

7. PSYCHOPATHOLOGY

UNIT-1

Psychopathology: Nature, Historical background, Perspectives-Biological and Psychological.
Classification: DSM system of classification: DSM-5; ICD-10.

UNIT-2

Anxiety and Obsessive Disorders: GAD, Panic, Specific phobia, OCD, PTSD. Dissociative Disorders: Dissociative identity disorder, Dissociative amnesia, Dissociative depersonalization; Sleep and eating disorders.

UNIT-3

Somatoform Disorders: Somatization disorder, Illness anxiety disorder, Body dysmorphic disorder, Conversion disorder. Bipolar and related disorders: Bipolar I disorder, Bipolar II disorder.

UNIT-4

Schizophrenia and Delusional Disorders: Clinical picture, Etiology and Treatment approaches. Substance Use Disorders: Alcohol abuse and dependence, Drug abuse and dependence, Personality disorders:

Unit -1

Introduction :

Psychopathology is the field of psychology which seeks to understand the complexities of human behaviour & emotions and mental disorder of the human being. The role of psychological, biological & social factors which make us mental ill is also including in it. .It is the scientific study of mental illness ,mental distress and manifestation of behaviour and experience which may be indicative of mental illness and psychological impairment. From the modern perspective it also encompasses the issues like the effect of culture, gender & ethnicity on modern society along with focus on the present issues of popular culture, technology & economics. With the emergence of various schools of thought & their collaboration has led to contemporary psychopathology which seeks the best from these models of, symptoms, etiology, clinical picture, diagnoses and test, treatment, assessment as well as research on the various mental patients around the world.

There are several symptoms like feeling sad, confused thinking , reduce ability to concentrate, excessive fear or anxiety, extreme feeling of guilt, high low of mood, feeling tiredness, problem in sleeping, detachment from reality, delusion, paranoia, excessive anger, alcohol and drug use, sexual drive change and suicidal thinking found in the behaviour of the person concerned.

Historical background of Psychopathology :

It was not the genesis of modern age. It began as human being existed on this earth. Stone Age cave dwellers were the first to treat mental disorders at half a million years of age. The medicine man or the early shaman treated the disorder by an operation called as 'trephination' in which a rod was inserted inside the head

During the supernatural tradition, demons or spirits were held responsible for the abnormal behaviour along with the other influences like that of sun, moon or stars. Many Egyptian, Hebrews, Chinese & Greek writings often had attributed abnormal behaviour to a god or demon who had taken possession of a human. Exorcism was the main type of treatment used in which the evil spirits were forced to leave the body.

In 460-377 B.C, Hippocrates proposed that mental disorders are same as the other diseases being having natural causes. They claimed that the reason for mental diseases is the pathology in the brain which can have appropriate treatments. Hippocrates, also referred to as the father of the modern medicine, proposed that there are four vital fluids or humors in a person's body viz. black bile, phlegm, yellow bile & blood. It is the imbalance among these which leads to the mental disorders.

In 130- 200 A.D, Galen, an influential Greek physician, elaborated on the traditions of Hippocrates. He took a scientific method by differentiating the causes of mental disorders to physical & mental categories.

In the Middle Age, Baghdad was the first place where a mental hospital was established, followed by Aleppo & Damascus. Humane treatment was being provided in these hospitals, but still based on superstitions or rituals. However in the later part of Middle Age, with the "Humanism" movement the scientific questioning emerged. But from the sixteenth century, special institutions called Asylums – place of refuge meant for ill, emerged. These were the storage places for the insane where mentally ill were more or less handled like beasts rather than like humans.

DSM-5

The fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was a massive undertaking that involved hundreds of people working toward a common goal over a 12-year process. Much thought and deliberation were involved in evaluating the diagnostic criteria, considering the organization of every aspect of the manual, and creating new features believed to be most useful to clinicians. All of these efforts were directed toward the goal of enhancing the clinical usefulness of DSM-5 as a guide in the diagnosis of mental disorders. Reliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information such as morbidity and mortality rates. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. While DSM has been the cornerstone of substantial progress in reliability, it has been well recognized by both the American Psychiatric Association (APA) and the broad scientific community working on mental disorders that past science was not mature enough to yield fully

