 17th, 18th and 19th Century
5. Modern Era / 21st Century

1. Super natural Model (Demonology, Gods, and Magic)

- abnormal behavior in early writings show that the Ancient Chinese, Ancient Egyptians, Ancient Hebrews, and Ancient Greeks often attributed such behavior to a demon, Spirits or god who had taken possession of a person.
- 'possession' – might be good spirits or evil spirits , which is depended on individual syptoms

Good spirit or bad spirit

- If a person's speech or behavior appeared to have a religious or mystical significance, it was usually thought that he or she was possessed by a good spirit or god..
- Such people were often treated with considerable awe and respect, for it was thought that they had supernatural powers
- Most possessions, however, were considered to be the work of an angry god or an evil spirit, particularly when a person became excited or overactive and engaged in behavior contrary to religious teachings.

Treatment for demonic possession

- Primary type- Trephining and Exorcism
- which included various techniques for casting an evil spirit out of an afflicted person
- Techniques include magic, prayer, noisemaking etc

- Excorism: Exorcism is one of the ancient methods for release evil spirits from patient's body. Exorcism was originally the task of healers or persons regarded as having healing powers.
- Trephining – making circular holes in the skull with stone tools.
- "Trephining" was a performed on those who had mental illness to literally cut the evil spirits out of the victims body.
- This historical period – human skull have been found , with a area removed by a method of surgery.

Demonological method

- Is the super natural tradition
- Behaviour is sttributed to the agent outside human bodies
- Acc/ to this model abnormal behaviors are caused by demons, spirits or the influence of planets.

2. Biological Model (Somatogenic) / Hippocrates, Early Medical Concept)

- Hippocrates denied that gods and demons intervened in the development of illnesses and insisted that mental disorders had natural causes and required treatments like other diseases.
- He believed that the brain was the central organ of intellectual activity and that mental disorders were due to brain pathology.
- He also emphasized the importance of heredity and predisposition and pointed out that injuries to the head could cause sensory and motor disorders.
- Hippocrates classified all mental disorder into three general categories

Three general categories

- mania,
- melancholia,
- phrenitis (brain fever)

Treatment

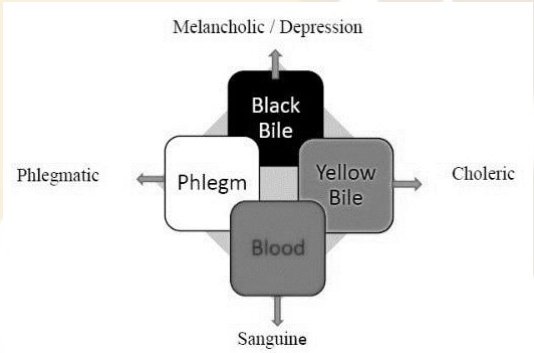
- Melancholia - a regular and tranquil life, sobriety and abstinence from all excesses, a vegetable diet, celibacy, exercise short of and bleeding if indicated.

Hippocrates had little knowledge of physiology.

- He believed that hysteria (the appearance of physical illness in the absence of organic pathology) was restricted to women and was caused by the uterus wandering to various parts of the body, pining for children .
- for this "disease", Hippocrates recommended marriage as the best remedy.

Hippocrates 4 bodily fluids of humors

- blood, black bile, yellow bile, and phlegm.



Greek and Roman Thought

- Hippocrates' work was continued by some of the later Greek and Roman physicians.
- Pleasant surroundings were considered of great therapeutic value for mental patients, who were provided with constant activities, including parties, dances, walks in the temple gardens, rowing along the Nile, and musical concerts.

Galen (A.D 130-200)

- One of the most influential Greek physicians was Galen, who practices in Rome.
- He made a new theory as "the humoral theory of abnormal behavior" it was based Hippocrates believes and after that Galan also believed abnormal behaviors are based on these four humor.
- Galan made a Number of original contributions the anatomy of the nervous system.

- Galen also maintained a scientific approach to the field, dividing the causes of psychological disorders into physical and mental categories.
- Among the causes he named were injuries to the head, alcoholic excess, shock, fear, adolescence, menstrual changes, economic reverses, and disappointment in love.
- Roman physicians wanted to make their patients comfortable and thus used pleasant physical Therapies, such as warm baths and massages.
- They also followed the principle of *contraries* (opposite by opposite) – for example, having their patients chilled wine they were in a warm tub.
- "Dark Ages" in the history of abnormal psychology began much earlier, with Galen's death in A. D. 200.
- The contributions of Hippocrates and the later Greek and Roman physicians were soon lost in the welter of popular superstition.