validated diagnoses—that is, to provide consistent, strong, and objective scientific validators of individual DSM disorders. The science of mental disorders continues to evolve. However, the last two decades since DSM-IV was released have seen real and durable progress in such areas as cognitive neuroscience, brain imaging, epidemiology, and genetics. The DSM-5 Task Force overseeing the new edition recognized that research advances will require careful, iterative changes if DSM is to maintain its place as the touchstone classification of mental disorders. Finding the right balance is critical. Speculative results do not belong in an official nosology, but at the same time, DSM must evolve in the context of other clinical research initiatives in the field. One important aspect of this transition derives from the broad recognition that a too-rigid categorical system does not capture clinical experience or important scientific observations. The results of numerous studies of comorbidity and disease transmission in families, including twin studies and molecular genetic studies, make strong arguments for what many astute clinicians have long observed: the boundaries between many disorder "categories" are more fluid over the life course than DSM-IV recognized, and many symptoms assigned to a single disorder may occur, at varying levels of severity, in many other disorders. These findings mean that DSM, like other medical disease classifications, should accommodate ways to introduce dimensional approaches to mental disorders, including dimensions that cut across current categories. Such an approach should permit a more accurate description of patient presentations and increase the validity of a diagnosis (i.e., the degree to which diagnostic criteria reflect the comprehensive manifestation of an underlying psychopathological disorder). DSM-5 is designed to better fill the need of clinicians, patients, families, and researchers for a clear and concise description of each mental disorder organized by explicit diagnostic criteria, supplemented, when appropriate, by dimensional measures that cross diagnostic boundaries, and a brief digest of information about the diagnosis, risk factors, associated features, research advances, and various expressions of the disorder. Clinical training and experience are needed to use DSM for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs, syndrome combinations, and durations that require clinical expertise to differentiate from normal life variation and transient responses to stress. To facilitate a thorough

examination of the range of symptoms present, DSM can serve clinicians as a guide to identify the most prominent symptoms that should be assessed when diagnosing a disorder. Although some mental disorders may have well-defined boundaries around symptom clusters, scientific evidence now places many, if not most, disorders on a spectrum with closely related disorders that have shared symptoms, shared genetic and environmental risk factors, and possibly shared neural substrates (perhaps most strongly established for a subset of anxiety disorders by neuroimaging and animal models). In short, we have come to recognize that the boundaries between disorders are more porous than originally perceived. Many health profession and educational groups have been involved in the development and testing of DSM-5, including physicians, psychologists, social workers, nurses, counselors, epidemiologists, statisticians, neuroscientists, and neuropsychologists. Finally, patients, families, lawyers, consumer organizations, and advocacy groups have all participated in revising DSM-5 by providing feedback on the mental disorders described in this volume. Their monitoring of the descriptions and explanatory text is essential to improve understanding, reduce stigma, and advance the treatment and eventual cures for these conditions.

ICD-10

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problem (ICD), a Medical Classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. Work on ICD-10 began in 1983, became endorsed by the Forty-third World Health Assembly in 1990, and was first used by member states in 1994. It remains current until January 1, 2022, when it will be replaced by ICD11. The 11th revision of ICD was accepted by WHA (World Health Assembly of WHO 25th May 2019 and the version of preparation was approved on 18th July 2018.

While WHO manages and publishes the base version of the ICD, several member states have modified it to better suit their needs. In the base classification, the code set allows for more than 14,000 different codes and permits the tracking of many new diagnoses compared to the preceding ICD9. Through the use of optional sub-classifications ICD-10 allows for specificity regarding the cause, manifestation, location, severity and type of injury or disease. The adapted versions may differ in a number of ways, and some national editions have expanded the code set even further; with some going so far as to add procedure code. ICD-10-CM, for example, has over 70,000 codes.

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UNIT 2

GAD:

Generalised Anxiety Disorder is a chronic state of worry and tension often occurs without provocation. It is an emotion which has an adaptive property, this property helps the individual to plan and prepare for future threats or sometimes even events. But, for some people this anxiety and worry becomes a matter of great concern because it takes a chronic, excessive and unreasonable twist for them. These individuals suffer from what may be diagnosed as the Generalized Anxiety Disorder or the free-floating anxiety.