VIEWS OF ABNORMALITY DURING THE MIDDLE AGES

- the more scientific aspects of Greek medicine survived in the Islamic Countries of the Middle East.
- The first mental hospital was established in Baghdad in A. D 792; it was soon followed by others in Damascus and Aleppo (Polvan, 1969).
- In these hospitals, the mentally disturbed individuals received humane treatment.
- The outstanding figure in Islamic medicine was Avicenna from Arabia (c. 980-1037), called the "prince of physicians" (Campbell, 1926) and author of *The Canon of Medicine*, perhaps the most widely studied medical work ever written.
- In his writings, Avicenna frequently referred to hysteria, epilepsy, manic reactions, and melancholia.

Middle Ages in Europe (c. 500- 1500)

- scientific inquiry into abnormal behavior was limited, and the treatment of psychologically disturbed individuals was more often characterized by ritual or superstition than by attempts to understand an individual's condition.
- Mental disorders were quite prevalent throughout the middle Ages in Europe.

- During this time, supernatural explanations of the causes of mental illness grew in popularity.

last half of the middle Ages in Europe

- a peculiar trend emerged in efforts to understand abnormal behavior.
- It involved mass madness- the widespread occurrence of group behavior disorders that were apparently cases of hysteria.
- Whole groups of people were affected simultaneously.
- Dancing Manias (epidemics of raving, jumping, dancing, and convulsions) were reported as early as the tenth century.
- One such episode, occurring in Italy early in the thirteenth century was known as tarantism. This dancing mania later spread to Germany and the rest of Europe, where it was known as Saint Vitus's dance.
- Lycanthropy- a condition in which people believed themselves to be possessed by wolves and imitated their behavior. (in rural areas)
- Exorcism and Witchcraft - In the middle Ages in Europe, management of the mentally disturbed was left largely to the clergy.
- During the early part of the medieval period, the mentally disturbed were, for the most part, treated with considerable kindness.
- "Treatment" consisted of prayer, holy water, sanctified ointments, the breath or spittle of the priests, the touching of relics, visits to holy places, and mild forms of exorcism.

latter part of the Middle Ages and the early Renaissance

- TOWARD HUMANITARIAN APPROACHES
- scientific questioning Reemerged and a movement emphasizing the importance of specifically human interests and concerns began-a movement (still with us today) that can be loosely referred to as humanism.

The Resurgence of Scientific Questioning in Europe

- Paracelsus, a Swiss physician (1490-1541), was an early critic of superstitious beliefs about possession. He insisted that the dancing mania was not a possession but a form of disease, and that it should be treated as such. Although Paracelsus rejected demonology, his view of abnormal

During the sixteenth century

- Teresa of Avila (1515-1582) a Spanish nun who was later canonized, made an extraordinary conceptual leap that has influenced thinking to the present day.
- Teresa, in charge of a group of cloistered nuns who had become hysterical and were therefore in danger from the Spanish Inquisition, argued convincingly that her nuns were not possessed but rather were " as if sick" (*comas enfermas)*.
- Apparently, she did not mean that they were sick of body. Rather, in the expression 'as if," we have what is perhaps the first suggestion that a mind can be ill just as a body can be ill?
- Johann Weyer (1515-1588), a German physician and writer who wrote under the Latin name of Joannus Wirus, was so deeply disturbed by the imprisonment, torture, and burning of people accused of witchcraft that he made a careful study of the entire problem.
- About 1563 he published a book, *The Deception of Demons,* which contains a step- by-step rebuttal of the *Malleus Malefic arum*, a witch-hunting handbook published in 1486 for use in recognizing and dealing with those suspected of being witches.
- Weyer was one of the first physicians to specialize in mental disorders.

Establishment of Early Asylums and Shrines

- From the sixteenth century on, special institutions called **asylums**, meant solely for the care of the mentally ill grew in number.
- Although the scientific inquiry into understanding abnormal behavior was on the increase, most early asylums, often referred to as madhouses, were not pleasant places or storage places for the insane.

- These early asylums were primarily modifications of penal institutions, and the inmates were treated more like beasts than like human beings

Humanitarian Reform

- The humanitarian treatment of patients received great impetus from the work of Philippe Pinel (1745-1826) in France.

Pinel's Experiment

- Reformer in the treatment and care of the mentally
- In 1792, shortly after the first phase of the French Revolution, Pinel was placed in charge of LaBicetre in Paris.
- he received the grudging permission of the Revolutionary Commune to remove the chains from some of the inmates as an experiment to test
- his views that mental patients should be treated with kindness and consideration-as sick people, not as vicious beasts or criminals.
- Had his experiment proved a failure, Pinel might have lost his head, but fortunately, it was a great success.
- Chains were removed
- sunny rooms were provided; patients were permitted to exercise on the hospital grounds
- kindness was extended to these poor beings, some of whom had been chained in dungeons for 30 years or more.
- Jean Esquirol (1772- 1840), continued Pinel's good work at La Salpetriere
- in addition, helped establish ten new mental hospitals.

William Tuke (1732-1822)

- At about the same time that Pinel was reforming La Bicetre, an English Quaker named William Tuke (1732-1822) established the York Retreat, a pleasant county house where mental patients lived, worked, and rested in a kindly religious atmosphere.

The success of Pinel's and Tuke's humanitarian experiments

- treatment of mental patients throughout the Western world

- In the United States, this revolution was reflected in the work of **Benjamin Rush(1745-1813),**
- the founder of American psychiatry,
- Rush encouraged more humane treatment of the mentally ill; wrote the first systematic treatise on psychiatry in America, *Medical Inquiries and Observations upon the Diseases of the Mind (1812);*
- *was the first American to organize a course in Psychiatry.*

period of humanitarian reform

- During the early part of this period of humanitarian reform, the use of **moral management**– a wide-ranging method of treatment that focused on a patient's social, individual, and occupational needs-became relatively widespread.

Dorathea Dix and the Mental Hygiene Movement

- Dorothea Dix (1809-1887) was an energetic New England school teacher who became a champion of poor and "forgotten" people in prisons and mental institutions for decades during the nineteenth century.

Nineteenth-Century Views of the Causes and Treatment of Mental Disorders

- early part of the nineteenth century, mental hospitals were controlled essentially by lay persons because of the prominence of moral management in the treatment of "lunatics" (mentally ill).
- Effective treatments for mental disorders were unavailable, however, during the latter part of the century, alienists gained control of the insane asylums and incorporated the traditional moral management therapy into their other rudimentary physical-medical procedures.

Changing Attitudes toward Mental Health in the Early Twentieth Century

- In America, the pioneering work of Dix was followed by that of Clifford Beers (1876-1943), whose book *A Mind That Found Itself was published in* 1908.

THE BEGINNING OF THE MODERN ERA

- **Brain Pathology as a Causal Factor**

- **The Beginnings of a Classification System**
- **Establishing the Psychological Basis of Mental Disorder**

Brain Pathology as a Causal Factor

- With the emergence of modern experimental science in the early part of the eighteenth century, knowledge of anatomy, physiology, neurology, chemistry, and general medicine increased rapidly.
- These advances led to the gradual identification of the biological, or organic, pathology underlying many physical ailments Scientists began to focus on diseased body organs as the cause of physical ailments.
- It was only another step for these researchers to assume that mental disorder was an illness based on the pathology of an organ-in this case, the brain.

The Beginnings of a Classification System

- Emil Kraepelin (1856-1926) played a dominant role in the early development of the biological viewpoint.
- The most important of these contributions was his system of classification of mental disorders, which became the forerunner of today's DSM-V.

Establishing the Psychological Basis of Mental Disorder

- **psychoanalytic perspective:** The methods used to study and treat patients came to be called **psychoanalysis.**
- taken by Sigmund Freud (1856- 1939)
- Freud developed a comprehensive theory of psychopathology that emphasized the inner dynamics of unconscious motives (often referred to as *psychodynamics*) that are at the heart of the **psychoanalytic perspective.**
- **Mesmerism**
- Franz Anton Mesmer (1734-1815), an Austrian physician who further developed Paracelsus' ideas about the influence of the planets on the human body.

- Mesmer believed that the planets affected a universal magnetic fluid in the body, the distribution of which determined health or disease
- Mesmer concluded that all people possessed magnetic forces that could be used to influence the distribution of the magnetic fluid in other people, thus effecting cures.
- Historical views of abnormal behaviour- Demonology gods and magic: the Chinese, Egyptians, Hebrews and Greeks often contributed such behaviour to a demon or god who had taken possession
- causal factors- Biological psychosocial and socio cultural