The person or patient must show primary symptoms of anxiety most days for at least many weeks at each time, and generally for many months. These symptoms should comprise elements of:

(a) Motor tension (headaches due to tension, restlessness, shaking in complete body, lack of relaxation); (b) Autonomic overactivity, sweating, tachycardia or tachypnoea, epigastric discomfort, dizziness, dry mouth, etc.

There are certain ways in which the therapist or the psychologist may diagnose the generalized anxiety disorder in the child. They use very specific observations and some tests that are completely suitable in assessing the level of anxiety in the child or adolescent. In cases where the child is too anxious or too small to talk, the parents are investigated in order to gain completely reliable information. In case of adolescents, it is better to ask him or her because at that age he or she is more aware of his or her bodily changes than anyone else.

Some causes of generalized anxiety disorder have been mentioned below:

Psychosocial perspective believes that this disorder is a result of the unconscious conflicts between the ego and the id impulses due the lack of development of the defence mechanisms in the patient or because they have been broken down. It is believed by Freud, that the sexual impulses or the aggressive feelings that were suppressed in the past

PANIC DISORDER:

A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur;

Note: The abrupt surge can occur from a calm state or an anxious state. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”). 2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

. 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, cardiopulmonary disorders). . The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder: in response to circumscribed phobic objects or situations, as in specific phobia: in response to obsessions, as in obsessive-compulsive disorder: in response to reminders of traumatic events and so on.

PTSD:

(Post Traumatic Stress Disorder) The DSM-IV presented with a criteria and a number of symptoms which need to be met in order to be diagnosed with PTSD. The DSM stated that a person suffering from PTSD must have at least three numbing, two symptoms of hyperarousal and one intrusion.

Out of the following, the person must show or report at least three numbing or symptoms that show avoiding behaviours:

Ignoring any type of feelings or conversation about the traumatic event .Making a hard effort to avoid going to places or seeing or meeting people who have been associated to the event in some way. Not being able to remember any aspect of the trauma Lack of interest to participate in any activity Showing numbness and being emotionless Restricted range of affect . No futuristic plans or views

Out of the following, any two of the hyperarousal symptoms must be present or reported by the person:

1. Lack of sleep
2. Anger bursts very often
3. Lack of concentration
4. Hypervigilance
5. Extreme and exaggerated responses

The patient must report at least one of the following intrusion symptoms:

Repeatedly occurring and intrusive flashbacks of the trauma , Nightmares , Illusions or hallucinations , Extreme distress

Etiology: Hippocampus and the amygdale are the two parts of the brain which are responsible for emotions and memory of an individual. Thus, when the traumatic event takes place, these two brain systems get activated and are held responsible for the memory and the related emotions with the trauma. There are two types of hormones which are also responsible in forming traumatic memories.

Some hormones are cortisol and norepinephrine. These two hormones rise in level when there is a memory recall of the traumatic event, which leads to the fear arousal in the individual. **Classical conditioning model:** in this case the individual is stuck in a cycle, where he keeps experiencing negative emotions which are associated with the traumatic event. The individual is unable to avoid the emotions which arise due to the memory of the trauma. Thus, it forms a vicious cycle which is difficult to stop.

Events or trauma that could lead to PTSD: Death of a loved one , War time , Sexual abuse . Childhood trauma or neglect , Natural disasters , Rape , Terrorist attacks

Treatment of PTSD:

1. **Debriefing:** this form is not exactly a treatment but a way of preventing PTSD from happening. In Debriefing, the person who has been in the trauma or has witnessed the trauma is talked to. It involves only one interview where the helper or the professional tries to talk to the victim n tries to encourage him to speak about the event. This helps the person to let out his emotions. Debriefing is believed to have positive effects along with negative ones by pushing the victim closer to PTSD. It helps to avoid secondary traumatization that is helps in avoiding the person from any further imagination about the trauma.
2. **Exposure techniques:** this type of intervention involves the exposure of the most traumatic part of the traumatic event that took place. The person suffering from the trauma talks about the event to such an extent and till a point where he stops feeling any type of distress and trauma. This technique is very commonly used to overcome traumatic events.
3. **Eye Movement Desensitization and Reprocessing (EMDR):** this technique was developed and discovered by Shapiro (1995). This technique is one of the most popular and effective techniques.
4. **Family therapy:** in this type of therapy the patient gains love and support from his loved ones or the family. This type of therapy provides the patient with support and a reason to live happily.
4. **Pharmacological**

intervention: there are many drugs involving some antidepressants such as MAOIs, SSRIs and tricyclics which have been effectively used for the treatment of PTSD.