Module2: Stress disorders and anxiety disorders

- Stress and stressors- Stress can be defined as **any type of change that causes physical, emotional or psychological strain**.
- Stressor-something that causes a state of strain or tension.
- Coping strategies- There are many different conceptualizations of coping strategies, but the five general types of coping strategies are **problem-focused coping, emotion-focused coping, social support, religious coping, and meaning making**
- stress disorders: Adjustment disorder-Post traumatic stress disorder
- Adjustment disorder- An adjustment disorder is an emotional or behavioral reaction to a stressful event or change in a person's life.
- diagnosis of adjustment disorders, the DSM-5 lists these criteria:
    - Having emotional or behavioral symptoms within three months of a specific stressor occurring in your life
    - Experiencing more stress than would normally be expected in response to a stressful life event and/or having stress that causes significant problems in your relationships, at work or at school
    - Symptoms are not the result of another mental health disorder or part of normal grieving
- ypes of adjustment disorders
- The DSM-5 lists six different types of adjustment disorders. Although they're all related, each type has unique signs and symptoms. Adjustment disorders can be:
    - With depressed mood. Symptoms mainly include feeling sad, tearful and hopeless and experiencing a lack of pleasure in the things you used to enjoy.
    - With anxiety. Symptoms mainly include nervousness, worry, difficulty concentrating or remembering things, and feeling overwhelmed. Children who have an adjustment disorder with anxiety may strongly fear being separated from their parents and loved ones.
    - With mixed anxiety and depressed mood. Symptoms include a combination of depression and anxiety.
    - With disturbance of conduct. Symptoms mainly involve behavioral problems, such as fighting or reckless driving. Youths may skip school or vandalize property.

- With mixed disturbance of emotions and conduct. Symptoms include a mix of depression and anxiety as well as behavioral problems.
- Unspecified. Symptoms don't fit the other types of adjustment disorders, but often include physical problems, problems with family or friends, or work or school problems.

- How long you have signs and symptoms of an adjustment disorder also can vary. Adjustment disorders can be:
  - Acute. Signs and symptoms last six months or less. They should ease once the stressor is removed.
  - Persistent (chronic). Signs and symptoms last more than six months. They continue to bother you and disrupt your life.
- Treatment – Psychotherapy , Medication.
- Causal factors- psychosocial , biological factors.
- Post traumatic stress disorder- Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event — either experiencing it or witnessing it.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

    1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

    2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

    1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

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

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

- Specify whether:

- **With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

- Post-traumatic stress disorder treatment can help you regain a sense of control over your life. The primary treatment is psychotherapy, but can also include medication. Combining these treatments can help improve your symptoms by:
    - Teaching you skills to address your symptoms
    - Helping you think better about yourself, others and the world
    - Learning ways to cope if any symptoms arise again
    - Treating other problems often related to traumatic experiences, such as depression, anxiety, or misuse of alcohol or drugs

You don't have to try to handle the burden of PTSD on your own.

- Psychotherapy

  Several types of psychotherapy, also called talk therapy, may be used to treat children and adults with PTSD. Some types of psychotherapy used in PTSD treatment include:

    - **Cognitive therapy.** This type of talk therapy helps you recognize the ways of thinking (cognitive patterns) that are keeping you stuck — for example, negative beliefs about yourself and the risk of traumatic things happening again. For PTSD, cognitive therapy often is used along with exposure therapy.

- **Exposure therapy.** This behavioral therapy helps you safely face both situations and memories that you find frightening so that you can learn to cope with them effectively. Exposure therapy can be particularly helpful for flashbacks and nightmares. One approach uses virtual reality programs that allow you to re-enter the setting in which you experienced trauma.
- **Eye movement desensitization and reprocessing (EMDR).** EMDR combines exposure therapy with a series of guided eye movements that help you process traumatic memories and change how you react to them.

- Your therapist can help you develop stress management skills to help you better handle stressful situations and cope with stress in your life.
- All these approaches can help you gain control of lasting fear after a traumatic event. You and your mental health professional can discuss what type of therapy or combination of therapies may best meet your needs.
- You may try individual therapy, group therapy or both. Group therapy can offer a way to connect with others going through similar experiences.

Medications

Several types of medications can help improve symptoms of PTSD:

- Treatment
- Post-traumatic stress disorder treatment can help you regain a sense of control over your life. The primary treatment is psychotherapy, but can also include medication. Combining these treatments can help improve your symptoms by:
- Teaching you skills to address your symptoms
- Helping you think better about yourself, others and the world
- Learning ways to cope if any symptoms arise again
- Treating other problems often related to traumatic experiences, such as depression, anxiety, or misuse of alcohol or drugs
- You don't have to try to handle the burden of PTSD on your own.
  Psychotherapy
- Several types of psychotherapy, also called talk therapy, may be used to treat children and adults with PTSD. Some types of psychotherapy used in PTSD treatment include:

Cognitive therapy. This type of talk therapy helps you recognize the ways of thinking (cognitive patterns) that are keeping you stuck — for example, negative beliefs about yourself and the risk of traumatic things happening again. For PTSD, cognitive therapy often is used along with exposure therapy.

- Exposure therapy. This behavioral therapy helps you safely face both situations and memories that you find frightening so that you can learn to cope with them effectively.
- Exposure therapy can be particularly helpful for flashbacks and nightmares. One approach uses virtual reality programs that allow you to re-enter the setting in which you experienced trauma.
- Eye movement desensitization and reprocessing (EMDR). EMDR combines exposure therapy with a series of guided eye movements that help you process traumatic memories and change how you react to them.
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- All these approaches can help you gain control of lasting fear after a traumatic event. You and your mental health professional can discuss what type of therapy or combination of therapies may best meet your needs.
- You may try individual therapy, group therapy or both. Group therapy can offer a way to connect with others going through similar experiences.

Medications

- Several types of medications can help improve symptoms of PTSD:
- Antidepressants. These medications can help symptoms of depression and anxiety.
- They can also help improve sleep problems and concentration. The selective serotonin reuptake inhibitor (SSRI) medications sertraline (Zoloft) and paroxetine (Paxil) are approved by the Food and Drug Administration (FDA) for PTSD treatment.
- Anti-anxiety medications. These drugs can relieve severe anxiety and related problems. Some anti-anxiety medications have the potential for abuse, so they are generally used only for a short time.
- Prazosin. While several studies indicated that prazosin (Minipress) may reduce or suppress nightmares in some people with PTSD, a more recent study showed no benefit over placebo. But participants in the recent study differed from others in ways that potentially could impact the results. Individuals who are considering prazosin should

speak with a doctor to determine whether their particular situation might merit a trial of this drug.

- Causal factors- psychosocial , biological factors.
- Anxiety disorder: specific phobia, social phobias, Generalized Anxiety disorders, obsessive-compulsive disorder. Causal factors
- There are several types of anxiety disorders, including generalized anxiety disorder, panic disorder, specific phobias, agoraphobia, social anxiety disorder and separation anxiety disorder.
- There are several types of anxiety disorders, including generalized anxiety disorder, panic disorder, specific phobias, agoraphobia, social anxiety disorder and separation anxiety disorder.
- A specific phobia involves an intense, persistent fear of a specific object or situation that's out of proportion to the actual risk. There are many types of phobias, and it's not unusual to experience a specific phobia about more than one object or situation
  - Fear and phobia may present similarly at first glance, but the latter is often much more intense and disruptive. There are five main types of specific phobia:
  - Animals, such as snakes, dogs, spiders, etc.
  - Natural environment, such as lightning, storms, tornadoes
  - Blood-injection-injury, such as receiving a shot or blood test, seeing blood, or going to the dentist
  - Situational, such as fear of public speaking or being in small spaces
  - Other, which are fears that do not fit into the other categories, such as fear of colors or fear of small things
- The DSM-5 outlines the following criteria to make a diagnosis of phobia:
- Marked fear or anxiety about a specific object or situation.
- The phobic object or situation almost always provokes immediate fear or anxiety.
- The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
- The phobic object or situation is actively avoided or endured with intense fear or anxiety.
- The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

- The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms; objects or situations related to obsessions; reminders of traumatic events; separation from home or attachment figures; or social situations.
- Phobia treatment- exposure therapy for phobias, systematic desensitization, medication etc.
- Causal factors- psychosocial factors, biological factors
- Specific phobias- Marked fear or anxiety about a specific object or situation. **Experiencing a frightening traumatic event, such as being trapped in an elevator or attacked by an animal**, may trigger the development of a specific phobia
- Social phobia- With social phobia, a person's fears and concerns are focused on their social performance, Social anxiety disorder, also called social phobia, is **a long-term and overwhelming fear of social situations.**
- Treatment for phobias- Psychotherapy. Talking with a mental health professional can help you manage your specific phobia. **Exposure therapy and cognitive behavioral therapy** are the most effective treatments. Exposure therapy focuses on changing your response to the object or situation that you fear.
- Talking with a mental health professional can help you manage your specific phobia. **Exposure therapy and cognitive behavioral therapy** are the most effective treatments. Exposure therapy focuses on changing your response to the object or situation that you fear.
- For Social phobia- cognitive behavioural therapy, medication , psychotherapy etc.
- Causal factors- psychosocial factors, biological factors
- Generalized anxiety disorder- Generalized anxiety disorder symptoms can vary. They may include: Persistent worrying or anxiety about a number of areas that are out of proportion to the impact of the events. Overthinking plans and solutions to all possible worst-case outcomes