EATING DISORDER

Eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder. The diagnostic criteria for rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder result in a classification scheme that is mutually exclusive, so that during a single episode, only one of these diagnoses can be assigned. The rationale for this approach is that, despite a number of common psychological and behavioral features, the disorders differ substantially in clinical course, outcome, and treatment needs. A diagnosis of pica, however, may be assigned in the presence of any other feeding and eating disorder. Some individuals with disorders described in this chapter report eating-related symptoms resembling those typically endorsed by individuals with substance use disorders, such as craving and patterns of compulsive use. This resemblance may reflect the involvement of the same neural systems, including those implicated in regulatory self-control and reward, in both groups of disorders. However, the relative contributions of shared and distinct factors in the development and perpetuation of eating and substance use disorders remain insufficiently understood. Finally, obesity is not included in DSM-5 as a mental disorder. Obesity (excess body fat) results from the long-term excess of energy intake relative to energy expenditure. A range of genetic, physiological, behavioral, and environmental factors that vary across individuals contributes to the development of obesity; thus, obesity is not considered a mental disorder. However, there are robust associations between obesity and a number of mental disorders (e.g., binge-eating disorder, depressive and bipolar disorders, schizophrenia). The side effects of some psychotropic medications contribute importantly to the development of obesity, and obesity may be a risk factor for the development of some mental disorders (e.g., depressive disorders).

SLEEP DISORDER:

Sleep-wake disorders is intended for use by general mental health and medical clinicians (those caring for adult, geriatric, and pediatric patients). Sleep-wake disorders encompass 10 disorders or disorder groups: insomnia disorder, hypersomnolence disorder, narcolepsy, breathing-related sleep disorders, circadian rhythm sleep-wake disorders, non-rapid eye movement (NREM) sleep arousal disorders, nightmare disorder, rapid eye movement (REM) sleep behavior disorder, restless legs syndrome, and substance/medication-induced sleep disorder. Individuals with these disorders typically present with sleep-wake complaints of dissatisfaction regarding the quality, timing, and amount of sleep. Resulting daytime distress and impairment are core features shared by

all of these sleep-wake disorders. The organization of this chapter is designed to facilitate differential diagnosis of sleep- wake complaints and to clarify when referral to a sleep specialist is appropriate for further assessment and treatment planning. The DSM-5 sleep disorders nosology uses a simple, clinically useful approach, while also reflecting scientific advances in epidemiology, genetics, pathophysiology, assessment, and interventions research since DSM-IV. In some cases (e.g., insomnia disorder), a "lumping" approach has been adopted, whereas in others (e.g., narcolepsy), a "splitting" approach has been taken, reflecting the availability of validators derived from epidemiological, neurobiological, and interventions research. Sleep disorders are often accompanied by depression, anxiety, and cognitive changes that must be addressed in treatment planning and management. Furthermore, persistent sleep disturbances (both insomnia and excessive sleepiness) are established risk factors for the subsequent development of mental illnesses and substance use disorders. They may also represent a prodromal expression of an episode of mental illness, allowing the possibility of early intervention to preempt or to attenuate a full-blown episode. The differential diagnosis of sleep-wake complaints necessitates a multidimensional approach, with consideration of possibly coexisting medical and neurological conditions. Coexisting clinical conditions are the rule, not the exception. Sleep disturbances furnish a clinically useful indicator of medical and neurological conditions that often coexist with depression and other common mental disorders. Prominent among these comorbidities are breathing-related sleep disorders, disorders of the heart and lungs (e.g., congestive heart failure, chronic obstructive pulmonary disease), neurodegenerative disorders (e.g., Alzheimer's disease), and disorders of the musculoskeletal system (e.g., osteoarthritis). These disorders not only may disturb sleep but also may themselves be worsened during sleep (e.g., prolonged apneas or electrocardiographic arrhythmias during REM sleep; confusional arousals in patients with dementing illness; seizures in persons with complex partial seizures). REM sleep behavior disorder is often an early indicator of neurodegenerative disorders (alpha synucleinopathies) like Parkinson's disease. For all of these reasons—related to differential diagnosis, clinical comorbidity, and facilitation of treatment planning—sleep disorders are included in DSM-5. The approach taken to the classification of sleep-wake disorders in DSM-5 can be understood within the context of "lumping versus splitting." DSM-IV represented an effort to simplify sleep-wake disorders classification and thus aggregated diagnoses under broader, less differentiated labels. At the other pole, the International Classification of Sleep Disorders,