Criteria

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry

C. The anxiety and worry are associated with three or more of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).

1. Restlessness or feeling keyed up or on edge
2. Being easily fatigued
3. Difficulty concentrating or mind going blank
4. Irritability
5. Muscle tension
6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

D. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder)

E. The focus of the anxiety and worry is not confined to features of an Axis I disorder (e.g., the anxiety or worry is not about having a panic attack [as in panic disorder], being embarrassed in public [as in social phobia], being contaminated [as in obsessive-compulsive disorder] being away from home or close relatives [as in separation anxiety disorder], gaining weight [as in anorexia Nervosa], or having a serious illness [as in hypochondriasis]), and the anxiety and worry do not occur exclusively during posttraumatic stress disorder

F. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

- Treatment: medications, CBT
- Causal factors- biological and psychosocial factors

- Obsessive compulsive disorder- Obsessive-compulsive disorder (OCD) is a mental illness that causes repeated unwanted thoughts or sensations (obsessions) or the urge to do something over and over again (compulsions).
- OCD types- Checking, such as locks, alarm systems, ovens, or light switches, or thinking you have a medical condition like pregnancy or schizophrenia
- Contamination, a fear of things that might be dirty or a compulsion to clean. Mental contamination involves feeling like you've been treated like dirt.
- Symmetry and ordering, the need to have things lined up in a certain way
- Ruminations and intrusive thoughts, an obsession with a line of thought. Some of these thoughts might be violent or disturbing.
- OCD causes and risk factors- Checking, such as locks, alarm systems, ovens, or light switches, or thinking you have a medical condition like pregnancy or schizophrenia
- Contamination, a fear of things that might be dirty or a compulsion to clean. Mental contamination involves feeling like you've been treated like dirt.
- Symmetry and ordering, the need to have things lined up in a certain way
- Ruminations and intrusive thoughts, an obsession with a line of thought. Some of these thoughts might be violent or disturbing.
- Treatment- psychotherapy, relaxation, medication etc.

Module 3: Somatoform and dissociative disorder

- The somatoform disorders are a group of psychiatric disorders in which patients present with a myriad of clinically significant but unexplained physical symptoms.
- A new category has therefore been created under the heading '*Somatic Symptom and Related Disorders*'. This includes diagnoses of *Somatic Symptom Disorder*, *Illness Anxiety Disorder*, *Conversion Disorder*, *Factitious Disorder*, and a variety of other related conditions. The term '*Hypochondriasis*' is no longer included. In two of the conditions the absence of any medical pathophysiology is a criteria for diagnosis; these are *Conversion Disorder* and *Other Specified Somatic Symptom and Related Disorder* (which includes *Pseudocyesis*, a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy).
- Somatic Symptom Disorders: emphasises diagnosis made on the basis of positive symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviours in response to these symptoms) rather than the absence of a medical explanation for somatic symptoms. A distinctive characteristic of many individuals with somatic symptom disorders is not the somatic symptoms per se, but instead the way they present and interpret them.'
- The diagnostic criteria for Somatic Symptom Disorder noted in DSM 5 are:

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

- Specify if: With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

- Specify if: Persistent: a persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).
- Specify if: Mild: Only one of the symptoms specified in Criterion B is fulfilled.
- Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.
- Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).
- Hypochondriasis: Hypochondriasis or hypochondria is a condition in which a person is excessively and unduly worried about having a serious illness.

DSM-5 - Illness Anxiety Disorder

A. Preoccupation with having or acquiring a serious illness.
B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

- Specify whether: Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used. Care-avoidant type: Medical care is rarely used.
- Somatization Disorder: Somatic symptom disorder is characterized by an extreme focus on physical symptoms — such as pain or fatigue — that causes major emotional distress and problems functioning. You may or may not have another diagnosed medical

condition associated with these symptoms, but your reaction to the symptoms is not normal

A. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
    1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
    2. Persistently high level of anxiety about health or symptoms.
    3. Excessive time and energy devoted to these symptoms or health concerns.

B. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

C. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

- Specify if:With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.
- Specify if: Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).
- Specify current severity:
- Mild: Only one of the symptoms specified in Criterion B is fulfilled.
- Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.
- Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).
- Pain Disorder: Pain disorder is chronic pain experienced by a patient in one or more areas, and is thought to be caused by psychological stress. The pain is often so severe that it disables the patient from proper functioning. Duration may be as short as a few days or as long as many years.
- Conversion Disorder: Conversion disorder is a mental condition in which a person has blindness, paralysis, or other nervous system (neurologic) symptoms that cannot be explained by medical evaluation.
- Dissociative Disorders: Dissociative disorders are mental disorders that involve experiencing a disconnection and lack of continuity between thoughts, memories, surroundings, actions and identity. People with dissociative disorders escape reality in

ways that are involuntary and unhealthy and cause problems with functioning in everyday life.

- Symptoms: Signs and symptoms depend on the type of dissociative disorders you have, but may include:
- Memory loss (amnesia) of certain time periods, events, people and personal information
- A sense of being detached from yourself and your emotions
- A perception of the people and things around you as distorted and unreal
- A blurred sense of identity
- Significant stress or problems in your relationships, work or other important areas of your life
- Inability to cope well with emotional or professional stress
- Mental health problems, such as depression, anxiety, and suicidal thoughts and behaviors
- Dissociative Amnesia : The main symptom is memory loss that's more severe than normal forgetfulness and that can't be explained by a medical condition. You can't recall information about yourself or events and people in your life, especially from a traumatic time. Dissociative amnesia can be specific to events in a certain time, such as intense combat, or more rarely, can involve complete loss of memory about yourself. It may sometimes involve travel or confused wandering away from your life (dissociative fugue). An episode of amnesia usually occurs suddenly and may last minutes, hours, or rarely, months or years.
- Dissociative Identity Disorder (DID): Formerly known as multiple personality disorder, this disorder is characterized by "switching" to alternate identities. You may feel the presence of two or more people talking or living inside your head, and you may feel as though you're possessed by other identities. Each identity may have a unique name, personal history and characteristics, including obvious differences in voice, gender, mannerisms and even such physical qualities as the need for eyeglasses. There also are differences in how familiar each identity is with the others. People with dissociative identity disorder typically also have dissociative amnesia and often have dissociative fugue.
- Depersonalization/ Derealization Disorder: This involves an ongoing or episodic sense of detachment or being outside yourself — observing your actions, feelings, thoughts and self from a distance as though watching a movie (depersonalization). Other people

and things around you may feel detached and foggy or dreamlike, time may be slowed down or sped up, and the world may seem unreal (derealization). You may experience depersonalization, derealization or both. Symptoms, which can be profoundly distressing, may last only a few moments or come and go over many years.

- Dissociative Fugue: A dissociative fugue is a temporary state where a person has memory loss (amnesia) and ends up in an unexpected place. People with this symptom can't remember who they are or details about their past. Other names for this include a "fugue" or a "fugue state."

Module 4: Personality disorders

- A personality disorder is a type of mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving. A person with a personality disorder has trouble perceiving and relating to situations and people. This causes significant problems and limitations in relationships, social activities, work and school.
- Types of personality disorders are grouped into three clusters, based on similar characteristics and symptoms. Many people with one personality disorder also have signs and symptoms of at least one additional personality disorder. It's not necessary to exhibit all the signs and symptoms listed for a disorder to be diagnosed.
- **Cluster A Personality Disorders-** Cluster A personality disorders are characterized by odd, eccentric thinking or behavior. They include paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder.
- **Paranoid Personality Disorder**
  - Pervasive distrust and suspicion of others and their motives
  - Unjustified belief that others are trying to harm or deceive you
  - Unjustified suspicion of the loyalty or trustworthiness of others
  - Hesitancy to confide in others due to unreasonable fear that others will use the information against you
  - Perception of innocent remarks or nonthreatening situations as personal insults or attacks
  - Angry or hostile reaction to perceived slights or insults
  - Tendency to hold grudges
  - Unjustified, recurrent suspicion that spouse or sexual partner is unfaithful
- **Schizoid Personality Disorder**
  - Lack of interest in social or personal relationships, preferring to be alone
  - Limited range of emotional expression
  - Inability to take pleasure in most activities
  - Inability to pick up normal social cues
  - Appearance of being cold or indifferent to others
  - Little or no interest in having sex with another person
- **Schizotypal Personality Disorder**
  - Peculiar dress, thinking, beliefs, speech or behavior
  - Odd perceptual experiences, such as hearing a voice whisper your name

- Flat emotions or inappropriate emotional responses
- Social anxiety and a lack of or discomfort with close relationships
- Indifferent, inappropriate or suspicious response to others
- "Magical thinking" — believing you can influence people and events with your thoughts
- Belief that certain casual incidents or events have hidden messages meant only for you

- **Cluster B Personality Disorders**- Cluster B personality disorders are characterized by dramatic, overly emotional or unpredictable thinking or behavior. They include antisocial personality disorder, borderline personality disorder, histrionic personality disorder and narcissistic personality disorder.