2nd Edition (ICSD-2) elaborated numerous diagnostic subtypes. DSM-IV was prepared for use by mental health and general medical clinicians who are not experts in sleep medicine. ICSD-2 reflected the science and opinions of the sleep specialist community and was prepared for use by specialists. The weight of available evidence supports the superior performance characteristics (interrater reliability, as well as convergent, discriminant, and face validity) of simpler, less- differentiated approaches to diagnosis of sleep-wake disorders. The text accompanying each set of diagnostic criteria provides linkages to the corresponding disorders included in ICSD-2. The DSM-5 sleep-wake disorders classification also specifies corresponding nonpsychiatric listings (e.g., neurology

codes) from the International Classification of Diseases (ICD). The field of sleep disorders medicine has progressed in this direction since the publication of DSM-IV. The use of biological validators is now embodied in the DSM-5 classification of sleep-wake disorders, particularly for disorders of excessive sleepiness, such as narcolepsy; for breathing-related sleep disorders, for which formal sleep studies (i.e., polysomnography) are indicated; and for restless legs syndrome, which can often coexist with periodic limb movements during sleep, detectable via polysomnography.

OCD:

OCD (Obsessive Compulsive Disorder) is characterized by the presence of obsessions and/or compulsions. Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. Some other obsessive-compulsive and related disorders are also characterized by preoccupations and by repetitive behaviors or mental acts in response to the preoccupations. Other obsessive-compulsive and related disorders are characterized primarily by recurrent body-focused repetitive behaviors (e.g., hair pulling, skin picking) and repeated attempts to decrease or stop the behaviors. The inclusion of a chapter on obsessive-compulsive and related disorders in DSM-5 reflects the increasing evidence of these disorders' relatedness to one another in terms of a range of diagnostic validators as well as the clinical utility of grouping these disorders in the same chapter. Clinicians are encouraged to screen for these conditions in individuals who present with one of them and be aware of overlaps between these conditions. At the same time, there are important differences in diagnostic validators and treatment approaches across these disorders. Moreover, there are close relationships between the anxiety disorders and some of the obsessive-compulsive and related disorders (e.g., OCD), which is reflected in the sequence of DSM-5 chapters, with obsessive-compulsive and related disorders following anxiety disorders. The obsessive-compulsive and related disorders differ from developmentally normative preoccupations and rituals by being excessive or persisting beyond developmentally appropriate periods. The distinction between the presence of subclinical symptoms and a clinical disorder requires assessment of a number of factors, including the individual's level of distress and impairment in functioning. The chapter begins with OCD. It then covers body dysmorphic disorder and hoarding disorder, which are characterized by cognitive symptoms such as perceived defects or flaws in physical appearance or the perceived need to save possessions, respectively. The chapter then covers trichotillomania (hair-pulling disorder) and excoriation (skin-picking) disorder, which are characterized by recurrent body-focused repetitive behaviors. Finally, it covers substance/medication-induced obsessive-compulsive and related disorder, obsessive-compulsive and related disorder due to another medical condition, and other specified obsessive-compulsive and related disorder and unspecified obsessive-compulsive and related disorder. While the specific content of obsessions and compulsions varies among individuals, certain symptom dimensions are common in OCD, including those of cleaning (contamination obsessions and cleaning compulsions); symmetry (symmetry obsessions and repeating, ordering, and counting