- **Histrionic Personality Disorder**
  - Constantly seeking attention
  - Excessively emotional, dramatic or sexually provocative to gain attention
  - Speaks dramatically with strong opinions, but few facts or details to back them up
  - Easily influenced by others
  - Shallow, rapidly changing emotions
  - Excessive concern with physical appearance
  - Thinks relationships with others are closer than they really are
- **Narcissistic Personality Disorder**
  - Belief that you're special and more important than others
  - Fantasies about power, success and attractiveness
  - Failure to recognize others' needs and feelings
  - Exaggeration of achievements or talents
  - Expectation of constant praise and admiration
  - Arrogance
  - Unreasonable expectations of favors and advantages, often taking advantage of others
  - Envy of others or belief that others envy you
- **Antisocial Personality Disorder**
  - Disregard for others' needs or feelings
  - Persistent lying, stealing, using aliases, conning others
  - Recurring problems with the law
  - Repeated violation of the rights of others
  - Aggressive, often violent behavior

- Disregard for the safety of self or others
- Impulsive behavior
- Consistently irresponsible
- Lack of remorse for behavior

- **Borderline Personality Disorder.**
- Impulsive and risky behavior, such as having unsafe sex, gambling or binge eating
- Unstable or fragile self-image
- Unstable and intense relationships
- Up and down moods, often as a reaction to interpersonal stress
- Suicidal behavior or threats of self-injury
- Intense fear of being alone or abandoned
- Ongoing feelings of emptiness
- Frequent, intense displays of anger
- Stress-related paranoia that comes and goes

- **Cluster C Personality Disorders –** Cluster C personality disorders are characterized by anxious, fearful thinking or behavior. They include avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder.

- **Avoidant Personality Disorder**
- Too sensitive to criticism or rejection
- Feeling inadequate, inferior or unattractive
- Avoidance of work activities that require interpersonal contact
- Socially inhibited, timid and isolated, avoiding new activities or meeting strangers
- Extreme shyness in social situations and personal relationships
- Fear of disapproval, embarrassment or ridicule

- **Dependent Personality Disorder**
- Excessive dependence on others and feeling the need to be taken care of
- Submissive or clingy behavior toward others
- Fear of having to provide self-care or fend for yourself if left alone
- Lack of self-confidence, requiring excessive advice and reassurance from others to make even small decisions
- Difficulty starting or doing projects on your own due to lack of self-confidence
- Difficulty disagreeing with others, fearing disapproval
- Tolerance of poor or abusive treatment, even when other options are available

- Urgent need to start a new relationship when a close one has ended

- **Obsessive-Compulsive Personality Disorder**
- Preoccupation with details, orderliness and rules
- Extreme perfectionism, resulting in dysfunction and distress when perfection is not achieved, such as feeling unable to finish a project because you don't meet your own strict standards
- Desire to be in control of people, tasks and situations, and inability to delegate tasks
- Neglect of friends and enjoyable activities because of excessive commitment to work or a project
- Inability to discard broken or worthless objects
- Rigid and stubborn
- Inflexible about morality, ethics or values
- Tight, miserly control over budgeting and spending money
- Obsessive-compulsive personality disorder is not the same as obsessive-compulsive disorder, a type of anxiety disorder.

Causal Factors

- Personality is the combination of thoughts, emotions and behaviors that makes you unique. It's the way you view, understand and relate to the outside world, as well as how you see yourself. Personality forms during childhood, shaped through an interaction of:
- Your genes. Certain personality traits may be passed on to you by your parents through inherited genes. These traits are sometimes called your temperament.
- Your environment. This involves the surroundings you grew up in, events that occurred, and relationships with family members and others.
- Personality disorders are thought to be caused by a combination of these genetic and environmental influences. Your genes may make you vulnerable to developing a personality disorder, and a life situation may trigger the actual development.
- Risk factors: Although the precise cause of personality disorders is not known, certain factors seem to increase the risk of developing or triggering personality disorders, including:
- Family history of personality disorders or other mental illness
- Abusive, unstable or chaotic family life during childhood
- Being diagnosed with childhood conduct disorder
- Variations in brain chemistry and structure

Reference:

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