compulsions); forbidden or taboo thoughts (e.g., aggressive, sexual, and religious obsessions and related compulsions); and harm (e.g., fears of harm to oneself or others and related checking compulsions). The tic-related specifier of OCD is used when an individual has a current or past history of a tic disorder. Body dysmorphic disorder is characterized by preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear only slight to others, and by repetitive behaviors (e.g., mirror checking, excessive grooming, skin picking, or reassurance seeking) or mental acts (e.g., comparing one's appearance with that of other people) in response to the appearance concerns. The appearance preoccupations are not better explained by concerns with body fat or weight in an individual with an eating disorder. Muscle dysmorphia is a form of body dysmorphic disorder that is characterized by the belief that one's body build is too small or is insufficiently muscular. Hoarding disorder is characterized by persistent difficulty discarding or parting with possessions, regardless of their actual value, as a result of a strong perceived need to save the items and to distress associated with discarding them. Hoarding disorder differs from normal collecting. For example, symptoms of hoarding disorder result in the accumulation of a large number of possessions that congest and clutter active living areas to the extent that their intended use is substantially compromised. The excessive acquisition form of hoarding disorder, which characterizes most but not all individuals with hoarding disorder, consists of excessive collecting, buying, or stealing of items that are not needed or for which there is no available space. Trichotillomania (hair-pulling disorder) is characterized by recurrent pulling out of one's hair resulting in hair loss, and repeated attempts to decrease or stop hair pulling. Excoriation (skin-picking) disorder is characterized by recurrent picking of one's skin resulting in skin lesions and repeated attempts to decrease or stop skin picking. The body-focused repetitive behaviors that characterize these two disorders are not triggered by obsessions or preoccupations; however, they may be preceded or accompanied by various emotional states, such as feelings of anxiety or boredom. They may also be preceded by an increasing sense of tension or may lead to gratification, pleasure, or a sense of relief when the hair is pulled out or the skin is picked. Individuals with these disorders may have varying degrees of conscious awareness of the behavior while engaging in it, with some individuals displaying more focused attention on the behavior (with preceding tension and subsequent relief) and other individuals displaying more automatic behavior (with the behaviors seeming to occur without full awareness). Substance/medication-induced obsessive-compulsive and related disorder consists of symptoms that are due to substance intoxication or withdrawal or to a medication. Obsessive-compulsive and related disorder due to another medical condition involves symptoms characteristic of obsessive-compulsive and related disorders that are the direct pathophysiological consequence of a medical disorder. Other specified obsessive-compulsive and related disorder and unspecified obsessive-compulsive and related disorder consist of symptoms that do not meet criteria for a specific obsessive-compulsive and related disorder because of atypical presentation or uncertain etiology; these categories are also used for other specific syndromes that are not listed in Section II and when insufficient information is available to diagnose the presentation as another obsessive-compulsive and related disorder. Examples of specific syndromes not listed in

Section Π, and therefore diagnosed as other specified obsessive-compulsive and related disorder or as unspecified obsessive-compulsive and related disorder include body-focused repetitive behavior disorder and obsessional jealousy. Obsessive-compulsive and related disorders that have a cognitive component have insight as the basis for specifiers; in each of these disorders, insight ranges from "good or fair insight" to "poor insight" to "absent insight/delusional beliefs" with respect to disorder-related beliefs. For individuals whose obsessive-compulsive and related disorder symptoms warrant the "with absent insight/delusional beliefs" specifier, these symptoms should not be diagnosed as a psychotic disorder.

Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly. Further the behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive

PHOBIA:

The key feature of this disorder is that the fear or anxiety is circumscribed to the presence of a particular situation or object (Criterion A), which may be termed the phobic stimulus. The categories of feared situations or objects are provided as specifiers. Many individuals fear objects or situations from more than one category, or phobic stimulus. For the diagnosis of specific phobia, the response must differ from normal, transient fears that commonly occur in the population. To meet the criteria for a diagnosis, the fear or anxiety must be intense or severe (i.e., "marked") (Criterion A). The amount of fear experienced may vary with proximity to the feared object or situation and may occur in anticipation of or in the actual presence of the object or situation. Also, the fear or anxiety may take the form of a full or limited symptom panic attack (i.e., expected panic attack). Another characteristic of specific phobias is that fear or anxiety is evoked nearly every time the individual comes into contact with the phobic stimulus (Criterion B). Thus, an individual who becomes anxious only occasionally upon being confronted with the situation or object (e.g., becomes anxious when flying only on one out of every five airplane flights) would not be diagnosed with specific phobia. However, the degree of fear or anxiety expressed may vary (from anticipatory anxiety to a full panic attack) across different occasions of encountering the phobic object or situation because of various contextual factors such as the presence of others, duration of exposure, and other threatening elements such as turbulence on a flight for individuals who fear flying. Fear and anxiety are often expressed differently between children and adults. Also, the fear or anxiety occurs as soon as the phobic object or situation is encountered (i.e., immediately rather than being delayed). The individual actively avoids the situation, or if he or she either is unable or decides not to avoid it, the situation or object evokes intense fear or anxiety (Criterion C). Active avoidance means the individual intentionally behaves in ways that are designed to prevent or minimize contact with phobic objects or situations (e.g., takes

tunnels instead of bridges on daily commute to work for fear of heights; avoids entering a dark room for fear of spiders; avoids accepting a job in a locale where a phobic stimulus is more common).

DEPERSONIZATION DISORDER:

Depersonization is defined as, “the sensation of unreality concerning oneself, parts of oneself, or one’s

environment”.. This state of surreal detachment can occur in states of stress, fatigue, or altered consciousness from drug use. Individuals with depersonalization disorder often report feeling as though they have cut off from themselves and are watching themselves from the outside as observers. They feel as though they are in a dream-like state, disconnected from reality. Derealization often accompanies depersonalization. In derealization, the individual feels the same kind of strangeness towards the world and feels as if other people are also dead, robotic, or unreal. Individuals often experience *deja-vu*, the sense of having seen or been in the particular place before knowing that this is not really the case, or *jamais-vu*, the sense of feeling like one has never encountered the familiar place before.

Depersonalization disorder differs from the other dissociative disorders in that the individual is aware that his/her perception of strangeness is invalid and incorrect. However, the individual continues to harbor such feelings and may also experience the fear of going crazy with such frightening perceptions. Depersonalization, as a dissociative disorder, has also been associated with childhood trauma, specifically emotional abuse .

DISSOCIATIVE AMNESIA:

Dissociative Amnesia refers to the partial or total loss of memories of past experiences. It usually has a neurological and physical cause, such as a hit on the skull due to some accident. However, when it occurs due to no known organic or neurological cause and seems to have psychological causes, it is identified as dissociative amnesia. Dissociative amnesia differs from organic amnesia in the nature and content of forgetting (Sackeim & Devanand, 1991; Sivec & Lynn, 1995; Kihlstrom, 2001). Dissociative amnesiacs always show patterns of anterograde memory loss as opposed to retrograde patterns observed in organic amnesia. Further, there is selective forgetting of information, i.e. those relating to the traumatic or stressful event, in dissociative amnesia and the individuals suffering from such a pattern of memory loss display “*la belle indifference*” to their condition.

There are five specific patterns of memory loss observed in dissociative amnesia. The most commonly seen is localized amnesia wherein the memory is blanked out for a certain period of time in which a traumatic event took place. For instance, a survivor of a Tsunami devastation might entirely forget the event as it took place and a few days after that while the officials cleared corpses and other destruction. It is usually the memory of several hours to a couple of days that is blanked out. Selective amnesia, as the name suggests, is noted when individuals forget specific events that occurred in a given period

of time. For instance, in the above example, the man may forget watching the corpse of his family being cleared away but may remember the Tsunami as it struck. A third and rare type is generalized amnesia in which the person forgets his/her entire past life. Another very rare pattern is the continuous amnesia in which the person does not remember anything that happened after a certain event took place that triggered the amnesia up until the present. In systematized amnesia, the person forgets specific categories of information with the rest of the memory remaining intact. For instance, the person may forget a specific location even he has been there frequently. In general, it has been found that dissociative amnesia affects episodic memory, with procedural and semantic memory intact.

According to the DSM-IV-TR, the defining characteristics of dissociative amnesia are that the individual experiences one or more episodes of forgetting personal information that is usually traumatic in nature. Further, this does not occur due to any other disorder or known medical condition and the experience of the symptoms causes a significant amount of distress and dysfunction in regular functioning.